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PSYCHIATRIC NEWS

Articles with "see" references appear as follows:

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Note for page 10
"A" refers to the article at the bottom of the page
"B" refers to the article on the right of the page. "

David Hathcox

APA Trustee David Fassler, M.D. (far right), introduces ParentsMedGuide.org, with (from right to left) Darrel Regier, M.D., APA's director of research; Gail Griffith, FDA advisory panel member; Leslie Walker, M.D., of the Society of Adolescent Medicine; Sherri Walton, parent/mental health advocate; and Darcy Gruttadaro, J.D., director of the NAMI Child and Adolescent Action Center.

Clinical &Research News

New Depression Resources Educate Parents, Physicians

A new Web site provides reliable, understandable information on the safety and effectiveness of treatments for children and adolescents with depression.

BY JIM ROSACK

APA and the American Academy of Child and Adolescent Psychiatry (AACAP) unveiled a new Web site last month to serve as a primary resource for parents of children with depression. The highlights of the Web site are two medication fact sheets: "ParentsMedGuide," which uses basic, straightforward language for parents and other family members of children and adolescents being treated for depression, and "PhysiciansMedGuide," which includes a referenced discussion of the evidence base on the use of antidepressant medications by primary care and family practice physicians to treat children and adolescents for depression.

"We've tried to address many of the specific questions we've been hearing from parents," said David Fassler, M.D., at a press briefing in Washington, D.C., launching the new resources.

Fassler, a child and adolescent psychiatrist, APA trustee-at-large, and member of the AACAP Council, chaired the task force of APA and AACAP members that developed the fact sheets and Web site. The task force worked closely with family members and advocacy organizations, including the National Mental Health Association and the National Alliance for the Mentally Ill.

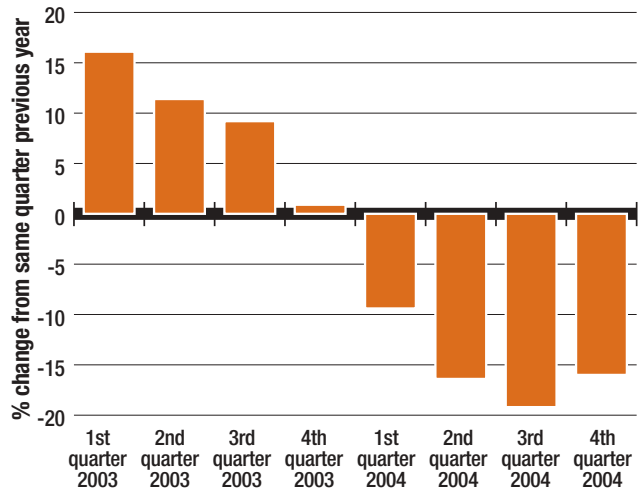
The resources have been approved by the APA Board of Trustees and the AACAP Council and endorsed by a wide array of patient, family, and professional organizations (see box on page 42). As Web-based resources, posted at <parentsmedguide.org>, the guides will be updated periodically as new data become available.

"The fact sheets explain that research has shown that a number of interventions are effective at treating the signs and symptoms of depression in children and adoles-

please see ***Parents Guide*** *on page 42*

Youngsters Getting Fewer Antidepressants

The number of antidepressant prescriptions for children and adolescents covered by Medco has been declining since the start of the controversy over SSRIs and youth suicide–in May 2003, when the U.K. effectively banned the prescription of paroxetine to youngsters.



Source: Medco Health Solutions Inc., 2005

FDA Tones Down Warning on Use Of Antidepressants In Children

Clinical & Researcl

BY JIM ROSACK

The U.S. Food and Drug Administration (FDA) posted the final language for its new, required labeling of antidepressants last month, including the black-box warning and patient medication guide that must be dispensed with each prescription.

With no explanation, the FDA has significantly modified the wording describing the association between antidepressants and suicidal thoughts and behaviors.

In the final version of the warning, the first sentence in the black box has changed. The October draft's sentence initially read: "Antidepressants increase the risk of suicidal thinking and behavior (suicidality) in children and adolescents with Major Depressive Disorder (MDD) and other psychiatric disorders." The revised sentence limits the association between the two, more narrowly defining its scope. The sentence now reads: "Antidepressants increased the risk of suicidal thinking and behavior (suicidality) in short-term studies in children and adolescents with Major Depressive Disorder (MDD) and other psychiatric disorders."

The change may be subtle, but it is significant. Even more significant is the deletion of a sentence from the first paragraph of text in the "WARNINGS-Clinical Worsening and Suicide Risk" section of the label. The draft warnings posted by the agency last October read: "A causal role for antidepressants in inducing suicidality has been established in pediatric patients." That sentence has been deleted from the final version of the new label and replaced with "Antidepressants increased the risk of suicidal thinking and behavior (suicidality) in short-term studies in children and adolescents with Major Depressive Disorder (MDD) and other psychiatric disorders."

"This is clearly an important change," said David Fassler, M.D., a child and adolescent psychiatrist and clinical associate professor of psychiatry at the University of Vermont School of Medicine. Fassler, an APA trustee, chaired the combined APA/American Academy of Child and Adolescent Psychiatry task force that developed the new resource <www.parentsmedguide.org>, which reviews the clinical trials data on the use of antidepressants in kids, and explains the FDA warnings (see story at left).

"The change in wording," Fassler continued, "brings the FDA warning closer to the actual science. I'm glad they responded

please see ***FDA*** *on page 44*

U.S. Regulators Puzzled by Canada's Ruling on Safety of ADHD Drug

Two government regulatory decisions on one drug dataset show that beauty—or danger—is in the eye of the beholder.

BY JIM ROSACK

Health Canada's suspension of marketing authorization for Adderall XR (mixed amphetamine salts extended release) surprised nearly all concerned and shows how differently two regulatory agencies can interpret the same set of data.

The Therapeutic Products Directorate, Health Canada's equivalent of the U.S. Food and Drug Administration (FDA), suspended all sales of Adderall XR on February 9 after a routine review of safety information provided to regulatory agencies worldwide by the drug's manufacturer, U.K.-based Shire Pharmaceuticals Group Plc.

Health Canada said the decision "comes as a result of a thorough review of safety information provided by the manufacturer, which indicated there were 20 international reports of sudden death in patients taking either Adderall (sold in the United States, not in Canada) or Adderall XR (sold in Canada). These deaths were not associated with overdose, misuse, or abuse. Fourteen deaths occurred in children, and six deaths in adults. There were 12 reports of stroke, two of which occurred in children. None of the deaths or strokes occurred in Canada."

The Health Canada statement went on to say that the agency had determined that the incidence of adverse events leading to death was "higher in Adderall and Adderall XR combined than in the other drugs of this class."

The statement noted that the agency asked the manufacturers of other related stimulants approved for the treatment of ADHD to provide a "thorough review of their worldwide safety data." In addition, Health Canada advised patients to consult their physicians immediately and select an alternate treatment.

A Shire spokesperson said that there were approximately 11,000 patients on the extended-release formulation of the drug in Canada, compared with more than 750,000 patients in the United States.

The company's chief executive officer noted that the company was asked to withdraw the product from the market voluntarily but declined to do so.

"We are surprised by this action from Health Canada," said CEO Matthew Emmens. "Shire remains confident in the safety and efficacy of Adderall XR."

In response to the Canadian action, the FDA posted an updated "Alert for Healthcare Professionals" on its Web site, in addition to a health advisory and fact sheets for the public.

The agency was put on the defensive by immediate Congressional inquiries as well as questions from the public about why Canadian regulators had pulled the drug when the FDA had seemingly not addressed the safety issue. In fact, the FDA had reviewed exactly the same dataset and last October required Shire to update the label of Adderall and Adderall XR immediately to include a strong statement that "misuse of amphetamine may cause sudden death and serious cardiovascular adverse events." It also required the company to include information in the label about the known cases of sudden death.

While Health Canada officials noted that they "did not believe that this adverse event—sudden death—could be dealt with through a labeling change," the FDA responded that "[a]t this time, the FDA cannot conclude that recommended doses of Adderall can cause [sudden death], but is continuing to carefully evaluate these data."

After the Health Canada action, the FDA also posted within its health care professionals alert a summary of the adverse events it has on file associated with patients taking Adderall or Adderall XR. Twelve cases of sudden death were reported between 1999 and 2003, all of which were males between ages 7 and 16. Five of the youngsters had significant cardiac risk factors, some of which were identified only on autopsy, such as abnormal coronary artery anatomy or abnormal valve structure. Seven of the youngsters had no abnormality, but at least one had a family history of cardiac ventricular arrhythmias. It also notes that several of the youngsters had unexplained and unusually high levels of the drug in their system, in the absence of any evidence indicating overdose.

The FDA concluded that "[sudden death] as a possible effect of amphetamines should be considered in the assessment of benefit versus risk during therapeutic decision making for individual patients. In the pediatric population, potential risk factors include cardiac abnormalities that may be undiagnosed, positive family history for ventricular arrhythmias, and as yet unidentified factors that may cause excessive levels of stimulant to accumulate in children who are apparently taking normal doses."

Health Canada's warning is posted online at <www.hc-sc.gc.ca/hpfb-dgpsa/tpd-dpt/adderall_xr_e.html>. The FDA information is posted at <www.fda.gov/medwatch/SAFETY/2005/safety05.htm#Adderall>. ■

APA, ABPN Collaborate On Certification Initiatives

BY MICHELLE RIBA, M.D., M.S.

Each year representatives of APA and the American Board of Psychiatry and Neurology (ABPN), the independent, nonprofit organization that certifies physicians practicing psychiatry, neurology, or their subspecialties, meet to review the changes and emerging issues for the field of psychiatry.

This year's meeting was held at APA headquarters on February 7 and addressed several important and complex issues that are evolving.

ABPN was represented by Elizabeth B. Weller, M.D., its president; Larry R. Faulkner, M.D., the member at large on its executive committee; Daniel K. Winstead, M.D., one of its psychiatry directors; and Steven C. Scheiber, M.D., executive vice president.

APA was represented by me; Richard Balon, M.D., chair of the Council on Medical Education and Career Development; John Oldham, M.D., chair of the Council on Quality Care; Medical Director James H. Scully Jr., M.D., who is also an ABPN psychiatry director; Deborah Hales, M.D., APA's director of education and career development; and staff Judith Carrier, Ph.D., Kathleen Debenham, M.A., and Nancy Delanoche.

Our meeting was productive and wide-ranging, and I would like to share with you some of the key issues:

- We are endeavoring to find ways to strengthen the number of psychiatrists who are board certified.
- There are fewer and fewer psychiatrists who are taking their recertification examinations in their psychiatric subspecialty, including child psychiatry. We are working to turn around these trends.
- Increasingly, state licensing boards, hospitals, and other key organizations are determining whether psychiatrists (and other physicians) need to take recertification examinations. In other words, even though many of us have lifetime certificates from ABPN, other organizations are requiring recertification.
- In psychiatry, we still do not allow residents to sit for Part I until after they complete four years of residency. Many other specialties allow or require residents to take their boards prior to graduation.
- We are working to identify better ways to track or help residents during their training so that they can be more successful at passing their boards.
- And we are developing new CME initiatives that will assist members as they prepare for recertification.

As you know, the American Board of Medical Specialties, to which the ABPN belongs as a member board, has mandated that all medical specialty boards develop a Maintenance of Certification (MOC) program. This initiative is part of a national movement to increase physicians' accountability to the patients we serve and to improve the quality of medical care provided.

The ABPN and APA are working together to define our respective roles in MOC. APA will have a significant contribution in lifelong learning and self-assessment and has a number of new products that provide valuable services to our members preparing to take the board for the first time or to recertify. Among them:

- APA's CME Web site at <www.psych.org/cme> offers psychiatrists an electronic tool, called the CME Recorder, to record and organize CME activities. That record can be used to prove the fulfillment of state and APA CME requirements and, in the future, the ABPN's MOC program.
- *Focus: The Journal of Lifelong Learning in Psychiatry* covers the recertification topic outline of ABPN and provides an annual self-assessment exam. It has been approved by the APBN to meet the lifelong learning and self-assessment requirements of MOC.
- Additionally, APA is piloting an online program to assist members in comparing their treatment plans to APA's practice guidelines and also to the treatment plans of colleagues who utilize the performance assessment program. It is our hope that this program will help our members evaluate their performance in practice, which is part of the requirements of the MOC.
- Last year APA initiated a pilot program to evaluate those who failed Part II boards two or more times. In the study, 24 candidates were evaluated by current board examiners and given feedback on their performance. APA will track their remediation and performance as they retake their boards.

To help us develop a strategy concerning the timing of taking Part I and Part II of the boards, as well as issues related to certification and subspecialty recertification, I have appointed a presidential task force co-chaired by Dan Winstead, M.D. (representing APA and ABPN), and David Goldberg, M.D. (representing APA and the American Association of Directors of Psychiatric Residency Training).

As always, I welcome hearing from you on these important issues. You may reach me at mriba@umich.edu. ■

Erratum

The "CPT Q&A" feature on the Psychiatric Practice and Managed Care page in the February 4 issue contained an error. The question concerned the coding of care provided in nursing homes, but the response told readers to use "subsequent hospital care codes (99231-99233)" for follow-up visits. The answer should have directed readers to use "subsequent nursing facility care codes (99311-99313)." ■

APA Continues Its Commitment To Fight Consequences of AIDS

BY JAMES H. SCULLY JR., M.D.

AIDS has been permanently etched in our consciousness. It was not long ago that we faced a sudden avalanche of rare conditions and diseases that signaled the arrival of this mysterious and devastating illness. Anxious, puzzled, and unprepared, many physicians, including psychiatrists, were reluctant to embrace this mounting clinical challenge. Those who did faced a roller coaster of emotions, fears, frustrations, failings, and triumphs.

While training medical students last fall, members of the APA Committee on AIDS and the American Psychiatric Institute for Research and Education's Steering Committee on HIV Psychiatry offered candid, often emotional, accounts of their personal and professional HIV experiences, some spanning decades.

Their stories revealed the tenacity and optimism that continue to drive activities of the Office of HIV Psychiatry. Students were moved and inspired by the broad experience and dedication of these members, who also serve as their mentors for a new APA minority fellowship program in HIV psychiatry.

Last September, the Office of HIV Psychiatry coordinated its first fellowship program matching mentors at seven sites with 10 medical students whose primary interests include psychiatry, HIV/AIDS, substance abuse, and ethnic minority health.

The program was designed to foster strong mentor relationships while offering well-supervised clinical experiences, comprehensive HIV training, online case discussions, and ongoing mentor consultations. Ten new students will be selected for the second group of fellowships in September 2005. Applications are now being accepted.

Residents are also at the forefront of HIV training efforts. First, real-time, distance learning has been incorporated into existing education and training programs, thus offering obvious advantages to residency training. The Office of HIV Psychiatry has piloted the program at four sites and received positive feedback. Of course, technical constraints and problems exist, limiting its use and possibilities. The challenges posed, however, are countered by opportunities to reach a wider audience, expand opportunities in underserved areas, involve expert faculty who might otherwise be unavailable, and provide a cost-effective alternative in resident education.

Second, grand rounds and case discussions continue to link our AIDS-network members with training programs around the country. Requests for on-site HIV residency trainings have increased sixfold since last year at this time. In January nearly 40 requests were received for HIV training for the 2005-06 academic year. This increase in demand is evidence of a need for not only continuing education in HIV psychiatry, but also for the expansion of our current training capacity.

Meeting this demand will require an increased number of experienced faculty and preceptors to lead and facilitate this process. Building the needed capacity will require identifying and supporting new trainers, developing and presenting workshops for basic and advanced HIV education, and expanding technical support. The Office of HIV Psychiatry will work to achieve these goals by collaborating with allied programs, seeking outside funding for new projects, and working within existing contracts and grants.

One such contract, awarded in September 2004 by the Center for Mental Health Services (CMHS), renewed funding for five years for training psychiatrists and residents, providing technical support to APA's HIV network, updating curriculum, expanding distance learning, and evaluating current HIV training programs.

I want to express a special note of thanks to Dr. Melvyn Haas, who was the leading proponent of HIV activities at CMHS and principal author of many of the HIV-related contracts APA has received. Dr. Haas served several years as the associate director for medical affairs and the CMHS AIDS coordinator until his retirement last December. His commitment to HIV psychiatry, unending support of APA, and compassion as a clinician make him an asset to the field.

In addition to its existing projects, the Office of HIV Psychiatry hopes to secure funds to create innovative Internet-based education programs, train residents to serve as HIV trainers, initiate computer-based consultations, and adapt current clinical tools for PDAs and pocket PCs. It would like to expand efforts in rural and underserved areas inside and outside the United States. When the Office of HIV Psychiatry was first established, the United States was a major site of the HIV epidemic. Today, AIDS is a global epidemic, with worldwide mental health consequences.

Increasingly, the Office of HIV Psychiatry and members of our HIV/AIDS committees are engaging in international collaborations. These projects include adapting interventions for severely mentally ill people in Brazil and China, collaborating with the World Health Organization on mental health guidelines to treat HIV-infected patients in resource-poor countries, and participating in international forums.

Also, the office is discussing with representatives from South Africa the development of an e-mail hotline to foster communication and case consultation, link physicians here and abroad, and deliver HIV information to underserved areas.

The global epidemic shows no signs of abating. And two decades into the epidemic, we face a second wave of infections in the United States.

For the Office of HIV Psychiatry, there exists a host of opportunities for crafting and implementing programs that can have an impact on HIV/AIDS care throughout the world. These opportunities make it important for APA members to support our HIV activities, staff, and inspiring colleagues who work in the fight against AIDS.

An application for the medical student fellowship in HIV psychiatry is posted online at <www.psych.org/aids>. ■

Annual Meeting News

Test Your Knowledge!

Three "Focus Live" sessions will be held at APA's 2005 annual meeting in which an audience-response system (ARS) is used to allow participants to test their knowledge.

The 90-minute sessions will cover topics from APA's new journal, *Focus: The Journal of Lifelong Learning in Psychiatry.* During the sessions, experts will lead lively discussions based on multiple-choice questions that the audience answers using the ARS. The ARS instantly projects a histogram on a screen allowing private comparison with the responses of others in the audience and offers a new and entertaining way to learn. Sessions will be moderated by the editors of *Focus,* Deborah Hales, M.D., and Mark Hyman Rapaport, M.D., and will be held in Room A405 on Level 4 of the Georgia World Congress Center.

Monday, May 23

9 a.m.-10:30 a.m.	**"Major Depressive Disorder"** *Alan F. Schatzberg, M.D.*
11 a.m.-12:30 p.m.	**"Psychosomatic Medicine: Consultation-Liaison Psychiatry and Beyond"** *Francisco Fernandez, M.D., and Jennifer Gotto M.D.*
2 p.m.-3:30 p.m.	**"Child And Adolescent Psychiatry"** *David L. Kaye M.D., and Eugene Beresin, M.D.*

MASSACHUSETTS GENERAL HOSPITAL

P4C

Psychologists Widen Push For Prescribing Privileges

In the wake of successes in New Mexico and Louisiana, supporters of prescribing privileges for psychologists have filed similar legislation in five more states in recent months.

BY AARON LEVIN

Bills to permit psychologists to prescribe drugs have been introduced in state legislatures in Connecticut, Oregon, Tennessee, Hawaii, and Wyoming, part of an ongoing push for prescribing privileges in the wake of their implementation in New Mexico and Louisiana. Similar bills are anticipated in more states this year.

APA and its local affiliates are following developments in these states closely. They continue to oppose prescribing privileges for psychologists on the grounds of patient safety and inadequate training.

Review of all the prescribing bills under consideration reveals a common theme among most—a shift in the role played by the medical profession, said Paula Johnson, deputy director for state affairs in APA's Department of Government Relations.

"If enacted, the big change would be the elimination of any responsibility or authority by state medical boards or societies," she said. "Nearly all the bills would vest authority in each state's psychology board."

