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Professional News

AMA Warns of Mental Health Consequences Of Bullying

A landmark report from the AMA asks all physicians to probe for signs and symptoms of bullying in America's youth, calling the problem complex, significant, and serious.

BY JIM ROSACK

At the June meeting of the American Medical Association's (AMA) policy-making body, the House of Delegates, an unprecedented report was approved recognizing bullying as "a complex and abusive behavior with potentially serious social and mental health consequences for children and adolescents."

The report, presented to the House by the AMA's Council on Scientific Affairs (CSA), is in response to a request by the American Academy of Child and Adolescent Psychiatry (AACAP) and the American College of Preventive Medicine, along with the support and endorsement of APA and the AMA Section Council on Psychiatry, that the AMA study the troubling subject.

Carolyn Robinowitz, M.D., a former APA deputy medical director, is a member of the CSA and cowrote the report on bul-

please see ***Bullying*** *on page 28*

Government News

Patients Paying Price for Medicaid Savings Scheme

Psychiatrists and mental health professionals are beginning to identify the hidden costs to patients and doctors of the Medicaid drug formulary program in Michigan.

BY KATE MULLIGAN

Disturbing reports about the impact of Michigan's newly instituted drug formulary for Medicaid patients are beginning to surface.

Last year a committee of physicians and pharmacists chose so-called best-in-class drugs in 40 categories covering a range of illnesses across all of medicine. The formulary policy stipulated that if a physician wanted to prescribe a drug not on the list, he or she must "call a state technician and get approval," which would be granted only if the drug was considered "medically necessary."

The effort was budgeted to generate $42 million annually in savings, which were projected to result from supplementary rebates extracted from pharmaceutical companies in return for a place for their medications on the preferred drug list (*Psychiatric News*, June 21, April 19).

On April 22 the Mental Health Association of Michigan (MHA of Michigan) and the Michigan Association for Children with Emotional Disorders (MACED) established a toll-free hotline to receive patient and provider complaints about the program. During its eight weeks of operation, the hotline received 455 calls.

The hotline, which was funded by Pfizer Inc., was also supported by the Michigan Partners for Patient Advocacy. The Michigan Psychiatric Society (MPS) is one of the members of that coalition.

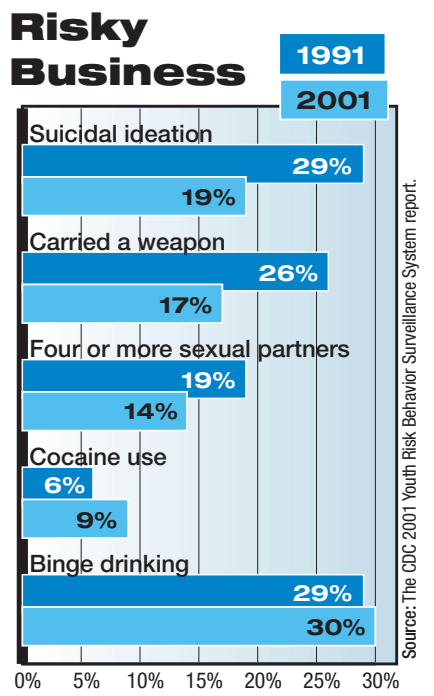
Mark Reinstein, president and CEO of the MHA of Michigan, told *Psychiatric News*, "Many patients have experienced dangerous medication delays and/or been switched off drugs on which they were stable. Physicians and other medical professionals are incurring tremendous expense to deal with the new layers of bureaucracy and problems that have been created."

He also pointed out that funds were available to publicize the hotline only in a limited geographic area, so the number of reports of problems likely were skewed downward. The hotline was not publicized in Detroit because of cost constraints.

Three hundred and sixty calls came from patients or family members of patients. Of these calls, 66 percent reported medication delay, denial, or switching with negative consequences.

Examples of problems cited in an MHA report summarizing data from the hotline include subsequent hospitalization, forced switching to a product causing allergic or other negative reaction, period of time without medication, and lack of continuity in

please see ***Medicaid*** *on page 29*



While fewer teens are contemplating suicide compared with a decade ago, the percentage is still quite high at 19%. In addition, more teens are engaging in behaviors that are harmful to their health. See story on page 17.

M.D.s May Soon Be Free of Current E&M Guidelines

An APA expert applauds a government advisory committee's recommendation to drop the burdensome E&M coding guidelines.

BY MARK MORAN

Ten years of making—and remaking—the federal government's guidelines for how physicians must document "evaluation and management" of patients for Medicare payment could be unmade entirely.

That's if the government heeds its own broad-based advisory committee on regulatory reform urging that the "E&M" documentation guidelines be scrapped.

The Department of Health and Human Services (HHS) Advisory Committee on Regulatory Reform recommended dumping the guidelines at a recent meeting in Denver. The 21-member committee has five physicians, including Nancy Nielsen, M.D., vice speaker of the AMA's House of Delegates, as well as administrators of the Centers for Medicare and Medicaid Services (formerly the Health Care Financing Administration).

The recommendation awaits action by HHS Secretary Tommy G. Thompson.

The guidelines for evaluation and management of patients are part of the government's resource-based relative value scale for determining physician payment under the Medicare program and have been the object of heated controversy. Physician groups hailed the recommendation as long overdue.

"The AMA has repeatedly informed HHS and the Regulatory Relief Advisory Committee that physicians identify E&M documentation guidelines as the single, largest paperwork burden imposed by the Medicare program," the AMA said following the committee's recommendation.

Chester Schmidt, M.D., chair of APA's Committee on RBRVS, Codes, and Reimbursement, echoed that view.

"This is a very positive development," he said. "The reason this panel is backing off is the very intense pressure that has been brought to bear to change the documentation requirements. Physicians believe that the guidelines are not clinically relevant and that they are merely a means for the government to do audits and to find fault, resulting either in civil or criminal actions [against doctors] because of documentation deficiencies."

Schmidt added, "The outcry from all specialties has consistently been that the E&M coding guidelines are not clinically relevant, are onerous, and impose on physicians extra paperwork for which there is no reimbursement."

Psychiatrists use the E&M codes for inpatient and partial hospitalization, consultation, nursing home visits, and some office visits. Especially controversial are the guidelines for determining the level of "medical decision making," which is one of the three E&M components, along with history taking and examination. The guidelines for that component use a four-by-four grid designed to produce a numerical approximation of medical decision making.

Schmidt has called the system so complex "it bears no resemblance to the actual practice of medicine."

Douglas L. Wood, M.D., chair of the advisory committee and a physician at the Mayo Clinic, summed up the view that the decade-long effort to revise or improve the guidelines has been exhausted.

"The documentation guidelines that have been used are unworkable, and I think 10 years of effort to try to find one that works is a pretty strong statement that there is something fundamentally difficult or fundamentally impossible about trying to create documentation guidelines for evaluation and management services," Wood said, according to transcripts of the advisory committee meeting in Denver.

"The fact that no other commercial insurer uses them should be a pretty strong statement that they're probably not applicable anyway," Wood said. "And indeed, there is now and has been an adversarial environment that's based on fraud and abuse actions and the actions of Medicare carrier medical directors."

The transcript of the Denver meeting is posted on the Web at <www.regreform.hhs.gov/sacrr5_16.htm>. ■

from the president

Building Alliances

BY PAUL APPELBAUM, M.D.

What's the best strategy for achieving our advocacy agenda? How do we get federal parity legislation, stop psychologist prescribing, and increase funding for psychiatric services? No matter how active our members are or hard working our staff, these are not things that we can accomplish on our own. We need allies.

Fortunately, there are other groups that share our interests in protecting the mental health and improving the psychiatric care of the citizens of the United States. The best allies, though, are often found closest to home. In our case, the first place we ought to look is to the rest of organized medicine. The American Medical Association, state medical societies, and other specialty groups have been invaluable collaborators with us over the years on countless advocacy efforts. And we need their help now more than ever.

These thoughts come in the wake of my visit, a few weeks ago, to the AMA's annual House of Delegates meeting in Chicago (*Psychiatric News*, July 19; see related story on page 1). I accompanied the Section Council on Psychiatry, composed of delegates and alternates from APA and the American Academy of Child and Adolescent Psychiatry, soon to be joined by a delegate from the American Academy of Psychiatry and the Law. As other psychiatric subspecialty organizations (several of which are members of an AMA-related specialty society group) reach appropriate levels of AMA membership among their own members, they too will be entitled to representation and may apply for seats in the House of Delegates. There is also a Psychiatry Caucus, comprising all AMA delegates and alternates who are psychiatrists, many of whom represent their state medical societies or other specialty organizations.

In some medical venues, psychiatrists may feel out of the mainstream, though I think that unfortunate phenomenon is becoming less common as we draw closer to our medical roots. At the AMA meeting, however, psychiatry is in the thick of things. Our delegation, led by Jay Scully, M.D., is large and influential, and has worked hard over the years to build bridges and win allies among other delegate groups. Thus, this meeting saw the House of Delegates reassert its rejection of psychologist prescribing and urge all state and specialty groups to form a common front against psychologists' legislative efforts. As delegates expressed their concern about the bureaucratic burdens that will derive from the rules embedded in the new HIPAA regulations on medical privacy and data transmission, they nevertheless—at APA's urging—reaffirmed their commitment to the principle of maintaining the confidentiality of medical treatment. These examples represent

please see ***From the President*** *on page 29*

Internet Gambling Alarms Addiction Experts, Government

An addiction expert urges the federal government to regulate Internet gambling, educate the public about its potential harm, and invest in treatment, while a congressional committee approves a bill that would ban Internet gambling.

BY CHRISTINE LEHMANN

Hundreds of gambling sites operate on the Internet to which teenagers can gain access. Restricting this access to Internet gambling is essential to reduce the risk of exposure to gambling, especially for young children, warned experts at a Federal Trade Commission (FTC) briefing on online gambling held in June on Capitol Hill.

Responding to the same issue, the House Judiciary Committee passed a bill (HR 3215) to combat illegal gambling on the Internet in June (see box).

Adolescents use the Internet more than any other age group, and recent studies have found that about 3 percent of adolescents and 8 percent of college students have gambled on the Internet, according to the National Council on Problem Gambling. The term "problem gambling" refers to pathological gambling and gambling-related problems.

In addition, regular or heavy Internet users are more likely to participate in Internet gambling than infrequent users, said Marianne Guschwan, M.D., chair of the APA Committee on Treatment Services for Patients With Addictive Disorders, at the FTC briefing.

Web sites geared to adolescents that feature adventure, sports, and action figures often advertise online gambling sites with direct links to Web sites. "Many gambling sites entice young people with offers of 'freebies' and other supposed discounts to get them started on gambling," said Guschwan.

The FTC conducted an informal survey of more than 100 gambling and nongambling Web sites at the request of Congress about a year ago, said FTC Chair Timothy Muris at the briefing. "It was easy for us to enter online gambling sites. Sites that attempted to prevent minors from entering were easy to [access]. In addition, some sites posted warnings that underage gambling is illegal, but the warnings were in fine print or hidden from view," said Muris.

Most of the sites the FTC surveyed were operated from servers outside the United States, thus evading federal and state regulations, said Muris. He added that every state has laws barring minors from gambling.

Internet gambling differs from other forms of gambling because there are few, if any, regulations to assure the fairness of games or establish the responsibility of game operators. There is no control on the hours of availability, age of participants, or type of games offered, according to the 2001 APA Advisory on Internet Gambling, which was developed by the committee that Guschwan chairs.

With online gambling, "an unscrupulous operator can merely close down a site or move its base to another country," the advisory states.

The FTC plans to work with the gambling industry's trade organization to encourage its members to block online access to minors and curtail advertising to them, said Muris. "We have taken a similar approach in working with the alcohol, tobacco, and entertainment industries to protect children from being exposed to harmful products and advertising."

He also released the FTC consumer alert "Online Gambling: A Bad Bet for Kids" to educate parents and children about the dangers of online gambling. An estimated 1 million adolescents between the ages of 12 and 18 may be pathological gamblers, according to the National Gambling Impact Study Commission 1999 Report.

To meet the *DSM-IV* criteria for a pathological gambling disorder, five or more of the following 10 symptoms must be present:

- Preoccupation with gambling-related thoughts, plans, or activities.
- Need to gamble with increased sums to produce the desired excitement.
- Restlessness or irritability when attempting to cut down or stop gambling.
- Gambling to escape from problems or relieve an undesired mood such as helplessness, guilt, anxiety, or depression.
- After losing money gambling, often returning to try to win it back.
- Lying to conceal gambling activities or consequences.
- Committing illegal acts to finance gambling.
- Jeopardizing or losing a significant relationship, job, or educational or career opportunity because of gambling.
- Relying on money from others to relieve a desperate gambling-related financial situation.
- Having made repeated unsuccessful attempts to control, cut back, or stop gambling.

"Just as with traditional forms of gambling, online gambling can result in addiction, bankruptcy, divorce, crime, and suicide—the costs of which must ultimately be borne by society," said Rep. Frank Wolf (R-Va.) at the briefing. He is a cosponsor of HR 3215.

Marianne Guschwan, M.D.: "Many gambling sites entice young people with offers of 'freebies' and other supposed discounts to get them started on gambling."

Guschwan commented that other measures are needed to combat the problem of pathological gambling including public education, prevention strategies, and funding for treatment. "A 1985 study found that for every dollar spent on treatment of pathological gambling, the benefit to society was $20," said Guschwan.

The National Council on Gambling reported in 1993 that there were more than 13,000 treatment programs for alcoholism but only 100 treatment programs for pathological gambling.

The APA Advisory on Internet Gambling is posted on the APA Web site at <www.psych.org/news_stand/internetgambling advisory11601.pdf>. The FTC consumer alert on online gambling is posted on the FTC Web site at <www.ftc.gov/gamble>. The 1999 National Gambling Impact Study Commission Report "The Gambling Debate" is posted at <www.umc-gbcs.org/csasep992.htm>. ■

Congress Attacks Web Gambling

The House Judiciary Committee voted 18-12 to pass the "Combatting Illegal Gambling Reform and Modernization Act" in June. HR 3215 would prohibit gambling businesses from operating Web sites if they are located in a state or nation other than that of the bettor.

Gambling Web sites would be required to verify that the person placing the bets is not a minor and resides in the same state as their business, according to the legislation.

Gambling enterprises located on Native-American tribal lands that are licensed for gambling under the Indian Gaming Regulatory Act would be exempt.

Rep. Robert Goodlatte (R-Va.) introduced the bill last year, which updates the 40-year-old Interstate Wire Act to encompass online lotteries and other games of chance.

"Illegal gambling on the Internet has expanded into a lucrative business that drains billions of dollars out of the U.S. economy every year and costs tens of thousands of jobs," said Goodlatte in a press release. "Illegal gambling sites evade existing gambling laws by operating off shore, providing a nearly undetectable harbor for criminal enterprises."

The Federal Communications Commission (FCC) would be charged with enforcing the law. Violators could be fined and or imprisoned for up to five years. The FCC could obtain a court order against banks and credit-card companies to force them to stop working with illegal gambling enterprises that accept bets across state or national lines, the legislation says.

Web sites could also be ordered to stop working with illegal gambling enterprises and remove banner advertisements of illegal online gambling sites.

As of July 10 the bill had 155 cosponsors in the House, which is short of the 218 votes needed to pass the House.

The text and status of HR 3215 can be accessed on the Web at <http://thomas.loc.gov> by searching on the bill number, HR 3215.

Supervising Sex Offenders Will Prevent Recidivism, Congress Believes

Judges would have greater leeway in deciding how long a sex offender should be supervised under a bill passed by the House of Representatives in June.

Sex offenders could be required to be supervised for a lifetime if a bill passed by the House of Representatives in June is enacted.

The Lifetime Consequences for Sex Offenders Act of 2002 would allow federal judges to impose supervision terms on sex offenders once they are released from prison that are longer than the five-year maximum supervision time judges can impose now.

Rep. George Gekas (R-Pa.), who introduced the bill, said in a press release, "This is a common-sense measure aimed at protecting potential victims of sexual predators. The high rate of recidivism among sex offenders makes this legislation a necessary tool in protecting the innocent from repeat criminals."

The judges with whom Gekas said he spoke on the issue "expressed grave concern about releasing serious sex offenders without the ability to check on their progress," he indicated.

Howard Zonana, M.D., former chair of APA's Commission on Judicial Action and editor of a 1999 report by the APA Task Force on Sexually Dangerous Offenders, commented to *Psychiatric News*, "Studies have shown that increasing sex offenders' supervision can have some impact on recidivism, but it also depends on the extent of the supervision and whether treatment is also provided. Many programs require treatment and supervision now."

The task force's report condemns these civil commitment statutes and the motivation behind them. It points out that "their broad definitions of mental abnormality" are troubling because they "establish a nonmedical definition of what purports to be a clinical condition without regard to scientific and clinical knowledge. In doing so, legislators have used psychiatric commitment to effect nonmedical societal ends that cannot be openly avowed."

The APA task force was created and the report developed in response to a 1997 Supreme Court ruling *(Kansas v. Hendricks)* that said it is legal for states to commit sex offenders to psychiatric hospitals once they have completed prison sentences if state officials believe they are a continuing danger to the community. No finding of a *DSM-IV* psychiatric disorder was required for such a commitment. By 1999, several states had joined Kansas in enacting such laws, often called "sexual predator" statutes.

The Court's majority was unswayed by arguments made by APA and other organizations that such forced commitments were inappropriate since the convicted sex offenders covered by the laws do not necessarily suffer from a treatable psychiatric disorder. APA insisted that if states want the option of continuing confinement for dangerous sex offenders, they should pass laws increasing prison sentences rather than dumping these individuals in a mental health system that is already overburdened and unprepared to treat them.

The House bill was referred to the Senate Judiciary Committee, which as of July 15 had not taken it up.

The text of the bill can be accessed on the Web at <http://thomas.loc.gov> by searching on the bill number, HR 4679. ■

House Renews IMG J-1 Visa-Waiver Program

The House of Representatives cleared a bill in June to renew J-1 visas for IMGs who finish residency training and agree to practice for three years in underserved areas.

BY CHRISTINE LEHMANN

A bill to renew a state-operated program that puts international medical graduates (IMGs) in underserved areas passed the House of Representatives in June. In mid-July, the bill, HR 4858, was pending before the Senate Judiciary Committee.

More than 20 million Americans live in areas where there are not enough physicians to meet their medical needs, said Rep. Jerry Moran (R-Kan.), the bill's chief sponsor, in a press release. "Enactment of this bill would clear the way for nearly 1,400 new doctors to practice in our nation's rural and underserved communities," said Moran.

Forty-six states participate in the J-1 visa program, which was established in 1993. Each participating state can recruit up to 20 IMGs who complete residency training in their state to practice in underserved areas for at least three years. In exchange for agreeing to serve, the IMG physicians are eligible for a waiver of the J-1 visa requirement that they return to their home country after they complete their residency for two years before they can seek to return to this country.

Chowallur Chacko, M.D., a member of APA's Committee of International Medical Graduates, reacted positively to the passage of the bill in the House. "Communities with shortages of psychiatrists benefit from the program, and IMGs benefit by having the option to remain in this country after residency training. Most IMGs would rather practice in the United States because the opportunities for employment are better here than in their home country, and their families benefit," said Chacko in an interview.

Moran's bill would renew the state-operated program, which expired on May 31, retroactively for an additional two years. It would also increase the number of IMGs that states can recruit to 30.

James Scully, M.D., chair of the APA Committee on Workforce Issues, applauded the House passage of the bill. But it is "only a stopgap measure given the widespread lack of access to affordable health care in many states. More measures need to be implemented, including parity and programs, that forgive medical student loans in exchange for service," Scully told *Psychiatric News*.

The states in the J-1 visa-waiver program submit applications on behalf of IMGs to the U.S. Department of Agriculture (USDA), which recommends them for a waiver to the Department of State. The Immigration and Naturalization Service (INS) grants the waivers and notifies the states, according to a USDA fact sheet.

Just two weeks after the September 11 attacks, however, the USDA abruptly stopped recommending IMGs for the waiver program, citing increased security concerns following September 11 and "a lack of authority to conduct adequate background checks on applicants" (*Psychiatric News*, May 17).

Moran and congressional colleagues from rural states protested the USDA's action in March. In April the USDA reversed its decision temporarily and processed the 86 pending applications, according to the USDA.

In the meantime, Moran has been meeting with a federal interagency task force including the INS, State Department, and USDA to resolve how the J-1 visa applications will be handled in the future, according to Moran's legislative assistant, Kimberly Rullman. As of July 10, no decision had been announced.

HR 4858 can be accessed on the Web at <http://thomas.loc.gov> by searching on the bill number. ■

Hill Experience Makes Resident Want to Do More

One APA member-in-training has been able to help craft mental health legislation by way of the American Psychiatric Foundation's Daniel X. Freedman Congressional Fellowship.

BY EVE BENDER

Psychiatry resident Brooke Parish, M.D., has been able to put her budding interest in disaster psychiatry to work in a way that most residents only dream of.

Parish has spent the past six months on Capitol Hill sharing her medical and mental health experience with senators and Senate staff as they work to develop mental health legislation and get it passed.

Her work on the Hill was made possible by the American Psychiatric Foundation's Daniel X. Freedman Congressional Fellowship. Now in its eighth year, the fellowship pays living and relocation expenses for senior residents while they work in the office of a House or Senate member or on the staff of a health-related committee of Congress. Fellows typically receive a $20,000 stipend, and the funds are provided through the American Psychiatric Foundation and Eli Lilly and Company.

Parish, who is a fourth-year resident at Tulane University, has been working closely with Sen. Mike Enzi (R-Wyo.), who is a member of the Senate Health, Education, Labor, and Pensions Committee and the ranking member of the Employment, Safety, and Training Subcommittee.

"I've been treated well on Capitol Hill," she told *Psychiatric News*, "and I only wish I could stay longer."

For the most part, Parish has lent her expertise in public health to politicians working on the conference report for the Bioterrorism Preparedness Act of 2001. In addition, she has advised politicians about the mental health aspects of bills relating to Native Americans.

One such bill, she said, "will allow Indian tribes to set their own priorities in preventative and primary health care, and streamline their health care delivery service system." Parish also conducted research for more than 20 bills related to women's health while on the Hill. The bills, still in committee, included components on breast cancer and domestic violence, for instance.

Parish also attended a number of conferences with Senate staff members and interest groups in which she helped to review the wording of these bills. She said that meeting with different interest groups provided her with a multitude of perspectives about these bills.

Parish said that her prior experience in public health and disaster psychiatry had prepared her well for her work on Capitol Hill. For instance, she is chair of the Louisiana State Medical Society's Subcommittee of Disaster and Mass Casualty Preparedness and a member of that organization's Subcommittee on Hazardous Materials and Terrorism Response.

She advised future Freedman fellowship awardees to "be enthusiastic, for this is a great opportunity to see how this country is run."

Brooke Parish, M.D.: "I've been treated well on Capitol Hill, and I only wish I could stay longer."

Parish plans to embark on another fellowship in the fall—this time in forensic psychiatry at Tulane University. She said she also hopes to finish her master's degree in public health by December.

"After my fellowship, I hope to return to Washington to work in health policy—in particular, I hope to work on public and international health care issues," Parish said.

"I have been honored to spend six months learning more about the political system, and I hope to be able to help other doctors understand what I learned. I feel it is important for doctors to be involved. The health of America depends on it." ■

Sharfstein Gives Survival Tips For Troubled Hospitals

Administrative Psychiatry Award winner Steven Sharfstein, M.D., advises psychiatrists to pay attention to public-sector funding, locating new customers, and coalition building to ensure institutional survival.

BY KATE MULLIGAN

"Does the psychiatric hospital have a future?," asked Steven Sharfstein, M.D., president and chief executive officer of the Sheppard Pratt Health System in Maryland.

He gave an affirmative, but guarded, response during his delivery of the Administrative Psychiatry Award Lecture at APA's 2002 annual meeting in Philadelphia.

Sharfstein, who is also an APA vice president, traced the history of an institution that upon his arrival in 1986 was wedded to the value of long-term hospitalization for patients with serious mental illness. The average length of stay at Sheppard Pratt then was 73.5 days.

Ninety percent of the hospital's revenue came from inpatient care, and 92 percent of the budget came from private sources. Coverage from insurance had expanded during the 1960s and 1970s and typically covered all inpatient charges. For 98 out of the institution's 100 years, it had been profitable.

"No one envisioned the hurricane that would result from managed care," Sharfstein emphasized.

Sheppard Pratt CEO Steven Sharfstein, M.D., tells an annual meeting audience how the institution grew its way out of the dilemmas posed by managed care.

In 1989 Green Spring Health Services, a behavioral managed care company, or carveout, that was later bought by Magellan Behavioral Health, received a contract to administer mental health benefits for Blue Cross and Blue Shield of Maryland. One-third of Sheppard Pratt's inpatient days were covered by that insurance company.

By 1992, when Sharfstein became medical director, the hospital was awash in a "sea of red ink." Sheppard Pratt was losing $5 million annually on a budget of $50 million.

"We were closing units and beds on a regular basis," said Sharfstein. The average length of stay decreased from 73.5 days to 33 by 1992. The figure continued declining until it stabilized at the current figure of nine days.

Some members of the hospital's board

please see ***Sharfstein*** *on page 10*

Psychiatrists Not Immune To Mental Illness—or Stigma

Psychiatrists may be more cognizant than most people of the devastating effects of stigmatizing the mentally ill, but that does not prevent them from suffering its consequences when they develop a mental illness.

BY KEN HAUSMAN

The stigma attached to mental illness is certainly not an abstract concept to psychiatrists. Their patients deal with it almost every day. But psychiatrists can be startled by how devastating stigma can really be when they are the ones on the receiving end.

When those psychiatrists are also members of a minority group, coping with and overcoming the effects of stigma add difficult, and often unexpected, challenges to the recovery process.

Three psychiatrists who have endured stigma from the public as well as their medical colleagues participated in an APA annual meeting workshop cosponsored by the National Alliance for the Mentally Ill. The psychiatrists described the anguish they experienced as they tried to recover from mental illness and overcome stigmatizing behavior.

Michelle Clark, M.D., began to experience some classic symptoms of major depression several years ago after a serious physical illness, but despite being an experienced psychiatrist who has treated many people with depression, she convinced herself that her symptoms were not signs that she needed treatment, but the result of the stress she was under.

A psychiatrist colleague at the University of California, San Francisco, where Clark is an associate clinical professor and has developed culture-based treatment programs, noticed her symptoms and eventually prescribed an SSRI for her, Clark said. She began to improve. Even after she acknowledged that she was suffering from depression, her family "remained clueless," about what the illness entailed and how some of her behaviors were manifestations of it.

It took a long time, Clark emphasized, but she finally realized that the stigma attached to having a mental illness, added to the stigma that comes with being African American in this country, left her in the position of "colluding with" the stigmatizers. She came away from the experience with a vivid picture of how stigma and the resulting failure to recognize symptoms that would have been evident in patients she treats had slowed her recovery process.

Suzanne Vogel-Scibilia, M.D., is also familiar with the devastating effects of stigma, having had bipolar illness so severe since she was a child that she has had several psychotic episodes. After the birth of her third child, she told the workshop audience, she experienced a period of catatonia.

Now medical director of a consumer-run mental health center in Beaver, Pa., Vogel-Scibilia stressed that psychiatrists

"We have a long way to go. . ." when psychiatrists and other physicians with mental illness are still forced to overcome stigma directed at them by their colleagues.

who are minority-group members can in fact confront a triple stigma—that of being a minority, a person with mental illness, and, in some communities, a psychiatrist.

She believes that as a psychiatry resident with a serious mental illness, she also was stigmatized by supervisors and other residents. One residency supervisor, she said, told her that other residents believed she needed ECT. While that supervisor agreed that such a response was "probably overkill," he advised Vogel-Scibilia to "stay away" until her symptoms abated and she was no longer "scaring the other residents," she said.

Too many physicians, and particularly psychiatrists, are convinced they're immune from mental illness, she said. When it strikes, an additional source of stigma often keeps psychiatrists and mental health professionals from acknowledging it and getting treatment. That, she stated, is the belief that many people inside and outside of medicine harbor that a mentally ill psychiatrist "must have done something to cause it or isn't qualified to be a psychiatrist." When a clinician is part of a minority group, it gives people an additional reason to distance that person from other psychiatrists, Vogel-Scibilia suggested, since it supplies some people with a reason to explain why a psychiatrist can end up with a mental illness.

She also warned that mentally ill psychiatrists should not expect to find empathy in the "ex-patient community." Many of those former patients refuse to view psychiatrists with mental illness as part of them, harboring resentment from what they consider to have been coercive medical treatment. Vogel-Scibilia calls these psychiatrists who have or have had mental illness "prosumers"—a blend of providers and consumers—and urged them to look for support in several arenas. These include through APA, which puts on educational workshops such as this one, and through the AMA, which is "welcoming of consumer-providers, especially those with minority status," she said.

One of the worst things psychiatrists can

please see ***Stigma*** *on page 10*

Depression Screening Day Adds Anxiety Disorder Assessment

Primary care patients and people with anxiety disorders could benefit from new and improved screening during National Depression Screening Day, to be held this year on October 10.

BY EVE BENDER

People visiting thousands of screening sites on this year's National Depression Screening Day (NDSD) will for the first time receive screening for generalized anxiety disorder and PTSD, in addition to mood disorders, such as depression and bipolar disorder.

The new and improved screening form incorporates elements of four different diagnostic tools, including the Harvard Department of Psychiatry/National Depression Screening Day Depression Test, Mood Disorder Questionnaire, Carroll-Davidson Generalized Anxiety Disorder Screen, and SPRINT-4 questionnaire for PTSD, which was created specifically for NDSD by Jonathan Davidson, M.D.

The screening will take place on October 10, just a month after the one-year anniversary of the September 11 terrorist attacks in New York City and Washington, D.C., and the related plane crash in Pennsylvania.

Each year since 1991, Screening for Mental Health Inc., a nonprofit agency based in Massachusetts, has organized NDSD. The event, which is held at nearly 6,000 screening sites throughout the United States and Canada, aims to help those with mood and anxiety disorders find treatment, educate the public about those disorders, and combat the stigma of mental illness. Last year about 100,000 people received screening for mood disorders. A similar number of people are expected to attend screenings this year.

"We wanted to create one simple screening form that effectively screens for a range of commonly underdiagnosed disorders and reflects current psychiatric understanding that these illnesses and symptoms frequently occur concurrently," Douglas Jacobs, M.D., founder and executive director of NDSD and Screening for Mental Health Inc., told *Psychiatric News*.

"We wanted to create a mechanism that would allow the screening clinician to get a fuller picture of the person's symptomatology, which will lead to earlier identification, and hopefully better treatment," he said.

Jacobs said he believes that the timing of this year's NDSD is "fortuitous," because "it is a perfect opportunity for people still struggling with the events of 9/11 and the economic upheaval of the past year to seek help in a nonthreatening format."

He added that many people with no psychiatric history who were affected by the attacks either directly or indirectly may be experiencing symptoms that they don't understand or are embarrassed to discuss. "We hope that NDSD is able to connect them with their local treatment services."

As NDSD has incorporated screening for different disorders into its annual event, it is also accounting for the specific needs of its diverse participants.

For instance, in 1999 NDSD spotlighted the mental health needs of high school students with the creation of the Signs of Suicide (SOS) High School Suicide Prevention Program.

In addition to screening tools, the SOS program includes educational materials for teaching teens to recognize the warning signs of depression and suicide in their peers and to alert a responsible adult about the problem. The materials include a video about teen depression and suicide and a discussion guide to help students better understand the video. A grant from Ronald McDonald House brought the program to 1,000 high schools last year, and that number is expected to double this year.

Elderly people who come in for screening have the option of completing screening forms printed in large type and receive brochures about mood and anxiety disorders in geriatric populations.

NDSD also includes a Spanish-language kit for screening sites that primarily serve Latino populations.

Patients visiting some primary care physicians and nonpsychiatric specialists will also receive screening for depression and related disorders. Since 1998 primary care doctors have been included in NDSD in hopes that they will incorporate the screening into their everyday practices.

"The U.S. Preventative Services Task Force recently recommended that primary care physicians screen all adult patients for depression," said Jacobs. "We hope that this recommendation will motivate our primary care colleagues to screen and refer patients with complicated, comorbid, or severe psychiatric disorders."

Jacobs explained that an important companion piece to the screening form is a reference guide to assist primary care clinicians in screening, diagnosing, and initiating treatment for clinical depression.

Those interested in providing screening on National Depression Screening Day must first register by downloading a form at the Web site <www.mentalhealthscreening.org/ndsd/psychnews> or by calling NDSD at (718) 239-0071. Registration fees are $150 for most private sites, $50 for sites in the public sector, and free for primary care screening sites. Fees include the cost of materials for setting up a site. ■

Positive Psychiatry Portrayals A Rarity in Hollywood

Psychiatrists find accurate portrayals of their profession the exception rather than the rule after watching clips from popular films at APA's 2002 annual meeting.

BY CHRISTINE LEHMANN

Hollywood continues to be fascinated with psychiatric themes. At least 10 movies that featured different kinds of relationships between therapists and patients were box-office hits in the 1990s, said Maj. Steven Pflanz, a psychiatrist who led a workshop on psychiatry and film at APA's 2002 annual meeting in May in Philadelphia.

Among these films were "Good Will Hunting," "Analyze This," "As Good as It Gets," "Don Juan DeMarco," and "Grosse Pointe Blank."

"Psychotherapy appeals to filmmakers because it deals with powerful human emotions, and art is really about human emotions at its core," said Pflanz, who has presented numerous workshops at previous annual meetings.

Pflanz is chief of mental health services and deputy squadron commander of the 90th Medical Operations Squadron at F.E. Warren Air Force Base in Cheyenne, Wyo.

But when does artistic license cross the line and become an irresponsible misrepresentation? The answer is not always clear.

For example, in the 1997 movie "Good Will Hunting," Robin Williams plays psychotherapist Shawn McGuire, who helps Will Hunting, a troubled math genius, come to terms with his abusive past. Pflanz and others at the workshop characterized the therapeutic relationship as a positive one that "transformed the patient and therapist."

However, the movie also includes a scene early in Will's therapy in which he insults McGuire's wife. McGuire responds by pushing Will against the wall and threatening to hit him if he ever again insults his wife, who is deceased. Later in the film, there are scenes of McGuire hugging Will and visiting each other at home.

"We are supposed to be the agency of compassion," said one psychiatrist who attended the session. "People seeing a therapist assault a patient might wonder if that would happen in therapy and feel unsafe."

Another audience member said, "Hugging a patient and visiting the patient in his home is clearly a line that many therapists would not cross."

In the 1999 movie "Analyze This," Robert de Niro plays a Mafia boss who consults a psychiatrist, played by Billy Crystal, to help him deal with his emotional problems. To avoid being "whacked by the mob" for revealing secrets to a psychiatrist, de Niro insists on clandestine meetings with the psychiatrist, including impromptu visits while the psychiatrist is on vacation and at the psychiatrist's home after breaking in.

Crystal's character "seemed weak and intimidated by de Niro," commented an audience member. "There were numerous violations of professional boundaries," said another.

By contrast, the 1997 film "As Good as It Gets" got high marks from the workshop audience for depicting the psychiatrist in the movie as a professional who set boundaries with patients and providing a more realistic portrayal of how psychiatry is practiced.

In one scene, for example, Melvin Udall, played by Jack Nicholson, barges into the psychiatrist's office without an appointment and clearly expects to be seen immediately. The psychiatrist patiently but firmly explains to Udall that he will not make an exception for him and instead schedules an appointment.

Hollywood movies tend to portray women therapists in more compromising roles than men, said Pflanz. As of 1989, there were twice as many films portraying unethical sexual behavior by women therapists as male therapists, according to the 1999 book *Psychiatry and the Cinema* by Gabbard and Gabbard (American Psychiatric Press Inc., 1999).

That pattern continued in the 1990s with such movies as "The Prince of Tides." Barbra Streisand plays a psychiatrist who becomes romantically involved with the brother of a suicidal patient. The brother is played by Nick Nolte.

Portrayals of psychotherapists as dark characters who murder their patients in movies such as "Dressed to Kill" and "Whispers in the Dark" are examples of art misrepresenting psychotherapy, said Pflanz.

"We should let producers know when they portray the profession in a responsible manner and when they don't. We should also educate them about the profession so they have a better understanding of psychotherapy," said Pflanz. ■

Maj. Steven Pflanz: "Psychotherapy appeals to filmmakers because it deals with powerful human emotions, and art at its core is about human emotions."

Stigma

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do in response to having suffered a mental illness, she stressed, is to change the way they practice. Doing so "becomes a knife you've sharpened for others to use."

A few years ago, when he worked at a Pennsylvania hospital, Raymond Reyes, M.D., refused to order restraints for a nonpsychotic patient who was exhibiting disruptive behavior. His refusal got him in hot water with his supervisor. Reyes, a son of Phillipine immigrants, wondered whether he would have taken such a stand if he had not suffered from a mental illness himself. Reyes explained that he has suffered from dysthymia and major depression, first realizing that he needed psychiatric treatment after he graduated from residency and joined the Air Force, where he supervised an inpatient unit.

After believing that as a physician he was expected to be "stoic" about his depression symptoms, he told a superior at the air base that he needed treatment. He asked the superior, who was also his friend, to treat him. "That ended both the friendship and our working relationship," Reyes said. At that point he had second thoughts about whether he should have put himself on the line by admitting he had a serious psychiatric disorder, but he explained that he didn't want to self-medicate or "do anything under the table."

He said that he has identified one "silver lining" in his continuing battle with mental illness, namely, that he has even more empathy with other people suffering from similar disorders than he might otherwise. He wonders, he noted, whether he would have refused to restrain that patient in Pennsylvania if he had not seen mental illness from the inside. He currently works at a community mental health center in Solano County, Calif.

Workshop cochair Michael Myers, M.D., pointed out, "We have a long way to go in the house of medicine" when psychiatrists and other physicians with mental illness are still forced to overcome stigma directed at them by their colleagues. ■

Sharfstein

continued from page 7

of trustees wanted to close the hospital and develop a small residential institution. Sharfstein disagreed and turned to a management approach he had learned during a four-month stint at the Advanced Management Program at the Harvard Business School.

"[That program] gave me an appreciation of the creativity of the marketplace and capitalistic approaches to coping and survival," he noted.

Sharfstein decided his institution had to "grow its way out of the dilemma," and he focused his energies on identifying new "customers" and eliminating costs.

Today, he calls Sheppard Pratt a "hospital without walls," or, more formally, a "comprehensive behavioral health care system."

Only 40 percent of the revenues for the Sheppard Pratt Health System come from payment for inpatient treatment. Seventy percent of its revenues come from public sources. Medicare and Medicaid are the primary funding sources.

"Today, we treat 40,000 individuals in 20 locations," said Sharfstein. Through five wholly owned affiliates, Sheppard Pratt provides rehabilitation, outpatient care, and housing for nearly 1,000 individuals with severe and persistent mental illness. The institution has more than 100 children and adolescents in residential treatment and 300 in special schools.

In 1986 the hospital treated about 4,000 patients, of whom 1,200 were in the hospital.

In a sign of optimism about the future, the institution's board of trustees recently voted to invest up to $90 million to build a new hospital.

Sharfstein recognizes, however, that the survival of any psychiatric hospital is not assured, although there will always be a need for institutions that offer a safe environment in which a person with mental illness can be stabilized and re-evaluated.

He also recognizes that the fate and role of psychiatric hospitals will continue to be impacted by larger social forces.

"As states continue to downsize public facilities, and as most patients begin to lose private insurance after one or two acute episodes involving inpatient care, the importance of funding in the public sector can not be overemphasized," he said.

More specifically, Sharfstein believes that treatment for persons with serious and persistent mental illness will continue to be a "major public health burden."

Up to 20 percent of patients cannot be treated effectively in the few days or even weeks of hospitalization that are permitted by public and private programs. Many of these patients end up in the criminal justice system.

Public and private payment for inpatient treatment have been cut dramatically, but resources for outpatient treatment did not expand sufficiently to compensate, he argued. "More and more community clinics are on the verge of extinction because of nonreimburseable items like missed visits and time spent on coordination of care," said Sharfstein.

The cost constraints are exacerbated by rising pharmaceutical costs. "The pharmaceutical industry is bankrupting limited budgets with medications of marginally improved benefit. . . . This short cut of medication strategies is a great overpromise," he said.

Sharfstein described strategies that offer promise in addressing some of the most serious problems with the mental health system. Because Sheppard Pratt had become the largest provider of acute services funded by Medicaid in Maryland, Sharfstein was able to negotiate with state officials for higher reimbursement rates.

"Develop a coalition," he advised. "Some of our best allies in the struggle over Medicaid were the Alliance for the Mentally Ill, On Our Own [a consumer group], and the Maryland Psychiatric Society."

He believes that the daily utilization reviews that are associated with managed care will give way to more evidence-based, disease-management approaches. This trend, however, will require psychiatric hospitals to learn to control costs and improve care through more aggressive management of inpatient stays.

Sharfstein concluded by answering another question.

"Ask me what I do," he said. "I run a large, nonprofit public/private partnership, community mental health center in Baltimore called Sheppard Pratt." ■

WYETH EFFEXOR

P4C

Conflicting Social Forces Impede Addiction Treatment

BY BREALYN SELLERS, M.D.

Treating addicts poses major ethical ambiguities. Behavior-related diseases have always been a source of frustration for health care practitioners, and substance use disorders, particularly heroin addiction, are especially problematic.

The addict's compulsive pursuit of disease over health defies many of the basic tenets of our profession and provokes conflict in us. As I train to become an addiction psychiatrist, I often wonder whether the problems may lie in our formulation of the illness and our expectations of ourselves as physicians. How comfortable can we make addicts without being complicit in their self-destruction? How far can we reasonably go to "meet the patient on his/her own terms"? These questions are unavoidable as we develop treatment strategies to address the complex and refractory nature of substance use disorders.

Harm reduction represents the most politically radical approach to addiction. It stands on the principle that total, sustained abstinence is but one of many favorable outcomes. Being addicted to heroin but not contracting HIV, hepatitis C, cellulitis, endocarditis, and so on are others. As a part of my fourth-year elective in addiction psychiatry, I had the opportunity to spend time in the Lower East Side Harm Reduction Center in New York City, a needle-exchange program that is funded largely by the city's Department of AIDS Services.

The center serves as a needle exchange and provides many ancillary services to addicts, including infectious disease tests, primary care medicine, massage and acupuncture, detox support, and referral to treatment. Studies have shown that needle-exchange programs prevent HIV infection and hepatitis—and at a very modest cost. Evidence refutes the fear that these programs promote IV drug use.

The exchange, one of 12 in New York City, serves 2,814 enrolled participants and had collected 519,887 needles when I was there. The center itself is shabby but homey, with sofas set around a coffee table, topically relevant literature organized in racks on the walls, and a chalkboard noting drugs to avoid, for example, "Stay away from Fentanyl—six deaths in one week." Tourniquets, sterile water, alcohol preps, cotton balls, cookers, condoms, and dental dams are provided in addition to sterile syringes. Neighboring restaurants donate food, and the center offers movies, self-defense classes, and free dog food for participants' pets.

New enrollees are required to sit through a demonstration of safe injection techniques. The demographics of the center's population defy stereotype; the only thing that clients appear to have in common is pinpoint pupils.

Nonetheless, it can be a stretch to feel on solid ethical ground in an environment that does so much to improve the quality of the addict's experience of addiction, to participate actively in abetting overtly self-destructive behavior. Our culture's position on immoderation has never been ambiguous. Historically, we have deemed "out-of-control" behavior immoral, and on the subject of inebriety we have been consistently punitive. On the one hand, for an adolescent to be protected against the possibility of infection with a devastating virus while he or she "experiments" with IV heroin use is a worthy effort. On the other hand, with a disease that is to a large degree tempered by social reinforcement, are we encouraging use by not discouraging it?

Yet despite society's consistently unequivocal discouragement, heroin addiction is on the rise. And as the greatest risk factor for the most devastating and expensive to treat of infectious diseases, intravenous drug use continues to move up on the list of public health concerns.

The onus of addressing these issues falls largely on psychiatry—where else can chronic, maladaptive behavioral issues be addressed in a clinical and nonjudgmental environment? And if total sustained abstinence is the highest goal to which we can aspire, isn't the disease-free addict more likely to attain it?

Models of chronic medical conditions such as diabetes and hypertension are frequently used as analogies for better understanding the nature of addictive disease, and the parallels are striking. Often the best we can do as physicians is to mitigate outcome by managing symptoms. Still in its infancy, the field of addiction psychiatry is faced with ever-increasing prevalence of disease, limited treatment options, and insufficient resources.

If the harm-reduction approach lies close to the boundaries of our ethics, perhaps our ethics need to be reevaluated to compensate for the inadequacies of what we presently have to offer those of us who suffer from substance use disorders. ■

Dr. Sellers is a second-year fellow in addiction psychiatry at New York University and a former APA/CMHS substance abuse fellow.

must have been published no longer than five years ago or officially accepted for publication in the near future.

The award is funded by a grant from the Ittleson Foundation and is named for Blanche F. Ittleson, who was a friend of mental health over many decades, especially concerned with the mental health and well-being of children.

A prize of $2,000 and a plaque will be presented to the winner at the Convocation of Fellows at APA's next annual meeting. The deadline for submissions is September 12.

Nominations for the Blanche F. Ittleson Award must include four copies of the published or soon-to-be-published research, a cover letter, and a curriculum vitae and sent to Peter Jensen, M.D., Chair, Blanche F. Ittleson Award Board, c/o Jane Edgerton, APA, 1400 K Street, N.W., Washington, D.C. 20005.

The deadline for the three awards is September 12. More information is available by contacting Jane Edgerton by e-mail at jedgerton@psych.org. ■

Child, Adolescent Psychiatrists Eligible for APA Awards

APA has three awards for recognizing the outstanding contributions of child and adolescent psychiatrists. Nominations are due September 12.

APA invites nominations for the three awards it presents each year to child and adolescent psychiatrists in recognition of their outstanding work in research, prevention, teaching, advocacy, or clinical care.

The Agnes Purcell McGavin Award for Distinguished Career Achievement in Child and Adolescent Psychiatry and the Agnes Purcell McGavin Award for Prevention recognize psychiatrists who have performed notable work in child and adolescent psychiatry. One McGavin Award was presented from 1964 through 1999 "to honor a psychiatrist who has made significant contributions to the prevention of mental disorders in children."

Beginning in 2000, two awards were presented. The distinguished career award is given to recognize a child/adolescent psychiatrist whose career has included noteworthy achievements in teaching, research, writing, clinical care, and advocacy in the care of children and adolescents. The prevention award honors a child/adolescent psychiatrist who has been successful with research or programs in primary prevention for children and adolescents.

Each award will include a $1,500 prize and a plaque to be presented at the 2003 annual meeting in San Francisco. The deadline for nominations is September 12.

Nominations for both awards should include six copies of a letter from an APA member telling how the nominee's work has had proven success in either research or policy that promoted primary prevention among children and adolescents or pursuing a career noted for significant contributions in teaching, research, and care for children and adolescents; and six copies of the nominee's curriculum vitae.

Nominations should be sent to Jerry M. Wiener, M.D., Chair, Agnes Purcell McGavin Awards Board, c/o Jane Edgerton, APA, 1400 K Street, N.W., Washington, D.C. 20005.

The Blanche F. Ittleson Research Award is given to a psychiatrist or a group of psychiatric investigators for published results of research in child psychiatry. This research has led, or may lead, to an important advance in promoting the mental health of children. Results of the applicant's research

APPI Online Library Offers Multiple Benefits

Are piles of journals taking over your office? APPI offers APA members a convenient, high-tech way to learn the latest developments in a burgeoning specialty.

BY KEN HAUSMAN

APA is making it easier for members to sift through the daunting volume of new data and reports that psychiatrists need to process to stay current in a field where knowledge is exploding.

The American Psychiatric Online Library (APOL) provides easy and convenient Web access to the full text of articles in the *American Journal of Psychiatry*, *Psychiatric Services*, *Academic Psychiatry*, *American Journal of Geriatric Psychiatry*, *Journal of Neuropsychiatry and Clinical Neurosciences*, and *Psychosomatics*. A subscription to the APOL comes with access not only to current issues, but to four years of back issues as well.

American Psychiatric Publishing Inc. (APPI), which operates the online library, is now offering a special subscription price for APA members who also belong to one of five other psychiatric associations whose journals are published by APPI. These organizations are the Academy of Psychosomatic Medicine, American Association for Geriatric Psychiatry, American Neuropsychiatric Association, American Association of Directors of Psychiatric Residency Training, and Association for Academic Psychiatry.

APA members who also belong to one of these associations can subscribe to the APOL for only $45. Of course, APA members can access the APA journals—the *American Journal of Psychiatry*, *Psychiatric Services*, and *Psychiatric News*—at no charge as a member benefit.

Psychiatrists who are members of APA but not one of the five other organizations can subscribe to the online library for $90. Print subscriptions to these seven publi-

please see ***Online Library*** *on page 14*

Coalition Building Will Enhance Psychiatry's Future, Sederer Says

Lloyd Sederer, M.D., who recently left APA after several years as director of its Division of Clinical Services, urges the Association to broaden its advocacy agenda and enlist support from mental health consumers.

BY KATE MULLIGAN

On July 1 Lloyd Sederer, M.D., former director of APA's Division of Clinical Services, became New York City's executive deputy commissioner for mental hygiene. In the newly created position, Sederer oversees the delivery of mental health, mental retardation, and addiction services in New York City.

In announcing the appointment, Steven Mirin, M.D., APA's medical director, wrote, "Since coming to APA two years ago, Lloyd and the staff of the division, which includes the Office of Healthcare Systems and Financing and the Office of Quality Improvement and Psychiatric Services, have made a tremendous impact on the central office, our Association, and the field."

Prior to joining APA, Sederer was medical director of McLean Hospital, a nonprofit teaching hospital of the Harvard Medical School.

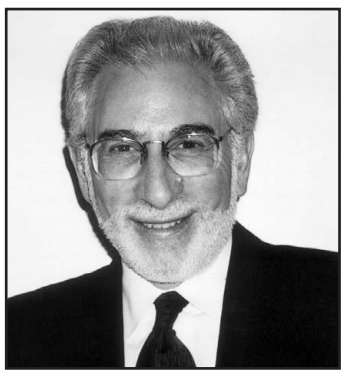
In a farewell interview with *Psychiatric News*, Sederer discussed his thoughts about his activities at APA and the Association's future.

Sederer described his work with APA's Committee on Psychiatric Reimbursement to develop a prospective payment system (PPS) for inpatient psychiatric care of Medicare patients as an effort that is "coming along nicely" *(Psychiatric News*, January 18). The committee is chaired by Joseph T. English, M.D.

"We advanced a model at the Centers for Medicare and Medicaid Services for payment that involves no administrative burden to doctors or other clinicians. It aims to be fair and transparent in terms of the rules," he said.

Since 1983 medical and surgical Medicare services at general hospitals have been reimbursed through a PPS based on diagnosis-related groups (DRGs). Psychiatric hospitals and units have been exempt since 1985 because of work done by APA demonstrating that DRGs could not effectively distinguish variation in psychiatric treatment cost among hospitals, but federal legislation set a deadline of October 2002 to implement a new system.

"The model we proposed was well received, but there is still plenty of room for mischief," said Sederer. He anticipates implementation in 2004.



Lloyd Sederer, M.D.: "We need to take a look at the architecture of public funding and identify leverage points for change, as we did with our work on Medicare hospital reimbursement."

Sederer also focused considerable attention on the APA Business Relations Initiative, which was launched in 2000.

The broad strategy of the initiative is to "go upstream" from managed care and insurance companies and persuade corporate decision makers of the value of providing accessible, high-quality mental health benefits, explained Sederer.

The initiative operates through the Committee on APA/Business Relationships, a component of the Council on Healthcare Systems and Financing.

Committee Chair Norman Clemens, M.D., told *Psychiatric News*, "Lloyd's contribution was enormous. He was respected by business leaders as a clinician, but he also could speak about how to assess the value of mental health services in terms those

Online Library

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cations would cost $772 annually.

In addition to access to four years of the journals, an APOL subscription permits members to search texts by keyword and offers hyperlinks to Medline and to the full text of many other online journals. It also lets subscribers read a new issue of one of the journals before print-edition subscribers receive their copies.

Psychiatrists who want a tour of what's available through the online library can check it out by going to <www.appi.org> and clicking on "View journal abstracts and table of contents."

APA members who want to subscribe to APOL have several options. They can call APPI at (800) 368-5777 between 9 a.m. and 5:30 p.m. Eastern time, Monday through Friday; fax their request to (202) 789-2648; send an e-mail to appi@psych.org; or sign up on the Web at <www.appi.org>. Four to six weeks after APPI receives payment, new subscribers will receive a postcard in the mail that includes a code number and instructions on how to activate their subscription. ■

leaders could understand."

APA met with major companies like Union Pacific Railroad, Hughes Electronics, Delta Airlines, Constellation Energy, Verizon, General Electric, Merrill Lynch, DuPont, and Dow Corning.

> **"Now that we have made progress in a long struggle for federal parity, APA should find ways to broaden and reinvigorate its advocacy agenda."**

In June 2001, at the invitation of the Carter Center in Atlanta and APA, nearly 100 representatives of business, government, and academia met for a symposium, "The Business Case for Mental Health."

Sederer provided a tutorial, "Demystifying Quality Measurement," designed to help businesses measure and determine whether they are providing quality mental health care to their employees *(Psychiatric News*, July 20, 2001).

Disaster-Response Program

The relationships Sederer developed through his work with the business initiative proved valuable after the terrorist attacks on September 11.

In December APA launched the National Partnership for Workplace Mental Health, a joint effort with major companies like Delta Airlines, Hughes Electronics, and Dow Chemical to provide education and resources about disaster-related stress and trauma to employers and employees *(Psychiatric News*, January 4).

On April 25 APA and the national partnership, with support from the Center for Mental Health Services (CMHS), hosted a conference, "Disaster, Terror, and Trauma in the Workplace: What Did We Know Before 9/11 and What Have We Learned Since?"

State Advocacy Should Be Increased

Sederer urged continuation of the business initiative and described other challenges for the organization.

"Now that we have made progress in a long struggle for federal parity, APA should find ways to broaden and reinvigorate its advocacy agenda," he said.

APA must pay more attention to legislative and budget decisions that impact psychiatry at the state level, Sederer said. He thinks the organization should identify allies at that level and work in coalitions.

"APA has functioned too much and too long in isolation or primarily with other medical specialty organizations," he said.

Sederer emphasized the effectiveness of a coalition of consumer organizations and the state psychiatric society in Maryland, for example, in obtaining an increase in reimbursement for Medicaid patients (see story on page 7).

He also described the power and influence of the Greater New York Hospital Association. "They don't go anywhere in terms of lobbying without legions of consumers with and behind them," he said.

Sederer emphasized the importance of public funding to the future of psychiatry. "Medicaid, in particular, is extraordinarily important because it is the largest source of public funds for mental health services," he said.

According to 1997 CMHS data, Medicaid was almost as important a source of funds for mental health and substance abuse treatment as was private insurance. Medicaid funds accounted for 20.3 percent of the total dollars spent on mental health and substance abuse, and private insurance accounted for 23.8 percent. The remainder came from other state and federal programs and out-of-pocket funds.

Sederer said, "We need to take a look at the architecture of public funding and identify leverage points for change, as we did with our work on Medicare hospital reimbursement. Then, APA should build a policy agenda and identify partners that can work in coalition with our Association."

He was pleased that APA President Paul Appelbaum, M.D., had used his inaugural address in May to comment about the crisis in the public mental health system (*Psychiatric News*, June 21).

Sederer also commended the Assembly Task Force on Seriously and Persistently Mentally Ill/Public Psychiatry for its report issued at the APA annual meeting in May.

Asked if he had any final thoughts, Sederer said, "Please convey my sadness about leaving so many dear colleagues and friends and our collective mission." ■

APA/GlaxoSmithKline Fellows Named For 2002-04

The following psychiatry residents have been named the 2002-04 APA/GlaxoSmithKline Fellows. They were selected by the APA/GlaxoSmithKline Corresponding Committee at APA's 2002 annual meeting in Philadelphia.

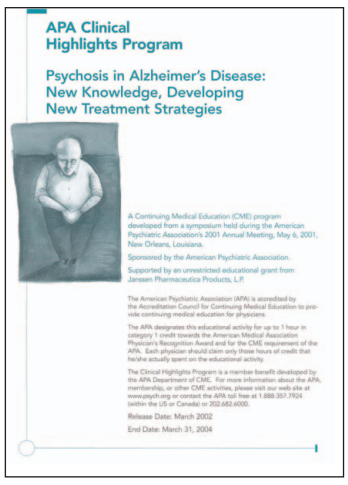
Rebecca W. Brendel, M.D, J.D., McLean Hospital
Jeffrey M. Friend, M.D., Columbia University
John W. Grace, M.D., University of South Florida
Alec Oskin, M.D., University of Toronto
Konasale Prasad, M.D., Western Psychiatric Institute and Clinic
Mark N. