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PSYCHIATRIC NEWS

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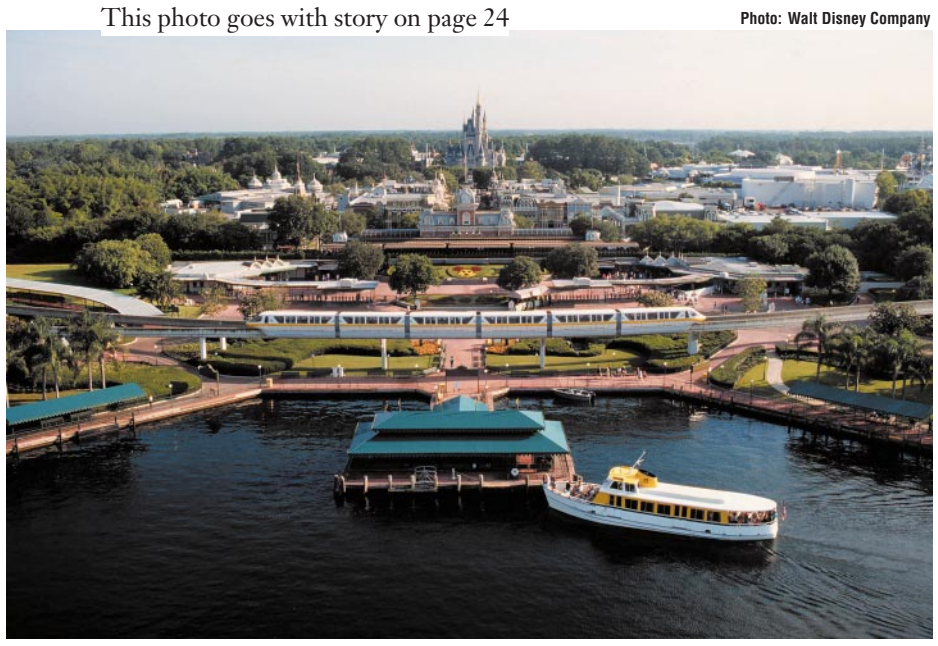
Photo: Walt Disney Company



Heigh-ho, heigh-ho, it's off to Orlando we go: APA's fall Institute on Psychiatric Services is being held in the nation's top destination for children of all ages. Above is an aerial view of Disney World's Magic Kingdom. General information on the institute and its preliminary program begin on page 24.

Government News

Bush Administration Issues Revised S&R Rule

After delaying the release of the Clinton administration's interim final rule on seclusion and restraint for a 60-day review, the Bush administration issues a revised version in late May.

BY CHRISTINE LEHMANN

Psychiatric residential treatment facilities that receive Medicaid funding for inpatient youth services must be in immediate compliance with the revised standards for the use of seclusion and restraint. Facilities with a current Medicaid agreement must provide documentation of compliance to their state Medicaid agency by July 21.

The Health Care Financing Administration (HCFA), the federal agency that oversees Medicaid, issued an interim final rule on seclusion and restraint in May with several changes from the previous version. The Bush administration had delayed the March implementation date of the rule designed by the Clinton administration for a 60-day review, which expired in May.

"We are pleased that the Bush administration has attempted to remedy several problems in the rule inherited from the Clinton administration," said Nicholas Meyers, deputy director for congressional relations in APA's Division of Government Relations (DGR). "For example, the definition of physical restraint now excludes temporarily holding a patient or escorting a patient by the hand or arm safely to another area."

HCFA also clarified that the rule applies to psychiatric residential treatment facilities that receive Medicaid payment for inpatient services including a youth's room and board and a comprehensive package of services. It also applies to psychiatric hospitals that meet the 1999 Medicaid standards on seclusion and restraint (*Psychiatric News*, October 1, 1999).

HCFA revised the rule's definition of physical restraint and its reporting and staffing requirements to be consistent with the Children's Health Act signed into law by President Bill Clinton last October, according to a HCFA press release (*Psychiatric News*, November 17, 2000).

HCFA also added a new requirement that facilities included in the rule must inform the federal agency of any deaths involving seclusion and restraint.

The Children's Health Act allowed the Secretary of Health and Human Services (HHS) to issue regulations that are more stringent than the act's provisions. However, APA protested to HHS in March that the staffing and reporting requirements in the interim final rule issued in January were burdensome and costly (*Psychiatric News*, May 5).

The interim rule allowed only a psychiatrist to issue the order to initiate seclusion and restraint to a registered nurse, and re-

see ***S&R*** *on page 36*

Association News

APA Joins House Members To Educate Staff On Mental Illness

Capitol Hill staffers, who play a major role in crafting federal legislation, receive an education in mental illness treatment and research, thanks to the efforts of the House of Representatives Working Group on Mental Illness and APA.

"Nothing happens until someone sells something," the adage goes. And no one apparently knows that better than the House of Representatives Working Group on Mental Illness, cosponsored by Rep. Marge Roukema (R-N.J.) and Rep. Peter DeFasio (D-Ore.) and made up of 17 other members of Congress.

The group decided to organize a Capitol Hill briefing luncheon for June 20, which would include not just tasty fare, but also some of the big guns in mental health. The idea was to attract Capitol Hill staffers who were hungry for both a good luncheon and for information about mental illness.

To fulfill its aim, the group turned to APA for support, which the Association enthusiastically provided. APA helped with the logistics for the luncheon, and sent Darrel Regier, M.D., executive director of APA's Office of Research, to serve as briefing moderator. Regier is also director of the American Psychiatric Institute for Research and Education.

The group also recruited some other major figures in the mental health field to serve as speakers. They were Benedetto Sarceno, M.D., an Italian psychiatrist and director of mental health and substance dependence at the World Health Organization; Steven Hyman, M.D., director of the National Institute of Mental Health; and Bernard Arons, M.D., director of the Center for Mental Health Services at the Substance Abuse and Mental Health Services Administration.

The luncheon briefing, as the working group had hoped, turned out to be a big success. Far more Hill staffers came than expected; some 90 people attended the luncheon. The staffers also listened with interest to what the speakers had to say. Some examples:

There are more than 400 million people in the world suffering from neuropsychiatric conditions, Sarceno reported. Twenty-five percent of the world's population are affected by mental and behavioral disorders at some point in their lives. Mental and neu-

see ***Capitol Hill*** *on page 35*

Medical Society Battles Carveout Over Managed Care Practices

The New Jersey Medical Society has lodged a complaint with the state of New Jersey against Magellan because of a host of administrative and clinical problems, and Magellan is fighting back.

BY MARK MORAN

The nation's largest managed behavioral health care carveout is feeling the heat from physicians in New Jersey—and giving it back.

The Medical Society of New Jersey (MSNJ) has charged Magellan Behavioral Health Care with "abusive practices" in its provision of mental health services and has called on the state's Department of Banking and Insurance and the Department of Health and Human Services to investigate the company.

Physicians in the state told *Psychiatric News* that the company maintains a "phantom network" of doctors who are listed on the company's provider panel but who are in fact no longer on the panel or not seeing new patients. Consequently, they said, many patients—especially those coming out of acute or partial hospitalization—are unable to access psychiatric care in the community.

"The most charitable way of putting it is that Magellan is not keeping its provider list up to date," said Marc Rothman, M.D., president of the New Jersey Psychiatric Association (NJPA). "The least charitable way of putting it is that the company is misrepresenting the services it provides."

Charges against the company also include the familiar litany of complaints about managed care: administrative hassles, slow or inadequate reimbursement, and fragmented care for patients. The cumulative effect of the company's practices, Rothman and other psychiatrists said, is a shortage of psychiatrists willing to work with the company, and this, in turn, has invariably affected patient care. One psychiatrist described the case of a patient who called seven practitioners listed on the company's provider panel—none of whom was accepting patients—until finding one whose earliest appointment was two months away.

Another psychiatrist told *Psychiatric News* that the company has also prohibited psychiatrists from using the "evaluation and management" codes for situations in which they are supervising the treatment of patients but not providing psychotherapy.

"It is the policy of Medicare and APA that E&M codes may be used legitimately by psychiatrists," said Nancy Block, M.D., president-elect of the NJPA. "I have used them for a number of my patients who see another mental health professional for psychotherapy while I manage medication and coordinate their overall treatment. This includes reviewing and coordinating treatment by other physicians for complex overlapping conditions."

Block said that the company has repeatedly insisted she use the 908 series psychotherapy codes even when another professional is providing the psychotherapy—a circumstance that can cause administrative delays when two professionals are submitting psychotherapy codes for the same patient.

"I object to being forced to code in a manner that I consider inaccurate because Magellan has arbitrarily decided which codes it will cover," Block said.

Block is not a member of the company's provider panel, but treats patients who are covered by Magellan, she said.

Eizabeth Rody, M.D., medical director at Magellan's New Jersey regional service center, said that the company's computer system is set up to reimburse physicians using the E&M codes for inpatient services and outpatient substance abuse services. The 908 psychotherapy codes are more typically required from psychiatrists because "that captures what they do typically do on an outpatient basis," she said.

But she noted the company does make exceptions on a case-by-case basis for psychiatrists using the E&M codes on an outpatient basis for services other than substance abuse. "It's a very unusual thing," she said.

To some extent, the complaints reflect well-established gripes with managed care generally. As Rothman observed, "It's not just Magellan—these complaints are endemic to managed care."

But the dominance of Magellan, which has contracted with most major insurers in the state to oversee mental health care, appears to have focused physicians' wrath on the company. And the shortage of psychiatrists on Magellan's panel has affected the practice of general physicians in the state and roused the ire of the state's medical society.

"After a full year of examining mental health problems in our state, we have concluded that Magellan is taking advantage of vulnerable individuals who are hard pressed to advocate for themselves," said Angelo S. Agro, M.D., president of MSNJ. "Magellan's built-in barriers are preventing mental health providers from delivering appropriate care. [The company] systematically eliminates customer choice and sacrifices quality and ratchets down care to a minimum level. Magellan is becoming

see ***Medical Society*** *on page 36*

A Challenge to the Newest Members of Our Profession

BY RICHARD HARDING, M.D.

During the first week of July about 1,400 psychiatry residents completed their residency training and became psychiatrists. I extend a heartfelt welcome into the most exciting of medical specialties. As this cohort of 1,400 comes into psychiatric practice, another cohort of 500 colleagues will be leaving practice because of retirement, disability, or death. Each group deserves the highest respect and support from their professional organization and each of us as individuals.

I must admit that I envy the resident class of 2001 as they begin their careers. In the last decade we have seen biopsychosocial research make broad gains in our field. Because of this new research and our broad psychotherapeutic traditions, each new resident has knowledge of human behavior and a treatment armamentarium that I could only dream of just a few decades ago. It will be up to us and the Class of 2001 to maintain the core principles of the doctor-patient relationship, privacy, and psychotherapy while incorporating these scientific advances into the daily clinical treatment of our patients. Each generation of psychiatrists has had the opportunity to define its roles in medicine and society and to make an impact on the burden of mental illness for individual patients' and the public's health. Now it is the Class of 2001's turn.

Before finishing its formal training, I have one final pop quiz for the Class of 2001.

- Are patients' needs and rights your highest priority?
- Are you setting and determined to live by the highest professional standards?
- Are you committed to continuing your medical education throughout your professional life cycle?
- Will you work hard to be a clear communicator with your patients, their families, and society?
- Will you be an advocate for your patients and those individuals and groups who happen to have a mental illness?
- Will you join your professional organization and become involved in local, state, and national advocacy for your patients and profession?
- Will you get to know your local, state, and national politicians and educate them and their staffs about the needs of the mentally ill?
- Will you become clinical faculty for local residency programs and give something back through that program and help train the next generation of psychiatrists?
- Will you resist systems of care that undermine the doctor-patient relationship and give incentives for withholding care?
- Is it your goal to become a business person or a professional?

The American Psychiatric Association and your state association, district branch, and local chapter want to be helpful to you as you start out your practice and career. Please join the Early Career Psychiatrist Committee in your state association and make a difference.

By doing so, you will find support from colleagues, and more important, you will gain an opportunity to help your patients and your profession. ■

Predicting Violence Risk Possible but Complex

The ability of psychiatrists to predict which patients may become violent is no longer science fiction, some experts say. Conducting interviews that focus on certain factors in a person's history and using new measurement tools allow psychiatrists to make reasonably accurate short-term predictions about violence risk.

BY KEN HAUSMAN

Psychiatrists have expended considerable effort over the last few decades to disabuse the legal system and the public of the notion that they can predict who will be violent in the future. Using modern assessment tools, however, there is a growing body of data to suggest that psychiatrists can, in fact, predict violence more accurately than many believe—at least in the short term.

This was the message hammered home by several speakers at an APA annual meeting session in New Orleans in May sponsored by the APA Task Force on Psychiatric Aspects of Violence.

"Psychiatrists have come a long way in assessing violence risk," said forensic psychiatrist Bradley Johnson, M.D., an assistant professor at the University of Arizona. "We can now predict short-term violence with moderate accuracy, which is substantially better than being wrong two-thirds of the time," he said, as was the case not too many years ago.

Renée Binder, M.D., lists the key factors that psychiatrists should assess when evaluating a patient for violence risk.

Psychiatrists can't, however, take shortcuts if they want to produce a comprehensive violence assessment, noted Johnson, who is also chief of psychiatry at the Arizona Community Protection and Treatment Center, which treats civilly committed sex offenders. This means "it is important to obtain information about the person from every possible source. This is a serious undertaking and cannot be rushed," he emphasized, cautioning that such an evaluation could take at least several hours. "This is not the time to do a brief, managed-care intake on a person," he stressed.

Among the key factors that should cause psychiatrists to sit up and take notice, he said, is a history of violence, "which is the single best predictor of future violence." Having a major mental illness, substance abuse disorder, or a combination of both is also associated with increased violence risk, Johnson said. He stressed, however, that most people with these disorders are not a danger to themselves or others.

Violence is "often underpredicted" in women, he noted, urging his audience not to ignore or minimize the possibility that a woman could become violent just because women do so less frequently than men.

In contrast to the situation of underprediction associated with women, data indicate that "violence is overpredicted in African-American patients, especially men," said Renée Binder, M.D. Binder is a professor of psychiatry and director of the law and psychiatry program at the University of California, San Francisco.

Assessment Factors

Key factors to assess during a clinical evaluation of violence risk include criminal history, possession of a gun, history of multiple psychiatric admissions, the presence of violence fantasies, and sexually aggressive behavior or fantasies about such behavior, Johnson pointed out. He noted as well that violent acts attributed to "homosexual panic" can also signal a violence risk.

Binder, who is chair of APA's Council on Judicial Action, said that additional risk factors for violence are a first criminal arrest occurring at a young age; being a male under age 40; a history of cruelty to animals, firesetting, or reckless driving; viewing oneself as a "victim"; being very resentful of authority; and a lack of compassion and empathy for others.

From the perspective of psychiatric diagnosis, Johnson suggested that violence risk rises among individuals who have acute mania, ADHD along with interim explosive disorder, antisocial personality disorder, or paranoid schizophrenia with acute decompensation. Binder also suggested that evaluators should be alert to a history of noncompliance with psychiatric treatment.

Johnson also pointed out that it is crucial that psychiatrists weigh mitigating factors before reaching a conclusion about a person's violence risk. Among such factors are the capacity to bond and the presence of mentors in the person's life.

Binder emphasized several elements that psychiatrists should include in a comprehensive violence-risk assessment, particularly when it is conducted in the emergency

*see **Violence Risk** on page 36*

Residency Program Addresses Drug Company Influence

A psychiatry residency program has established clear guidelines for limiting residents' interactions with pharmaceutical representatives.

BY JIM ROSACK

In an attempt to maintain its psychiatry residents' objectivity and avoid either real or perceived conflicts of interest, a major Canadian medical school has adopted a set of guidelines for interactions with the pharmaceutical industry. The guidelines are the culmination of efforts to combat the ever-growing amount of time, energy, and money that the pharmaceutical industry spends on "detailing" physicians, beginning early in residency.

"There are few issues in all of medicine that will bring clinicians into such a heated debate as the interactions between the pharmaceutical industry and the medical profession," said Ashley Wazana, M.D., a fifth-year psychiatry resident at McGill University School of Medicine in Montreal. Wazana cited several surprising statistics at an annual meeting session in New Orleans in May.

According to some studies, Wazana said, the pharmaceutical industry in 1999 spent more than $11 billion in the U.S. on promoting and marketing its products to physicians. Five billion of that amount went directly to pharmaceutical sales representatives whose job it was to sell their products to those prescribing physicians. In 2000 that number rose to $15 billion on marketing, with $8.3 billion being spent directly on a rapidly increasing number of industry representatives. Indeed, the number of representatives nearly doubled between 1996 and 2000, to an astonishing 83,000 representatives working on selling pharmaceuticals to nearly 900,000 physicians across the U.S.

"That amounts to between $8,000 and $15,000 spent by the industry on each physician, depending upon the particular statistics in individual studies," explained François Primeau, M.D., a staff psychiatrist at McGill University and chair of the annual meeting symposium. "Another way to look at it is to say that the pharmaceutical industry spends nearly $100,000 and devotes one representative to every 11 physicians in the U.S."

Unfortunately, Primeau continued, there are few specific guidelines available for residents with regard to their interactions with the pharmaceutical industry.

Nor is there consensus on what the real impact is of the free samples, gifts, complimentary meals, travel subsidies, sponsored teaching, and supported symposia used by the industry to try to influence physicians' prescribing habits. In one study, according to Wazana, 85 percent of the medical students surveyed believed it was improper for politicians to accept a gift, but only 46 percent found it to be improper for themselves to accept a similarly valued gift from a pharmaceutical company.

Most medical associations either have or are developing guidelines for their own members regarding gifts from industry, according to Primeau. APA follows the American Medical Association's policy on "Gifts to Physicians From Industry" and the AMA's Council on Ethical and Judicial Affairs' "Clarification of Gifts to Physicians from Industry," which give broad guidelines on how to handle industry gifts. However, even within the AMA there has recently been a movement toward developing a more specific policy that would limit the types and amounts of gifts that physicians can accept from pharmaceutical companies.

Many inside the AMA often refer to the association's policy on gifts as "our most ignored ethical opinion." A recent study by Michael A. Steinman, M.D., a fellow in internal medicine at the University of California, San Francisco (UCSF), seems to back up that feeling. The results of a survey of first- and second-year residents at UCSF, which appeared in the May 1 issue of the *American Journal of Medicine*, revealed that about 42 percent of the residents said it was OK for a company to pay for their travel to an educational conference, and 15 percent said that they would accept luggage for the trip from a drug representative. Neither of these "gifts" would be acceptable under the AMA's current guidelines.

François Primeau, M.D.: The pharmaceutical industry annually spends between $8,000 and $15,000 per physician on marketing activities.

Believing that the AMA guidelines are not specific enough or strict enough, the McGill psychiatry faculty decided to formulate their own guidelines, geared toward residents' interactions with industry. The psychiatry faculty felt it was especially important to focus on residents because of the uniquely vulnerable and impressionable point at which they are in their careers, according to Annette Granich, M.D., the psychiatry residency

see ***Residency Program*** *on page 40*

Artist Paints Her Dreams To Understand Her Mind

May Lesser's art exhibit at the American Academy of Psychoanalysis annual meeting in New Orleans explores Freud's early religious influences.

BY LYNNE LAMBERG

New Orleans artist May Lesser believes Freud's early exposure to religion profoundly shaped the development of psychoanalysis. Talmudic scholars, she suggests, taught Freud to look for hidden meanings in every word and story.

The Hebrew scriptures Freud studied in his youth show real people, not deities, expressing love, hate, anger, fear, envy, lust—the entire range of human emotions. Moses dared to talk back to God, Lesser notes. Freud, too, challenged the prevailing assumptions of his time.

Lesser drew on the Hebrew scriptures to create a series of etchings and paintings that explore human strengths and frailties. Her works were exhibited at the annual meeting of the American Academy of Psychoanalysis in New Orleans in May. One also captured a prize in APA's annual meeting art exhibit. The Freud Museum in London will exhibit these and other works by Lesser in 2002.

"Jacob Wrestled a Man" (see photo at right) depicts the resolution of Jacob's nightlong struggle with God and man. At daybreak, Jacob receives a blessing and a new name, Israel, signifying his role as a leader of his people. Jacob's two wives, their handmaidens, and his children wait for him across the stream. The work is a dry-point engraving on copper, printed on rag paper and colored with egg tempera.

"This work portrays Jacob wrestling with himself and prevailing," Lesser said in an interview. "In so doing, he becomes stronger. He was blessed because he succeeded. I see this as a symbolic story," she added. "Maturation is painful, but worth the effort. I would subtitle it 'permission to be free.' We must give this permission to ourselves."

Other works in the series depict such stories as Solomon's identification of a baby's true mother, Jonah's discovery of purpose in the belly of the whale, Samson's seduction and loss of strength, and God's promise of peace to Noah.

Dreams Captured in Work

Rich in symbolic imagery, Lesser's scriptural series has much in common with the hundreds of paintings, drawings, and etchings she has made to record her own dreams over the past three decades. On awakening in the morning, she often goes directly to her studio.

"When I paint," she said, "it's a little like being in a dream state. Because the language of dreams is pictoral, I gain more direct access to feelings in my dreams by recording dream images than by simply translating these images into words. This is in contrast to Freud, who focused on verbal reports of dreams."

The economy of a dream, Lesser said, is similar to that of a physics equation. She finds that her choices of shapes, sizes, colors, positions of objects, and other elements help her grasp the relationship between various aspects of a dream.

Sheila Hafter Gray, M.D. (left), president of the American Academy of Psychoanalysis, poses with artist May Lesser, shown with "Jacob Wrestled a Man." This painting is one in a series on Biblical themes displayed at the American Academy of Psychoanalysis' annual meeting in New Orleans in May.

"Some seemingly small element may turn out to be quite prominent when I paint it," she said. "With a written description, I might not have seen that."

Lesser jots notes to help her decode the work later, but, she joked, she often can't read her own handwriting or find the paper she wrote on, an indicator that dreams sometimes reveal secrets she'd prefer to keep from herself.

"The dream is the most creative process I know, other than creating a baby," she said. "Paying attention to one's dreams can offer insight into how one's mind works. It makes the invisible visible."

For many years, she kept her dream paintings private, but recently, she's begun to exhibit some of them and to talk about her dream work, usually with groups of psychiatrists or students.

Career Rooted in Medicine

Lesser is best known for her work depicting life in university medical centers. As a child, she loved to study the steel engravings in her physician father's anatomy, obstetrics, and surgery books. She had had to pursue this interest in secret, as the books were deemed "unsuitable" for a young girl. After receiving her B.F.A. with honors in drawing in 1947 from Sophie Newcomb College, now part of Tulane University in New Orleans, she earned an M.A. in painting from the University of Alabama, Tuscaloosa, and did further graduate work in art at the University of California at Los Angeles (UCLA).

To learn more about human bone and muscle anatomy, she obtained permission in 1967 to attend anatomy lectures at the UCLA School of Medicine. Her work so impressed the faculty that they invited her to observe dissections of cadavers and to chronicle the progress of the Class of '71 through medical school. She followed them to classrooms, clinics, laboratories, operating rooms, and bedsides, documenting interactions with patients, nurses, families, faculty, and each other. She eventually published her artwork, along with

see ***Artist*** *on page 40*

New Group Will Accredit Programs That Conduct Human-Subject Research

A new accrediting body, organized by leading universities, medical schools, and teaching hospitals, hopes to ensure higher standards for the protection of human research participants.

BY JIM ROSACK

In response to increased public and political scrutiny of research involving human participants, a consortium led by the Association of American Medical Colleges (AAMC) has launched a new accrediting body for programs that conduct clinical protocols with human participants.

The Association for the Accreditation of Human Research Protection Programs (AAHRPP), based in Rockville, Md., is the combined effort of the AAMC and six other organizations representing leadership from universities; medical schools; teaching hospitals; biomedical, behavioral, and social scientists; and patient and disease advocacy groups.

"This was an intense, two-and-a-half-year effort to create an entity to accredit human research," said David Korn, M.D., senior vice president for biomedical and health research at the AAMC. The group, Korn told *Psychiatric News*, agreed with Greg Koski, M.D., director of the federal Office of Human Research Protections, that clinical research needed to move from an environment of compliance to one of conscience and responsibility.

"It is a duty shared by all who conduct research," according to an AAHRPP fact sheet, "all of whom have a stake in assuring the public that such research—which holds so much promise to improve health and the quality of life—will be carried out safely."

Recent press accounts about shutdowns of research programs around the country and alleged violations of ethics guidelines and protocols, particularly surrounding issues of informed consent, have underscored the need to ensure greater consistency of high standards for protection of human research participants. AAHRPP, founded by bioethicists, patient advocates, medical investigators, and research institutions represents the full complement of perspectives needed to encourage continued confidence on the part of the public in scientific research as a way of improving the health and quality of life of all people, said Korn.

"We, coming from an academic and research environment, know that accreditation has a powerful effect on whatever entity whose quality it is trying to maintain," Korn told *Psychiatric News*. "We are used to it, we understand it, and its very theory and practice drive quality."

The new accrediting body will be governed by a board of directors composed of individuals from the member organizations, as well as other associations concerned with research involving human participants. In addition, five representatives will be drawn from the public to represent patients and other community stakeholders.

Although the Burroughs Wellcome Fund and the Pharmaceutical Research Manufacturers' Association have contributed financially to help establish AAHRPP, neither has a role of any kind in the governing or day-to-day running of the organization.

Accreditation will be granted to programs that have completed a rigorous self-study and peer evaluation for a set period, generally three years, after which reaccreditation will require both internal and peer review to be repeated. AAHRPP will focus not only on institutional review boards, but also on institutionwide efforts, including the role of investigators in promoting and ensuring the protection of human participants.

AAHRPP expects to begin piloting its new accreditation standards by late summer and to be fully operational by January 2002.

More information on AAHRPP is posted on the AAMC Web site at <www.aamc.org/newsroom/pressrel/010523.htm>. ■

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Members of Human Research Accreditation Consortium

The new Association for the Accreditation of Human Research Protection Programs is a consortium of clinicians, administrators, researchers, and patient advocates offering voluntary accreditation to programs that conduct clinical research with human participants.

These are the seven founding member organizations of AAHRPP:

- Association of American Medical Colleges
- Association of American Universities
- Consortium of Social Science Associations
- Federation of American Societies for Experimental Biology
- National Association of State Universities and Land-Grant Colleges
- National Health Council
- Public Responsibility in Medicine and Research

The association will be headquartered in Rockville, Md., and expects to be operational by January 2002.

Psychiatry Trainees Face Many Rich Career Choices

Psychiatry trainees who are unsure about what career option to choose hear from four panelists about the day-to-day practice realities of some of the field's subspecialties.

BY EVE KUPERSANIN

Seeking information about career options available in psychiatry, residents and medical students attending a workshop at APA's 2001 annual meeting came away better prepared to choose the career path best for them.

Barry Wall, M.D., who is the director of forensic services at the Eleanor Slater Hospital in Cranston, R.I., and a private practitioner in Providence, began the workshop with a discussion about forensic psychiatry. Psychiatrists who choose this subspecialty can work either in the private sector, as he does, or the public sector, where common settings include courtrooms, jails, prisons, and hospitals. Although working in state hospitals and correctional settings does not pay well, noted Wall, "the work is extremely important," because the prevalence of mental illness is higher in correctional settings than in the community. Moreover, there is a great need for assessment and treatment in this underserved population.

Barry Wall, M.D., and Patrice Harris, M.D., discuss the pros and cons of choosing forensic and child psychiary as a career path.

In addition, forensic psychiatrists have many opportunities to consult for lawyers and judges, he noted.

Wall cited professional autonomy and the relative absence of managed care in forensic work as some of the drawing cards of the subspecialty. On the down side is short-term consultation work because of the limited time involved in working with patients.

Forensic and Child Psychiatry

Panel member Patrice Harris, M.D., is not only board certified in forensic psychiatry, as Wall is, but also in child and adolescent psychiatry.

Harris, who is an APA trustee-at-large and former Board representative from APA's Committee of Black Psychiatrists, spoke about where her career has taken her.

"I do forensic work with children and adolescents," said Harris. There is no shortage of work because, for one reason, "there are a lot of kids being tried as adults."

Harris, a private practitioner in Atlanta, noted that much of her work is not office based—she is only in her office one day a week. Part of her private practice involves consultation work with social workers.

Harris went to medical school at West Virginia University with her sights set on a career in pediatrics. After she did her clerkship in psychiatry, however, she decided to combine her love for children with a career in psychiatry, she said.

Although Harris observed that medical students and residents thinking about a career in child and adolescent psychiatry are passionate about working with youngsters, they should know that the job entails other work as well.

"Child and adolescent psychiatrists spend a great deal of time and energy talking to parents, other caregivers, teachers, day care providers, and grandparents, for example," said Harris. These conversations, she said, are necessary for obtaining additional background information about a child. As critical to the system as they are, however, psychiatrists are not always reimbursed for this background work, she pointed out.

Harris cited another major incentive to becoming a child and adolescent psychiatrist. "Since there is no debate that this is a shortage subspecialty," she said, "you will be in demand, and you'll have a greater choice of geographic areas in which to practice."

She added that there is plenty of work to be found in both the private and public sectors for child and adolescent psychiatrists.

Geriatric Psychiatry

Blaine Greenwald, M.D., said that geriatric psychiatry, too, is a subspecialty in dire need of more psychiatrists, and that need will only increase with time.

"Between 1980 and 2020, the general population will increase by about 31 percent, but the geriatric population will in-

see ***Career Choices*** *on page 21*

Prison Psychiatrists Must Overcome Barriers to Effective Care

According to the Bureau of Justice Statistics, as many as 25 percent of prisoners require mental health services at some time during their incarceration, but the barriers to proper psychiatric treatment are formidable.

BY EVE KUPERSANIN

Practicing psychiatry in prison is much like practicing psychiatry in a foreign country, maintains Lee Rome, M.D., clinical director of the Bureau of Mental Health Services at the Michigan Department of Community Health.

Lee Rome, M.D.: "It is a humbling experience to work in prisons."

"It's a self-contained society with its own language, customs, and rituals," said Rome, noting that the customs and rituals are usually related to security measures that can seem daunting for many psychiatrists. "Some metal detectors can be so sensitive that you'd swear they were picking up the iron in your hemoglobin."

"Discharge planning is an essential component of mental health treatment of the inmate."

Rome traveled to APA's 2001 annual meeting in New Orleans in May to be part of a panel of experts discussing the most crucial issues in prison psychiatry.

Rome said he has seen unresolved issues relating to dependency or control emerge in practitioners unprepared for what can seem to them to be degrading practices. "It is a humbling experience to work in prisons," said Rome, "and I have seen psychiatrists leave the prison setting for good because they have been narcissistically injured from having to surrender their wallet or be patted down."

Countertransference is perhaps the most significant issue in prison psychiatry, according to Rome.

Psychiatrists often have emotional reactions that mirror the patient's behavior and interpersonal style, Rome noted. He explained that they can serve as a barrier to appropriate diagnosis and treatment if acted out by the psychiatrist, or an opportunity to better understand the patient's issues if appreciated as important clinical information.

In a prison setting, some prison patients may seem threatening to the psychiatrist, and others may appear helpless. The psychiatrist may feel fearful of the prisoner who seems threatening or may have fantasies of rescuing the patient who seems helpless, according to Rome. The psychiatrist may then unconsciously act out in a punitive manner toward the patient or in a way that inappropriately appeases the patient, Rome pointed out.

"If that happens," said Rome, "the therapist can unconsciously withhold or provide treatment that isn't clinically indicated. This, of course, can interfere with an objective diagnosis and treatment of behaviorally disordered prisoners," said Rome.

He suggested that due to countertransference, it is possible for psychiatrists to "criminalize mentally ill behavior or medicalize criminal or antisocial behavior," said Rome.

The prison psychiatrist must determine whether the prisoner's maladaptive behavior relates to an underlying major mental disorder, which should respond to medication or psychotherapy, or is linked to personality disorders that don't respond to psychiatric treatment, or both, said Rome.

In one instance, for example, the psychiatrist can misinterpret maladaptive behavior as an antisocial personality disorder when its underlying cause is a major mental illness—and then the patient doesn't get the appropriate treatment. Instead the prisoner is placed in administrative segregation as a punitive measure, Rome noted.

In contrast, he said, if the psychiatrist places a psychiatric diagnosis on behavior that is purely predatory, narcissistic, and antisocial, obvious problems are created.

Jeffrey Metzner, M.D., talks about the importance of discharge planning when treating inmates who have a mental illness.

"The prisoner may be placed on a mental health unit [in the prison], and the antisocial behavior will continue—the prisoner won't respond to medical treatment and may assault staff and mentally ill prisoners on the unit," said Rome.

He noted that when the psychiatrist steps back from emotional reactions toward the prisoner such as fear, anger, and punitive feelings, he or she will be more effective at sorting out personality-disordered behavior from the elements of an Axis I major mental disorders.

Rome also focused on populations in prisons that need special treatment considerations. These include suicidal prisoners, prisoners who self-mutilate, women, juveniles, and prisoners with developmental disabilities.

Another panel member, forensic psychiatrist Jeffrey Metzner, M.D., emphasized the importance of post-release planning for the inmate.

Metzner, who is chair of APA's Council on Psychiatry and Law and president of the American Academy of Psychiatry and the Law, said, "Discharge planning is an essential component of mental health treatment of the inmate." He added that the extent of discharge-planning services provided to the inmate needs to be adjusted to the nature and severity of the inmate's mental illness and his or her ability to function independently after release.

Metzner noted that key obstacles to an inmate's effective transition into the community after release are homelessness, symptoms of mental illness, poor socialization skills, and cognitive deficits.

"Adequate discharge planning includes creating a written service plan that identifies the needs of the inmate and the appropriate resources available to him or her upon release," said Metzner. He also suggested that psychiatrists refer inmates to community-based mental health services and provide inmates with a temporary supply of medication when clinically appropriate. ■

Ex-Inmate Makes Prison Less-Forbidding Place to Die

While incarcerated for more than a decade, one mental health professional made prison a better place for fellow inmates who didn't get out alive.

BY EVE KUPERSANIN

Imprisoned in what can be a hostile and uncaring environment, a mental health professional left behind a legacy of compassion and decency after his release.

Fleet Maull, M.A., is a master's-level psychotherapist who spent 14 years behind bars at the U.S. Medical Center for Federal Prisoners in St. Louis, Mo., where he experienced what he called a "serious existential and spiritual crisis."

However, he found deep meaning in what can be a devastating experience for many.

During the course of an APA annual meeting session in May on prison psychiatry, Maull talked about his time in and out of prison.

Psychotherapist Fleet Maull, M.A., who was incarcerated for 14 years, established the first prison hospice in the U.S. with the help of another prisoner.

Maull, who is now an adjunct faculty member at Naropa University in Boulder, Colo., received his master's degree in Buddhist and western psychology. He said he was on a spiritual quest from a young age and involved in Tibetan Buddhism.

"But I carried with me into that path a history of drug and alcohol addiction, and a past involvement with some drug trafficking—I had this split life going on," said Maull.

That life caught up with him in 1985, when he was sentenced to 25 years in prison without parole. However, between the "good behavior" rules and one charge being dropped, he served a little over 14 years at the facility, which housed prisoners with medical, mental health, and substance use problems.

Maull said his spiritual crisis "came out of a deep sense of remorse from the pain I caused my family and spiritual community," adding that he believes that spirituality is rooted in helping others. "I felt as if I had wasted my life, when so much of my time and energy could have been devoted to helping others."

To remedy that situation, Maull said he began teaching meditation to his fellow prisoners, and in 1987 he created the Prison Dharma Network, which promotes meditation and Buddhism.

He began to spend time with prisoners in the facility's hospital, many of whom were casualties of the U.S. AIDS epidemic.

Despite resistance from the prison administration, Maull established a hospice in the prison—the first prison hospice in the U.S.—with the help of another prisoner, Maull said. He and others received extensive training on bedside care, grief and bereavement, and hospice care from hospice workers outside the prison. The prisoners helped their sick and dying peers by reading to them, helping them write letters, taking them outside to the yard or to the prison chapel, and counseling and listening to the prisoners.

"Before our hospice program began," said Maull, "men were dying in complete isolation, and the pain management was poor—prisoners were left unattended for long periods of time."

In 1991, Maull founded the National Hospice Prison Association, which promotes hospice and palliative care within the prison system. The organization has helped to establish 25 additional prison hospice programs across the country.

Since his release from prison in 1999, Maull has served as the director of the Prison Dharma Network and the National Prison Hospice Association, as well as U.S. director of the Peacemaker Community, a global interfaith network that seeks to integrate spirituality with social action and peacemaking.

More information on the National Prison Hospice Association is posted on the Web at <www.npha.org>, and information on the Prison Dharma Network is posted at <www.prisondharmanetwork.org>. ■

Federal Parity Mandate Disappoints D.C. Psychiatrists

The smiles that greeted President Bill Clinton's order mandating parity for mental health care in all health plans that insure federal employees are beginning to turn to frowns as preliminary anecdotal reports suggest the program is missing its mark.

BY KEN HAUSMAN

Psychiatrists at one of Washington, D.C.,'s largest hospitals have decided that, on the basis of early evidence, they don't want to stick around to see how the federal government's mental health parity mandate turns out.

On January 1 the Office of Personnel Management, which oversees the Federal Employees Health Benefits Program (FEHBP), began to implement a Clinton administration executive order stating that insurance plans covering the health of 9 million government workers and their families must offer the same coverage for mental health services as they do for physical health (*Psychiatric News*, June 2, 2000; October 20, 2000).

While this news was welcomed by the psychiatric community, implementation of the mandate has had its downside. The psychiatrists at George Washington University Medical Center decided that on the basis of what they had to endure in terms of additional paperwork burdens and treatment-authorization protocols since the parity program began, they were going to withdraw from participating in all the FEHBP insurance plans, except the university's own health plan, said Jeffrey Akman, M.D., professor and interim chair of the psychiatry department.

"The early signs indicate that the spirit and letter of the parity order are in jeopardy."

Parity in Jeopardy?

Eliot Sorel, M.D., a past president of the Washington (D.C.) Psychiatric Society (WPS), chairs a WPS-sponsored group called the Partnership for Parity Working Group, which "monitors, assesses, and provides feedback to OPM" on how the parity implementation is proceeding. He told *Psychiatric News* that "the early signs indicate that the spirit and letter of the parity order are in jeopardy" because of the way it is being implemented by the insurance companies that participate in the FEHBP.

Though deductibles and copayments did go down following parity implementation, focus groups of psychiatrists convened by the parity partnership in March and April raised concerns about more extensive preauthorization requirements and burdensome paperwork, as well as more frequent and time-consuming utilization reviews of inpatient and outpatient psychiatric care, Sorel said.

Sorel noted that focus-group participants also reported that patients were dealing with "grossly inaccurate provider lists," sometimes including the names of deceased psychiatrists. Participants also reported that few of their patients were aware of the parity implementation, and that there was a decrease in the number of outpatient sessions that managed care companies in the FEHBP were willing to authorize since the parity mandate began.

At this point in the implementation, "[w]hat parity means to the clinicians is very unclear and poorly understood," said Akman. "Allegedly, mental and nervous disorders are to be covered on par with physical illness, but people are unclear as to what this really means or how it is to be implemented."

The WPS parity partnership presented the anecdotal reports of a lack of improvement in psychiatric care to the OPM as part of its evaluation of how the parity implementation is going. Sorel added that meetings between the OPM staff dealing with parity and the WPS psychiatrists have been "open, candid, and at times heated." In these meetings, he noted, the OPM officials have "stressed the importance of having practicing physicians involved in evaluating the parity implementation."

Other Evaluation Efforts

The WPS partnership is not the only group evaluating how parity is unfolding for clinicians and federal workers.

The American Psychiatric Institute for Research and Education (APIRE) is in the early stages of a multiyear assessment of how the federal parity mandate is playing out. The APIRE project is focusing on "the effect of parity on access and management of mental health and substance abuse services and its impact on psychiatrists' practices and the nature and quality of treatments provided," said APIRE Director Darrel Regier, M.D., who is heading the parity-evaluation project.

Once baseline information is gathered, the next phase of the APIRE project, which will begin around January 2002, will survey psychiatric practices to learn about clinicians' experiences with FEHBP parity, explained William Narrow, M.D., associate director for classification and diagnosis in the APA Division of Research.

see ***Parity*** *on facing page*

Medicare Telehealth Program To Reimburse for Psychotherapy

The addition of individual psychotherapy is one of the hallmarks of the government's recently announced expansion of Medicare's telehealth program.

Some psychiatrists who use telecommunication systems to provide individual psychotherapy or medication management will soon be eligible for Medicare reimbursement for these services, thanks to an expansion of the health plan's telehealth project.

The federal agency that administers the Medicare program, the Health Care Financing Administration (HCFA), is expanding its telehealth service program effective October 1 to add coverage for psychotherapy and medication management, as well as for consultations in certain regions of the country.

Psychotherapy codes covered by the program are CPT codes 90804 through 90809; the applicable medication management code is 90862.

In addition to adding individual psychotherapy and medication management to the services eligible for reimbursement under the Medicare telehealth program, HCFA is expanding the program geographically. Only physicians practicing in rural areas that the government has designated "health professional shortage areas" have been included in the telehealth project. As of October 1, however, the eligible regions will include all counties throughout the country that are not included in a metropolitan statistical area.

Physicians and other health professionals who want to be eligible for the expanded Medicare program must have an "interactive telecommunications system" in place, according to the HCFA memorandum announcing the expansion. The agency notes that for a clinician or facility to be eligible for reimbursement, "interactive audio and video telecommunications must be used, permitting real-time communication between the distant site physician or practitioner and the Medicare beneficiary. As a condition of payment, the patient must be present and participating in the telehealth visit."

Programs in Alaska and Hawaii will be allowed to use "asynchronous store and forward" telecommunications equipment, which allows the medical data to be transmitted and reviewed at a later date by the clinician at the distant site, according to HCFA. This does not, however, open the door to the inclusion of telephone calls, fax transmissions, and electronic mail "without visualization of the patient."

Medicare telehealth services will be reimbursed at the same fee-schedule rate Medicare pays for face-to-face services, and the service must be within a practitioner's scope of practice according to applicable state laws. Clinicians are to use the appropriate CPT code for the service they provide but add a "GT" suffix, which designates it as an eligible telecommunication service.

HCFA is also requiring Medicare insurance carriers to publish information about the telehealth changes in their next regularly scheduled bulletin and on their Web sites. They must also have the appropriate "edits" installed in their claims processing systems by the October 1 expansion date.

Additional details about the telehealth expansion under Medicare can be read on HCFA's Web site at <www.hcfa.gov/pubforms/transmit/ab0169.pdf>. ■

Parity

continued from facing page

The third phase of the APIRE study will begin early in 2003 and consist of a follow-up survey of psychiatric practices and the gathering of additional clinical information on the care patients are receiving under FEHBP insurance plans compared with baseline. Narrow noted that the evaluations have been structured to occur over several years to allow for the parity program to work out its "growing pains."

In addition, APA is attempting to coordinate its survey efforts with those of other professional associations and a research firm that has a federal contract to evaluate the parity implementation, Regier pointed out. ■

Congress Addresses Child Psychiatrist Shortage

The need for child and adolescent psychiatrists in the United States far outweighs the supply. A new bill in Congress would boost the number of trainees by increasing Medicare funding for subspecialty training.

BY CHRISTINE LEHMANN

APA and the American Academy of Child and Adolescent Psychiatry (AACAP) are backing a new bill in Congress designed to increase the number of trainees in designated subspecialties, which is expected to include child and adolescent psychiatry.

APA President Richard Harding, M.D.: The Medicare Critical Need GME Protection Act "is crucial to increasing the supply of child and adolescent psychiatrists in the United States."

The proposed legislation, introduced in May by Rep. Pete Stark (D-Calif.), allows the Secretary of Health and Human Services to determine which specialties or subspecialties have professional shortages and fully fund their training programs.

Child and adolescent psychiatry training programs were among the casualties of the 1997 Balanced Budget Act, which halved Medicare graduate medical education funding for subspecialty residency programs.

APA President Richard Harding, M.D., told *Psychiatric News*, "Everyone from the Surgeon General to medical directors of adolescent treatment programs knows there is a severe shortage of child psychiatrists."

The 1999 Surgeon General's Report on Mental Health noted the dearth of child psychiatrists to care for an estimated 15 million children with diagnosable psychiatric disorders.

"We know that untreated mental illness in children has long-term negative consequences and increases health care costs later on," Harding continued.

There are only about 6,300 child and adolescent psychiatrists practicing in the United States, according to a draft AACAP report. Meanwhile, the number of residents being trained in child and adolescent psychiatry has decreased in the past decade from 712 in 1990 to 669 last year. The number of child and adolescent training programs has decreased in the last decade from 120 to 115, according to the AACAP report.

The government relations staffs of APA and AACAP have been meeting with leaders of key congressional committees that will be voting on the bill, titled the Medicare Critical Need GME Protection Act of 2001. The bill (HR 1928) had 21 cosponsors at press time and was before the House Ways and Means Subcommittee on Health, which oversees Medicare issues. A companion bill is expected to be introduced in the Senate and referred to the Finance Committee, which oversees Medicare in the Senate.

"This bill is crucial to increasing the supply of child and adolescent psychiatrists in the United States. We need to do everything we can to support this valuable subspecialty," said Harding.

The summary, status, and text of the bill can be accessed on the Web at <thomas.loc.gov> by searching on the bill number, HR 1928. APA's Division of Government Relations posted an Action Alert on the bill on APA's Web site at <www.psych.org/pub_pol_adv/Action_alerts.cfm>. ■

Colorado Psychiatrists Succeed In Getting Parity Loophole Closed

Psychiatrists in Colorado will get some relief from discriminatory utilization review procedures when a new law goes into effect.

BY CHRISTINE LEHMANN

The Colorado Psychiatric Society's effort to convince lawmakers to improve the state's parity law paid off last month when Colorado Governor Bill Owens (R) signed a bill that ends one form of insurance bias against mental health care in the state's 1997 mental health parity law.

The new legislation prohibits managed care companies from using utilization review procedures to restrict payment for mental illness treatment more than they do for treatment of physical illnesses, according to the bill. It closes a loophole in Colorado's 1997 parity law.

State Representative Kathleen Matthews, M.D., told *Psychiatric News* that managed care companies were circumventing the parity law by imposing "unfair" utilization review practices on psychiatrists.

*see **Parity Loophole** on page 22*

APA Journal Seeks Articles By and for Residents

APA is bolstering the visibility of research and training programs for residents and fellows in a way that is sure to attract their attention.

BY EVE KUPERSANIN

Although it can be difficult for residents to publish original research, one benefit of a new feature in *Psychiatric Services* is making it easier.

The monthly, peer-reviewed journal that recently became free to all U.S. and Canadian APA members is now accepting submissions for a series of articles by trainees, as well as articles for trainees and about trainees.

"It is very important for psychiatry residents to have an opportunity to get published while they are in training," said Michelle Riba, M.D., an APA vice president and member of the *Psychiatric Services* Editorial Board. "Similarly, it is important. . .to publish articles of interest to residents."

Avram Mack, M.D., is editor of the new series. He is APA's member-in-training trustee and a fellow in adolescent psychiatry at the New York State Psychiatric Institute/Columbia-Presbyterian Medical Center. Mack is soliciting articles focusing on trainees in psychiatry, including residents and fellows, as well as psychiatrists who have just completed residency. The articles may be written by residents, fellows, early career psychiatrists, or psychiatric educators.

Avram Mack, M.D., is editor of *Psychiatric Services'* new trainee-oriented series that will feature articles of interest to residents.

Some examples of topics that Mack suggested for submissions were "how residents in this country are learning, different types of residency programs, and certain features of these programs."

He is also soliciting articles that report on research undertaken by trainees regarding psychiatric services provided to patients.

As the series' first editor, Mack's task is, in part, to lay the groundwork for future editors of the trainee-oriented series. He will also work with members-in-training, as well as *Psychiatric Services* Editor John Talbott, M.D., and the journal's editorial board to identify a selection process for future editors for this series.

"We hope that this series will be useful for all those involved in psychiatric education and resident training," Talbott said.

The regularity of the series will be determined by the volume of acceptable submissions, according to Mack.

Submissions should be formatted according to the "Information for Authors" section of* Psychiatric Services *on page 613 of the May issue. This information is also posted on the journal's Web site at <http://psychservices.psychiatryonline.org/misc/ifora.shtml>. Those seeking advice about whether an intended submission is appropriate may contact Avram Mack, M.D., by e-mail at avram_mack @hotmail.com. ■

P.E.O.P.L.e Finds Jobs For People With Mental Illness

The oldest agency in New York state run for and by people with mental illness has an impressive track record in its mission of matching clients with jobs.

BY LIZ LIPTON

There is a mental health agency in New York state with a $720,000 annual budget. This would not be particularly impressive except that every one of its 23 employees—including the executive director—lives with mental illness.

The agency is P.E.O.P.L.e Inc., which stands for Projects to Empower and Organize the Psychiatrically Labeled. It is the oldest completely peer-run agency in New York.

Started 14 years ago by a few patients on the grounds of the Hudson River Psychiatric Center in Poughkeepsie, P.E.O.P.L.e now has an office in Kingston and one in Poughkeepsie.

> **"P.E.O.P.L.e serves a vital purpose in the recovery process, and its work helps to destigmatize mental illness."**

Last year the agency served 2,400 individuals with severe and persistent mental illness. Most receive SSI or SSDI payments and are between the ages of 30 and 50.

Variety of Initiatives

How does the agency serve these individuals, whom it calls "members"? P.E.O.P.L.e offers a wide variety of programs, including a two-year-old job training program that has helped 32 members find and keep jobs, and a peer advocacy program that includes an initiative serving patients in mental health settings.

Regarding this latter initiative, advocates work set hours at Benedictine Hospital's two psychiatric units and emergency service in Kingston, N.Y. (see box above right). In addition, they work on an on-call basis at Hudson River Psychiatric Center, St. Francis Hospital's two psychiatric units in Poughkeepsie, and several mental health outpatient clinics in Ulster and Dutchess counties.

Besides providing companionship and emotional support, advocates assess patients' needs. Patients' most common requests are to change rooms, therapists, or medications. The advocates then set up a meeting with the treating psychiatrist, other therapist, and case manager to address these requests.

To assist patients in solving their hospital-related problems, advocates may role play the situation with the patients and coach them on controlling their emotions while acting assertively. Also, advocates often stay with patients when they speak with the nurse, psychiatrist, or other staff. The advocates' long-term goal is to have patients advocate for themselves.

Advocates do not give advice on medication or other treatment.

"There are probably only a handful of programs doing this," said Paul Seifert, director of government affairs for the International Association of Psychosocial Rehabilitation Services (IAPRS). "This is an upcoming part of the consumer-empowerment movement, which we at IAPRS welcome."

Most of P.E.O.P.L.e's other programs are designed to help members live in the community. They include peer-support groups (about 100 are offered every month), two drop-in centers, social and recreational activities, assistance with housing, and peer advocacy in non–mental health settings, such as problems getting Medicaid.

In addition to offering these programs, last year P.E.O.P.L.e's staff helped 104 patients or former patients, most of whom were homeless. As a result of their efforts, now some have housing, and most receive Medicaid, food stamps, and SSI or SSDI or welfare, said Executive Director Steven Miccio.

In addition to the programs in Ulster and Dutchess counties (where Poughkeepsie and Kingston, respectively, are located), it has a project in neighboring Orange County. Officials from these three counties have received $720,000 in contracts from the New York State Office of Mental Health to support P.E.O.P.L.e.

"P.E.O.P.L.e serves a vital purpose in the recovery process, and its work helps to destigmatize mental illness," said Kenneth M. Glatt, Ph.D., Dutchess County's commissioner of mental hygiene. "The agency has helped a lot of people over the years, and we consider it a vital part of the community mental health network."

Vocational Training

P.E.O.P.L.e's Poughkeepsie office is the lead agency in a job consortium of 20 agencies serving individuals with psychiatric or physical disabilities. Kim Bonanno, P.E.O.P.L.e's job coordinator, finds appropriate jobs for the clients at the Galleria Mall in Poughkeepsie.

In conjunction with these services, P.E.O.P.L.e offers a comprehensive job-training program for members at its Poughkeepsie office.

Has this hard work paid off? Well, in 1999, 12 members began working part-time; in 2000, 20 members did the same. For most members, this was their first competitive job, yet only one of the 32 new employees is no longer working. And about 20 percent of these positions have become full time.

Furthermore, four of the employees have discontinued their SSI or SSDI benefits, and three receive substantially lower SSI or SSDI benefits, according to Miccio.

How are they able to achieve this success? First, the staff helps members find jobs that they truly enjoy, including positions in retail sales, stocking, picture framing, and photo developing, for example.

"We try to get away from the typical jobs offered to [mentally ill individuals] like cleaning or fast food. We focus on empowering them and letting them know they have a choice of where they want to work," said Miccio.

Second, Bonanno helps members every step of the way. This includes assessing the members' interests and skills, finding them jobs, and arranging for a job coach to accompany them for the first few days. The county provides funding for clothes and transportation. Once employed, members often attend P.E.O.P.L.e's Working People's Peer Support Group.

Third, Bonanno and Miccio focus their efforts on the Galleria Mall, which has enabled them to develop a good reputation among store managers.

Miccio explained, "At first, some managers would ask, 'Are [the members] dangerous? Should I be concerned about anything like stealing?' But once they began working, these fears went away. And now we can't meet their demand for employees." Miccio noted that despite their efforts, about 10 percent of the managers refuse to hire P.E.O.P.L.e's members.

Advocacy Efforts

Nineteen of P.E.O.P.L.e's 23 employees are advocates. One advocate, Lesleigh Ozburn-Miller, devotes all her time to working on large-scale issues such as mental health insurance parity. Although the other 18 advocates also work on large-scale issues, they primarily advocate for individual members.

They work on a variety of issues in a variety of settings. One day they might advocate for a patient on a psychiatric unit, while the next they might advocate for a member at social services offices. Most have about eight years of experience. Twice a year they participate in a six- to eight-day training seminar covering such topics as mental health law, patients' rights, conflict resolution, and multicultural training. Those working in hospitals participate in on-site training and orientation by the hospital's staff. ■

Lesleigh Ozburn-Miller and Steven Miccio of P.E.O.P.L.e are photographed in its Kingston, N.Y., office. Miccio is executive director and Ozburn-Miller is an advocate who works on major mental health causes.

Advocates Improve Hospital Experience

At Benedictine Hospital in Kingston, N.Y., P.E.O.P.L.e.'s advocates work a total of 50 hours a week on the psychiatric emergency service and 15 hours a week on two psychiatric units.

The advocates who work on the psychiatric emergency service explain emergency department procedures to patients, accompany them during the admissions process, and help in other ways, said Thomas Dowling, R.N., M.S.N., coordinator of the psychiatric emergency service.

"Overall, the advocates are very helpful," explained Dowling. "There have not been any problems. They do not approach patients who are acting out or who are intoxicated. The advocates have different priorities and offer a different perspective" than would a physician or other professional, he added.

Dowling said that these advocates have helped him "be more aware of what it would be like to be a patient in the ER, and their reassurance to patients has enabled patients to work with us with less resistance." He described the example of one advocate who calmed a fearful patient by saying, "I know this guy [Dowling]; you really can trust him."

The most important service the advocates provide, Dowling emphasized, is that "they offer the patients hope and help them see that they can take an active role in their recovery."

John Mitchell, M.D., a psychiatrist on Benedictine's two psychiatric units, has worked with advocates about 30 times in the last two years. With rare exceptions, he thought the advocates were "objective, professional, and very helpful."

"They remind me and others on the treatment team about patients' fears and concerns. . . . And their presence in treatment-team meetings lets patients see that we really are listening to them and we do really respect their concerns," Mitchell noted.

Mitchell said the advocates often help improve communication between patients and the treatment team. For example, on a few occasions, the advocates have told the treatment team that patients would like information about medication explained more clearly, a step that is likely to facilitate treatment for both patients and caregivers.

community news

Landmark Hospital Celebrates Birth of American Psychiatry

At a major milestone in its history, Pennsylvania Hospital is remembered for its role in influencing the development of psychiatry in the United States.

BY TRICIA DYCH

Pennsylvania Hospital, the nation's first hospital, is celebrating a unique milestone in the field of medicine and psychiatry in the United States—the 250th anniversary of the creation of the hospital, the birth of formalized American medicine, and the start of the field of psychiatry.

The Philadelphia institution was established on May 11, 1751, by Benjamin Franklin and Dr. Thomas Bond, who saw the need to "care for the sick-poor and insane who were wandering the streets of Philadelphia." A few months later, the first patients were admitted, and six were treated for psychiatric illness.

"It is an honor to lead this institution's psychiatric services during this remarkable time," said Jody J. Foster, M.D., M.B.A., interim chair of the department of psychiatry. "It is incredible to work in the same place where psychiatry was born and to walk the same halls as Franklin, Bond, and psychiatry's most prominent forefathers, Benjamin Rush and Thomas Story Kirkbride."

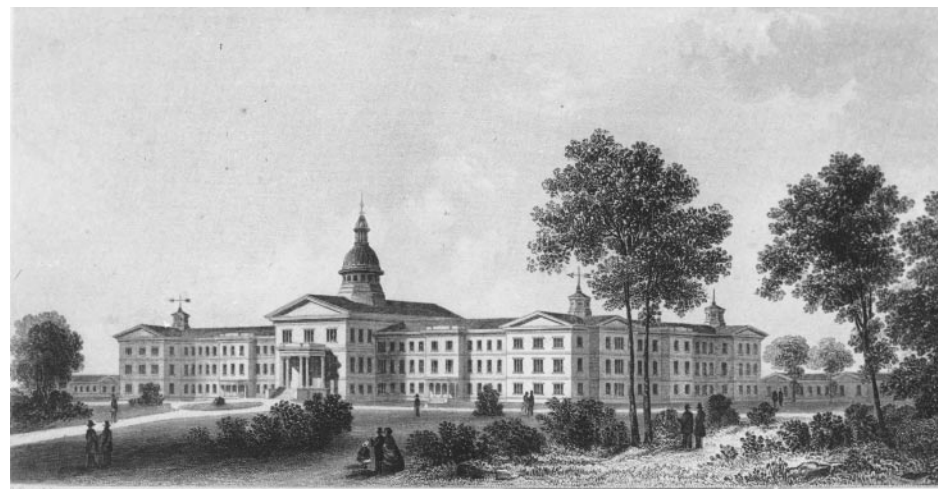
From the time the hospital was established to 30 years later when Dr. Benjamin Rush came to Pennsylvania Hospital, psychiatric patients were treated as if they were possessed by demons. It was Rush, a signer of the Declaration of Independence and an esteemed military physician, who first believed that mental illness was a disease of the mind. It was because of this and his writing of a now classic work, "Observations and Inquiries upon Diseases of the Mind," published in 1812, that he became known as the "father of American psychiatry."

"Although by today's standards the care provided was horrific and usually ineffective, Rush and his colleagues truly believed they were providing the most appropriate and compassionate treatment possible," explained Foster.

In 1841 the hospital opened the doors of what became known as the Institute of Pennsylvania Hospital. By this time, Dr. Kirkbride was in charge, and treatment for the mentally ill took a new, enlightened direction.

Kirkbride practiced what was known as "moral treatment" and believed those with mental illness could be cured. Kirkbride strongly influenced the construction of the Institute and made sure it provided patients with many recreational and educational opportunities to help prepare them to return to society.

In 1844 Kirkbride hosted a meeting of the 13 superintendents of the U.S. hospitals for the insane, which led to the creation of what is now known as the American Psychiatric Association, the nation's first specialty medical society.



The plan for a new mental hospital, known as the Kirkbride Building of the Institute of Pennsylvania Hospital, was devised by Thomas Kirkbride, M.D., and used as a model by all 30 states then in existence in constructing their state hospitals.

Photos: Pennsylvania Hospital

During its 150-plus years in operation, the Institute gave rise to 12 APA presidents—more than any other hospital in the country.

"Although economic forces closed the doors of the Institute in 1997," explained Foster, "our Behavioral Health Service continues to thrive, and our recent merger with the University of Pennsylvania Health System has expanded our opportunities tremendously."

The hospital continues to provide unparalleled psychiatric care via both inpatient and outpatient programs, many of which are offered through the hospital's Hall-Mercer Community Mental Health and Mental Retardation Center. The institution remains committed to teaching and trains psychiatry residents from the University of Pennsylvania and runs an independent psychology internship program.

"The strength behind the Penn system has only expanded the hospital's opportunities for education, research, and the continued provision of superior care," said Foster. "Psychiatry is as important to Pennsylvania Hospital as it was in 1751 and 1841."

Dr. Benjamin Rush's "tranquilizing chair" was used to restrict the blood flow to the patient's brain.

APA returns to the city of its birth next year to hold its 2002 annual meeting there. ■

Ms. Dych is director of public affairs at Pennsylvania Hospital, Philadelphia.

residents' forum

On Being Tired

BY HAGIT BAT-AVI, M.D.

Many of my clinic patients complain that they are tired. "How many hours do you sleep at night?," I ask.

"No, doc," they answer. "It has nothing to do with lack of sleep."

"Can you tell me more?" I continue; now I am puzzled.

In my mind I run through differentials for fatigue, but somehow I have a premonition that I am going to miss the real diagnosis.

"You see," they say in a diplomatic manner, "don't take it personally but. . . ."

Now I am really curious about the etiology of this tiredness. What could it be? I conjure up multiple guesses about side effects of drugs, drug-drug interactions, underlying medical illnesses. . . . "Hold it," I mumble to myself. "Listen to what the patients are trying to tell you." The answer turns out to be simpler than what I had imagined.

Most of my patients are quite open and willing to talk. They claim to be tired not from mental illness or side effects of medications but from having to switch doctors at the end of every residency year.

"Do you know how many doctors I have seen already?," they ask rhetorically.

I can easily estimate that number by the date of their admission, but I wait for them to inform me. They do so once they realize that the topic has caught my attention.

"Finally, after seven months you feel comfortable with the new psychiatrist," they explain, "and this is the time when you are told that in three months someone else will pick you up."

It is frustrating for patients to get used to a new resident every year, and it is even more difficult for those who have a chronic illness and other serious problems. They resemble infants leaning how to walk when suddenly, after taking several steps with the help of a known caretaker, they find out that when they let go of the supporting hand, they are on their own, and when they gaze up there is a stranger standing in front of them. They stop and wonder if they should take the next step.

When I "inherited" my caseload from my predecessor, all I could think about was how to get my schedule organized so that I could start meeting these patients. For patients, this transition time was equivalent to a panic episode. Some came to see me because of their monthly need for medication; others postponed the appointment and decompensated, until finally a family member called me, frantically asking for help. There were also those who questioned me on the phone several times, and only after I promised that I was indeed a nice person did they come to the clinic to renew their therapeutic commitment.

One by one they returned to the clinic, and as time passed, like a process of acculturation, they learned to trust me too. Not surprisingly, however, they often ask, "When are you leaving? We are very tired of new doctors. Why can't you stay for a while? Don't you like us?"

I have explained many times that liking has nothing to do with the yearly abandonment. We talk about abandonment in its various presentations in our sessions. I try to be open, as my patients are, now that I understand what it means for them to be tired of the changes they are expecting in several months. Deep inside of me, I too have regrets about moving forward and leaving patients behind to be cared for by someone else. After all, they have become "my patients"—my responsibility—even if only for 12 months.

We residents are part of a training program that continues on each year with a new group of residents. We are the moving passengers in a place where patients are the permanent fixtures for the time they need psychiatric care. The therapeutic marks that I leave upon my patients' lives may last for a while, until another resident picks up the cases and follows his or her own style of treatment.

The life of a resident is very fragmented. I too move from one rotation to the next, and I also get tired. All of us get attached to our patients. Residents live in a state of revolving doors; it is indeed arduous to be constantly starting work with patients and leaving them to move on to other patients. I understand my patients' frustration and their anxiety about meeting someone new each year. Nonetheless, I hope I have prepared them to face the new residents with a sense of excitement rather than abandonment. ■

Dr. Bat-Avi is a PGY-4 resident at Beth Israel Medical Center in New York City.

Furor Erupts Over Study On Sexual Orientation

A psychiatrist who played a major role in removing homosexuality as a mental disorder from *DSM* nearly 30 years ago ignites controversy and media frenzy when he claims that conversion therapies can in fact work for some people.

BY KEN HAUSMAN

In 1973, when Columbia University psychiatry professor Robert Spitzer, M.D., chaired the committee that oversaw the revision of the first edition of APA's *Diagnostic and Statistical Manual (DSM)*, he brought to the APA Board of Trustees the controversial proposal that homosexuality should be dropped as a psychiatric diagnosis.

Spitzer stressed that there were no valid data linking sexual orientation to mental illness and that studies showed that homosexuals functioned just as well as heterosexuals.

The Board overwhelmingly agreed with Spitzer, and when *DSM-II* appeared, only the concept of ego-dystonic homosexuality remained as a way to categorize those who were unhappy with their sexual orientation. That diagnosis, whose inclusion was also proposed by Spitzer, was deleted from the next edition of the diagnostic manual.

Now 28 years later, Spitzer has ignited a controversy involving the same topic, and it has become the focus of media attention throughout the country.

Speaking at APA's 2001 annual meeting in New Orleans in May, Spitzer maintained that so-called reparative psychotherapies can and have successfully changed homosexuals into heterosexuals and that he has the data to prove it.

Spitzer's position runs counter to that of APA and other major medical and mental health organizations, which are on record rejecting the notion that "reparative" therapies do what they claim. To date there have been no rigorous scientific studies that validate the notion that sexual orientation is mutable, even after psychotherapy. The only "evidence" is from anecdotal reports of "cures" or of being harmed by such attempts at therapy.

His contention, which was reported in major print and broadcast news media within a day of the May 9 annual meeting presentation, has provoked heated responses from psychiatrists, mental health professionals, gay and lesbian activists, and others.

Survey Results Reported

Spitzer based his conclusions on a telephone survey he conducted of 153 men and 47 women who sought to change their sexual orientation through conversion therapy or an "ex-gay ministry." Subjects, who were identified by reparative therapists, an ex-gay ministry called Exodus, and radio and print notices, were given a structured interview asking about their sexual orientation before and after therapy. The interview consisted of 112 closed-ended and nine open-ended questions. Spitzer is submitting the study to various journals for publication.

He reported that the survey results showed that "some" of these individuals were able to alter their sexual behaviors and fantasies as a result of their participation in these reorientation programs and that they had maintained that shift for at least five years. He indicated that about 66 percent of the men respondents and 44 percent of the women were able to function as heterosexuals after the therapy. Almost all of them, he acknowledged, were extremely religious individuals who were "highly motivated" to change their sexual orientation.

About 90 percent of the respondents indicated that they were only slightly or not at all troubled by the intrusion of homosexual thoughts or feelings, though 89 percent of the men and 37 percent of the women said they still had some degree of same-sex attraction.

The therapist these subjects turned to most often was a psychologist (23 percent); only 3 percent said their therapy was provided by a psychiatrist.

Spitzer explained in a summary of his presentation that "the subjects' self-reports of change appear to be, by and large, valid, rather than gross exaggerations, brain washing, or wishful thinking." He added that his survey "provides no information as to how frequently such changes are possible," and cautioned that his conclusions should not be "misused to justify coercive treatment". He noted that his subjects did not constitute a study population representative of the gay and lesbian population in the U.S.

'Straw Man'

Jack Drescher, M.D., a psychiatrist and psychoanalyst in New York City who was also on the annual meeting panel, took strong exception to Spitzer's position.

"The question of whether some people can change their sexual behavior has never been in doubt, and it is a misrepresentation to claim there is 'another side' saying that no one can change," he said in an interview with *Psychiatric News*. "Spitzer has set up a straw man with whom he's now arguing."

In addition, Spitzer's "focus on people

see ***Sexual Orientation*** *on page 34*

Intervening With Depressed Friend Leads to Prize-Winning Essay

The APA Alliance's annual essay competition has once again proven to be a big success, and this year's winner is compelling testimony to the good that can ensue from *not* keeping a secret.

BY JOAN AREHART-TREICHEL

The APA Alliance's "When Not to Keep a Secret" essay project has now completed its third year, and once again with great élan. The first-place winner for the 2000-01 school year was Lance Jones, a 15-year-old from Lamar, Colo.

Aside from being an honor student, Jones participates in many activities and hobbies, such as calf-roping with his dad and serving as a Sunday School teacher. He said that he chose to participate in the essay contest because he was intrigued by the topic, because teen suicide is touching everyone, and because he wanted to influence people favorably with his perspective on the subject.

His essay was titled "Can Buried Thoughts Be Deadly?" It is potent testimony to the good that can ensue from *not* keeping a dreaded secret when a friend, classmate, or sibling shows signs of psychological distress. In his essay, Lance related how his best friend, Brian, gave signs that he had become a "stranger in trouble"—that is, gave signs of being deeply depressed and even confessed that he was thinking of killing himself. Yet rather than keep such troubling observations and confidences to himself, Lance took immediate action. First, he did some research on the Internet about suicide and suicide prevention, and then he dialed a suicide-prevention hotline. As a result, Brian received psychiatric help before it was too late. For several weeks Brian was so angry at Lance for betraying his secret that he didn't speak to him. After that, however, he not only forgave Lance for his betrayal, but expressed his appreciation.

APA Alliance President-elect Alicia Muñoz (left) poses with APA Alliance President Gail Fuller at the awards banquet.

Winners Honored

Jones was honored for his winning essay at APA's annual meeting in New Orleans in May. Present during the ceremony were, among others, APA President Daniel Borenstein, M.D., APA Assembly Speaker Michael Pearce, M.D., APA Alliance President Gail Fuller, and APA Alliance President-elect Alicia Muñoz. In addition to giving Jones a plaque for his winning essay, the APA Alliance rewarded him with a computer, printer, computer software, and computer scanner that he picked out himself.

Jennifer Nobles, a 15-year-old from Philadelphia, took second place in this year's essay competition, and two 15-year-olds tied for third place, Robert Hatt of Lexington, Ky., and Jami DeVolder of Sherrard, Ill.

The essays by the runners-up reflect the anguish that young people experience when they suspect that siblings, friends, and classmates are in psychological and physical danger, yet do not act on their suspicions until it is too late.

For her second-place essay, Nobles received a $500 savings bond. Both Hatt and DeVolder received a $300 savings bond for their third-place essays.

First-place essay contest winner Lance Jones poses with (left) APA President Daniel Borenstein, M.D., and APA Assembly Speaker Michael Pearce, M.D.

Among the judges for this year's essay competition were Borenstein; David Fassler, M.D., chair of APA's Council on Children, Adolescents, and Their Families; Rep. Susan Davis (D-Calif.); Rep. Robert Filmer (D-Calif.); Kay Redfield Jamison, Ph.D., a psychologist and author; and Cheryl Corley, a journalist with National Public Radio.

Contest Nationally Acclaimed

Thousands of students in 22 states participated in the essay competition this year. Only three of the top essays in each state were then accepted for national judging. Some 90 percent of essays that reached the national competition dealt with depression and suicide. The remaining addressed themes such as incest, domestic violence, relationship violence, eating disorders, substance abuse, and weapon carrying.

The essay competition continues to attract increasing national publicity. For instance, it was spotlighted on National Public Radio's "All Things Considered" in February and "Morning Edition" in March. A cable TV station popular with teens—MTV—is also interested in doing something on the competition, according to Muñoz.

"That is a positive venue," Muñoz told *Psychiatric News*. "If it pans out, then we would really have an effective tool for communicating with students."

The APA Alliance would like to hear from APA members and APA district branches about which topics they think should be addressed in next year's "When Not to Keep a Secret" essay competition. In other words, should the competition continue to solicit essays on any mental or behavioral health problem that affects the lives of young people or should it perhaps focus on only one—say, eating disorders or substance abuse? Comments should be sent to Muñoz by phone at (619) 298-4782 or by e-mail at aamunoz@aol.com. ■

Essay Contest Excerpts

The 2001 APA Alliance Essay Contest received thousands of submissions with poignant stories and expressions of fear and heartfelt concern. The following passages are from the winning essays.

"I didn't call his parents; I didn't tell my mom; I didn't tell anyone. I did what I thought was the right thing to do at the time. I thought I was being a good friend. He trusted me with his life, and I failed, so the best friend I ever had is dead."

—Robert Hatt of Lexington, Ky.

"As Billy became more and more violent in school, his friends started to become more and more worried. Finally, Billy's friend George asked Billy if anything was bothering him at home. Billy broke down and told George what his dad was doing to him, but threatened he would kill George if George told anyone."

—Jami DeVolder of Sherrard, Ill.

"There were warning signs. She spent hours locked away in her room, either lying on her bed staring at her ceiling or writing depressing poetry. I'll never forget when Kelly discovered it and showed the poems to me. 'Maybe the angels would accept me as I am,' one said. It scared me, but I never told anyone."

—Jennifer Nobles of Philadelphia

"It's been over a month since I made that call. I feel a huge weight lifted from my heart, but it sure hasn't been easier. Brian hasn't spoken to me in over three weeks. The school counselor says that Brian's getting help, that I was a true friend. I wish that I could believe him."

—Lance Jones of Lamar, Colo.

Note: The names of the children in the essays have been changed to protect their privacy.

Career Choices

continued from page 8

crease by 102 percent," said Greenwald, the director of the division of geriatric psychiatry at Hillside Hospital at Long Island Jewish Medical Center and an associate professor of psychiatry at Albert Einstein College of Medicine. This means that by 2020, 1 in 5 Americans will be over the age of 65.

Among the elderly, Greenwald noted, there is a tremendous incidence of psychiatric disorders, with depression and dementia being two of the most common among the elderly.

In addition to patient care, he pointed out, there is also a great need for research in geriatric psychiatry. Currently, he said, "there is a dearth of good, controlled studies."

Greenwald himself has gotten involved in geriatric research. For example, he has used magnetic resonance imagining to study structural abnormalities of the brain in people with late-life depression.

He said there is also ample opportunity for geriatric psychiatrists to educate other physicians. "Our primary care colleagues, although well intentioned, are ill informed" about the diagnosis of mental disorders in the elderly and treatment options, particularly in the area of depression.

Addiction Psychiatry

Education is also a large part of the work in addiction psychiatry, according to Petros Levounis, M.D., an assistant professor of psychiatry at New York University and a part-time private practitioner.

Levounis emphasized that people who choose to specialize in addiction psychiatry must have an interest in teaching.

"We must answer a lot of questions from family members, other medical professionals, the media, and society," said Levounis, "because we are the only subspecialty devoted to treating substance abuse, and there are few of us around."

He spends much of his time educating fellows, medical students, and residents, as well mental health professionals, at New York University about different aspects of substance abuse.

"We have a program where we teach the evening staff at the hospital about topics such as withdrawal, detoxification, dual diagnosis, and substance abuse in adolescents," he said.

Despite the great need for addiction psychiatrists, he noted, only 42 people took the 2000 board certification exam, which is given every two years.

The postresidency training for addiction psychiatry involves a fellowship of one to two years, Levounis pointed out, and usually the longer fellowships involve research as well as clinical training.

What Levounis finds particularly gratifying about working in addiction psychiatry, he said, is seeing patients recover from substance abuse.

"Within a few months of someone's stopping drugs, a different and much healthier person emerges," said Levounis. "It's an enriching experience to see someone go through this and know that you helped." ■

association news

Psychiatric Foundation Celebrates 10 Years of Service To Psychiatry

Amid piranhas and pastries, APA members and their guests show their support of the work of the American Psychiatric Foundation.

BY DONNA REDD

The 10th anniversary celebration of the American Psychiatric Foundation at the Aquarium of the Americas in New Orleans last month raised nearly $60,000 in support of the foundation's programs in public education, patient advocacy, and research.

Guests attending the event at APA's 2001 annual meeting got something in return: an exclusive evening at one of the nation's best-known aquariums and a seductive array of Louisiana delicacies and pastries. As they nibbled or gorged—as they so chose—guests meandered through the aquarium's small-scale replicas of the Amazonian rain forest, Mississippi Delta, and Gulf of Mexico.

The evening provided a relaxing backdrop for the foundation to welcome the inaugural members of its new Founders Circle. The Founders Circle, created recently by the foundation's Board of Directors, recognizes individuals who have been pivotal to the growth and development of the foundation. Elissa P. Benedek, M.D., Robert S. Garber, M.D., Clifford A. Parish Jr., Carolyn B. Robinowitz, M.D., and Howard F. Wallach, M.D., were honored for their vision and dedication in helping to launch the foundation a decade ago.

Photo: Ellen Dallager

Archie Manning, who was the field leader of the New Orleans Saints for 12 years and still holds team passing records, urges people attending the May fundraiser of the American Psychiatric Foundation to increase their support.

The foundation also recognized the newest members of the Benjamin Rush Circle (lifetime giving of $10,000 or more) and Aventis Pharmaceuticals, which is continuing its support of a special program that matches the gifts of APA members to the foundation dollar for dollar.

Archie Manning, a former New Orleans Saints quarterback, was among those who addressed the guests. Manning challenged the audience to increase its support of the foundation.

"Mental illness is everywhere," he said. "As psychiatrists, you need to help people understand that mental illness is nothing to be ashamed of. The impact of mental illness is felt by more than just the patient. It is also families and friends that suffer as well. We need to let people know that there are treatments available to help people cope with mental illness. I urge you to support the American Psychiatric Foundation, which is working hard everyday to overcome the stigma of mental illness and educate people about treatment options."

The American Psychiatric Foundation acknowledges the generosity of Eli Lilly & Company, Forest Laboratories, Abbott Laboratories, AstraZeneca, and Aventis Pharmaceuticals, which provided grants in support of the event. The foundation also thanks the APA Alliance for its dedication and support in helping to make the event so successful. ■

Ms. Redd is senior development officer in APA's Office of Resource Development.

government news

Parity Loophole

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The parity law mandated equal coverage for schizophrenia, schizoaffective disorder, bipolar disorder, major depression, obsessive-compulsive disorder, and panic disorder, according to Matthews.

"[Some] questions are intrusive and are not on managed care forms filled out by other medical specialties."

"Psychiatrists have been required to fill out lengthy managed care forms to get approval for treatment every three or four sessions. Among the questions asked are does the patient have a history of sexual abuse or substance abuse," said Matthews.

She complained that when psychiatrists answered yes to one of these questions, the managed care companies used that information to deny treatment, stating that the problem wasn't psychiatric. "These questions are intrusive and are not on managed care forms filled out by other medical specialties."

Although the bill sailed through the Colorado House of Representatives in March, it bogged down in the Senate when lobbyists for the HMO industry had the language changed to "more burdensome" utilization review practices rather than "more restrictive."

The Colorado Psychiatric Society thought that was too vague and negotiated successfully with lawmakers to have the original language reinstated. The legislature passed the bill last month.

Colorado was not the only state where parity implementation raised issues about fairness. Minnesota enacted legislation in May to close a loophole in its 1995 parity law. An amendment requires managed care companies to use a psychiatrist certified by the American Board of Psychiatry and Neurology and licensed by the state to make the final decision on payment for treating mental illnesses, according to Paula Johnson, deputy director for state relations in APA's Division of Government Relations.

There are now 32 states with parity laws on the books. With the exception of Rhode Island, none of them addresses the discriminatory utilization review problem, said Johnson. "However, as more states have experience with parity laws, I expect to see more bills like Minnesota's and Colorado's." ■

clinical & research news

Architect Provides Dignity Through Walls

Aside from designing facilities to improve the lives of Alzheimer's patients, J. David Hoglund, an architect with the Pittsburgh architectural firm of Perkins Eastman, and his coworkers have been doing something else during the past decade that should be of interest to psychiatrists. They have been designing shelters for the homeless.

One of the ones of which Hoglund is especially proud, he told *Psychiatric News*, is the Frederic Fleming Residence in the Chelsea section of New York City. "We took an old historic building and renovated it and opened it to provide shelter," he said. He is currently involved with helping the University Lutheran Church in Cambridge, Mass., build the Harvard Square Homeless Shelter.

Hoglund's architectural work is considered so good by fellow architects that he was named a fellow of the American Institute of Architects last year. With the exception of the Gold Medal, fellowship is the highest national honor the AIA can bestow on a member.

More information about the facilities that Hoglund and his team are designing and constructing that interface with psychiatry is available by contacting him at Perkins Eastman Architects, The Pennsylvanian, 1100 Liberty Avenue, Pittsburgh, Pa. 15222; (412) 456-0900. Information about Hoglund can also be found on the Web site of the American Institute of Architects at <www.aiapa.org>. ■

apa institute

APA Institute: Theme Park For Clinicians

Come to Orlando this fall for APA's intimate annual meeting. This is no Mickey Mouse affair—although it is in Disney's backyard.

BY HARVEY BLUESTONE, M.D.

This year's Institute on Psychiatric Services offers continuing psychiatric education to clinicians working in diverse practice settings. It will be held in Orlando, reputed to be the most visitor-friendly setting in the United States.

Now is the time to make your reservations for APA's exciting fall meeting. All sessions will be held at the Renaissance Orlando Resort from October 10 to 14. I am sure that many attendees will want to extend their stays beyond these dates to enjoy the many attractions that this area offers.

APA President Richard Harding M.D., selected "Multidisciplinary Roles in the 21st Century" as the theme of this year's institute. The Scientific Program Committee is enthusiastic about the opportunity that this theme gives us to exchange ideas with our colleagues in primary care, other medical specialties including substance abuse, and allied mental health practitioners. To enhance these interchanges, we have scheduled 50 sessions cosponsored by allied groups.

The program is focused on clinically useful information, which will include up-to-the-minute research. Various formats are utilized to enhance learning opportunities and provide time for active interchange of ideas and experiences with 500 presenters. We will offer medical updates, clinical consultations with experts, workshops, symposia, and discussion groups. The discussion groups are limited to 25 participants so that in-depth discussion can take place. President Harding will lead one on how the new privacy regulations will affect your practice. He had considerable input during the development of the regulations as a member of the National Committee on Vital and Health Statistics.

There will be two debates. The first, organized by APA's Elections Committee, will feature the nominees for APA president-elect. The second, organized by the American Association of Community Psychiatrists, is "Should faith-based mental health and substance abuse services have liberalized access to federal funding?"

We have scheduled a variety of multimedia sessions, several forums, and six caucuses for members with diverse interests all the way from rural-psychiatry to criminal-justice settings. There will be a psychiatric service achievement awards session and many other innovative programs presented.

There are 25 lectures scheduled. These include the George Tarjan, Patient Advocacy, and Alexandra Symonds Award lectures. There will be 12 industry-supported breakfast, lunch, and dinner symposia. Due to the more intimate setting of the institute, these symposia are less crowded and more comfortable than those at APA's annual meeting. There also will be an exhibit hall, book displays, and poster sessions.

If all that is not enough, we are offering 12 CME courses, including a special eight-hour course on office-based buprenorphine treatment. This is given in conjunction with the APA Council on Addiction Psychiatry and the American Academy of Addiction Psychiatry. This course can be used to qualify physicians to prescribe buprenorphine for treatment of opioid-dependent patients in their offices.

Particularly welcome at the institute are medical students and residents, who will receive a warm welcome and find that many sessions have been planned specifically for them, including seminars on leadership and career development and a meet-the-experts luncheon. Bristol-Myers Squibb fellows, the future leaders of psychiatry, will each make one or more presentations.

Orlando is a marvelous site for this meeting. The Renaissance Orlando Resort is located at the entrance to Sea World, an internationally famous attraction. The hotel is an easy 11 miles from the airport (15 minutes from downtown Orlando) and offers easy access to Universal Studios, Epcot Center, Disney's Magic Kingdom, and MGM Studios. To be sure that everyone is happy, stimulated, and fulfilled, Dr. Andrew Cutler and his local arrangement committee have developed a program that will meet your highest expectations. Watch future issues of *Psychiatric News* for further details.

The institute's preliminary program begins on the facing page. A copy of the program, which includes additional information and registration and housing forms, is available by calling APA at (888) 357-7924 or visiting APA's Web site at <www.psych.org>. You can also register online for this meeting. ■

Dr. Bluestone is chair of the Program Committee of the Institute on Psychiatric Services.

Evidence Is in: Psychotherapy Changes the Brain

Psychotherapy not only can lead to clinical improvement in patients with psychiatric disorders, but also can favorably influence their brains and physiology as well, increasing scientific evidence shows.

BY JOAN AREHART-TREICHEL

Psychiatrists have long known that psychotherapy truly helps persons with various psychiatric disorders. Science is now buttressing their conviction.

Several recent studies, for instance, have demonstrated that psychotherapy can lead to clinical improvement in patients with panic disorder or with borderline personality disorder (*Psychiatric News*, February 2). Evidence is also starting to come out that psychotherapy can even favorably alter the brains and physiology of patients with psychiatric disorders.

The news came at APA's 2001 annual meeting in New Orleans in May from Glen Gabbard, M.D., a professor at the Menninger School of Psychiatry in Topeka, Kan., and vice chair of APA's Commission on Psychotherapy by Psychiatrists. His talk was titled "Psychoanalysis and Psychotherapy: Long-Term Outcome."

In a 1992 study, for instance, Gabbard reported, a researcher focused on patients with obsessive-compulsive disorder, half of whom received behavior therapy and half of whom received the serotonin-reuptake inhibitor fluoxetine. The researcher then examined the brains of subjects in both groups and found that subjects in both experienced a decrease in metabolism in an area of the brain known to be involved in movement, memory, and emotion. It was the right caudate nucleus. The finding suggested that behavior therapy and drug therapy were affecting the same brain area and in the same manner.

Then there was a 1998 Finnish study, Gabbard continued, that focused on only two patients, but which was "very provocative and suggestive of the brain changes that occur with long-term therapy."

Both patients had borderline personality with mild depression. One patient had once-weekly dynamic psychotherapy for one year, and the other patient did not. The brains of both patients were imaged at the start of the study and one year later. At the start of the study, both patients had abnormally low uptake of the nerve transmitter serotonin in areas of the brain known to be involved in judgment, planning, decision making, and other functions—the medial prefrontal area and the thalamus. One year later, the patient who had received dynamic psychotherapy had normal uptake of serotonin in these brain areas, and this also coincided with the clinical improvement he had shown from the therapy. In contrast, the control patient still had abnormally low levels of serotonin in these brain areas a year later. Thus, dynamic psychotherapy appeared to help the patient who received it by normalizing serotonin metabolism in specific brain areas, Gabbard said.

"It is so important, I think, to get scientific results that lend credibility to psychotherapy as a real treatment. . . ."

"And this fits in with what we know about borderline pathology," he explained. "As you may know, there are at least three double-blind, placebo-controlled trials using fluoxetine with borderline personality disorder, and all three suggest that the reason fluoxetine helps the borderline patient is probably because it helps correct some serotonergic disturbance. We also know that serotonergic disturbance is connected with mild depression. So this would make sense that if psychotherapy works on a borderline patient who is depressed, something in the serotonergic system might be affected."

There are also indications, Gabbard continued, that cognitive-behavioral therapy can affect patients' physiology. One investigator compared the thyroid hormone levels of depressed patients who responded favorably to cognitive-behavioral therapy with those of depressed patients who did not so respond. He found a difference in the levels, suggesting, Gabbard said, that "something in the endocrine system reacts to the psychotherapy." Another researcher found effects of cognitive-behavioral therapy on sleep.

Psychotherapy even seems capable of favorably influencing the minds and bodies of persons with bodily diseases, and perhaps is even capable of countering those diseases, Gabbard reported.

In one study, for instance, a Stanford University investigator compared the outcome of a group of patients who had metastatic breast cancer and received group psychotherapy for a year with the outcome of a group of patients who had metastatic breast cancer and had not gotten such therapy. Both groups were at a comparable stage of the disease. The former lived on average 18 months longer.

"We don't understand the mechanism," Gabbard admitted. "It certainly suggests that the immune system could be involved. [In any event] we do know that there was some effect of. . .the therapy."

In another study, some patients with malignant melanoma received six weeks of group psychotherapy, whereas others did not. Both groups were at a comparable stage in their illnesses. The former were found to experience longer remissions and fewer deaths than the latter. Gabbard said that he found it hard to believe that such short-term psychotherapy could have such a dramatic impact on cancer patients' outcomes. When he talked with the investigator about it, he learned that the patients who had received the psychotherapy had found it so helpful that they had continued to meet informally after it was officially over. These informal get-togethers, Gabbard believes, probably contributed along with the formal psychotherapy to the patients' more positive outcomes.

Still more studies like these, Gabbard implied, need to be conducted to demonstrate psychotherapy's ability to benefit the mind and body and to counter psychiatric and somatic disease. For instance, he said, patients with posttraumatic stress disorder are known to have fewer neurons in the brain's bastion of memory processing—the hippocampus—than is normal and also to have abnormally small hippocampi. Might psychotherapy have any advantageous effects on such brain devastation? An imaging study might be able to provide an answer, Gabbard believes.

"You know," he pointed out, "we are in a society that is enamored of high tech. So people think that psychotherapy is just handholding—that it cannot actually have a serious impact on a person or his brain. This is one of the reasons it is so important, I think, to get scientific results that lend credibility to psychotherapy as a real treatment. . . ." ■

Researchers Identify Brain Regions Linked to Alcohol Craving

New images of metabolic activity in the brain have identified areas involved in the craving of alcohol by alcoholic individuals.

New images of the metabolic activity of the brain have identified particular regions of the cortex and thalamus that "light up" when an alcoholic patient views pictures of alcoholic beverages. Moderate, nonalcoholic drinkers do not experience the same increase in brain activity when shown the same visual images, according to a study in the April *Archives of General Psychiatry*.

Lead investigator Mark S. George, M.D., a distinguished professor of psychiatry, neurology, and radiology and director of the Center for Advanced Imaging Research at the Medical University of South Carolina (MUSC), and his fellow researchers used functional magnetic resonance imaging (fMRI) to determine whether alcohol cues stimulate specific brain regions. Functional MRI imaging allows researchers to measure and track glucose utilization in brain tissue, thereby monitoring metabolic activity in response to particular stimuli.

The research is among the first reports using fMRI to image the areas of the brain implicated in the craving for alcohol. Other reports have previously documented an association between increased activity in particular areas of the brain and other substances of abuse, such as cocaine.

The current report describes specific areas of the prefrontal cortex and the anterior thalamus, areas that have been associated with emotion regulation, attention, and appetite-seeking behaviors. In alcoholic subjects, these areas showed increased activity when subjects were shown pictures of alcoholic beverages.

Nonalcoholic moderate drinkers did not show the same increase in metabolic activity; however, the researchers cautioned that it is too early to say that the areas of the brain identified in the study are responsible for the craving of alcohol.

"The regions activated in this study should not yet be interpreted as correlates of craving *per se*," said George.

The activated regions are known to be associated with attention and regulating emotion and are prominent components of the working models of alcohol craving, noted Enoch Gordis, M.D., director of the National Institute on Alcohol Abuse and Alcoholism, which funded the research. "Whether the activity in these areas accompanies craving or is in part responsible for it remains to be determined."

"Our goals were to learn whether certain brain areas would be activated for the alcohol cues but not for neutral cues and whether brain areas in alcoholic [individuals] would be activated differently from those of moderated drinkers," said Raymond F. Anton, M.D., scientific director of MUSC's NIAAA-funded Alcohol Research Center. Anton said the current report shows that certain brain regions were clearly activated in alcoholic individuals, but only with alcohol-specific cues. "It appears that the alcoholic subjects paid greater attention to the alcohol images," Anton told reporters at a press conference announcing the findings.

"This work confirms a significant biological and brain component to alcoholism and provides information toward understanding the differences between alcoholic and nonalcoholic individuals," said George. "Our next project will use fMRI scans to measure subjective craving in real time so that we can relate subjective craving temporarily to the presentation of visual cues."

An abstract of the study, "Activation of Prefrontal Cortex and Anterior Thalamus in Alcoholic Subjects on Exposure to Alcohol-Specific Cues" is posted on the Web at <http://archpsyc.ama-assn.org/issues/v58n4/abs/yoa9468.html>. Additional research information on alcohol is posted at the NIAAA's site at <www.niaaa.nih.gov>. ■

Optimism Will Prevail

Dr. Jerry M. Wiener alluded to me in his letter in the April 20 issue. He was evidently quoting a *Psychiatric News* report that claimed I had "inveterate optimism" regarding negotiations with managed care. Dr. Wiener confesses that he has learned the folly of such optimism.

It is true I am an optimistic person and that I firmly believe we will ultimately prevail over managed care, as I have been saying for years. Indeed there was a recent article in the *Journal of the American Medical Association* describing the death of managed care. This represents a major change from the defeatist position of most of organized medicine of just a few years ago that managed care is here to stay.

My optimism is about the defeat of managed care, and the negotiations I would recommend are the terms of their surrender.

HAROLD I. EIST, M.D.
Bethesda, Md.

Dr. Eist is a former president of APA.

Mental Health Promotion

In his president's column in the January 19 issue, Dr. Daniel Borenstein writes, "The psychiatric profession and our academic institutions have largely ceded promotion of health and prevention efforts to others. . . ." Some in psychiatry have, in fact, dedicated our careers to the promotion of mental health.

At the University of Louisville School of Medicine, I direct such a program for entering medical students and their significant others: the Health Awareness Workshop. This is a voluntary four-day program of large- and small-group presentations by university faculty, community experts, students, and residents about the all-encompassing issues of mental health promotion for medical students.

After 20 very successful years, we know students "get the message" to care well for themselves, their colleagues, and significant others in terms of mental health and, in time, take the same knowledge to patients. Some colleagues know of this program, and I'd be pleased to share with others.

LEAH J. DICKSTEIN, M.D.
Louisville, Ky.

More on Managed Care

I read the Residents' Forum each month even though I am 18 years out of residency. Usually I find something touching and hopeful. So it has been with Dr. Sandra Dejong's articles, but I was dismayed by the column in the March 16 issue titled "Managed Care and Psychiatric Training."

I had barely started practice when managed care hit like gangbusters. For years, I tried to play the game until I was involved in several tragic experiences when care was cut, transferred to other "providers," or denied entirely. These experiences convinced me that the insurance industry does not know and does not care about either the welfare or the treatment of the mentally ill.

Gradually, as I could afford it, I went off panels and now take only out-of-network insurance. My income did drop somewhat but so did my anxiety and depression at colluding with an unjust system. I had to do it—it was that or leave medicine. And what I have found, despite my initial belief that I would be driven out of business, is that I am actually doing real psychotherapy again, as opposed to the truncated nonsense that managed care peddles, which doesn't help anyone. Well, I take that back. It helps managed care's profit.

With the advent of discussions about the possibility of repeal of ERISA legislation, I have begun to receive some charming and amusing letters from insurance companies aimed at enticing me back on their panels. They often earnestly admonish me to practice ethically and to provide adequate and effective treatment—as though they knew anything about that.

The irony is that effective treatment is efficient and cost-effective. This is so even when treatment is a long-term psychotherapy, psychoanalysis, residential treatment, or supportive treatment with medication. Effective treatment keeps people from running to internists, abusing their spouses and children, and misusing substances. When, some years ago, I attempted to engage an insurance company executive in this discussion, he shrugged and said that he couldn't care about that because the expenses of those tragedies didn't come out of his cost center.

The current system is immoral and cruel and must change. The ERISA legislation has to be repealed so that insurance companies are held liable for the medical decisions they do in fact make. When that happens, the notion of insurance company ethics will not be such an oxymoron; these companies will have to underwrite effective and ethical care because cash will be coming out of their hides when they make a mistake—just like it comes out of the hides of doctors when we are negligent or make a bad decision. And won't that be a glorious day!

SHEILA WALL, M.D.
Cincinnati, Ohio

Readers are invited to submit letters not more than 500 words long for possible publication. Submission of a letter implies consent for publication unless otherwise indicated. All letters are subject to editing to meet style, clarity, and space requirements. Receipt of letters is not acknowledged. Send submissions to Letters to the Editor, *Psychiatric News,* at 1400 K Street, N.W., Washington, D.C., 20005; fax: (202) 682–6031; e-mail: pnews@psych.org.

Sexual Orientation

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who claim to have changed their sexual orientation does not address the larger issue, which is how to distinguish patients who may be able to change their sexuality from those who cannot and are often harmed" by their "treatment," said Drescher, who was one of the authors of APA's 2000 position statement on therapies to change sexual orientation (see box).

Drescher is concerned about the harm that patients can suffer after going through some of the conversion therapies, an issue not addressed in Spitzer's selective patient sample.

"Religious reparative therapies, like the faith healing from which they are derived, are a treatment modality that purports to provide definitive answers regarding human nature and sexuality. They always define homosexuality as wrong and require that individuals trying to change their sexual orientation submit to the therapist's authority as a condition of treatment," he said in his annual meeting presentation.

In the type of interventions Spitzer assessed, "it is the client's compliance with the therapist's authority, rather than the therapist's interpretations, that will determine the outcome of treatment," Drescher suggested. "This is a clinical stance with troubling ethical implications."

Spitzer's report was startling enough that at least 30 newspapers and news magazines, 14 television programs, and 26 radio shows reported on the annual meeting presentation. Major wire services and Internet health sites also covered the session. Almost all of them emphasized the controversy his report sparked in light of his involvement in the *DSM* depathologizing of homosexuality and how conservative religious groups are leaping to his defense, while the medical community, as well as gay and lesbian advocates, are condemning it for being shoddy science and an attempt to further stigmatize people who are not heterosexual.

Spitzer told *Psychiatric News* that while he was not surprised that the media were intrigued by his paper, he was "flabbergasted" by how extensive the coverage turned out to be.

"I am happy that people were taking note of the presentation," he said. "It confirms what I've said, namely, that there is a lot of media interest in the idea that once a homosexual, always a homosexual."

He was disappointed, however, that many reports overlooked his statements explaining that his sample was limited and that he was not maintaining that a substantial number of gays and lesbians could become straight if they sought reparative therapy. "For the vast majority it is not possible for them to change their sexual orientation," he said.

Spitzer also acknowledged that "a lot of people will misuse" his findings, which could cause pain for many individuals. "It may help 5,000 people, but harm 500,000," he said. He is concerned, he added, that "the Christian right," with its intolerance of and opposition to homosexuality, will use his findings in its campaign to prevent gays and lesbians from gaining civil rights protections.

His goal, he pointed out, is "to open a dialogue between the people who do [conversion] therapies and the gay and scientific communities" who do not believe these therapies are of any value. "That dialogue is not likely to happen," he acknowledged.

APA issued a press release at the annual meeting in which Medical Director Steven Mirin, M.D., emphasized that "APA maintains there is no published scientific evidence supporting the efficacy of reparative therapy as a treatment to change one's sexual orientation."

The press release points out that APA does not endorse annual meeting presentations and that many papers presented at the meeting "have not been subject to traditional peer review, nor have they been published in the scientific literature."

More information about APA's position on therapies that attempt to change sexual orientation is available on the Web at <www.psych.org/pract_of_psych/copptherapyaddendum83100.cfm>. ■

APA Reiterates Position On Reparative Therapies

In 2000 APA expanded its 1998 position on therapies, often called reparative or conversion therapies, that claim they can successfully transform homosexuals into heterosexuals. The policy makes the following points and recommendations:

- APA affirms its 1973 position that homosexuality per se is not a mental disorder. Recent publicized efforts to repathologize homosexuality by claiming that it can be cured are often guided not by rigorous scientific or psychiatric research, but sometimes by religious and political forces opposed to full civil rights for gay men and lesbians. APA should respond quickly and appropriately as a scientific organization when claims that homosexuality is a curable illness are made by political or religious groups.

- As a general principle, a therapist should not determine the goal of treatment either coercively or through subtle influence. Psychotherapeutic modalities to convert or "repair" homosexuality are based on developmental theories whose scientific validity is questionable. Furthermore, anecdotal reports of "cures" are counterbalanced by anecdotal claims of psychological harm. . . .Until there is rigorous research available, APA recommends that ethical practitioners refrain from attempts to change individuals' sexual orientation, keeping in mind the medical dictum to first, do no harm.

- The "reparative" therapy literature uses theories that make it difficult to formulate scientific selection criteria for [reparative therapists'] treatment modality. This literature not only ignores the impact of social stigma motivating efforts to cure homosexuality; it actively stigmatizes homosexuality as well. "Reparative" therapy literature also tends to overstate the treatment's accomplishments while neglecting potential risks. APA encourages and supports research in the NIMH and the academic research community to further determine "reparative" therapy's risks and benefits.

Capitol Hill

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rological disorders account for 12 percent of the total global burden of disease, and by 2020, this 12 percent is expected to increase to 15 percent, which would then be larger than the world's cancer incidence.

Stigma against mental illness is universal, he continued. "How many of you," he asked, "would say, 'I am not coming into work for 15 days because I am being treated for depression'?"

And while the medical knowledge to successfully treat a number of mental illnesses exists, he added, there is a lack of rational application of treatment in many countries. For instance, too many countries, mostly developed ones, still spend most of their resources on a few large mental asylums that focus on a small fraction of those who need treatment, and 38 percent of countries do not have any community care for people with mental illness. What's more, 43 percent of countries do not have a mental health policy, and 23 percent have not enacted mental health legislation. Thus, policymakers around the world need to be educated about what needs to be done to help persons with mental illness and convinced that they should implement it.

"It is an extraordinarily exciting time to be doing mental health research," Hyman declared. "Scientists are flocking to the cause." For instance, there are now, for the first time, neuroimaging techniques to see the living human brain. The human genome project has given investigators a platform on which to stand. But while psychiatric researchers are looking toward the future, not enough of what is already known about diagnosing and treating mental illness is reaching people in the U.S. and other countries, he stressed.

Throughout the years, Arons pointed out, Surgeon Generals' reports about health have had some profoundly positive effects on the health of Americans, for instance, the one about the dangers of cigarette smoking. Thus, the Surgeon General's 1999 report on mental health can also be used for similarly good purpose, he contended. "What you should do," he urged, "is hold a town meeting in your Congressional district and invite the Surgeon General to speak. . . ."

Hill staffers had a chance to ask questions after the talks. One asked, for example, "Has the NIMH been getting its fair share of research dollars during the past few years?," and another wanted to know "What is WHO doing regarding cultural differences in mental health?"

Among those who spoke at the briefing luncheon include (from left): Darrel Regier, M.D., director of APA's Office of Research and director of the American Psychiatric Institute for Research and Education; Rep. Patrick Kennedy (D-R.I.); Bernard Arons, M.D., director of the Center for Mental Health Services at the Substance Abuse and Mental Health Services Administration; Steven Hyman, M.D., director of the National Institute of Mental Health; Benedetto Sarceno, M.D., director of mental health and substance dependence at the World Health Organization.

Rep. DeFasio told the group that although the Mental Health Parity Act of 1996 sunsets this September, he hopes that he and other members of Congress can not only reauthorize it, but also get legislation that is "more enforceable." And as working group member Rep. Patrick Kennedy (D-R.I.) asserted, funding for NIMH research "needs to be increased dramatically."

The briefing was such a success that the working group is planning more. The next one is scheduled to include a patient's presentation of what it's like to live with mental illness; what it's like to treat mental illness; and some of the new developments in mental health research. ■

Rep. Marge Roukema (R-N.J.), cosponsor of the House of Representatives Working Group on Mental Illness, addresses the attendees at the luncheon, which her group organized.

S&R

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quired a physician or a clinically qualified registered nurse to perform an evaluation of the patient within one hour of issuing the order.

APA and the Pennsylvania Psychiatric Society complained to HHS that compliance would mean hiring additional psychiatrists and registered nurses to be available 24 hours a day, seven days a week, which could force some psychiatric residential treatment facilities out of business.

The decision by HHS to revise the rule's staffing requirements was based on several comments it received about the "severe shortage of registered nurses and unavailability of psychiatrists," according to HCFA.

The amended rule allows a physician or other state-licensed practitioner to issue orders for the use of seclusion and restraint and to evaluate the patient within one hour, according to the HCFA press release. Another change is that in addition to registered nurses, the rule allows licensed practical nurses to receive the physician's or practitioner's verbal order.

"These requirements ensure that seclusion and restraint will be conducted only by properly trained personnel while accommodating the staffing challenges that facilities face today," said HHS Secretary Tommy Thompson in the press release.

DGR Director Jay Cutler commented in an APA member update, "We view any changes easing the burden of compliance as a positive development."

HCFA recognizes however, that "some facilities will have to hire additional registered nurses or other licensed practitioners to meet the requirement for 24 hour per day coverage," according to the regulation.

The Bush administration did not change the following requirements that were included in the Clinton administration rule:

- Seclusion and restraint may not be initiated simultaneously.
- Residents aged 18 to 21 cannot be restrained or secluded for more than four hours, residents aged 9 to 17 for more than two hours, and residents aged 8 and under for more than one hour.
- A debriefing with staff involved in the procedure and the resident must be held within 24 hours. Staff must also discuss the incident with their supervisor.
- Staff must be trained in the safe use of restraint and CPR and demonstrate their competencies twice a year.

Said Cutler, "The seclusion and restraint debate is of course, larger than the psychiatric residential treatment facility rule. We continue to be deeply concerned about the proliferation of overlapping, duplicative and inconsistent standards across settings" (see box).

APA Medical Director Steven Mirin, M.D., and DGR staff plan to raise these concerns when they meet with senior White House staff later this summer.

DGR is submitting a comment letter to HHS on the changes to the rule this month.

Additional information can be obtained by calling DGR at (202) 682-6060. The full text of the HCFA amendments is available at <www.access.gpo.gov/su_docs/fedreg/a010522c.html> by scrolling to "Health Care Financing Administration," "Rules," and "Medicaid." ■

Evolution of S&R Regulations

There are too many conflicting standards on the use of seclusion and restraint in hospitals and residential treatment facilities, says APA. Below is a timeline of government regulatory and legislative efforts in this controversial area.

- **November 1994:** The Health Care Financing Administration (HCFA) proposes a new rule to establish federal standards for psychiatric residential treatment facilities with limits on physical and chemical restraints. The rule never becomes final.
- **July 1999:** HCFA issues an "interim final rule" establishing Medicare and Medicaid conditions of participation (CoP) for hospitals that include standards on seclusion and restraint. The controversial requirement for conducting a face-to-face evaluation by a physician or licensed independent practitioner within one hour of ordering seclusion or restraint is imposed. There is a 60-day comment period.
- **August 1999:** HCFA puts into effect the hospital CoP without revising the one-hour rule.
- **October 2000:** The Children's Health Act becomes law. It requires federally funded health care facilities to limit the use of seclusion and restraint to emergency situations to ensure the safety of the patient or others, among other provisions.
- **January 2001:** The Joint Commission on the Accreditation of Healthcare Organizations and the Council on Accreditation for Children and Family Services put into effect their revised standards on seclusion and restraint for behavioral health care programs.
- **January 2001:** HCFA issues its interim final rule on seclusion and restraint for Medicaid-funded psychiatric residential treatment facilities treating youth. It allows a 60-day comment period.
- **January 2001:** Soon after the Bush administration takes office, it postpones the effective date of March 23 for 60 days to review the interim final rule. Possible outcomes include withdrawing the rule, allowing it to become effective without further changes, or implementing it with changes within one year.
- **May 2001:** HCFA issues a revised interim final rule without some of the more burdensome staffing and reporting requirements. The definition of physical restraint no longer includes temporary holds or escorting.

legal news

Violence Risk

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room, a common venue for these evaluations.

The basis of such an evaluation is, of course, a clinical interview during which the person is asked specifically about intent; possible victims; and history of violence, violent thoughts, and criminal behavior, Binder said. This information is, she warned, "highly unreliable" if a psychiatrist stops at this point without gathering additional data.

The additional data should come from interviewing the person's therapist, family members, and police, Binder suggested. And remember, she cautioned, that while the evaluator can ask these individuals any relevant questions, he or she cannot give information about the patient without written consent, despite the likelihood that the psychiatrist will be asked to provide such information in the course of these interviews.

It is also critical to review medical records, though these may be unavailable in the emergency room setting. If the medical records of the person being evaluated turn out to be easily available and the psychiatrist does not review them, the evaluator opens himself or herself up to later accusations of "laziness or sloppiness" if their prediction is wrong, she noted.

Assessment Tools

Johnson pointed out that there are now "helpful tools" such as checklists, scales, and interview protocols that can aid in arriving at a violence-risk prediction.

Judith Becker, Ph.D., a professor of psychology and psychiatry at the University of Arizona and editor of the journal *Sexual Abuse*, cited several such assessment tools that are now on the market, such as the Psychopathy Checklist, Revised; Static-99; Violence Risk Appraisal Guide (VRAG); and Sexual Offender Risk Assessment Guide (SORAG).

"There has been tremendous progress in developing actuarial tools" to help psychiatrists conduct a violence-risk evaluation, Becker said, "but there is still a long way to go."

If a psychiatrist believes that a person being evaluated does present a high risk of becoming violent, Binder urged taking several "essential actions" to support that determination and minimize liability risks.

These begin with a clinical interview with the patient that results in a hospital admission, followed by the psychiatrist's visiting the patient more often than might be necessary with other types of patients, obtaining appropriate consultations and referrals, and prescribing medication.

The psychiatrist should also back up the assessment with interviews of victims or potential victims, even in states that do not mandate a legal duty to warn, Binder stressed. In addition to alerting these individuals to potential danger, the psychiatrist should advise them on steps that could decrease their risk, she added.

Session chair Paul J. Fink, M.D., who chairs the APA Task Force on Psychiatric Aspects of Violence, emphasized that "psychiatrists have been too modest about their ability to predict violence and afraid to take that risk." But when they do offer their knowledge and expertise in evaluating risk, they take a step that helps the community and goes a long way to "undoing the notion that all mentally ill people are violent." ■

Medical Society

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shorthand for an inadequate network, a stranglehold on the market, and bargain-basement care."

Magellan Responds

Magellan has not been tepid in its response, however, and in a statement released after the allegations were made appeared to hint at legal retaliation.

"The New Jersey Medical Society, in an opportunistic and self-serving move, has misrepresented the way Magellan serves its customers and members," said Jonathan Book, M.D., chief medical officer for Magellan in a statement released by the company. "This is particularly disturbing given the fact that we have been working closely with the society in recent months and believed that we had established a constructive dialogue with the society. . . .Given the inflammatory nature of their sentiments, we are considering all of our options for response."

Book acknowledged in the statement that "availability of psychiatrists has been an issue for the industry" and that the company is taking steps including raising reimbursement rates where appropriate, simplifying the treatment authorization process, and eliminating the need for authorization for certain services.

But Book also said some aspects of the shortage of psychiatrists—especially child and adolescent psychiatrists—might not be amenable to such remedies.

"There are fewer than 200 members of the American Academy of Child and Adolescent Psychiatry in New Jersey and approximately 7,000 child and adolescent psychiatrists practicing in this entire country," he said. "There are simply not enough practitioners to address the demand for these services in our society today."

Magellan was especially vehement in its response to complaints about the company's provision of follow-up services.

The medical society, in its statement of complaints, had quoted statistics from the state's report card on HMOs saying that only 26 percent of patients covered by Horizon and 19 percent covered by Aetna (both of which contract with Magellan) had follow-up visits after receiving medication for depression. The statement cited the report card showing that hospitalized patients covered by the two insurance companies only rarely received follow-up care (21 percent for Aetna patients and 25 percent for Horizon).

But Magellan said the society misrepresented the facts. "Magellan's statistics for following up with patients after a hospitalization for mental illness exceed both the New Jersey average and the standard set by the National Committee for Quality Assurance," said Book. "A recent clinical audit found that all Magellan members had follow-up appointments scheduled prior to discharge from a behavioral health facility."

Book said the society ignores the fact that the vast majority of prescriptions for antidepressants are written by primary care physicians, not psychiatrists, so that follow-up for those patients falls outside Magellan's scope of responsibility.

Mental Health Dollars

Psychiatrists agree that the root of the impasse is the inadequate portion of the health care dollar allotted to mental health. "We don't have infinite resources, but the resources for mental health are too small to provide the care that is necessary," said Linda Gochfeld, M.D., a past president of the NJPA and the association's liaison to the state medical society.

In the meantime, the American Medical Association has weighed in with support for the medical society's position. "We have been working closely with MSNJ on this issue and share its very serious concerns about the adequacy of Magellan's physician network and other business practices that operate as barriers to needed care for people with mental health problems," said Tim Flaherty, M.D., vice chair of the AMA's Board of Trustees in the statement released by the medical society. "Unfortunately, these problems are not isolated to New Jersey." ■

Residency Program

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training director at McGill.

The McGill psychiatry residency program put together a Pharmaceutical Industry Relations Committee (PIRC), headed by Granich. The committee includes two resident representatives and two faculty representatives, one of whom must have expertise with ethics.

The committee's guidelines address educational activities such as industry-supported symposia; gifts such as textbooks, meals, and travel; and fundraising efforts such as fellowships, and in addition provide guidelines for presentations to residents and the academic community by industry representatives. The PIRC also developed training for residents on proper interactions with the pharmaceutical industry. This training occurs early in a resident's program, and no meetings with a pharmaceutical representative may occur until this training has been completed.

The pharmaceutical industry has vehemently denied any wrongdoing and has said recently that the industry's efforts are aimed at education. According to a spokesperson for the Pharmaceutical Research Manufacturers of America (PhRMA), which represents the industry's leading pharmaceutical and biotechnology firms, the companies adopted the AMA guidelines into their own "Code of Pharmaceutical Marketing Practices."

Annette Granich, M.D., leads McGill's Pharmaceutical Industry Relations Committee, whose guidelines govern industry interaction with the school's residents.

However, the faculty at McGill is only one of a growing number of residency faculties throughout North America that are looking to restrict industry-resident interactions.

"We have a duty to educate residents on how to deal with these often complex ethical questions," Granich told *Psychiatric News*. "We owe it to them to make sure they are prepared to deal with industry once they have finished their residency programs."

AMA Policy E-8.061, "Gifts to Physicians From Industry," and its clarification are posted on the Web at <www.ama-assn.org/ama/pub/category/2947.html>.

Artist

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her observations and musings on the scenes she recorded, in *The Art of Learning Medicine* (Appleton-Century-Crofts, 1974).

"There is a loveliness in human beings helping one another," she wrote in the book's introduction. "As they came to understand the art of medicine, I was learning the role of medicine in my art: I was becoming aware of the universal truths all around me in the hospital setting."

Lesser later followed some of the same students through their internship and residency training in Los Angeles. Over the years, she has observed caregivers, patients, and researchers in diverse settings, trying to capture participants' feelings as well as clinical details. A second book documents her experiences as a resident artist at the Tulane University Medical Center, where she is a lecturer in the department of psychiatry. The book is titled *An Artist in the University Medical Center* (Tulane University Press, 1989). She is preparing an updated edition to reflect the impact of new technology on medical practice and teaching.

Her book for children undergoing radiation therapy for cancer will be published next year by Tulane. She hopes her drawings will make the procedures and machinery less frightening for both children and their parents. In 1998 she worked at the University of Cambridge, England, while on a Burroughs Wellcome Fund travel fellowship.

Her work is owned by museums around the world and has been exhibited at many medical institutions including the Clinical Center of the National Institutes of Health and the National Library of Medicine.

Lesser's work has been featured on 10 *JAMA* covers. One of her paintings appeared on the cover of the *American Journal of Psychiatry* in April 1999.

Lesser's husband, Leonard, a prominent New Orleans child psychiatrist, died last year. Three of their four children are physicians, one of whom, Lillian Lesser Niditch, M.D., is a child psychiatrist who practices in New Orleans.

Lesser's medical art is posted on the following Web sites: <www.tulane.edu/~lesser2/>, <http://lhc.nlm.nih.gov/M3W3/lesser/lesser_theartist.html>, <www.nlm.nih.gov/exhibition/lesser/lesser_1.html>, and <http://www.usc.edu/hsc/nml/artist_gallery/>. More on Lesser's thoughts about dream art and links to her pictorial records is posted at <www.tulane.edu/~lesser2/preface.html>. ■