Connecticut

The Connecticut bill was submitted by Rep. Walter Pawelkiewicz (D), the deputy majority leader of the state House of Representatives. Pawelkiewicz holds a Ph.D. in child and educational psychology from the University of Connecticut. The bill is in preliminary form and states that its intent is "[t]o improve the availability of mental health services by permitting licensed psychologists to prescribe certain pharmaceutical agents within the scope of their practice."

The bill was referred to the Public Health Committee, which can either draft formal legislation first and then hold hearings, or hold a public hearing on the subject matter of the proposed bill and then draft legislative language, said Jacquelyn Coleman, executive director of the Connecticut Psychiatric Society.

A similar bill was introduced in 2001, but died in committee after public hearings were held. This year the Public Health Committee must vote by April to decide whether the bill proceeds.

Hawaii

Bills before the Hawaii legislature differ from those in other states. They seek to offer prescribing authority only to psychologists practicing at federally qualified health centers or clinics located in designated medically underserved areas. Although this might appear to limit privileges geographically, large areas of Hawaii fall within these federal designations, said Johnson.

Psychologists working out of the U.S. Army's Tripler Medical Center now collaborate with primary care physicians in some of these areas.

Although advocates for the psychologists have pointed to the now-defunct Department of Defense psychologist-prescribing program as a model, the situation is much different at federal clinics in Hawaii, said Lydia Hemmings, executive director of the Hawaii Psychiatric Association. The Department of Defense patients were relatively young and healthy compared with the general population.

However, at the federally qualified health clinics in underserved rural Hawaii, patients are often poor and not in good general health, and may have comorbid substance abuse diagnoses, said Hemmings: "Psychologists would be testing their lack of adequate training on a vulnerable population, with few backup resources in these remote areas."

Psychiatrists in Hawaii will urge that more funds be allocated to getting psychiatrists to rural areas (some now fly in one day a week to see patients), increasing the use of telemedicine, and organizing community liaison psychiatrists to work with primary care physicians in the federally qualified clinics, she said.

The chief sponsor and advocate of the senate version of the bill is Sen. Rosalind Baker (D-Maui), the powerful chair of the Health Committee, who previously supported prescribing privileges for nurse practitioners and optometrists. The Hawaii Psychological Association named her Legislator of the Year in 2003 for "outstanding contributions to psychology and mental health in the State of Hawaii." The committee held hearings on the bill on February 18, voting 3-0 with two absences that the bill be adopted (with amendments) and sent to the Commerce, Consumer Protection, and Housing Committee. Baker is vice-chair of that body, which oversees occupational licensing.

Oregon

The Oregon bill calls for 350 hours of psychopharmacology training, plus "a supervised clinical practicum treating at least 100 patients with mental disorder." The bill does not limit the conditions for which drugs may be prescribed, but would create the Council on Psychologist Formulary to establish which medications could be prescribed, "including controlled substances listed in [federal] schedules II, III, IIIN, IV, and V."

The formulary council would include one member of the State Board of Psychologist Examiners, one other psychologist appointed by the board, two pharmacists, one physician, and two members of the public.

"There is no probationary or supervised prescribing period mandated by the bill, and all rule-making authority rests with the Board of Psychologist Examiners," said Johnson.

At a hearing in mid-February, psychologists argued that passage would improve access to mental health care, especially in rural areas, and reduce waiting times to see a mental health professional. Members of the Oregon Psychiatric Association (OPA) opposed the bill as a threat to patient safety and no cure for questions of access.

"We explained how dealing with adverse drug effects requires medical skills and judgment and how physicians' training prepares them for that, but psychologists' study of social sciences does not," said J. Teresa Shelby, M.D.,the legislative representative for the OPA. "As for access, in Oregon the problem is not lack of psychiatrists but rather one of economics, poverty, the uninsured, and cuts in the state health plan leaving thousands without coverage."

The committee took no vote on the bill, but the chair suggested that proponents consider changing the composition of the formulary council. Thus, the bill is still alive and could come back at any time during the current legislative session, which runs until July.

please see ***Psychologists*** *on page 40*

N.M. Psychologists Seek To Expand Privileges

Regulations permitting qualified psychologists to prescribe psychotropic medications in New Mexico went into effect on January 7. Since then, advocates have introduced bills to expand the list of drugs that psychologists can prescribe, allowing them to prescribe off-label and possibly to prescribe nonpsychotropic drugs as well, said Paula Johnson, deputy director for state affairs in APA's Department of Government Relations.

Language in the original legislation limits psychologists to prescribing drugs only for FDA-approved indications. The new bills would permit psychologists to prescribe drugs "recognized and customarily used . . . for the treatment of mental, emotional, behavioral, or cognitive disorders. . . ." Drugs listed as used "sometimes" for mental or emotional disorders in *Drug Facts and Comparisons* or in the American Hospital Formulary Service would be acceptable.

In addition, the new proposal would permit psychologists to prescribe drugs to manage the side effects of psychotropic drugs. These could cover drugs to treat any condition from high blood pressure and seizures to Parkinson's disease and impotence, according to a report prepared by the Psychiatric Medical Association of New Mexico and the New Mexico Medical Society in opposing the proposed legislation.

"Psychiatrists who prescribe these drugs off-label are medical doctors with years of training and experience in recognizing and treating complex body chemistry actions and reactions," said the report.

The physicians also expressed dismay about the timing of the new bill. New Mexico's prescribing law requires a two-year supervised prescribing program for psychologists who want prescription privileges. Their advocates now are pushing for expanded rights even before any psychologist has completed this initial program.

Military Boosts Monitoring Of Soldiers' Mental Health

The military is designing a survey to identify soldiers with mental health problems several months after they return from Iraq or Afghanistan.

BY CHRISTINE LEHMANN

In the next few months, the U.S. military will begin conducting a second survey of American soldiers three to six months after their return from Iraq and Afghanistan to identify whether they need mental health care.

The military already conducts surveys of all active-duty soldiers within two weeks of their return from overseas deployment to detect health and mental health symptoms. That initiative began in April 2003 when the war in Iraq started.

"We made the initial postdeployment health survey as inclusive and routine as possible to decrease potential stigma and increase participation," William Winkenwerder Jr., M.D., assistant secretary of defense for health affairs, told reporters at a January briefing in Washington, D.C.

"We have since learned from research published in last July's *New England Journal of Medicine* that soldiers who were assessed three to four months after deployment in Iraq in particular had significantly higher rates of PTSD and depression than predeployment," Winkenwerder said.

William Winkenwerder Jr., M.D., oversees the military's readiness to provide health care services and support to soldiers during military operations.

To detect mental health problems that emerge months afterward, the Department of Defense (DoD) has assembled a multidisciplinary team that includes several psychiatrists to design the survey questions and implementation process, according to Col. Joyce Adkins, the DoD's program manager for operational stress deployment for mental health. She added that more details would be released at a later date.

"Our goal has always been to identify health concerns at the earliest possible time, so that we can begin care quickly and effectively," Adkins told *Psychiatric News*.

The surveys are anonymous but include Social Security numbers. "This information allows us to add the surveys to the person's health record and compare responses to health and mental health questions in previous surveys," said Adkins. ■

APA wants to hear from members who qualify for membership in one of its minority/underrepresented caucuses. This will help APA keep these members informed about news and activities that may be of particular interest to them.

Members who haven't indicated their ethnicity or race on their membership records are encouraged to do so and to join one of the minority/underrepresented group caucuses.

Name _____

Phone _____

E-Mail _____

These are the ethnicities/races listed on the APA membership application:
☐ American Indian/Eskimo/Aleut/Native Hawaiian
☐ Mexican/Mexican American
☐ Puerto Rican
☐ Other Spanish descent (Cuban, Central American, or South American)
☐ Filipino
☐ Indian/Pakistani/Ceylonese/Malay
☐ Japanese/Chinese/Korean/Other Asian
☐ African American/Black

These are the seven APA minority/underrepresented group caucuses:
☐ American Indian/Alaska Native/Native Hawaiian
☐ International Medical Graduates
☐ Gay/Lesbian/Bisexual
☐ Hispanic
☐ Asian American
☐ Black
☐ Women

Members can provide this information to APA's Membership Department by e-mail to apa@psych.org or by phone at (888) 357-7924 or by mailing this form to APA Department of Minority and National Affairs, Suite 1825, 1000 Wilson Boulevard, Arlington, Va. 22209.

PROFESSIONAL RISK MANAGEMENT
1/2H BW

DISTANCE LEARNING NETWORK
1/2H 4C

Final Medicare Rule Doesn't Allay Patient-Care Concerns

APA is concerned that the Medicare Part D prescription benefit could limit timely access to appropriate medications for those with a mental illness.

BY JIM ROSACK

Following numerous public hearings and the receipt of more than 7,500 comments from organizations and individuals, the Centers for Medicare and Medicaid Services (CMS) in January released the final rule it will use to implement and operate the vast new Medicare Part D prescription drug benefit.

The new prescription drug benefit and other provisions in the more than 1,100 pages of regulations are the key elements of the Medicare Modernization Act (MMA) passed by Congress and signed into law by President Bush in December 2003. Enrollment in the new prescription drug plans that will administer the new benefit will begin this fall, and the program will debut officially on January 1, 2006.

The regulations create the first prescription drug benefit for those enrolled in fee-for-service Medicare. The Medicare Advantage program will continue to offer prescription coverage as well. Low-income Medicare beneficiaries served under Medicaid (so called "dual eligibles") will be shifted to Medicare Part D.

The draft rules implementing the MMA were released last August. During the public comment period, APA's Department of Government Relations (DGR) and Office of Healthcare Systems and Financing (OHSF) prepared extensive comments that APA filed with CMS. The comments addressed both the proposed regulations and the proposed drug-classification system that was developed by United States Pharmacopeia (USP) for use by participating plans as they create drug formularies for the new benefit *(Psychiatric News*, October 1, 2004; November 5, 2004).

While APA staff continue to analyze the massive final rule document, APA Medical Director James H. Scully Jr., M.D., noted that "implementation will require constant vigilance to ensure that the balance will play out in favor of patients."

In the interim, Scully added, "APA continues to be concerned that the MMA final rule does not adequately ensure that patients with mental illness will have timely access to all the medically appropriate medications they need."

The MMA provides that all Medicare beneficiaries will have access to at least two prescription drug plans (PDPs) that will administer the standard Part D benefit. According to CMS, the standard benefit in 2006 will pay an average of 75 percent of drug costs after a $250 deductible, up to an initial coverage limit of $2,250. The plan will pay about 95 percent of drug costs once a beneficiary spends $3,600 out of pocket.

CMS estimates that the average premium paid by beneficiaries will be less than $37 per month. Medicare will pay an estimated $113 per month, per beneficiary, to the PDP with which the individual enrolls. For low-income individuals who meet defined poverty-level criteria, there is no premium.

The final rule requires PDPs to have a "cost-management program that lowers prescription drug costs for beneficiaries, including the use of medication therapy management programs and a coordination of benefits system." However, PDPs are also required to have an "up-to-date" formulary.

In response to public comments, CMS modified the proposed Pharmacy and Therapeutics Committee membership requirements and procedures to ensure that beneficiaries will be able to get drugs that might not be among the plan's preferred drugs in a timely manner and that the formulary will not exclude access to drugs that discriminate against beneficiaries with certain illnesses.

Specifically, CMS shortened the timeframe for plans to make coverage determinations and appeal decisions so that enrollees will be able to receive medications as soon as possible. The final rule requires that decisions be received by enrollees within 72 hours of their request for a routine exception and no longer than 24 hours for an expedited exception.

> **"Implementation will require constant vigilance to ensure that the balance will play out in favor of patients."**

Responding to the numerous concerns expressed during the public-comment period, CMS also changed the procedures by which dual-eligible patients will be transitioned from Medicaid into Medicare. The final rule now ensures that those beneficiaries will be placed into a Medicare PDP before the end of 2005 to prevent interruption in coverage. CMS will work with states to identify all current dual-eligible patients by the middle of 2005 and notify each of the impending transition. All identified dual-el-

please see ***Final Rule*** *on page 40*

Medicare Formulary Guidelines Still Provoke Anxiety

They set the threshold for acceptable formularies for the new Part D prescription benefit.

The Centers for Medicare and Medicaid Services (CMS) will utilize the Model Guidelines developed by the United States Pharmacopeia (USP) to help determine whether prescription drug plans offering coverage to Medicare beneficiaries under the new Part D drug benefit meet the minimum legal standards.

The Medicare Modernization Act (MMA) specifically charged USP with the development of guidelines for formulary composition. However, CMS has noted that prescription drug plans (PDPs) will be encouraged, but not required, to use the USP Model Guidelines. In addition, regulators have said that whether PDPs model their formularies on the USP guideline or not, approval of a drug plan's formulary will entail an extensive review.

The Model Guidelines detail 146 therapeutic categories and pharmacologic classes that should be used to guide PDPs in building their Medicare Part D formularies. USP also provided CMS with a listing of "key drug types," a listing of some of the most commonly prescribed drugs. USP added the listing after significant public comment that many common drugs did not appear to be included in the Model Guidelines. USP hopes the key drug types listing will prompt PDPs to include the drugs in their formularies. CMS staff then produced a "Comprehensive Listing of Drugs in the USP Model Guidelines," detailing which individual pharmaceutical products CMS believes "fit" within the USP's individual categories and classes.

For example, the USP's "antipsychotic" therapeutic category includes three pharmacologic classes: "non-phenothiazines," "non-phenothiazines/atypicals," and "phenothiazines." In its comprehensive listing, CMS has assigned several medications to each class. However, under the final rule for the Medicare Part D drug benefit, PDPs would have to provide coverage for only two medications in each category and class. Conceivably—based on, for example, generic availability or comparatively low pricing—a formulary could include only haloperidol (Haldol) and thiothixene (Navane) as non-phenothiazines, quetiapine (Seroquel) and risperidone (Risperdal) as non-phenothiazine/atypicals, and chlorpromazine (Thorazine) and fluphenazine (Prolixin) as phenothiazine antipsychotics. Patients will have no access to other available antipsychotics except through an "exceptions and appeals" process.

APA argued both at public hearings and through written comments during development of the guidelines that the proposed categories and classes were not only inadequate, but did not represent the actual classification of the medications as they are used clinically. The USP's response was simply that "the existing categories and classes were deemed sufficient."

CMS's "Comprehensive Listing of Drugs in the USP Model Guidelines" is posted online at <www.cms.hhs.gov/pdps/usplist.xls>. ■

Govt. Urges Physicians to Adopt Medicare E-Prescribing Standards

The federal government proposes regulations for electronic prescriptions under Medicare that establish standards for transactions between physicians and pharmacies.

BY CHRISTINE LEHMANN

The Department of Health and Human Services (HHS) is encouraging physicians and pharmacies to adopt its proposed electronic-prescribing standards for Medicare patients who sign up for the new Part D prescription drug benefit.

The proposed Medicare e-prescribing rule was published in the February 4 *Federal Register*; and public comments will be accepted through April 5.

"We are committed to widespread use of e-prescribing as quickly as possible," said Mark McClellan, M.D., Ph.D., administrator of the Centers for Medicare and Medicaid Services (CMS), in a press release.

"In issuing these proposed rules today, seven months ahead of the Medicare Modernization Act (MMA) deadline, we are laying the foundation for having major e-prescribing standards in place when the Medicare prescription drug benefit begins next January," McClellan stated (see story above).

CMS will require prescription drug plans to support electronic prescribing as a condition of participation in the new Medicare Part D drug benefit. However, compliance with the rules is voluntary for physicians and pharmacies.

President George W. Bush signed the MMA into law December 2003. To promote patient safety and reduce costly medication errors, the law mandated that the National Committee on Vital and Health Statistics (NCVHS) develop recommendations for uniform standards for e-prescribing.

"The current lack of standards is a barrier to the use of health-information technology including e-prescribing," according to HHS.

From March 2004 to September 2004, the NCVHS heard testimony from 65 witnesses including industry experts, software developers, and representatives of e-prescribing networks, demonstration projects, and consumer advocacy organizations.

The proposed e-prescribing regulations are based on the NCVHS's recommendations to the HHS secretary. The regulations will set standards for the following:

- Transactions between physicians and pharmacists on new prescriptions, refills, changes, cancellations, and related messaging and administrative transactions.
- Eligibility and benefit inquiries between physicians and prescription drug plans.
- Eligibility and benefit inquiries between pharmacies and Medicare Part D sponsors.
- Formulary and benefit coverage information including the availability of lower-cost drugs that are "therapeutically appropriate and meet certain characteristics."

CMS proposes to make the compliance date for these standards January 1, 2006, "to be ready for immediate use with the Medicare drug benefit," according to HHS.

Additional electronic information can be used with these standards to provide more support for using drugs safely and effectively, according to the HHS statement.

A summary of the proposed Medicare e-prescribing rule and a link to the full rule are posted online at <www.cms.hhs.gov/providerupdate/regsum.asp#0011p>. Information on NCVHS deliberations and recommendations on e-prescribing are posted at <http://ncvhs.hhs.gov>. ■

Donald Langsley, M.D., Dies at Age 79

APA and psychiatry lose a leader whose contributions will continue to shape the field for many years to come.

BY KEN HAUSMAN

Psychiatry lost one of its leading lights in January with the death of former APA president Donald Langsley, M.D., at age 79. In addition to serving as APA president for the 1980-81 term, Langsley was a higly respected psychiatric educator and an expert in issues concerning accreditation and licensing of physicians. He was director of the American Board of Medical Specialties for a decade beginning in 1981.

After completing his psychiatry residency, Langsley joined the faculty of the University of Colorado School of Medicine as an associate professor and director of the Colorado Psychopathic Hospital. In 1968 he headed for the West Coast, where he founded the psychiatry department at the University of California at Davis School of Medicine and became director of mental health programs for Sacramento County.

From 1976 to 1981 Langsley chaired the psychiatry department at the University of Cincinnati School of Medicine.

After his term as APA president ended in 1981, he continued to contribute his expertise to APA in multiple capacities as a member of the Board of Trustees and as chair or member of several committees, including the Ethics Committee.

APA President Michelle Riba, M.D., remembered Langsley as "a great psychiatrist, teacher, mentor, and friend. He believed in the importance of ethics and was a role model for medical students, residents, early career psychiatrists, and colleagues."

Former APA president Lawrence Hartmann, M.D., commented that for many years Langsley was "a steady and calm presence in American psychiatric leadership," noting that although his APA presidency ended more than 20 years ago, he continued attending and contributing his wisdom to APA Board meetings until last year.

Recently, Langsley "energized and edited the useful, brief, and clear *APA Ethics Primer*—which was sent free to all psychiatric residents in the U.S. three years ago," Hartmann noted. "It is a good example of Don's longstanding interest in ethics; in psychiatry residents; in combining local and national, as well as psychiatric and other medical, issues; and in education."

He continued, "Don and I became friends when he asked me to take a long walk with him on a deserted, off-season, Martha's Vineyard beach after an Area 1 meeting 30 years ago," Hartmann recalled. "We both asked questions; we had different points of view and experiences; we challenged each other on all kinds of issues, and we remained friends. I miss him."

At the time of his death on January 13, he was a professor emeritus in psychiatry at Northwestern University.

Langsley is survived by his wife, Pauline, who is also a psychiatrist; three daughters; and three grandchildren. ■

APA Posts Updates On Practice Guidelines

In an effort to keep members and other clinicians as up to date as possible on key developments in psychiatric practice, APA has begun publishing a new series of "Practice Guideline Watches" (see related "Viewpoints" on page 34).

These are interim reports that follow publication of a practice guideline and describe important developments in the evidence base related to a disorder or other topic addressed in one of the guidelines. Through these updates, APA is able to keep clinicians informed between major revisions of a practice guideline.

The updates are written and reviewed by experts associated with the development of the original guideline and are approved for publication by APA's Executive Committee on Practice Guidelines. Thus, watches represent opinions of the authors and approval of the Executive Committee but are not policy of APA.

The first of the "Practice Guideline Watches" appeared last August and updated the guidelines on psychiatric evaluation, delirium, and Alzheimer's disease and other late-life dementias. Two additional watches are scheduled to be published this month and will address developments related to major depressive disorder and eating disorders.

Information on APA's practice guidelines and the new watches are posted online at <www.psych.org/psych_pract/treatg/pg/prac_guide.cfm> The updates appear under the column labeled "Watch." ■

Minority Med Students Get Insider's View of Psychiatry

APA and district branches partner to show minority medical students the many career paths they can follow if they specialize in psychiatry.

BY EVE BENDER

A group of more than 30 minority medical students in the Washington, D.C., area met with leaders of the Washington Psychiatric Society (WPS) over dinner one evening in January to consider the idea of pursuing a career in psychiatry.

As they sat around the table, APA leaders and D.C.-area psychiatrists working "in the trenches" spoke to the students about their odysseys into successful careers as psychiatric researchers, professors, and practitioners.

The dinner was an initiative of APA's District Branch Minority Recruitment Program, established by the American Psychiatric Foundation with the support of AstraZeneca in 2002 to recruit minorities to the psychiatric workforce.

Second- , third- , and fourth-year medical students from Georgetown University, Howard University, and George Washington University got an insider's perspective on how to navigate a psychiatry residency, how to get involved in psychiatric research, and what it is like to treat patients in a private practice.

Eve Bender

Presenters at the Washington Psychiatric Society spoke to area medical students about the need for minorities in the psychiatric workforce. From left are Niku Singh, M.D., Annelle Primm, M.D., Constance Dunlap, M.D., William Lawson, M.D., Ph.D., and Aly Rifai, M.D. Not pictured is Marilyn Benoit, M.D.

"Recently, the field of psychiatry has exploded with new findings and discoveries," said William Lawson, M.D., Ph.D., chair of psychiatry at Howard University. Lawson, who chaired the dinner meeting, also pointed out that minority practitioners are underrepresented in psychiatry.

This was a point further emphasized by Annelle Primm, M.D., who graduated from Howard University's medical school in 1980 before beginning her career in psychiatry and is now director of APA's Office of Minority and National Affairs.

"We have low percentages of ethnic and minority practitioners in psychiatry and in the mental health profession in general," she said. She described the many opportunities available to minority medical students through APA, including research fellowships in HIV/AIDS psychiatry and substance abuse, among other offerings.

There is no better time to get involved in psychiatric research than the present, according to Muhamad Aly Rifai, M.D., who is an Area 3 member-in-training (MIT) deputy representative to APA's Assembly and the National Institute of Mental Health MIT representative at the WPS.

please see ***Med Students*** *on page 41*

Why Psychiatry?

For Jason Freeman, an African-American medical student in his fourth year at Georgetown University School of Medicine, a dinner for minority medical students hosted by the Washington Psychiatric Society in January helped him learn more about the field he has decided to pursue.

"As a neuroscience major at Brandeis University, I was always interested in psychiatry," he told *Psychiatric News*.

Freeman said that during his psychiatry rotation, he "found that the field seems to fit my goals—it's the kind of medicine I eventually want to practice."

At the dinner, Freeman said he learned about "the numerous opportunities available to those who enter the field in the coming years," opportunities that can include research, clinical practice, and academic medicine.

He also was struck by the fact that the presence of minority psychiatrists "is strongly needed" and that they "have almost complete freedom in where and how they choose to practice psychiatry."

FOREST SYMPOSIUM
ISL 4C (SHEAR)

APA 'Tour' Spreads Word On MH Disparities

National and local organizations came together to give a powerful send-off to an ambitious effort to address disparities in health care.

BY KATE MULLIGAN

Annelle Primm, M.D., M.P.H., has vowed to take "OMNA on Tour" to the "ebony towers and ivory towers of academia to the 'hoods and to the woods."

The new program, which will educate communities about the significance of disparities in mental health and encourage them to take collaborative action, is a major effort of APA's revitalized Office of Minority and National Affairs.

Primm began work as OMNA's director in April 2004.

The power of collaboration in action was evident at the program's first stop on January 22.

David Hathcox

Annelle Primm, M.D., is taking "OMNA on Tour" to Philadelphia and Memphis next.

The American Association of Community Psychiatrists (AACP), the Howard University Hospital department of psychiatry, and the Washington Psychiatric Society joined OMNA in sponsoring the meeting. AACP was celebrating its 20th anniversary.

The conference, AACP's winter conference as well as OMNA on Tour's launch, was called, "Strengthening Collaboration and Advocacy to Achieve Mental Health Equity and OMNA on Tour."

Howard University, a historically black, private university, hosted the meeting.

William Lawson, M.D., Ph.D., chair of the department of psychiatry at Howard University College of Medicine, reminded the group about the commonalities between the goals of community psychiatry and those of his department to improve health care for "marginalized" people.

Primm, who called herself a "proud graduate of Howard University College of Medicine," described OMNA's mission and major activities (see box).

She offered a definition of health care disparities and a survey of recent research and other findings concerning their effect.

Racial and ethnic disparities in terms of access to health care exist independently of a person's socioeconomic class, Primm said.

Those disparities lead to higher morbidity and mortality from leading causes of death such as diabetes and cardiovascular disease.

In terms of mental health, she cited findings from "Mental Health: Culture, Race, and Ethnicity," a report issued in 2001 by David Satcher, M.D., when he was the U.S. surgeon general. Members of minority groups receive poorer quality of care, are less likely to receive services, and are underrepresented in mental health research.

The result is a vicious cycle in which socioeconomic problems and mental illness, sometimes including substance abuse, interact to result in violence, incarceration, and poor physical health. Those three factors then exacerbate the original problems.

Primm said, "The timing is great for OMNA on Tour." The effort brings together many issues and recommendations that recently have received national visibility.

The New Freedom Commission on Mental Health, for example, recommended that states address disparities as part of their comprehensive mental health plans and promote the inclusion of people with diverse cultural backgrounds in the mental health workforce.

The Substance Abuse and Mental Health Services Administration (SAMHSA) issued a priorities matrix for 2003 that identified "cultural competence/eliminating disparities" as a cross-cutting principle that applies to all its work.

David Hathcox

Martha Knisley, director of the Department of Mental Health in Washington, D.C., leads a discussion on local mental health issues. Other panelists are (from left) Adeline Benovil, clinical manager of Woodley House, a local psychiatric facility; Yvonne Smith, a spokesperson for NAMI-DC; and Thomas Green Jr. M.D., a medical officer at St. Elizabeths Hospital.

Primm told the audience that there are many successful models for addressing disparities that "no one knows about."

The Institute for Mental Health Ministry through its PRAISE project, for example, brings together the faith community and mental health professionals. The institute, located in Baltimore and directed by psychiatrist Michael Torres, M.D., offers a variety of educational, consultative, and clinical services.

The Clinical Research Investigator Support Program, developed and adminstered by BDH Clinical Research Services Inc., is a nationwide network of minority physicians whose mission is to increase minority participation in clinical research. It has supported an array of clinical trials with racial and ethnic minorities (physicians and patients) in depression, schizophrenia, bipolar disorder, diabetes, and many other medical conditions.

The video "Black and Blue: Depression in the African-American Community," which Primm developed, features first-person accounts of African Americans who have dealt with depression and the associated stigma.

Disseminating information about models that work is an important goal of OMNA on Tour.

In January, the daylong launch of OMNA on Tour offered five panel sessions that together provided a comprehensive picture of problems resulting from inequities and strategies for addressing them.

Primm said that the topics and presentations represented a smorgasbord from which communities hosting OMNA on Tour could select. The variety in the presentations also suggested the complexities of the issues related to disparities.

Several speakers mentioned that the United States is becoming a country in which the majority of its citizens will be members of minority groups. They argued for a sophisticated view of cultural competence that takes into account the multiplicity of ethnic groups and nationalities.

Stephen Goldfinger, M.D., said, "Diversity in all too many places means black and white." Brooklyn, where he is interim chair of the department of psychiatry at the State University of New York Downstate Medical Center, has the largest population of Russians outside Russia and the largest population of Haitians outside Haiti. "That's true of 13 ethnic groups in Brooklyn," he said.

Andres Pumariega, M.D., described research that demonstrates the effectiveness of culturally specific interventions.

"We must revisit the cultural competence model for specific populations," said Pumariega, director of child and adolescent psychiatry at East Tennessee State University.

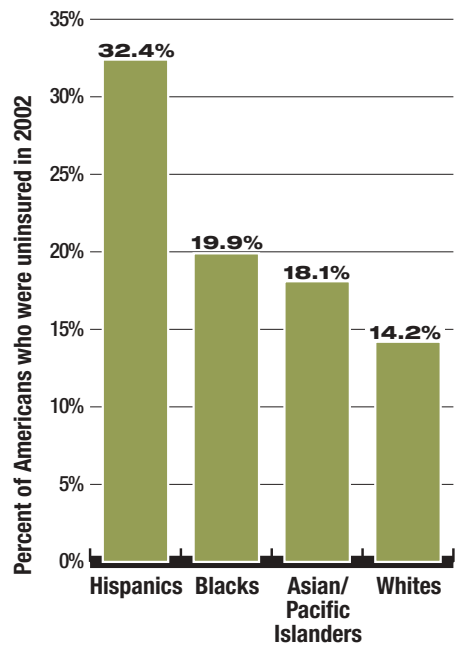
Jacqueline Feldman, M.D., linked access to mental health services to the idea that patients and physicians might have different ideas about what constitutes recovery. She asked patients at the University of Alabama at Birmingham community mental health center how they defined recovery.

"It's not just not hearing voices. None said 'I want my voices to go away,' " said Feldman. "Instead, they want the same things we do."

Satya Chandragiri, M.D., medical director of the Eastern Oregon Psychiatric Center, described how he promoted the recovery model at a psychiatric hospital by taking "small steps" that encouraged patients' independence.

please see ***APA Tour*** *on page 44*

Minorities More Likely To Be Uninsured



Source: Current Population Survey (2003), U.S. Census Bureau

OMNA on the Move

Annelle Primm, M.D., director of APA's Office of Minority and National Affairs (OMNA), launched a new effort called "OMNA on Tour" at Howard University in Washington, D.C., in late January. These are among the program's goals:

- Identify and analyze needs of regions of the country with high concentrations of underserved ethnic and racial groups.
- Educate audiences about mental health disparities.
- Disseminate information about local resources and models that work.
- Mobilize stakeholders of various backgrounds and disciplines to collaborate to eliminate mental health disparities.

The following is OMNA's mission, said Primm:

- To enlarge APA's profile as a leader in eliminating mental health disparities.
- To inspire, elevate, and recognize minority psychiatrists and those from underrepresented groups.
- To serve as a clearinghouse for information on mental health disparities.
- To increase diversity in psychiatry.

OMNA administers fellowship programs and offers a mentoring network to support and encourage members of minority groups interested in the field of psychiatry. The office developed "Real Psychiatry: Doctors in Action," a video aimed at recruiting medical graduates, particularly members of minorities, into psychiatry.

OMNA established the Health Disparities Roundtable in partnership with the American Psychiatric Foundation to encourage health care leaders to address relevant issues and is seeking to expand its speakers bureau by inviting more minority psychiatrists to join.

Vermont Bear Consigned To Permanent Hibernation

The manufacturer of a teddy bear intended to be a Valentine's Day gift is accused of being heartless and insensitive to people with mental illness.

BY KEN HAUSMAN

A Vermont teddy bear recently found itself at the heart of a bitter controversy in which it has been accused of being anything but lovable.

The Vermont Teddy Bear Company thought it would be a cute idea to market a new bear that people might want to give to their loved one for Valentine's Day and named it the "Crazy for You" bear. The brouhaha over use of a term that many consider offensive to people with mental illness grew substantially, however, when marketing materials showed that "Crazy for You" bear would come dressed in a straitjacket that's embroidered with a small red heart in the front.

The bear also comes with commitment papers that show three boxes with check marks in each. The boxes say "can't eat," "can't sleep," and "my heart's racing," followed by the phrase "Crazy for you."

AP Photo/TobyTalbot

"Crazy for You" bears continued to be marketed by the Vermont Teddy Bear Company in Shelburne, Vt., until they sold out, despite complaints from psychiatrists and mental health advocates who maintained that the bears stigmatize people with mental illness.

The bear's ensemble quickly brought protests from representatives of advocacy groups such as NAMI-Vermont and the Vermont Association for Mental Health, as well as from the Vermont Psychiatric Association and at least one state legislator.

In a January 13 letter to the company's president, Elisabeth Robert, those organizations expressed their disappointment that after being informed of the stigmatizing nature of the new teddy bear, the company "decided to choose profit margin over public sensitivity."

The groups asked to meet with Robert to explain "why this marketing strategy is so damaging to persons with mental illness. Specifically, the use of a straitjacket and commitment papers as symbols of love minimizes the plight of those who suffer from mental illness and their loved ones."

They called on the company to stop marketing the teddy bear, which sold for $69.95. It was one of a series of 39 bears the company marketed as Valentine's Day gifts.

The Vermont Psychiatric Association's executive committee voted to ask Robert to resign as a member of the Board of Trustees of Fletcher Allen Health Care, the state's largest medical center.

On February 9, several Vermont newspapers reported that she had submitted her resignation to the Fletcher Allen board the previous day, saying that "the recent controversy surrounding one of my company's teddy bears will detract from my ability to serve effectively."

Editorials condemning the "Crazy for You" bear appeared on a Vermont television station and in the *Burlington Free Press* newspaper. Not everyone, however, found the bear stigmatizing or insulting. The largest newspaper in neighboring New Hampshire, the *Manchester Union Leader*, labeled the controversy an example of political correctness gone too far. In a January 30 editorial, the paper expressed its consternation that "the sensitivity police in Vermont have nothing better to do this winter than examine teddy bears for possible offenses against the emotionally thin-skinned."

Ignoring the symbolism of the straitjacket and commitment papers, the editorial focused on the word "crazy" and maintained that using it "as a metaphor for love is hardly a human rights violation. If it were, we would have to go after poets, songwriters, and enraptured lovers as well as supposedly 'insensitive' teddy bear makers."

On January 28 Robert Appel, executive director of the Vermont Human Rights Commission, weighed in on the controversy. He accused the company of an "apparent lack of understanding. . .of the real hurt and emotional turmoil" that continued marketing of the bear would cause those with psychiatric disorders.

please see ***Bear*** *on page 41*

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Follow-Up Found Lacking In Public MH Services

A review of 813 patient charts reveals good evaluations of children with mental health problems but inadequate documentation of medication monitoring and coordination of care.

BY AARON LEVIN

California's public mental health clinics evaluate children well but do only a "moderate to poor" job of sticking to quality indicators for patient care, said a study commissioned by the state's Department of Mental Health.

"Findings from this study raise serious questions about the adequacy of medical monitoring for children receiving psychoactive medication at Medicaid-funded public clinics," said lead author Bonnie Zima, M.D., M.P.H., of the University of California, Los Angeles. "Almost three-fourths of the children receiving medication treatment did not have adequate monitoring of vital signs or laboratory studies."

Initial clinical assessment of children met accepted standards 87.2 percent of the time, but documentation of parental involvement, linkage with schools or primary providers, patient safety, or psychosocial treatment generally fell below the 50 percent level, according to Zima and her colleagues, whose report appears in the February *Journal of the American Academy of Child and Adolescent Psychiatry*.

"This is a helpful reminder that there is a real need and a gap between developing evidence-based guidelines and actual practice," said John Oldham, M.D., professor and chair of psychiatry and behavioral sciences at the Medical University of South Carolina in Charleston and chair of APA's Committee on Quality Care.

However, the study results should not be seen as criticism of doctors caring for very sick children, cautioned Zima. Rather, those doctors need more resources to do their jobs better.

"Doctors should have more time to monitor patients, contact schools, and document what they do," she said. "They need better reimbursement, more support in the clinic, and more information technology."

About 6 percent to 7.5 percent of children aged 3 to 17 use mental health services in the course of a year, estimated Zima, and Medicaid plays the largest public role in financing those services. Understanding whether children in these outpatient programs receive care that meets current treatment guidelines and practice parameters is important medically and economically.

"This is the first time a state department of mental health asked health-quality researchers to assess the quality of outpatient care for children in Medicaid-funded clinics," she said. "And it's the first time anyone has assessed children with psychiatric disorders in the same way it's been done for surgery or other medical specialties."

Zima and colleagues sampled chart records of children on Medicaid and compared them against evidence-based care recommendations and clinical consensus for three conditions: ADHD, conduct disorder, and major depression. They chose common conditions for which effective treatments were known.

The researchers selected 62 of 188 eligible clinics based on their treatment of children and adolescents, the number and percentage of Medicaid outpatient service contacts, and the number of new episodes of care for at least one of the three conditions. They then identified 4,958 records of patients who were between 6 and 17 years old and had at least three clinic visits in a 90-day period, but no visits in the 30 days before the initial visit date. The latter was a marker indicating a probable new episode of care. Out of 1,487 randomly selected records, 813 met all criteria for abstraction.

Standards were based on guidelines produced by national professional organizations such as the American Academy of Child and Adolescent Psychiatry, American Academy of Family Physicians, American Academy of Pediatrics, and other sources. A trained team of 12 registered nurses and one mental health professional abstracted the records.

While acknowledging that everything done for a patient might not be recorded in a chart, Zima said that documentation was a key to both assessment and care.

The children averaged 10.6 years old. About 34 percent were white, 24 percent were black, and 30 percent were Latino. About 26 percent met criteria for two conditions, of which two-thirds were identified as having ADHD and conduct disorder.

Although documentation of initial assessments was high, said the authors, other indications of basic treatment principles were not. The parents of barely 25 percent of the children were informed of their child's diagnosis and given information about it. Less than half of the children had monthly mental health visits or any family intervention. Only 8 percent of children with ADHD or conduct disorder had one or more behavioral therapy sessions, although 54 percent of children with major depression received psychosocial treatment monthly for six to nine months.

While written consent was obtained from 76 percent of primary caregivers before starting drug therapy, only 33 percent received mandated medication information. Thirty percent of the children pre-

please see ***Follow-Up*** *on page 41*

States Try Diverse Strategies To Reform Health Care

Elected officials in every state recognize that health care is an unavoidable issue, and every sort of option—from limited benefit packages and mandate-free benefits to health savings accounts—is under consideration.

BY MARK MORAN

In a season of dire austerity, and with little or no help from Washington, states are scraping together a variety of means for addressing health care access and quality within their borders.

Most prominent among these efforts are "premium-assistance" programs in which a state uses public funds to pay for a portion of the premium costs of employer-sponsored insurance for eligible populations, said Alan Weil, executive director and president of the National Academy of State Health Policy (NASHP), at last month's Health Action conference in Washington, D.C., sponsored by Families USA.

Somewhat less common, given the thin margin with which states are working, are expansions of Medicaid and the State Children's Health Insurance Program. But some states are finding cost-cutting measures allowing them to grow those programs.

A few states are busy building a consensus for more sweeping, comprehensive health care measures aimed at ensuring everyone in the state is covered. These measures are not likely to be enacted soon, but are being pursued with an eye toward a more fiscally robust future, Weil said.

Finally, apart from the issue of access, a number of states are working on improving health care quality and efficiency, he said.

Striving to find the lighter tones in what was rendered throughout the conference as a grim picture for public health and social service programs in general, Weil said states bring a pragmatic, let's-make-something-work approach to health care that is generally lacking in Washington.

He said that politicians of every stripe and in every state view health care as an unavoidable issue. Every sort of option—from limited benefit packages, mandate-free benefits, and health savings accounts—is under consideration.

"No one can go out to the voters and say health care is someone else's problem or that the government doesn't have a role in helping people figure out how to get health care coverage. The fact that it's on the agenda of both parties and in every state, as we gain some experience and learn what works and what doesn't work, creates some room for moving forward."

Bridging Gap Between Public, Private

Weil said premium-assistance programs, which are the predominant approach states are taking today, are basically about building a bridge between public and private health insurance systems. They have grown up around the recognition that the majority of the uninsured are workers employed by businesses that do not offer health insurance.

So, for instance, a state may publicly subsidize the purchase of employer-provided health insurance for workers who qualify. Some contribution is also expected from either the employer or the employee, or both, Weil said.

According to the NASHP, 14 states now operate some form of premium assistance: California, Illinois, Georgia, Iowa, Massachusetts, Missouri, New Jersey, Oregon, Pennsylvania, Rhode Island, Texas, Utah, Virginia, and Wisconsin. At least 10 other states are in the process of developing a premium-assistance program.

"The bad news is that because they are trying to cobble together different dollars from different sources, it's hard to come up with the financing to achieve a solid, comprehensive insurance policy," Weil said.

He added, however, that there is an emerging consensus among elected officials in both parties and across the country that the gap between public insurance and private insurance—where most of the uninsured fall—is ripe for action.

Growing Programs in Austere Times

What Weil called "garden variety" expansions of Medicaid and the State Children's Health Insurance Program are rare in today's austere environment, but a few states are looking at creative ways to expand their programs.

"Illinois stands out as having made a significant effort with some success and is trying to go further," he said. "Colorado approved taxes to fund health care programs, and the legislature is looking seriously at some expansions. And through a variety of waiver methods, states are looking at their Children's Health Insurance Program funds, those that have them available, to expand the program.

"Even though so many states are looking at ways to minimize cuts, there are even in bad years a few that are looking at Medicaid the way they have in the past as a tremendous opportunity to expand coverage," Weil said.

He said that in a number of states—notably Missouri, New York, and Massachusetts—there are grass-roots or foundation-led efforts to build a consensus for universal coverage within the state.

"Now, they are not looking to implement [these proposals] next month," Weil said, "but one of the nice things about states is that when they're seeing that times are tough, there are advocates who keep health care on the agenda and basically force conversations to occur so that you're building the foundation for activities that may not be possible until the budget situation gets better." ■

AMERICAN PROFESSIONAL RISK AGENCY

P4C

Senator Sounds Alarm On Medicaid's Future

Proposed block grants for state Medicaid programs may occasion a showdown about the future of the 40-year-old public health insurance program for the nation's poor.

BY MARK MORAN

Mark Moran

Sen. Hillary Rodham Clinton (D-N.Y.) tells participants at the Families USA conference in Washington, D.C., that the Bush administration has launched an aggressive assault on the "structure and funding of public health programs in our country."

America's public health safety net is under assault, said Sen. Hillary Rodham Clinton (D-N.Y.). Keynoting a conference sponsored by Families USA in Washington, D.C., in January, Clinton sounded a chord that would reverberate throughout the meeting—a combination of grim foreboding about the intentions of a second-term Bush administration toward the public health systems that have been the legacy of the liberal Democratic establishment and a defiant resolve to protect those systems against Republican efforts to privatize and downsize.

"These are perilous times for America's health care infrastructure," the former first lady told a crowded ballroom at Washington's Mayflower Hotel. "We are about to experience one of the most aggressive assaults on the structure and funding of public health programs in our history."

Clinton focused especially on administration proposals to cap Medicaid funding through block grants to states—effectively overturning the system of matching funding that has been in place since the program began 40 years ago—and the new prescription drug benefit under the Medicare Modernization Act (see page 10).

Famlies USA, calling itself "the voice for health care consumers," is a network of grass-roots advocacy groups that champion public funding for Medicare, Medicaid, and the State Children's Health Insurance Program, as well as such issues as minority health, access to prescription drugs for the elderly, and relief of medical debt incurred by individuals with and without insurance.

Echoing many others at the conference, Clinton said the new Medicare drug benefit is rife with potential pitfalls and complications that could leave some beneficiaries with much higher costs and a far less generous benefit than has been touted.

She especially highlighted the subgroup known as "dual eligibles," who qualify for both Medicaid and Medicare; when the new Medicare drug benefit is initiated in January 2006, the Medicaid drug benefit for those who are dually eligible will end, and the transition from one program to the other is expected to be fraught with problems and uncertainties.

"If the transition from Medicaid to Medicare doesn't go smoothly, if [there are] implementation problems that are just bound to occur when the Medicare prescription drug benefit takes place, and if some of the problems embedded in the prescription drug benefit come to pass, these individuals could be left with no or inadequate coverage," Clinton said.

Clinton noted that most seniors in the Medicare program will have six months to enroll in a prescription drug plan. The plans will be announced October 13, and enrollment will begin November 15. Those who are dually eligible have far less time to make a selection, however. They must be enrolled in one of the new plans by January 1, 2006, since their Medicaid coverage ends on December 31.

In response to this problem, the Centers for Medicare and Medicaid Services (CMS) said it will automatically enroll dual eligibles into a prescription drug plan. But that could create problems, Clinton said.

"When seniors are randomly enrolled in a drug plan, there is no guarantee that the plan chosen is the one that will fit their specific prescription drug needs," she said. "And, remember, we are talking about a population that is juggling multiple chronic conditions and multiple medications.

"If seniors are placed in a plan that is not a good fit, it is going to require a lot of paperwork and research to find the right plan, assuming it's in the right region where they live and that they can even get into the plan," Clinton continued. "Can we really place that burden on our already overburdened caregivers or medical professionals? Are we going to turn doctors and RNs and nursing home administrators into government bureaucrats, going through all the plans and trying to find the one that will fit the person in need of continuity?

"I also think there will likely not be enough targeted public education to help the dual eligibles with this transition process."

Even beyond the likely problems associated with dual eligibles, the new prescription drug benefit received a thumbs-down review from Clinton—who voted against the measure—and from many others at the Families USA conference.

A principal complaint throughout the conference was the enormous complexity of the benefit, with multiple plans expected to offer different formularies at varying costs. "Just because a drug is on the formulary at the beginning of the year doesn't even mean it stays on the plan for all of the year, or that it's on the plan next year, or that the plan you signed up for is available [the next year]," Clinton said.

"If this is confusing for you, imagine

please see ***Medicaid*** *on page 41*

Health Reform Must Be Priority One

Health system—not Social Security—reform is the nation's most pressing domestic issue, said newly elected Sen. Barak Obama (D-Ill.).

Obama, the young freshman senator who spoke at last year's Democratic convention and whom some observers have called the future of the Democratic Party, told an audience at a conference sponsored by Families USA that lack of access to health care and increasing medical debt were pervasive issues, simmering beneath the radar of an administration that was looking the other way.

Obama said that in his campaign across the state of Illinois, those problems were expressed by people in every demographic.

"The single constant in every conversation I had in every community was the belief backed by facts that our health care system was badly broken and that it needed to be repaired fundamentally, not at the margins, and that it was serving nobody particularly well," Obama said.

"But there has not been a single comment from this administration, beyond the issue of medical malpractice, about the health care system, and we have an administration that has decided it's going to invest its entire political capital into fixing a Social Security system that's not broke instead of fixing a health care system that everyone knows is broke."

Beyond that, Obama said that entrenched interests aligned against change are unlikely to move without leadership from the top or a groundswell from the bottom. "It's not just the bad guys, it's not just venal insurance companies and drug companies, it's the fact that you've got hospitals and doctors and insurance companies and drug companies and, in some cases, patients who prefer the devil they know to the devil they don't," he said.

"It would help if we had a president who was using the bully pulpit to encourage and nudge and push those entrenched interests and the public in general into believing that we have to change and that change is better than the status quo. But we don't have that, so we are going to have to generate from the ground up a set of organizations and conversations and institutions that will galvanize people and embolden politicians to take a stand on this issue."

Kerry Plan Would Cover Millions of Uninsured Kids

Under Sen. Kerry's recent proposal, the federal government would extend financial assistance to states to cover children and require parents to show proof of coverage to claim the child tax credit.

BY MARK MORAN

Mark Moran

Sen. John Kerry (D-Mass.) greets supporters at the Families USA conference in Washington, D.C., where he announced the introduction of his Kids First Act of 2005. The legislation is aimed at expanding health insurance coverage to all children in the United States.

Looking and sounding as though he were still on the campaign trail, Sen. John Kerry (D-Mass.) chided President Bush for what he claimed was the administration's neglect of an estimated 11 million children without health insurance.

In an address that had the look and feel of a campaign stop, Kerry also announced his own Kids First Act of 2005, introduced the same week in Congress, to address that problem.

Speaking to a gathering of health care advocates in Washington, D.C., sponsored by Families USA, Kerry mocked the domestic agenda of the president, who was that same day in Cleveland, Ohio, touting his plans for expanding access through tax credits and health savings accounts.

"His effort is the same window dressing—avoidance of reality that we've seen the last four years," Kerry said. "Unfortunately, the White House plan for health care will. . . decisively repudiate the national responsibility to promote quality, affordable health care at a time when health care is unmistakably a national challenge.

"Pare back all the rhetoric," he continued, "and the White House plan is this: raise premiums with a phony small-business health plan; pretend the answer for families struggling to afford insurance is just another tax cut for the wealthy that leaves them behind; and, while we're at it, dump the responsibility for covering low-income families and their kids on the states and let them take the heat for dumping them altogether.

"That's how the president who promised to usher in a 'responsibility era' proposes to deal with a real and present health care crisis, even as he seeks to hype a phony crisis in Social Security," Kerry said.

The Massachusetts senator explained his new plan, "Kids First," which he had introduced in Congress just days before. The plan focuses on expanding enrollment of children in the Medicaid and State Children's Health Insurance Program (SCHIP) through a series of incentives aimed at states and parents.

Under the plan, the federal government would pay for all Medicaid outreach and coverage costs for children under age 21 in families whose incomes are at or below the poverty level ($15,670 annual income for a family of three). In exchange, the state would agree to cover children under age 21 in families with incomes at or below 300 percent of the poverty level ($47,010 annual income for a family of three) through SCHIP or Medicaid.

To claim the federal tax credit, parents must insure all children under age 19 and show proof of that coverage. Forfeited child tax credits would finance automatic enrollment in the SCHIP program.

The Kerry plan also includes the following proposals:

- Allowing higher-income parents the right to buy into the SCHIP program for their children at cost.
- Allowing parents to use the SCHIP subsidy to purchase qualified employer-sponsored coverage.
- Providing tax credits to higher-income parents to maintain coverage affordability. Parents would not be required to spend any more than 5 percent of their adjusted gross income on health care premiums for their children under age 19.

"Instead of dumping the problem on

please see ***Kerry*** *on page 42*

Some Golfers Find Analysis Par for the Course

More often than not, golfers must be willing to risk failure to improve. This situation is akin to an analytic patient's experimenting with a change in behavior.

BY JOAN AREHART-TREICHEL

Hank is a sports fanatic. What sport does he like best? "Whatever is currently playing!" he replies. However, his wife confides that he does have a favorite—golf.

"I don't see what he sees in the game," she sighs.

Golfers, however, see a lot. And so do some psychoanalysts who attended the session "Psychoanalytic Perspectives on Teaching, Learning, and Playing Golf" at the American Psychoanalytic Association meeting in New York City in January.

Participants included Richard Harris, M.D., a Chicago psychoanalyst in private practice; Howard Katz, M.D., a psychiatry instructor at Harvard Medical School and a training and supervising analyst at Boston Psychoanalytic Society and Institute; and Phil Lebovitz, M.D., an assistant clinical professor of psychiatry at Chicago Medical School and a training and supervising analyst at Chicago Institute for Psychoanalysis. A professional golfer who teaches at Tamarack Country Club in Greenwich, Conn., Bob Farrell, also attended the session and contributed thoughts on the subject. Farrell is the third generation in his family to teach golf. His grandfather is a U.S. Golf Association Open champion.

Golf is an effort to master one's environment, Katz reported. The drive to master one's environment is fundamental to building an ego. Therefore, a big part of one's self-respect is involved in playing golf.

Emotional equilibrium is also crucial for the game, Lebovitz pointed out. Thus, when psychological issues intrude on one's golf game, they can really mess it up, several anecdotes reported during the session revealed.

One concerned a high school student, "Jim." He was anxious about his putting ability and wanted to quit playing golf. During analysis, Jim revealed that his father wanted him to go to college on a golf scholarship, yet he did not want to do so and feared telling his father that. His conflict over the matter was interfering with his golf game.

The other anecdote concerned Lebovitz. Once he was accompanied on a round of golf by a friend who was dying from cancer. "I played as though I were a rank beginner," Lebovitz lamented. "I had a slice like I hadn't had for years. I chopped up the ground; I went into sand traps and couldn't get out of them."

Lebovitz attributed his miserable performance to sadness over his friend's imminent demise, as well as to the round reminding him of his father. The last time Lebovitz and his father had golfed together, his father was dying from cancer.

Building a Golf Alliance

Golfers who want to improve their game may work with golf teachers, who then combine golf-stroke assistance with some psychology, said Lebovitz.

Lebovitz cited as an example, Jim Suttie, Ph.D., a golf professional and teacher from whom Lebovitz has taken some golf lessons. Suttie videotapes a student's strokes, then shows the student how they compare with the strokes of a professional golfer. During his most recent golf lesson with Suttie, Lebovitz said, "one side of the screen was me; on the other side was Tiger Woods."

Suttie also evaluates the student's learning style—is the student a visual or auditory learner?—and attempts to establish a relationship with the student to relax him or her. It is akin to an analyst trying to establish an analyst-patient alliance, Lebovitz observed. Farrell employs a similar tactic with students. During the first 10 minutes of a lesson, he tries to get students to relax. "You can tell if they are tense," he said.

Suttie likewise uses a clever psychological ploy that he calls "going through the back door to teach." Lebovitz calls it "disarming a narcissistic defense against learning." The ploy consists of convincing a student that a golf-stroke change was his or her idea, not the teacher's; this way the student is more receptive to it.

Still other golfers who want to improve their game may visit sports psychologists, Lebovitz said. Sports psychologists usually push positive thinking. Their typical advice: "Stay in the present; golf is a game of confidence." And certainly the power of positive thinking in golf should not be underestimated. What matters isn't whether the swing is right, but whether you believe in it, Farrell pointed out. Some students have beautiful swings but do not play golf well, he said.

Where Psychodynamics Can Help

Nonetheless, sports psychologists generally do not deal with psychological conflicts that may be interfering with a golfer's game, an analyst participating in the session said, and that is where analysts can especially help.

A case cited by Lebovitz illustrates the point. A 32-year-old woman, "Sandy," entered analysis because of embarrassing outbursts of anger in social settings. However, during analysis her golf game deteriorated, and for a while she talked about nothing else. Then she had a dream about looking for a lost golf ball. Her analyst helped her realize that she was searching for her mother, who had died while she was in college. This realization helped her work through unresolved grief, and her golf game improved.

Still another example of how analysts can help psychologically conflicted golfers can be seen in the case of 15-year-old "Jason." Whenever Jason played golf poorly, he would explode in anger at himself, and his fury would lead to an even worse golf performance. So Jason sought sports psychology help from Katz.

In addition to doing analysis, Katz engages in some sports-psychology work. Although such work is quite different from psychoanalysis—it often involves visiting an athlete at a practice facility—Katz applies what he knows about people and relationships from analysis in that work.

For example, while Jason played nine holes of golf, Katz walked along. As he observed what Jason was doing, he asked him questions about what he was thinking. Katz came to realize that Jason's outbursts of anger over playing poorly were due to his obsession with perfection, and that this obsession arose from his upbringing.

The way most golfers can improve their game, however, is by risking failure, Farrell stressed. Yet the biggest problem that golf students have is the fear of failure, a golf teacher told Katz. And such anxiety, Lebovitz added, is akin to an analytic patient's experimenting with new forms of intimacy or some other behavior change.

"It is going to feel wrong until it feels right," an analyst attending the session commented. "That is how you grow in any domain, that is how you change for the better."

Moving from one level of golf to another is like taking a step forward in child development, Harris said. Golfers who want to improve their game must "develop themselves psychologically as well." ■

Annual Meeting News

Advocate for Your Practice and Patients

A reception for all supporters of APA*PAC* will take place during APA's 2005 annual meeting in Atlanta on Saturday, May 21, at the Omni Hotel. (APA*PAC* is APA's political action committee.) If you are not among that number yet, then rectify the situation by stopping by the APA*PAC* suite at the Omni Hotel. Your support is needed to help make APA*PAC* an integral part of APA's campaign to educate and influence Congress about the needs of the profession and your patients.

APA*PAC* provides the Association with a direct opportunity to support the election of federal candidates who will best advocate for psychiatry's interest in Congress.

With a new Congress before us, psychiatry faces a crucial time that will determine what protections are in place from abusive managed care practices for patients and the profession, protection of the privacy of medical records,the future of the Mental Health Equitable Treatment Act, medical liability reform, and reimbursement funding for psychiatrists. Your PAC support enables APA to increase its proactive education and lobbying campaign on these, and other, issues.

Information about joining APA*PAC *is posted online at APA's Web site at <www.psych.org/members/apapac/index.cfm>. Information is also available from APA*PAC *Manager Jason Pray by e-mail at jpray@psych.org or by phone (703) 907-8581.

Golf: It's Really A Mind Game

Golf is an effort to master one's environment, it was stated at a session at the recent American Psychoanalytic Association meeting (see story at left). *Psychiatric News* asked session participants Richard Harris, M.D., Howard Katz, M.D., and Phil Lebovitz, M.D., about the psychological rewards that a person can receive from succeeding at golf.

PN: What are the chances of a golfer making a hole in one during his or her lifetime?

Harris: I don't think that anyone can expect to make a hole-in-one in their lifetime. It is fairly rare.

Lebovitz: Over the course of the year, there are about 81,000 tee shots on par 3s by PGA Tour professionals. In most years, about one of every 2,500 par-3 tee shots ends up in the hole. And these are the best golfers on the planet. For us amateurs, the chances are closer to one in 20,000 tee shots or greater. Chances of making a hole in one are only slightly better than winning a lottery prize.

PN: What does a hole in one mean psychologically to the golfer who makes it?

Katz: A hole in one is a great pleasure, but a rare event that always includes luck as well as skill.

Harris: From a psychological standpoint, it's a kind of kick, it's almost surreal. It isn't something that you really anticipate happening.

Lebovitz: A hole in one is the equivalent of hitting the perfect golf shot. Golfers live with the constant hope that they will achieve perfection and with the frustration that it so rarely happens. Psychologically, a hole in one enhances one's pride and is narcissistically reinforcing. It makes one feel special, part of an elite group.

PN: How important is a low handicap in golf, psychologically speaking?

Lebovitz: Whereas a hole in one can be chalked up to luck, a low handicap gives the golfer a sense of achievement that is repeatable and reliable. A low handicap provides more substantial bragging rights.

PN: How important is beating competitors in golf?

Katz: My own view is that achievement is quite personal—the development of a sense of mastery that may for some be measured in terms of competitive victories (winning a tournament or a match); for others in achieving a "personal best," such as breaking [a score of] 90, or 80, or, for the best players, 70; and for others in improving one's average score, as reflected by a lower handicap.

Harris: People can have low handicaps and be very good golfers, but in competition don't do well. For one reason or another, when the pressure is on, they can't perform. So I would say the greatest accomplishment is to win—to beat the competition. And that is where some of the psychological aspects come into play.

Plan Points Physicians Toward Best Practices in Prescribing

A Michigan foundation is backing efforts to implement an ambitious plan to improve the prescribing patterns of doctors who treat patients with major mental illness.

BY KATE MULLIGAN

Health care experts frequently lament the gap between what is known about good medical treatment and what is practiced.

A group of Michigan mental health care practitioners and advocates has come up with a plan that tackles an important aspect of that problem in a project called the Michigan Mental Health Evidence-Based Practice Initiative.

With support from the Ethel and James Flinn Foundation, they have produced a comprehensive, multiphase approach to encourage and assist physicians to adopt best practice or evidence-based practice (EBP) in the prescription and monitoring of drugs for people with major depression, bipolar disorder, and schizophrenia. (The terms "best practice" and "evidence-based" practice are used synonymously in their report.)

Thomas Carli, M.D., chair of the panel, told *Psychiatric News* that the effort came about after a study by Blue Cross/Blue Shield of Michigan found "unexplained variations in prescription patterns in Michigan." Carli is a clinical associate professor of psychiatry at the University of Michigan.

He said, "We know that certain treatments for people who have depression, schizophrenia, and bipolar disorder work better than others. Unfortunately, guidelines [promoting effective treatment] are not used frequently enough. For example, only a minority of primary care patients with major depression received recommended dosages and duration of antidepressant medications."

At the national level, the Institute of Medicine and President Bush's New Freedom Commission on Mental Health had emphasized the importance of finding ways to implement what medical researchers have discovered about effective treatment.

Panel members noted how difficult it is for physicians to keep up with and assess which treatments are best for their patients in light of the amount of information on treatment options.

The 25-member Michigan panel considered various guidelines and algorithms and recommended that the Texas Implementation of Medication Algorithms (TIMA) be modified for use in Michigan.

Carli said that the guidelines and algorithms the panel considered "don't differ a great deal" from each other. TIMA has the advantage of including provisions for the education and support of patients and families and could be adopted for use in a variety of settings.

"It was important to find guidelines that will correspond with changes in thinking and knowledge."

Michael Engel, D.O., a member of the panel and immediate past president of the Michigan Psychiatric Society, pointed out that TIMA is frequently updated. "It was important to find guidelines that will correspond with changes in thinking and knowledge."

Both physicians commented on the challenges of implementation.

Carli said, "We know that dissemination of practice guidelines alone will reach too few doctors."

The Michigan practice initiative differs from efforts to change prescribing practices in other states, such as Missouri and Massachusetts, in its comprehensive nature.

It aims to use multiple strategies to influence practice in a wide variety of settings and to educate a broad range of stakeholders. The panel members wrote, "For the EBP project to succeed, there must be buy-in from stakeholders—practitioners, patients, advocacy groups, payers, and academic researchers on both the broad state and local level."

Ultimately, the panel wants its recommendations to affect practice by primary care physicians, as well as psychiatrists, and in both the public and private sectors.

Panel members focused considerable attention on identifying barriers to adoption of guidelines and factors that would promote their use.

They reviewed research results on how practice changes occur among physicians and came up with four principles:

- Guidelines/algorithms must be easy to use and valuable.
- Guidelines/algorithms by themselves are not enough. They must be part of a broader education and disease-management approach.
- Differences in knowledge and needs among psychiatrists, primary care physicians, and consumers must be part of the action plan.
- The action plan should be rolled out over time, with pilot programs to enlist opinion leaders and early adopters.

Mark Reinstein, Ph.D., president and CEO of Michigan's Mental Health Association, told *Psychiatric News* that TIMA, as currently presented, would be very difficult for a family member or patient to understand. Success of the project for these individuals will require considerable redesign of how TIMA is presented.

please see ***Best Practices*** *on page 40*

PFIZER SYMPOSIUM
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Treating Inmates' Drug Use Cost-Effective in Long Run

While treating inmates for substance abuse problems is expensive, it is less expensive than leaving them untreated when the costs associated with recidivism are factored in.

BY EVE BENDER

Inmates in Connecticut prisons who received substance abuse treatment while incarcerated were significantly less likely to be rearrested, thus resulting in reduced costs to taxpayers.

This is the major finding from a study conducted by researchers from Brandeis University in Waltham, Mass., who estimated that cost savings associated with providing substance abuse treatment of inmates ranged from $20,098 to $37,605 per prisoner, depending on the type of substance abuse treatment program implemented.

The results of the study appeared in the February *Journal of Offender Rehabilitation*.

"The public's perception is that substance abuse treatment programs don't work. These findings show otherwise," Marilyn Daley, Ph.D., told *Psychiatric News*. Daley is one of the lead authors of the article and a senior research associate at the Schneider Institute for Health Policy at Brandeis University.

Daley and her colleagues studied the records of 831 inmates who were incarcerated in Connecticut for at least 180 days and then released between May 1, 1996, and April 30, 1997. These records represented two small random samples from the Connecticut Department of Corrections combined with a nonrandom sample of 545 records from the Connecticut Department of Mental Health and Addiction Services.

All inmates in the study had been diagnosed with a drug or alcohol problem.

Researchers collected data on the inmates for a year before and a year after release to assess participation in substance abuse treatment programs and to determine whether inmates had been arrested again. Among inmates in the study, 358 received substance abuse treatment and 473 did not.

Treatment consisted of participation in one of four "tiers" of substance abuse treatment. Each tier had a different intensity, ranging from a tier-one program, which consisted of a one-week session of drug and alcohol education at the prison, to a tier-four program, which consisted of full-time, daily substance abuse treatment for six months in a separate housing unit.

Daley found that almost half of the inmates who didn't receive substance abuse treatment (46 percent) were rearrested within the first year after release, but that figure dropped to 37.4 percent for those who received tier-two treatment, which consisted of 30 group sessions three days a week for 10 weeks.

Of those who received the intensive substance abuse treatment within a tier-four program, just 23.5 percent were rearrested.

The drop in recidivism rates for Connecticut inmates who participated in substance abuse treatment translated into cost savings for taxpayers, according to the report.

Daley said each inmate who is rearrested costs taxpayers an average of $45,536. (The figure is based on a sentence of 646 days, the average length of sentence for inmates in the sample, at a cost of $70.49 a day.) This is about 5.7 times the cost of basic treatment per inmate ($7,931) and almost twice the cost of intensive, or tier-four, substance abuse treatment, which costs on average $25,438. The cost estimates take into account the direct and indirect costs associated with incarceration and treatment in the prison setting.

Daley pointed out that the benefits associated with inmates receiving substance abuse treatment extend far beyond taxpayers' wallets. "There are less crime in the community and greater public safety," she said.

Though she acknowledged that drug treatment programs for prison inmates are low on government priority lists, she said that "states should increase funding for these programs" because more j24

inmates could receive treatment and because it is a prudent long-term investment.

The Robert Wood Johnson Foundation funded the study.

An abstract of the article, "Cost-Effectiveness of Connecticut's In-Prison Substance Abuse Treatment," is posted online at <www.haworthpressinc.com/web/JOR/>. ■

For Lifers in Atlanta

Annual Meeting News

If you are a life member or life fellow of APA, plan to join the APA Lifers for activities to be held in conjunction with APA's 2005 annual meeting in Atlanta.

On Tuesday, May 24, from 7:30 a.m. to 9 a.m., the Lifers will hold its annual Business Meeting/Forum. The meeting will begin with a continental breakfast, and presentations will be made by invited guests.

On Tuesday, May 24, from 7 p.m. to 9 p.m. the Lifers will hold its annual reception. The Harold Berson, M.D., Award will be presented, and a drawing for a $100 door prize will be held.

On Wednesday, May 25, from 11 a.m. to 12:30 p.m., the Lifers will sponsor the component workshop "Mental Status After CABG: Implications for Psychiatrists' Competence."

More information is available by contacting Barbara Matos, staff liaison, at (703) 907-8517. Additional information will be mailed to all Lifers this month. ■

Psychiatric Crisis Team Aids Americans Overseas

After manmade and natural disasters such as the December 2004 tsunami, psychiatrists in the State Department's Foreign Service provide support and counseling to U.S. Embassy staff.

BY CHRISTINE LEHMANN

American diplomats and their families assigned to embassies abroad are vulnerable to crisis situations such as terrorist attacks, hostage taking, assassinations, and kidnappings.

Embassy consular affairs staff who serve American citizens abroad have also been the target of attacks in recent years. In the past year alone, the American consulate in Jeddah, Saudi Arabia, and the consular section of the American embassy in Tashkent, Uzbekistan, have been bombed, and Americans and foreign nationals have been injured, according to psychiatrist Samuel Thielman, M.D., Ph.D., chief of mental health services at the U.S. Department of State. He is the immediate past chief of crisis response mental health services at the department, a position created recently to organize and coordinate psychiatric responses to disasters and crises overseas.

Thielman oversees 14 full-time psychiatrists in the Foreign Service who rotate to new assignments every two to four years, including Washington, D.C. Regional Medical Officer–Psychiatrists (RMO-Ps) cover more than 240 embassies and consulates worldwide, Thielman told *Psychiatric News*.

The State Department realized in the 1970s that providing on-site mental health counseling and treatment and establishing community programs were more effective and less costly alternatives to evacuating personnel who were suffering from mental health problems after a disaster or other crisis.

The first RMO-P position was established in Vienna, Austria, to serve posts primarily in Eastern Europe. Other positions were then established in Bangkok, Thailand; Cairo, Egypt; Monrovia, Liberia; and New Delhi, India, according to Thielman. These RMO-P "circuit riders" visit several embassies in their region and conduct crisis intervention, teaching, supportive psychotherapy, and consultations with school psychologists, counselors, and others.

Psychiatrist Kenneth Dekleva, M.D., is based at the U.S. Embassy in New Delhi. When *Psychiatric News* reached Dekleva by telephone in late January, he had recently visited embassy staff in Colombo, Sri Lanka, and southern India to discuss how they were coping in the aftermath of the December 2004 tsunami. The American embassies in Thailand and Sri Lanka received the most tsunami-related inquiries about Americans, because of those countries' popular beach resorts.

> **"It is critical for our psychiatrists to be well-versed in disaster responses."**

"Some employees of the embassy in Colombo were on the beach in southern Sri Lanka when the tsunami struck and barely escaped. They witnessed people being swept away and a lot of death and destruction." Dekleva said.

Consular affairs employees were assigned to help local authorities with identifying dead bodies, which involved handling human remains. Dekleva talked to the staff about common psychiatric reactions and how to avoid physical exhaustion by working in regular shifts, taking breaks, and eating regularly.

The consular affairs staff in Colombo responded to hundreds of inquiries from concerned relatives and friends about American citizens presumed to be somewhere in the country at the time of the tsunami.

The Bureau of Consular Affairs in Washington, D.C., estimated that it received 30,000 phone calls within a few weeks of the tsunami, according to a State Department spokesperson.

By mid-February, the bureau confirmed that 18 American citizens had died as a result of the tsunami in Thailand and Sri Lanka. Fifteen Americans in the affected region were presumed dead, given their proximity to the tsunami.

Several Sri Lankan employees of the American embassy lost relatives in the tsunami. "I was impressed with their dedication to helping American citizens despite their personal loss and hardship," Dekleva said.

The consular affairs staff also made arrangements for visiting members of Congress and the Bush administration.

"Embassy and consular staff are highly dedicated and resilient individuals. It was deeply rewarding for me personally and professionally to be able to listen to their stories and provide support and consultation. The next challenge will be the slow and painful process of helping Sri Lanka in its reconstruction efforts," Dekleva commented.

Many of his Foreign Service colleagues also have experienced the aftermath of a natural disaster, terrorist event, or crisis during an overseas assignment.

Thielman, for example, was assigned to the U.S. Embassy in Nairobi, Kenya, in 1998 after bombs killed 213 people and injuredd about 4,000. Bombs exploded nearly simultaneously at the U.S. Embassy in Dar Es Salaam, Tanzania, killing 12 people and injuring about 85, according to the State

please see ***Crisis Team*** *on facing page*

Tsunami Leaves Behind Mental Health Crisis

The World Health Organization is working with organizations in tsunami-affected regions of South Asia to train community-based workers to be counselors for traumatized individuals.

BY CHRISTINE LEHMANN

Health and mental health workers in southern Asia have observed varying degrees of psychological trauma in several communities hard hit by the December 2004 tsunami, according to the World Health Organization (WHO).

A physician who directs regional operations for the WHO in affected regions of Asia reported that normal grief over the loss of loved ones has been compounded by the loss of homes, livelihood, and entire community networks, according to a WHO press release.

"Many can cope and will gradually come to terms with what has happened. But many others will sit motionless or cry for hours on end. If support is not urgently provided, the long-term effect on these populations could be terrible," Samlee Plianbangchang, M.D., WHO regional director for South-East Asia, said in the release.

The situation is further exacerbated by an acute shortage of health workers trained in mental health care and counseling. In Banda Aceh, Indonesia, near the epicenter of the earthquake that triggered the tsunami, more than 150 people worked at the psychiatric hospital before the tsunami. After the disaster the staff was down to one psychiatrist, three trained counselors, and six nurses.

The WHO recommended that community-based workers from the region should provide psychosocial support because they understand the needs and culture of disaster victims.

"Importing psychiatrists from other regions to talk to the bereaved isn't an appropriate response," the WHO statement emphasized.

To coordinate the training of community workers in India, the WHO is working with United Nations agencies including UNICEF, nongovernmental organizations, and local field representatives of these organizations.

Using standardized manuals, the WHO training will involve role playing and empathizing with victims, providing support, and encouraging victims to talk about their problems.

The WHO is also rapidly increasing its support to other tsunami-affected countries and implementing recommendations in the "WHO Guidelines for Mental Health in Emergencies."

The guidelines call for increased community outreach, particularly taking into account the special needs of populations such as children, women, the elderly, and the severely injured, that incorporates a culturally appropriate approach for each region.

Soon after the tsunami, the organization sent four mental health experts to Sri Lanka and Indonesia to work with local psychiatrists and mental health professionals, as well as ministries of health, on implementing psychosocial training in hard-hit communities. The WHO stated that the components that make up the training honor the dignity of survivors, identify potentially high-risk populations, help survivors reunite with friends or family, and provide self-help materials that could aid victims in reestablishing a more normal life.

In a province in Thailand, for example, local authorities are rotating 80 mental health workers on a weekly basis to support devastated communities. "Many people are suffering emotional aftershocks. We saw a son who was extremely distressed at not having been able to save his father from the force of the tsunami. Such people urgently need a support system to help them cope with this traumatic experience," said Aphaluck Bhatiasevi of WHO in Thailand, in the press release.

Information on the WHO's response to the Asian tsunami disaster is posted online at <www.who.int> and <www.whosea.org>. ■

Crisis Team

continued from facing page

Department.

After the Nairobi bombing, Thielman collaborated on postdisaster mental health studies with researchers including psychiatrists Carol North, M.D., and Betty Pfefferbaum, M.D. The papers resulting from their studies have been accepted for publication, said Thielman.

"It is critical for our psychiatrists to be well-versed in disaster responses," said Thielman. North, Pfefferbaum, and disaster psychiatry specialist and researcher Robert Ursano, M.D., have presented their work to State Department psychiatrists meeting in conjunction with APA annual meetings in recent years.

Dekleva praised the APA disaster psychiatry workshops and seminars at annual meetings that he attended.

Information about Foreign Service Regional Medical Officer–Psychiatrists is posted online at <www.careers.state.gov/specialist/opportunities/medpsych.html>.

Information about U.S. Department of State tsunami relief efforts is posted at <www.state.gov/p/sa/tsunami>. ■

PFIZER SYMPOSIUM IS 4C (LIEBERMAN)

Data Lacking on Link Between Drugs, Behavior

CNS drugs may produce behavioral toxicity in children, but not all such side effects can be explained by these medications.

BY AARON LEVIN

Drugs designed to treat psychiatric illnesses may sometimes produce side effects expressed as behavioral changes, yet they are less common than often believed.

"If it crosses the blood-brain barrier, it's likely to have an effect on children's behavior," according to Gabrielle A. Carlson, M.D., a professor of psychiatry and pediatrics at Stony Brook University School of Medicine.

Although SSRI antidepressants have received most attention recently, Carlson pointed out at a conference sponsored by the American Academy of Child and Adolescent Psychiatry that alcohol and barbiturates can cause aggression, excitement, or irritability, while tricyclics can do the same and induce hallucinations, as well.

The most common effect on behavior is disinhibition, the loss of restraint over social behavior. Such disinhibitions are considered rare, but when they do occur, they are often the result of some combination of a drug, the child, and the psychiatric conditions already present, she said.

Drug combinations, especially antidepressants and alcohol or street drugs, can heighten the risk, as does physical illness. Learning-disabled children or those with degenerative brain diseases are more vulnerable as well, as are children with impulse-control problems, such as those associated with ADHD, bipolar disorder, or borderline personality disorder, Carlson pointed out.

At the same time, it can be hard to find good epidemiological data. Events are uncommon, and only people with psychiatric symptoms get studied, while asymptomatic subjects don't get the same scrutiny. Even in clinical trials, adverse events are not the focus of separate reports, so it is harder to collect information from the medical literature, said Carlson.

The dearth of pediatric drug trials poses other problems. Many drugs are used off-label, because few studies have been done to seek pediatric approvals. "There is so much we don't know about how children metabolize drugs," she said.

Behavioral side effects of medications in children vary with the drug. Stimulants are approved for patients down to 6 years of age. "Stimulant rebound" describes the greater irritability, sadness, crying, or euphoria after their drugs wear off in the afternoon or evening. Experts say it's hard to find, but clinicians see it all the time, said Carlson. A study of 149 inpatient children found that 60 percent showed no diurnal changes in those symptoms. Of the remainder, many children not on any stimulant did worse in the evening, while others had only "trivial rebound," depending only on dosage level.

> "We need more standardized ways of eliciting side effects from young patients."

However, a third group, about 21 percent of the total, clearly showed rebound effects that required stopping medication. That, said Carlson, means that clinicians should not be so quick to blame the drug for rebound and discontinue medications without a closer look.

As an example, she cited the case of a child who developed psychotic symptoms after going back on 15 mg of a stimulant after a summer hiatus from school. It was found that the year before, the child had started at 5 mg and had been titrated slowly upward to 10 mg and then 15 mg. But restarting the drug at the full 15 mg dose had produced psychosis. Stopping the drug and then retitrating slowly produced no ill effects.

A second question regarding stimulants is whether they will make children who have both ADHD and bipolar disorder sicker. In her own research, Carlson found that children with ADHD and manic symptoms responded well to methylphenidate during a one-month titration trial. Those with ADHD and bipolar symptoms responded as well as other ADHD children in the 14-month treatment phase.

"Continue to carefully diagnose and treat patients who have some bipolar symptoms and full ADHD," she said. "Stimulants and combination therapies remain the first choice, but treat mood problems first."

Rates for activation in trials of SSRIs, of which only fluoxetine and fluvoxamine are approved for use in children, vary from less than 1 percent to 27 percent, clustering around 10 percent. Results of a dozen trials in children provide conflicting data that amount to a "dog's breakfast," said Carlson.

"There's no common definition of activation," she said. "We need more standardized ways of eliciting side effects from young patients."

Finally, a small study of 76 patients with bipolar depression found that in only 9 percent could a switch from depression to mania be attributed to use of antidepressants. These data are consistent with other studies suggesting that people taking antidepressants have been depressed longer than untreated subjects, but while they are at greater risk for switching, not all bipolar patients will switch on antidepressants. ■

PFIZER SYMPOSIUM
ISL 4C (TARIOT)

No Simple Solution To Childhood Insomnia

Sleep disturbances may accompany psychiatric disorders and their treatment in children. These problems require more attention from pediatricians and child psychiatrists.

BY AARON LEVIN

Sleep problems are closely intertwined with psychiatric diagnoses in young people. Common disorders and their treatments may affect sleep, and troubled sleep patterns in turn affect daily functioning.

Unknotting this tangled web presents a challenge to clinicians, said Judith Owens, M.D., M.P.H., at a conference sponsored by the American Academy of Child and Adolescent Psychiatry. Yet many primary care physicians are unfamiliar with sleep issues.

"Things have improved over the last five years," said Mark Goetting, M.D., another pediatric sleep specialist, "but a survey in the 1990s found that pediatricians learned more about sleep medications from their own mothers and children than they did in medical school."

There is no one cause or constellation of symptoms for insomnia in children, said Owens. "Information comes largely from parents," she said. "Clinicians often respond to a parental problem."

"Insomnia is a problem because it disturbs the sleep and function of the whole family," agreed Goetting, director of Sleep Health in Kalamazoo, Mich. A sleepless child may keep parents awake at night or provoke a power struggle at wake-up time.

The current consensus definition of pediatric insomnia includes three components: difficulty initiating or maintaining sleep; a severe, chronic, or frequent sleep problem, associated with impaired daytime functioning in the child or family; or a primary sleep disorder or one associated with medical or psychiatric disorders. In any case, according to the American Academy of Sleep Medicine, "insomnia is a symptom and not a diagnosis."

"The key is excessive daytime sleepiness leading to behavioral deficits, mood disturbances, or changes in affect," said Owens, co-author with Jodi A. Mindell, Ph.D., of *Clinical Guide to Pediatric Sleep: Diagnosis and Management of Sleep Problems* (Lippincott Williams & Wilkins, 2003).

Behavioral problems can include aggressiveness, hyperactivity, or poor impulse control. Neurocognitive deficits can appear in attention, memory, or executive functions or in cognitive flexibility, verbal creativity, or abstract reasoning. Academic, family, and social life may suffer, too.

"With a psychiatric condition combined with insomnia, the initial focus should be on improving the psychiatric condition," Goetting said. ADHD, depression, anxiety, and bipolar disease can be aggravated by sleep disorders.

ADHD Complicates Matters

"A substantial percentage of ADHD kids may have sleep deficits," said Owens. In fact, said Goetting, some subsyndromic hyperactivity and impulsivity in ADHD may be solely due to sleep disorders.

Diagnosis is complicated by the fact that some primary sleep disorders may present with ADHD-like symptoms. Physicians should use some simple screening tool to evaluate the child's sleeping patterns and differentiate between primary sleep disorders and those influenced by other causes, said Owens.

Comorbid psychiatric disorders with ADHD may also account for sleep problems. Bipolar disorder may reduce the need for sleep. Insomnia or early awakening may be tied to depression, while bedtime resistance or sleep-onset delays may occur with oppositional defiant disorder, obsessive-compulsive disorder, or anxiety. At the same time, treatment may also affect sleep. ADHD may alter circadian sleep patterns, shift sleeping time, and cause increased daytime sleepiness.

"Medications used to treat ADHD or comorbid conditions may affect sleep or wakefulness," said Owens. Psychostimulants may directly delay sleep onset, decrease time asleep, or disrupt sleep continuity. Rebound effects—increased irritability and insomnia after the drug wears off—may occur too.

Insomnia Common With Depression

Depression and its treatments also engender sleep problems. About 75 percent of children and adolescents with major depressive disorder report insomnia, of which 30 percent is characterized as severe. One-third of depressed adolescents report sleep-onset delays, while 25 percent say they sleep too much. Worse sleep quality, as measured by wristband motion detectors, is associated with more depressed mood and hopelessness among hospitalized psychiatric patients, said Owens.

Antidepressants have their effects as well. Tricyclics can be sedating and can suppress random-eye movement (REM) sleep while increasing REM latency, she said. Rapid withdrawal may lead to nightmares and parasomnias. SSRIs can increase periodic limb movements, while buproprion seems to have no effect on sleep latency or total sleep time, but may increase the percentage of REM as it reduces REM latency. Some newer antidepressants, like citalopram, nefazodone, or mirtazapine, are sedating and may be useful in treating depression associated with insomnia.

Mood stabilizers and anticonvulsants like carbamazepine, valproic acid, topiramate, and gabapentin appear to be slightly sedating, she said. Most antipsychotics increase daytime somnolence, reduce sleep-onset latency, and increase sleep continuity, but they suppress REM sleep.

Use Medication Sparingly

Treating insomnia in children and adolescents raises a problem common to those age groups: "There are no sleep medications currently labeled for use in children by the FDA, and there's too little empirical, outcome-based data to recommend specific drugs in specific situations," said Owens.

The American Academy of Sleep Medicine's Pediatric Pharmacology Task Force emphasizes that drugs be used judiciously in treating insomnia. According to their recent review of the subject (co-written by Owens), medication should rarely be the first or only treatment option. Instead, behavioral therapies should be tried first, and "pharmacological approaches should be largely considered adjuncts in the treatment of pediatric insomnia."

However, many physicians often don't have the time or expertise to work with parents on behavioral strategies, so medication may be useful in a crisis. "Drugs can be used to bring the child or the family down from the boiling point when the safety or welfare of the child is threatened," said Owens.

Treatment should be based on a careful diagnosis, and goals should be realistic, defined, and measurable, she said. Physicians should review side effects with the family, monitor the patient's response frequently, and avoid abrupt discontinuation. Combining behavioral with pharmacological therapy increases long-term efficacy and decreases side effects.

From a parent's point of view, the ideal sleep inducer would be in liquid form and have a quick onset; an intermediate duration; no effect on sleep architecture; and no rebound, tolerance, withdrawal, or side effects, said Owens.

By those standards, many medications used for adults are questionable when prescribed for children. The central alpha-2 agonist clonidine, for example, has a rapid onset but also has a variable half-life of from six to 24 hours, too broad a window for convenient use. Clonidine does reduce sleep-onset latency, but also increases slow wave sleep and decreases REM. Side effects include hypotension, bradycardia, irritability, dysphoria, and potential for overdose. Patients may develop tolerance or develop higher rebound blood pressure on discontinuation. Although clonidine is approved for adults, Owens prefers not to prescribe it for children for these reasons.

Benzodiazepines decrease sleep latency but produce morning hangover, cause daytime drowsiness, induce withdrawal symptoms on discontinuation, and interact with central nervous system depressants. They may mask sleep symptoms, not improve them, she said.

Zolpidem, the most widely used short-acting hypnotic in adults, acts quickly and has minimal effects on sleep architecture and few aftereffects, but so far it has not been used much in pediatrics.

Antihistamines are weak soporifics that are seen as benign, but produce daytime drowsiness, cholinergic effects, and paradoxical excitation.

"They are not the best choice in serious cases, but familiarity may make them a more acceptable choice for families," she said.

Melatonin, often used for circadian rhythm disturbances, is sometimes used as a sedative. However, it affects the hypothalamic-gonadal axis and, in sudden withdrawal, may kick young patients into premature puberty.

Physicians and parents should collaborate on behavioral interventions. Owens disapproves of allowing children to watch late-night television or playing video games. The light levels may be enough to prevent the body's melatonin from kicking in. Some parents are "enablers" of their children's sleep problems, she said. Parents of a child who stays awake all night and sleeps all day may collaborate with the child by providing excuses to keep the child out of school.

Rather than trying to "pull" a child's sleep schedule back to normal by attempting to enforce a progressively earlier bedtime, she suggests pushing the child to delay sleep by two hours each night until reaching an acceptable normal bedtime.

In any case, clinicians should not shrug off children's sleep problems.

"A child waking up in the middle of the night is a crisis for the whole family," said Goetting. "It destroys quality of life. The emotions accompanying the event start with sympathy and caring, but if a parent can do nothing and the child can't go back to sleep, feelings of anger and frustration emerge. So children who are sleepless are at high risk for child abuse. Sadly, most children and families who could benefit from treatment don't get it." ■

Workers Focus on Positives of Genetic Research

Researchers were surprised to find that American employees at two work sites were generally open to the idea of having people participate in research exploring the genetics of mental and physical illnesses.

BY JOAN AREHART-TREICHEL

How do Americans view participation in research having to do with the genetics of mental and physical illnesses?

Quite favorably, a pilot study suggests. It was headed by Laura Roberts, M.D., chair of psychiatry at the Medical College of Wisconsin and a bioethics professor for the college's Health Policy Institute. Results appeared in the January-February *Comprehensive Psychiatry*.

Roberts and her colleagues developed a written survey to explore people's attitudes toward participation in research pertaining to the genetics of mental and physical illnesses. The survey did not ask respondents whether they would be willing to participate in such research.

The investigators then pilot-tested the survey on 63 subjects. These were healthy adults working in two settings—an academic medical center (the University of New Mexico Health Sciences Center) and a large laboratory dedicated to scientific and defense development (the U.S. Department of Energy's Sandia National Laboratories). Respondents ranged in age from 21 to 65 years and included a similar number of men and women. Most were Caucasian, and about a third were of Hispanic background. They worked in technical, professional, or administrative positions.

Results from the pilot test revealed that respondents viewed participation in research concerning the genetics of mental and physical illnesses as acceptable for all 12 subpopulations inquired about: healthy people, people with serious mental illnesses, people with serious physical illnesses, members of ethnic minorities, elderly people, health care employees, people in the military, government employees, pregnant women, prisoners, people living in nursing homes

please see ***Genetic Research*** *on page 35*

Familiar Often Wins Out In Struggle to Change

People are resistant to psychotherapy because they prefer the familiar, a psychiatrist argues, and they prefer the familiar because their brain structures are formed by the time they reach adulthood.

BY JOAN AREHART-TREICHEL

All psychotherapies are based on the premise that people can change their thoughts, emotions, and behaviors. But to what extent are people really open to change?

Not all that much, Bruce Wexler, M.D., a professor of psychiatry and a brain-function scientist at Yale University, argues. All of us like a little novelty, and some of us like a lot, but generally "most of us seek the familiar most of the time."

Wexler presented data to support his position at the American Psychoanalytic Association meeting in New York City in January at the seminar "Neuroplasticity Over the Life Span: How People Can and Can't Change."

For example, brain-imaging data in both humans and animals show that early life experiences—sensory inputs—are indispensable in shaping brain formation and function. Further, brain neurons have been found to be most readily formed and reformed in both humans and animals prior to sexual maturity. The frontal and parietal lobes—the brain areas that most distinguish humans from other primates—are the last to mature, doing so around age 21. Therefore, while adults can learn and make brain changes, Wexler concluded, it is more difficult for them than for children and teenagers because adults' brain structures are essentially formed.

And once people's brain structures are formed, Wexler posited, they tend to seek sensory inputs consonant with those structures—for example, "Democrats marry Democrats, and Republicans marry Republicans."

In one experiment, subjects were found to prefer those letters of the alphabet that they had viewed the most often during the test. In another experiment, men were found to look more at ads of the car model they owned than at ads of other car models.

Further, if people are faced with situations in which there is a mismatch between their brain structures and their sensory stimuli, it can prove unpleasant or unsettling, Wexler asserted.

One example of where sensory inputs no longer match brain structures and where the mismatch can be traumatic for people is bereavement. Sensory inputs of the beloved are gone forever, so that "all of the internal representations of the deceased have to be reworked." Another instance where the clash between brain structures and sensory inputs can be very troubling is immigration. That is why immigrants often surround themselves with fellow immigrants and objects from their homeland, he said.

And of course, psychotherapy can be highly anxiety provoking, Wexler declared. "We want to create change, to alter brain structures, which is painful and difficult for people."

In psychoanalysis, the transference reflects the patient's brain structures, and the challenge is changing those structures first, then the transference.

Nonetheless, over a period of time patients in psychotherapy will probably come to feel comfortable, Wexler opined, and this comfort level should help pave the way for change—for "a paradigm shift." ■

Suicide Risk May Increase When Debts Pile Up

Who commits suicide in the wake of economic recessions and depressions? One group consists of middle-aged men in the throes of debt, not individuals with preexisting mental illness.

BY JOAN AREHART-TREICHEL

It is well known that economic recessions and depressions are often accompanied by psychological difficulties and suicides. Stories of businessmen jumping out of windows following the stock-market crash of 1929 are legendary.

Little is known, however, about the kinds of people who commit suicide in the wake of an economic downturn or about the specific circumstances that prompt people to make such a tragic choice.

Now a study published in the January *British Journal of Psychiatry* offers some tentative answers to these questions.

The study was headed by Kathy Chan, M.D., an honorary associate professor at Kwai Chung Hospital in Hong Kong. Chan is also a research psychiatrist with training in ethnography.

From the mid-1980s to the mid-1990s, Hong Kong experienced a breathtaking economic "upper," or as Alan Greenspan would say, "an era of irrational exuberance," where properties increased 600 percent in value and the stock market soared over 400 percent.

In 1997, however, as Britain handed control of Hong Kong over to China, Hong Kong plunged into a severe, unexpected recession, accompanied by psychological repercussions. Between 1998 and 2000, more and more Hong Kong residents killed themselves, and many used a novel tool to achieve it—carbon-monoxide poisoning created by burning a charcoal grill in a small, sealed room.

Chan and her coworkers set out to learn more about these individuals, as well as the financial or psychological factors that might have prompted them to undertake such an act.

The researchers performed financial and psychological "autopsies" on 160 Hong Kong residents who committed suicide by indoor charcoal burning between 1998 and 2000, as well as on 160 Hong Kong residents who had committed suicide during the same period but used other methods. Both cases and controls were matched on age and gender.

The persons who killed themselves by indoor charcoal burning tended to be less likely to have preexisting mental illness than persons who killed themselves by other methods. Further, financial indebtedness was significantly more common among persons who had committed suicide by indoor charcoal burning than it was among those who used other means.

Thus, those who killed themselves by indoor charcoal burning appeared to undertake such actions not because of preexisting mental illness, but because of financial debt.

Moreover, those who killed themselves by indoor charcoal burning tended to be middle-aged men who planned their suicides in advance, but often they did not attempt suicide until they were drinking alcohol.

Information gleaned from 25 survivors of indoor charcoal-burning suicide attempts also suggested that many, if not most, of such suicides had been driven by financial indebtedness. Said one survivor: "I had loans of 1 million Hong Kong dollars when I attempted to kill myself."

Information culled from the 25 survivors likewise implied that the charcoal-burning suicide phenomenon may have been fueled by the public media in Hong Kong. For instance, indoor charcoal burning was quickly connected with indebtedness in newspaper reports. Newspapers carried pictures of the suicide scene, the paraphernalia, and the necessary arrangements. The reports conveyed the idea that indoor charcoal burning was an easy, painless, and effective means of ending one's life, especially in the face of insurmountable debts. Said one survivor, "I read about this method in the papers. I know it's easy. Jumping and wrist-cutting need more courage."

On a more positive note, however, the researchers also found that persons who are in debt and who seek help to resolve their financial problems are no more at risk of suicide than is the general population. This information was conveyed to *Psychiatric News* by Paul Yip, Ph.D., one of the study authors and director of the University of Hong Kong's Center for Suicide Research and Prevention.

Although suicide by indoor charcoal burning may be a local phenomenon, Chan and her team believe that their findings might have implications for the United States, the United Kingdom, and other countries, where, as they pointed out in their study report, "overindebtedness is more serious than ever."

The study was funded by the Hong Kong Health Care and Promotion Fund and the Hong Kong Jockey Club Charities Trust.

An abstract of "Charcoal-Burning Suicide in Post-Transition Hong Kong" is posted online at <http://bjp.rcpsych.org/cgi/content/abstract/186/1/67>. ■

FOREST NAMENDA
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How to Access E-Mail While Away

BY JOHN LUO, M.D.

Computer technology has become an increasingly vital part of psychiatric practice today. It seems there are new software programs and computer equipment reviewed in the *Wall Street Journal* each week. Trying to keep up and make sense of what technology you need may appear to be an exercise in futility—or perhaps the Health Information Portability and Accountability Act has left you thinking that paper and pen is good enough.

John Luo, M.D., is an assistant professor of psychiatry at the UCLA Neuropsychiatric Institute and Hospital in Los Angeles and president of the American Association for Technology in Psychiatry.

The goal of this column is to make these new technologies less daunting by explaining the basics and exploring the latest innovations. You may have heard of the term "medical informatics." Dr. Edward H. Shortliffe, director of medical informatics at Columbia University, defines it as "the scientific field that deals with biomedical information, data, and knowledge—their storage, retrieval, and optimal use for problem solving and decision making."

Before you begin to think that it's time to go back for that master's degree in medical informatics or even contemplate giving up on using technology, there is an alternative. The American Association for Technology in Psychiatry (AATP, formerly known as the Psychiatric Society for Informatics) is a nonprofit membership organization of physicians and mental health professionals dedicated to the development and use of information technology to improve the quality and availability of psychiatric and mental health care. I am currently president of the AATP.

Most AATP members are also APA members. There is no degree or fellowship requirement to join—only a desire to expand your knowledge base and appreciation for what technology offers psychiatric practice. This column will be written by AATP members to help you understand and enhance your use of information technology.

Let's start with a very basic but pervasive use of technology: e-mail. E-mail has become the de facto alternative to voicemail as a method to communicate and exchange information. Here are a few key concepts to understand about e-mail and a few tips to get your e-mail on the road.

E-mail accounts, whether set up at home or at work, have several key elements. You should know your account name, password, e-mail server name, and what type of protocol (method) your server uses to retrieve e-mail.

There are three types of e-mail protocols: POP (post office protocol), IMAP (Internet message access protocol), and SMTP (simple mail transfer protocol). SMTP is used to send e-mail from the server, whereas POP and IMAP are used to retrieve e-mail.

Both POP and IMAP follow the client-server model. That means that your e-mail is sent to your e-mail server (a computer connected to the Internet) and held there by the server until you connect with your client program on your computer, such as Eudora or Microsoft Outlook. In POP e-mail retrieval, all of your e-mail is then sent from the server to your computer. With IMAP, you have the option to download selected e-mail messages.

E-mail can be accessed from computers other than your own. One simple method is to use a Web browser that permits you to utilize any computer connected to the Internet, hence the term "Web mail." Many Internet service providers (ISPs) offer a Web-mail service to their subscribers. For example, if Comcast is your ISP, you'd begin by typing in your browser the URL <http://www.comcast.net>. Then you would sign in by entering your e-mail address and password; your e-mail then appears in the Web browser. One issue to keep in mind is that you can access only those messages still on the server; any e-mail you have already downloaded onto your home or office computer will not be available to you.

If your ISP doesn't provide Web mail, you can utilize a free service at <http://www.mail2web.com> or a paid service at <http://www.mollymail.com>. All you have to enter into the Web site is your e-mail address and password. These sites try to guess the name of your e-mail server and its method for e-mail retrieval. If mail2web cannot guess, you can try the advanced log in, which requires the e-mail server name. While mail2web adds two lines in your sent e-mail messages advertising its free service, the ad is not very intrusive.

It might seem simpler to use only Web-based e-mail services, such as Yahoo or Onebox. Such services are available from any computer connected to the Internet. There are free and paid accounts, which offer different features.

Free accounts typically require you to log in and check e-mail at least once a week; otherwise, your account will be deactivated. The providers want you to check your e-mail often because it will be seen with random ads along the side. Paid accounts, which range in cost, do not have advertisements, and they come with more features, such as extra storage space, virus scanning, fewer restrictions on attachment size, and spam blocking.

A major disadvantage with Web-based e-mail-only accounts is that your computer must be connected to the Internet to access your e-mail.

If you are exceeding your e-mail size capacity on the server, you must delete messages or attempt to save them on your computer. To save messages is an unwieldy process. The simplest way is to print the message, but to keep the contents digital, you can copy the message and save it in a document such as Microsoft Word or text file. ■

Guidelines Launch 'Watches'

BY JOHN S. MCINTYRE, M.D.

Over the past decade, APA has published 14 practice guidelines using an evidence-based process. After some initial concerns about "cookbook medicine" and the possibility of increased malpractice actions, neither of which have materialized, psychiatrists have increasingly accepted the guidelines as an aid in making clinical decisions.

There have been three major challenges in the project: (1) developing a reliable and effective process that incorporates the relevant evidence in a usable form, (2) disseminating the guidelines and having them used in day-to-day clinical work, and (3) keeping the guidelines current.

Development process: The process we developed for producing practice guidelines is based on an Institute of Medicine report and criteria developed by the American Medical Association. The process includes development by expert work groups, a systematic review of evidence and the development of evidence tables, broad review and iterative revisions, and approval by the APA Assembly and Board of Trustees.

The Assembly and the Board have been very attentive to guidelines and have made many substantive contributions to the content of individual guidelines and to the process. Under the guidance of the devoted Steering Committee on Practice Guidelines and a very effective APA project staff, the development process has become almost automatic, with high acceptance from APA leaders and other members. A challenging aspect of this work has been struggling with the nature of evidence and how to develop recommendations in areas where the evidence, at least as represented by randomized controlled trials (RCTs), is spotty or nonexistent. A humorous article in the December 2003 *British Medical Journal* pointed out the fallacy of relying exclusively on RCTs by noting that there has not been an RCT on the effectiveness of parachutes in saving lives. Waiting for such a study before using parachutes does not seem like a good idea!

Dissemination: Throughout medicine, effective dissemination of guidelines has been a major challenge. Many well-developed guidelines are available, but their use by physicians in practice remains low. Each APA guideline is published in the *American Journal of Psychiatry*. In addition, each guideline is posted on the APA Web site at <www.psych.org>, and a summary of the guideline is included in the federal Agency for Health Care Research and Quality's guideline clearinghouse site, with a link to the APA site. Also, every two years, a compendium of all APA practice guidelines, including the most recent revisions, is published by APPI. Actually, the iterative development process and the reality that about 800 members have reviewed various drafts of each guideline helps significantly with dissemination efforts.

Quick-reference guides have been published that present the recommendations in algorhythmic and bulleted format, and these guides will soon be available for handheld PDAs. Pocket cards are also being developed. Continuing medical education courses focusing on the guidelines are available, and increasingly the guidelines are being incorporated into residency training programs. Questions from the guidelines are included in PRITE examinations, and the guidelines are a major source for ABPN certification and recertification examinations.

Keeping guidelines current: As the explosion of new knowledge in our field continues, it is essential that practice guidelines be kept current. The APA guideline process aims to revise each guideline within five years of publication. To date, four guidelines have been revised, and revisions of four others are in the pipeline.

An article in the September *American Journal of Psychiatry* suggested that recent evidence would lead to a recommendation different from that identified in the APA Practice Guideline on Bipolar Disorder, published in 2002. To deal with such issues between major revisions of the guidelines, the Steering Committee on Practice Guidelines recently agreed on a solution: "Guideline Watches." Watches are brief updates that identify new findings that should be considered when using a guideline. The watches are written by experts associated with the development of the particular guideline and are approved by the executive committee of the project but not by the Assembly or Board. Hence they are not APA policy statements. Watches have been published for Alzheimer's disease, psychiatric evaluation, and delirium, and four more are in development—for major depressive disorder, panic disorder, borderline personality disorder, and bipolar disorder. Each watch is published online at the APA Web site and will be included in each two-year compendium. We are also exploring other means of disseminating the watches. For example, the watch on major depressive disorder is expected to be included in the next issue of *Focus*, APA's continuing education journal.

Practice guidelines can be an aid to psychiatrists in their clinical work with patients. However, for that to occur, the process of the guideline development must be thoughtful and rigorous, and the recommendations must reflect current evidence and clinical consensus. The Guideline Watches should be helpful in meeting that challenge. ■

John S. McIntyre, M.D., is chair of APA's Steering Committee on Practice Guidelines.

letters to the editor

Risk Factors Important In Autism

The comments about the possible causes of autism by Dr. Jane Ripperger-Suhler in her letter to the editor in the January 21 issue are very helpful, but when we haven't learned the exact causes of an illness such as autism, it is very important to know the objective risk factors (for example, perinatal damages), because they could lead us to possible ways to prevent these disorders.

PROF. NIKOLA ILANKOVIC, M.D.
Belgrade, Yugoslavia

Chodoff's Syndrome

I heartily endorse Dr. Paul Chodoff's proposal in his letter in the January 21 issue that a new diagnosis called "the human condition" be added to *DSM-V.* To facilitate insurance reimbursement, however, I propose the eponymous "Chodoff's syndrome." Knowing your psychiatric ABCs, after Asperger's and Briquet's, who wouldn't be happy to be diagnosed a Chodoff's?

EUGENE H. KAPLAN, M.D.
Columbia, S.C.

Breaking Free

After being in the field of psychiatry for nearly three decades, I recently decided to change how I am paid for my services. Six months ago I informed my patients that at the beginning of this year, I would terminate my participation in all third-party payment plans, including Medicare. I explained to them that I wanted to practice without the constraints imposed by insurers and experience the sense of freedom that would result.

Some of my patients accepted this, and others expressed their discontent. For those who wanted to stay in my practice, I offered the option of submitting my receipt to their insurer for possible reimbursment or paying me on a sliding-scale basis. More than half of my patients chose to transfer to other psychiatrists whom I had recommended.

Now I have a lighter caseload and am able to see patients with fewer time constraints. An answering machine plays a message about my practice and tells callers how to reach me by pager if necessary; it also records messages for later playback. I have found that patients like the feeling that I have more time for them and that their records have greater confidentiality since no information is transmitted to their insurers.

From the bookkeeping point of view, I no longer have to worry about staying up to date on tax guidelines regarding quarterly filings and maintaining current in-

please see ***Letters*** *on page 41*

Readers are invited to submit letters not more than 500 words long for possible publication. *Psychiatric News* reserves the right to edit letters and to publish them in all editions, print, electronic, or other media. Receipt of letters is not acknowledged. Letters should be sent by mail to *Psychiatric News,* APA, Suite 1825, 1000 Wilson Boulevard, Arlington, Va. 22209 or by e-mail to pnews@psych.org. Clinical opinions are not peer reviewed and thus should be independently verified.

clinical & research news

Genetic Research

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or other health care facilities, and children.

Further, respondents rated such research as most acceptable for individuals with serious physical or mental illnesses and least acceptable for vulnerable groups such as prisoners, individuals in health-care facilities, and children.

Respondents indicated that they saw more "positives" than "negatives" in genetic research participation. They agreed that such participation would more likely entail psychological risks than physical risks.

Most respondents said that people should consider participating in genetic research if it could benefit family members, coworkers, or society, but contended that people with an elevated risk of genetic illness should be especially willing to participate.

"This high level of support for genetic inquiry by working persons was unexpected," Roberts and her team concluded in their report. "Another striking result was the pattern of perspectives offered by men and women. Male workers rated the genetic research importance, involvement, positives/benefits, and motivations more highly than did female workers. This is very interesting because women in other studies have been shown to be more supportive than men of clinical research participation."

Roberts told *Psychiatric News* that the study results "highlight the importance of genetics and genetically based health issues for working people. They also demonstrate the rather remarkable level of openness and excitement about participation in genetic research—and perhaps human clinical research or scientific work more generally."

The project was funded by the U.S. Department of Energy, the National Institute on Drug Abuse, and the National Institute of Mental Health.

The study, "Employees' Perspectives on Ethically Important Aspects of Genetic Research Participation: A Pilot Study," can be accessed online at <www.sciencedirect.com> by clicking on "Browse A-Z of journals," then "C," then **Comprehensive Psychiatry.** ■

annual meeting

Exciting Dining Need Not Require a Second Mortgage

While a handful of Atlanta's culinary stars has gained national reputations, there are abundant choices for those who are in the mood for something delicious, even adventurous, but less than luxe.

BY MILES CROWDER, M.D.

Welcome to Atlanta and the 158th Annual Meeting of the American Psychiatric Association. Those who attend the meeting will be visiting Atlanta at a time when the city is savoring a dramatic, decade-long improvement in its culinary reputation, promising ample rewards for those inclined to explore dining options beyond the limited range of choices in and around the downtown hotels.

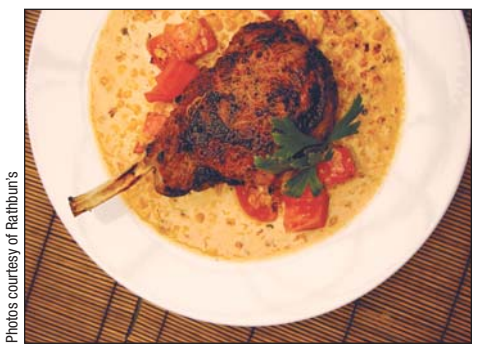
Aria, Bacchanalia, the Dining Room at the Ritz Carlton, Joël, and Seeger's enjoy national reputations and are easy to learn about. If you're interested in any of these establishments, be sure to make a reservation well in advance. Interesting casual dining spots abound—you might want to consider Ria's Bluebird, Rolling Bones BBQ, lunch at Son's Place, Thumbs Up Diner, and the "World Famous Varsity" at Georgia Tech.

What follows, however, is a list of 10 moderately priced restaurants in several of Atlanta's thriving neighborhoods. Some have been around for awhile; others are quite new and promising. None of these options are typical convention- or tourist-oriented restaurants, and all are located out of the downtown area but can be reached easily by taxi or MARTA, Atlanta's subway system. Most of these restaurants offer outdoor dining and accept reservations.

• **Agave:** Jack Sobel's New Mexico roots show at this successful Southwestern venue on the edge of Atlanta's Cabbagetown district. Agave offers authentic, creative, fun, and quite reasonably priced Southwestern cuisine. Located across the street from Oakland Cemetery, the final resting place of numerous Georgia governors, along with author Margaret Mitchell and golfing legend Bobby Jones. (Note to golfers: An Atlanta tradition is to leave one of your golf balls on his gravesite.)

• **Babette's Café:** This restaurant is the old-timer of this group. Babette's changed location a few years ago and has maintained a solid reputation as a consistently pleasant dining experience. This is a rare exception in Atlanta's fast start/slow decline restaurant tradition.

• **Floataway Café:** This more casual Emory-area spinoff of Bacchanalia restaurant fills the bill with fresh, innovative dishes with an emphasis on organic ingredients. You will appreciate Floataway Café's airy décor and extensive wine list.



Photos courtesy of Rathbun's

Left: The Bar at Rathburn's. Above: Leg of lamb is one of Rathbun's signature dishes.

• **Iris:** Iris is a brave and determined effort in the seemingly constant transition of East Atlanta. Can a converted service station really have an appealing edgy feel? Yes, it certainly can and does. Iris's always good, sometimes great, food helps to achieve this objective. The restaurant is an urban pioneer that has become quite popular.

• **Rathbun's:** This eatery has become the hottest ticket in town and has gained national recognition. Kevin Rathbun, following his nomadic journey through the Buckhead Life Restaurant group, has flourished in his latest digs at the interface of the Inman Park and North Highland areas.

• **Rustic Gourmet:** Perhaps the least known of this list, Cynthia Holt's restaurant is hidden on an unusual commercial street, close to previously listed Floataway Café, in the Emory University area. It's hard to beat the ability to enjoy three tasty courses—usually soup, salad, and a choice of entrees—for about $25. It also boasts a reasonably priced and offbeat wine list. Rustic Gourmet is open only Wednesday through Saturday. When you arrive, be sure to request Drew, a waiter-extraordinaire.

• **Sotto Sotto:** Riccardo Ullio proves that Georgia Tech grads can build more than bridges, buildings, and computers. In this case, he built an authentic northern Italian outpost that has gained considerable buzz. At Sotto Sotto, you'll find high-quality pasta dishes, but also give serious consideration to the wood-fired-grill fish special and the Italian wines.

• **Tierra:** Nestled in the Midtown neighborhood, close to the Atlanta Botanical Gardens, this casual and innovative Latin-fusion effort has made a mark on Atlanta's culinary front. Some wines are half price on Tuesdays.

• **Watershed:** Watershed has been a surprisingly successful venture in the close-in suburb of Decatur. Some southern influences are evident in the cooking, particularly with the Tuesday night fried chicken tradition. Emily Saliers of the rock group Indigo Girls is a co-owner. You can take a MARTA train to this restaurant and enjoy a stroll through "small-town" Decatur.

• **Woodfire Grill:** Echoes of California wine country are reflected in Michael Tuohy's effort, especially evident in his emphasis on whatever is freshest in the market that day. Fish dishes and Rocky the Free Range Chicken are good choices. Half price wines are offered on Sundays. ■

Miles Crowder, M.D., is an associate professor of psychiatry and behavioral sciences and director of residency education at Emory University.

Dining Out

• **Agave:** 242 Boulevard SE, (404) 588-0006, www.agaverestaurant.com
• **Babette's Café:** 573 North Highland Avenue, (404) 523-9121, www.babettescafe.com
• **Floataway Café:** 1123 Zonolite Road, (404) 892-1414, starprovisions.com/float/
• **Iris:** 1314 Glenwood Avenue, (404) 221-1300, www.irisatlanta.com
• **Rathbun's:** 12 Krog Street, (404) 524-8280, www.rathbunsrestaurant.com
• **Rustic Gourmet:** 1145 Zonolite Road, (404) 881-1288, www.rusticgourmet.com
• **Sotto Sotto:** 313 North Highland Avenue, (404) 523-6678, www.sottosottorestaurant.com
• **Tierra:** 1425 Piedmont Avenue, (404) 874-5951, www.tierrarestaurant.com
• **Watershed:** 406 West Ponce de Leon Avenue, (404) 378-4900, www.watershedrestaurant.com
• **Woodfire Grill:** 1782 Cheshire Bridge Road, (404) 347-9055, www.woodfiregrill.com

How to Register

There are two easy ways for APA members to register for APA's 2005 annual meeting:

• Go to APA's Web site at www.psych.org, click on "2005 APA Annual Meeting," and select "Online Registration for Members." You will be asked to log into Members Corner. Also, reserve your hotel room by clicking on "Reservations for Members."

• Fill out the forms in the 2005 Annual Meeting Advance Registration Information packet and submit them by mail or fax. If you have not yet received your packet, call the APA Answer Center at (888) 35-PSYCH; from outside the U.S. and Canada, call (703) 907-3800.

The deadline for course enrollment and advance registration is April 23.

FOREST CAMPRAL
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government news

Psychologists

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Tennessee

Legislation introduced in Tennessee follows a familiar pattern. The bill calls for 450 hours of classroom training and a one-year preceptorship covering at least 100 outpatients under the supervision of a physician. The psychology board would have sole control over who may become a prescribing psychologist.

Prescribing psychologists could not treat patients who do not have an established relationship with a primary care physician. For the first two years after being allowed to prescribe, psychologists could do so only under a formal, written, "collaborative practice agreement" with a physician.

Rules, regulations, and a formulary would be set out by a group composed of members of "current health-related boards of healing arts," including psychology, pharmacy, nursing, optometry, and medicine. However, the law does not specify the presence of a physician on this group, said Johnson.

"These bills have come up several years in a row," said Nashville's Gregory Kyser, M.D., chair of the Tennessee Psychiatric Association's legislative committee. "Last year it was defeated in committee when no one would second the chairman's motion to bring it to the floor." The psychologists' strategy this year has been to give an early push to the legislation, said Kyser.

"They've done a much better job between legislative sessions, holding regional dinners and contacting members of the health committee," agreed Anne Carr, a lobbyist for the Tennessee psychiatrists. "We've been playing catch-up."

Kyser said there is a difference between the psychologists' push for prescribing privileges and rights previously granted nurse practitioners in the state.

"Many nurse practitioners have graduated and gone to serve in rural areas, and their work is reviewed frequently by physicians," he said. "But they have basic medical training, as opposed to just learning how to prescribe psychotropic medications in a vacuum."

Wyoming

The psychologist-prescribing bill in Wyoming never had a hearing and so did not leave the Committee on Labor, Health, and Social Services in the state senate.

"According to the rules, that means that the bill is dead for this session," said APA's Johnson.

The bill delineated prescribing authority by directing that the state "board of pharmacy, in collaboration with the board of psychology, shall develop a formulary of commonly used drugs for the treatment of mental and emotional disorders for use by psychologists with prescriptive authority."

The bill's education section also called for licensed psychologists with doctorates to take 380 hours of "intensive didactic instruction" and complete one year's "supervised and relevant clinical experience" to qualify for prescribing authority.

The Wyoming Psychiatric Society, backed by the state's medical society, approached legislators by talking about not just the prescribing question but other issues, too, like changes in the involuntary commitment law and suicide-prevention coordination. ■

Final Rule

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igible patients will be automatically enrolled in a PDP operating in their geographic region unless they opt out of the automatic PDP and choose a PDP themselves.

The final rule appears to ensure that beneficiaries will be covered for medically necessary drugs. For example, the final rule establishes drug formulary standards and oversight. PDPs will be required to include at least two drugs in every therapeutic category within their formulary (see article on page 10 at right).

Each PDP will be responsible for the design of its own formulary, including the mechanisms the plan uses to control drug costs and the actual list of preferred drugs. CMS also released a draft guidance regarding its formulary review processes that will guide each PDP through the approval process. While CMS will support the USP Model Guidelines for formulary drug categories and classes, the guidance said, "CMS will review specific drugs in each category and class to ensure that the formulary offers a sufficient breadth of drugs necessary to treat all disease states in a nondiscriminatory way."

More information on the Medicare Part D benefit is posted online at <www.cms.hhs.gov/medicarereform/pdbma/>. ■

professional news

Best Practices

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The first stage of the initiative was conducted concurrently with deliberations of the Michigan Mental Health Commission. "We were able to get strong support from the commission for evidence-based practice as a core ingredient of system reform," Carli said.

The Flinn Foundation supported staff work of the Michigan Mental Health Commission, as well as of the prescribing initiative.

The next step will be the issuance of a request for proposal for three to five pilot projects that would run for approximately three years. The aim of those projects is to identify "innovative and early adopting champions" to implement and test the TIMA and other related EBPs, with the expectation that success of the pilots will help promote use elsewhere.

Among the sites being considered are state hospitals, university consortia, and private mental health practices with a university affiliation.

That stage will be funded by the Flinn Foundation and other sources yet to be identified.

"Closing the Quality Gap in Michigan: A Prescription for Mental Health Care" is posted online at <www.mimentalhealthebp.net/action_plan.htm>. ■

Follow-Up

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scribed psychotropic medication did not have at least one monthly drug monitoring in the first three months of treatment. Less than 25 percent had any indicators that simple medication-related checks like blood pressure, pulse, height, or weight were done, and only a similar proportion recorded any laboratory monitoring of patients.

"In the light of the Food and Drug Administration's recent black-box warning for 'close clinical monitoring' of patients on antidepressants, there's a need to improve laboratory and physical observation of these children," said Julie Magno Zito, Ph.D., an associate professor of pharmacy and psychiatry at the University of Maryland, Baltimore. "But we just don't know if that's being operationalized. The study says it's not being fulfilled."

The need for monitoring should extend across the board to all psychotropic drugs, not just antidepressants, Zito added.

Only half the children had the requisite patient-protection indicators in their charts. While half were screened for possible physical or sexual abuse, charts for 36 percent of the patients recorded no notice that clinicians had filed a report of suspected abuse.

"Nearly three-quarters of the children with recent suicidal ideation had follow-up care meeting the recommended standards," said Zima, "but less than half of the children clinically identified as being at imminent risk of harm to self or others had documentation that treatment in a more restrictive environment was recommended."

Care for these children may be fragmented, since only 51 percent of the charts indicated links with schools or general health care providers.

The researchers had hypothesized that boys and white children would be more likely to receive proper care than girls and members of ethnic minorities. However, they were surprised to find that "acceptable care did not vary by child gender or ethnicity," said Zima.

There were geographic variations. Children in wealthier and urban counties had greater documented adherence to treatment principles than did children from poorer and rural counties. Some of that difference, the researchers speculated, may be due to the higher density of other medical and social-service agencies in urban or wealthy districts.

The study relied on chart review, but Zima suggested that future quality of care studies tie these quality variables to patient outcomes and Medicaid administrative claims data.

Much can be done immediately, however, to improve documented care.

"To monitor the safety of children getting medication, clinics should consider using information technologies to support physicians and help them connect with clinical information from the child's primary care doctor," she said. "They might also add a nurse or nurse practitioner to the clinic team to measure vital signs and to follow up on laboratory study orders at the beginning of every medication visit."

The study, "Quality of Publicly Funded Outpatient Specialty Mental Health Care for Common Childhood Psychiatric Disorders in California," can be accessed at <www.jaacap.com> under the February issue. ■

Bear

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Apparently not swayed by these and a growing chorus of other protests, Robert said her company planned to continue marketing the bear.

Despite her initial refusal to halt the bear's marketing, Robert may have had at least a partial change of heart after seeing the number and passion of the protests. She agreed to meet on February 1 with representatives of four advocacy groups including NAMI-Vermont and indicated at the meeting that she had decided that "Crazy for You" bear would no longer be offered for sale. She did not say it was because of the protests.

By February 4 the company's Web site at <http://store.yahoo.com/vtbear/valentines-day-gifts-ideas.html> said "Sorry, sold out" under the picture of "Crazy for You" bear. A company spokesperson announced on February 3 that the bear had sold out, and it would not be manufacturing any more of them. In addition, Robert said in a prepared statement that the bear "was not intended to diminish the serious nature of mental illness [but] was meant to convey the sentiment of love at Valentine's Day."

Company spokesperson Nicole L'Hillier confirmed to *Psychiatric News* that while the protests against the teddy bear may have had an indirect impact on the decision to stop selling it, the decision was primarily due to the production run being sold out. She also noted that soon after the protests began, the company did pull advertising for this particular bear from the 500 radio stations that its marketers had targeted and stopped featuring it on its Web site's home page. The company did, however, include it among several dozen bears on the Valentine's Day gift page of its Web site.

Vermont psychiatrist and APA Board of Trustees member David Fassler, M.D., suggested, however, that the company is downplaying the impact of the protests. "There's no question in my mind that the overall public reaction and response caused the company to modify its plans for the product," Fassler told *Psychiatric News*, "and I doubt we'll see this product again next year." ■

Med Students

continued from page 12

"This is an exciting time in psychiatry," Rifai said. "We are in the process of discovering new clues about how we can better diagnose, treat, and even prevent mental illness."

Rifai explained that there is a "lack of knowledge about mental illness in minority patients" and that the manifestations of certain mental illnesses may be influenced by a patient's culture.

He also described for the medical students a number of opportunities to participate in research on schizophrenia, mood and anxiety disorders, and child and adolescent psychiatry through the NIMH intramural research program.

It was only when he entered the psychiatry residency program at George Washington University that Niku Singh, M.D., began to feel "like a real practitioner of medicine," he said. Singh is a PGY-3 resident and an MIT representative to the WPS.

Psychiatry residents see patients in a variety of settings ranging from state-hospital facilities to outpatient settings, Singh said, and get extensive exposure to psychopharmacological and psychotherapeutic modes of treatment. "You get to be a jack of all trades" as a psychiatry resident, Singh declared.

The students also heard about what inspired some of the speakers to choose psychiatry and what continues to inspire them today.

By her fourth year of medical school at Georgetown University, Constance Dunlap, M.D., had decided that she would pursue a career in obstetrics/gynecology.

"As a medical student, I didn't even consider psychiatry," she recalled.

But her experience working alongside a psychiatrist during an internship on a maternity ward changed her mind, she said, and she entered a psychiatry residency program at George Washington University.

These days, Dunlap is an associate clinical professor of psychiatry at George Washington University and Howard University, where she teaches residents. She also maintains a private practice in which she treats adult patients with mood and anxiety disorders.

"There is something appealing about being able to maintain relationships with my patients" over time, Dunlap noted.

Child and adolescent psychiatrist Marilyn Benoit, M.D., called her subspecialty "the most fascinating" in psychiatry and told the students that "every adult has a wounded child within." Benoit is a clinical associate professor of psychiatry at Georgetown University and past president of the American Academy of Child and Adolescent Psychiatry.

In her fourth year of medical school at Georgetown University in the early 1970s, Benoit became pregnant. Soon after giving birth, she embarked on a research project that required her to interview families of children with attention-deficit/hyperactivity disorder in their homes.

"I took [my baby] along in a little basket, and we went to the homes of the children," she recalled. "He was an easy baby."

Benoit remarked that one of the "privileges" of having practiced for more than 25 years is seeing patients with their families many years after their first session. "Because that single person got treatment, that has made a difference and enabled him or her to become a parent," she said.

In addition, Benoit marveled that she has been alive to witness advances in brain research "that tell us that these illnesses are not made up—these people have real illnesses, and we can administer treatments we know will work."

Information about APA's District Branch Minority Recruitment Program is available by contacting Barbara Matos at (703) 907-8517 or by e-mail at bmatos@psych.org. ■

Medicaid

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what it would be like for people in their 80s or 90s, or a person with a disability, or a middle- or low-income family trying to keep a loved one at home to walk through all of this and make sense of it," she said. "We have larded in so much extra cost into this drug benefit instead of providing a straight benefit at the lowest possible cost to cover the maximum number of seniors.

"I think there is about $150 billion going to insurance companies and related entities to provide this service," Clinton said.

But it was looming cuts to the Medicaid program, and especially administration proposals for replacing federal matching funds with block grants, that elicited the greatest foreboding among participants at the conference, along with a sense of an impending showdown that would engage fundamental values about how the nation intends to care for its poor.

One plenary at the conference that was closed to the press—a strategy-making session to help grass-roots organizations in states challenged by Medicaid cuts—was called "The Mother of all Medicaid Fights."

"Block grants are a bad idea from nearly every angle," Clinton said. "Currently, the federal government and the states share the risks of greater-than-anticipated increases in Medicaid enrollment and costs. . . so federal payments rise as a state's costs increase. A block grant would end this federal commitment by providing states with a fixed amount of Medicaid funding each year without regard to the state's costs or enrollment figures.

"This would freeze Medicaid programs over time and erode quality and access, and states would have limited capacity to incorporate advances in medical treatment and other proven remedies and interventions into their programs due to cost," Clinton said. ■

letters to the editor

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surance information on multiple companies for the secretary, who was spending most of her time on the phone with insurers.

A few years ago I was warned by a managed care agency that my documentation did not meet its guidelines. The documentation had been reviewed by a social worker contracted by the agency, and he had gone into areas apparently outside his field of expertise. I was given a chance to improve my documentation along with a recommendation to enroll in an educational activity! Another agency asked me to file my curriculum vitae on the Internet and update it every three months to maintain my credentials. With such treatment by insurance companies, you cannot imagine the glee I felt when I advised them that I was withdrawing from their plans.

Time will tell how my professional future will go, but one thing is certain—I will never go back to being an employee of managed care.

SREENIVASA R. DESAI, M.D.
Binghamton, N.Y.

Parents Guide

continued from page 1

cents," Fassler noted. "ParentsMedGuide" and "PhysiciansMedGuide" also emphasize that all treatments have risks and benefits, he continued, "and we believe that parents and physicians deserve as much information as possible to make appropriate decisions for their children and their patients. That's why we've developed these fact sheets."

The two med guides include a detailed

David Hathcox

Gail Griffith, the patient representative to the FDA's Psychopharmacological Drugs Advisory Committee, says that had she known then what she knows now, she would never have voted in favor of the black-box warnings.

discussion of the decision by the Food and Drug Administration (FDA) to implement black-box warnings last fall on all antidepressants marketed in the United States (*Psychiatric News*, November 5, 2004).

"The FDA identified a small increase in the percentage of children who spontaneously expressed thoughts about suicide or demonstrated potentially harmful behaviors," Fassler explained. "The data actually show that in those studies that asked kids about suicidal thoughts, there were no significant differences between those on medication and those taking a placebo."

The need for balanced, accurate information on the risks and benefits of antidepressants was made all the more evident with the release of updated prescription sales data the day before the launch of the new Web site. Those data, spanning 12 quarters from the first quarter of 2002 through the fourth quarter of 2004, showed dramatic decreases in pediatric antidepressant utilization, apparently in response to the FDA's advisory committee meetings and imposition of black-box warnings (see chart on page 1). The data, from a Medco Health Solutions Inc. analysis, show an overall 10 percent decrease in the proportion of patients under age 18 on an antidepressant in 2004, in sharp contrast to the nearly 9 percent increase during 2003.

Usage of the drugs in pediatric patients had steadily been on the increase through all four quarters of 2002. However, with the first quarter of 2003, that trend began to change as the quarter-to-quarter increases that had been common became ever smaller. In the first quarter of 2004—at the same time as the FDA's first advisory committee meeting on antidepressants and suicidality—usage declined by 9.4 percent compared with the first quarter of 2003. The most dramatic declines were registered in the third and fourth quarters of 2004, when the FDA held its second set of advisory committee hearings and ordered the strong warnings.

However, the Medco Health data also reveal that, on the whole, antidepressants are prescribed to a very small proportion of eligible patients under the age of 18 and thus strongly suggest that undertreatment continues to be a significant dilemma.

For example, during the three years the data cover, the fourth quarter of 2002 saw the highest number of patients under 18 receive prescriptions for antidepressants: 103,102 out of a total of 12,374,932 patients under 18 covered by Medco. That amounts to a prescribing rate of only 0.83 percent. Over the 12 quarters of data released by Medco Health, prescribing rates ranged from a low of 0.66 percent to a high of 0.84 percent—far below the expected incidence of depression in the population (between 3 percent and 5 percent, according to the NIMH).

"I had grave misgivings about imposing a black-box warning on all antidepressants because the repercussions of that action will be incalculable for years to come," said Gail Griffith, the patient representative on the FDA's Psychopharmacological Drugs Advisory Committee. That committee and the Pediatric Drugs Advisory Committee voted for the warnings.

Griffith, who attended the press briefing launching the pair of med guides, has long grappled with depression herself, she said, and has a son who attempted suicide amid a severe depression at the age of 16.

"If I would have known how sharply prescription rates were falling," Griffith added, "I would not have voted in favor of the black-box warning. I had hoped the FDA could help to inform parents, but it seems many parents have simply become fearful of antidepressants, which so often are the lifejacket preserving us from being sucked under by depression's powerful undertow."

APA research staff reviewed the evidence base relating antidepressants and suicidal thoughts and behaviors in preparation for developing the fact sheets and Web site. It quickly became apparent that part of the difficulty in analyzing the FDA's position was the agency's narrow focus on spontaneous adverse-event reporting.

"We wanted to focus on the broader context," explained Darrel Regier, M.D., M.P.H.,director of research at APA and executive director of the American Psychiatric Institute for Research and Education. "The FDA was focusing on a very narrow and specific issue: adverse events that are spontaneously reported by patients in a clinical trial. The problem we had was that [the FDA's approach] missed a much larger picture that we think is important for parents and physicians to understand."

The experience of suicidal thoughts, Regier explained, "is one of the characteristics of depression. And it is not surprising then that you would have [a high percentage] of patients who meet criteria for depression also have, as a part of meeting that criteria, the presence of suicidal ideation."

While spontaneously reported events involving suicidal thoughts or behaviors do occur at a higher rate in those taking medication than in those on placebo within the context of clinical trials, Regier said, this narrow focus misses the much larger picture.

The problem, both Fassler and Regier explained, is that systematic assessment of suicidal thoughts and behaviors—actually asking youngsters in clinical trials about suicidal thoughts and behaviors—shows no difference between patients on drug compared with placebo. The FDA noted this finding in its analysis, but only briefly, and did not discuss it at all at the public advisory committee meetings.

"We know that the FDA's adverse-event reports are just the tip of the iceberg of suicidality," Regier continued. "We know that systematic assessment finds much higher rates and is certainly preferable from a research standpoint. Children don't often say anything spontaneously about suicidal thoughts—and it is when they don't talk about it that they are at gravest risk."

Antidepressant medications, Regier noted, "seemingly allow people to be more communicative about suicidal ideation," and this may be what is reflected in the clinical trials data.

"But there is certainly a research issue here regarding what is the best predictor of not simply suicidal thinking or suicide attempts, but of completed suicide," Regier said. "We need research to evaluate the value of spontaneously reported events versus systematic assessment. We need to recognize that suicide itself is not equivalent to suicidal thoughts or attempts."

"ParentsMedGuide," "PhysiciansMedGuide," and related resources are posted at <parentsmedguide.org>. ■

On Board With APA, AACAP

These organizations have endorsed the "ParentsMedGuide" developed by APA and AACAP:

- American Association of Suicidology
- American Foundation for Suicide Prevention
- American Society for Adolescent Psychiatry
- Depression and Bipolar Support Alliance
- Families for Depression Awareness
- National Alliance for the Mentally Ill
- National Association of Psychiatric Health Systems
- National Mental Health Association
- Society for Adolescent Medicine
- Suicide Awareness Voices of Education
- Suicide Prevention Action Network

These organizations have endorsed the "PhysiciansMedGuide" developed by APA and AACAP. The National Alliance for the Mentally Ill, National Mental Health Association, and Suicide Prevention Action Network chose not to weigh in on the guide since they felt it fell outside their scope of expertise.

- American Association of Suicidology
- American Foundation for Suicide Prevention
- American Society for Adolescent Psychiatry
- Depression and Bipolar Support Alliance
- Families for Depression Awareness
- National Association of Psychiatric Health Systems
- Society for Adolescent Medicine
- Suicide Awareness Voices of Education

professional news

Kerry

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cash-strapped states with a severance check and best wishes for success, my proposal offers states a new bargain," Kerry said. "The national government will give states significant, immediate fiscal relief in exchange for a state commitment not only to cover all kids, but to aggressively make sure they get the coverage they're eligible for. That means cutting out the red tape and bureaucratic obstacles that are responsible for about two-thirds of the gap between kids who are eligible and kids who actually get covered. And it is a net plus in dollars to cash-strapped states."

Kerry also stressed the responsibility of parents to seek out insurance coverage for their children.

"We will make it possible for them to use money set aside for children's health care to buy employer-sponsored coverage where it's available, and we will also allow parents who don't normally qualify for public programs to buy coverage for their kids at cost and to maintain current coverage at an affordable cost," Kerry said. "Their side of the bargain is to take advantage of these tools to get their kids covered, and if they don't exercise this basic parental responsibility, they will not be able to claim the child tax credit on their federal tax returns.

"I don't think that's too much to ask. If we believe drivers have a responsibility to buy car insurance, surely we believe parents have a responsibility to buy health insurance for their kids."

Finally, Kerry said his plan would be financed by rolling back administration tax cuts for those in the highest income brackets. Specifically, he referred to individuals earning "well over $300,000 per year."

"A portion of the Bush tax cuts benefiting these most-fortunate citizens would be repealed, making the top rate a bit closer to the rate under which wealthy individuals did so spectacularly during the 1990s."

The text of the Kids First Act of 2005 can be accessed at <http://thomas.loc.gov> by searching on the bill number, S 114. ■

Have You Received Your Medallion Yet?

Annual Meeting New

APA members who were elected to APA distinguished fellowship in prior years but never attended a Convocation to receive their medallion are invited to participate in the Convocation ceremony at this year's meeting in Atlanta on Monday, May 23, from 5:30 p.m. to 7:30 p.m. These distinguished fellows are asked to notify the APA Membership Department that they plan to attend so that they can be sent further details.

The Membership Department may be contacted by phone at (888) 35-PSYCH, ext. 7365, or (703) 907-7365; or by e-mail at drunels@psych.org. ■

FDA

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to the extensive and detailed input from both practicing psychiatrists and the research community. Hopefully, the FDA will consider further revisions in the future, as more long-term and follow-up data become available."

However, Darrel Regier, M.D., M.P.H., director of research at APA and executive director of the American Psychiatric Institute for Research and Education, emphasized, "We continue to be concerned about the use of the term 'suicidality,' which the public widely equates with risk for completed suicides."

It would have been more instructive, Regier said, had the FDA noted that there was no systematic monitoring for suidicality in some of the clinical trials it reviewed; thus, the only suicidal thoughts or behaviors that were noted were those that were spontaneously reported. In 17 of the 24 clinical trials reviewed, however, participants were directly questioned about suicidal thoughts or behaviors.

"We believe that additional research is necessary to determine how to evaluate both the systematic assessment and spontaneous adverse-event reports in these studies," Regier said. "Such research should continue to inform recommendations coming from the FDA."

The process that leads to the final approved language included in drug-product labeling is often convoluted, complicated, and intricate. Essentially the FDA and the drug company (which the FDA refers to as the "sponsor" of the application for approval to market a drug) negotiate the final wording. In many instances the sponsor submits its own version of the wording for FDA approval. In the case of the antidepressant warnings, however, it was the FDA that had informed sponsors of the language it was proposing in October of last year.

While the FDA would not comment on what input shaped the final wording of the labeling, it is likely that the agency's staff in the Office of Drug Safety took primary responsibility for drafting the language. They may have taken into account input from the advisory committees; public comments; and written comments submitted by clinicians, researchers, and professional associations, including APA and AACAP, as well as others.

Revisions of draft language usually occur through a back-and-forth negotiation that ends with the ball in the FDA's court.

"Although every attempt is made to negotiate labeling with the sponsor," noted FDA spokesperson Christine Parker, "the agency has the final say on the wording."

Indeed, Parker told *Psychiatric News*, "In our January 12, 2005, and January 26, 2005, letters, we informed the sponsors that 'Failure to make these changes within the specified period of time could make your product misbranded.' " Drugs that are labeled misbranded no longer meet agency standards and thus lose marketing approval.

The new labeling was effective immediately upon issuance of the January 26 letter, Parker said. Sponsors were required to submit their individual revised product labeling to the FDA within 10 days, and all sponsors complied. However, weeks or even months may pass before patients see the new labeling.

"Stock on pharmacy shelves with the old labeling can be dispensed, and stock in distributors' warehouses with the old labeling can still be shipped to pharmacies," noted Parker. The new labeling "will gradually make its way into the pharmacies over the next couple of months."

Parker emphasized that "all Internet listings of the labeling would be expected to include the new labeling immediately."

Medications with black-box warnings may continue to be advertised to both health care professionals and consumers, Parker noted.

"The body of the ads do not have to contain the box warning verbatim, but the body of the ad must include the information contained in the boxed warning, along with other important risk information about the product," she explained. "Risk information, including the black-box warning, must be presented with comparable prominence to benefit information."

The FDA's final versions of the warnings on antidepressants are posted online at <www.fda.gov/cder/drug/antidepressants/default.htm>. ■

professional news

APA Tour

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Several speakers took a broad view of the problem of disparities and advocated for major health care and social reforms. Fred Osher, M.D., is director of the Center for Behavioral Health, Justice, and Public Policy at the University of Maryland School of Medicine. He opened his presentation by saying that it is a "shame and tragedy" that more than 44 million Americans lack health insurance. He pointed out that members of minority groups are more likely to be uninsured (see chart on page 13). He urged "universal health care" and asked, "Who do we partner with to get it?"

Kenneth Thompson, M.D., said, "Provision of health care is a tiny, tiny piece of what makes people healthy." He urged psychiatrists to consider ways that social development policies affect health and to learn how to create political will. Thompson is an associate professor of psychiatry at the University of Pittsburgh.

Anita Everett, M.D., senior medical adviser at SAMHSA, said that effective advocacy requires understanding how legislators see their mission. "They all may not feel a need to be altruistic, but they will agree on the duty to create equal opportunity. Paint a picture of how addressing disparities creates a level playing field."

Each stop of OMNA on Tour will include presentations about local issues. Martha Knisley, commissioner of the Washington, D.C., Department of Mental Health, told the audience about the challenges of building a community mental health system after D.C. residents gained the right to elect their city officials.

"It's a tough system to work in," she said. "We've tried to learn from the mistakes of others and use the best practices we could find."

Primm urged audience members to spread the word about the availability of OMNA on Tour presentations. Stops now are planned for Philadelphia and Memphis.

More information about OMNA on Tour is available by e-mailing Primm at omna@psych.org. ■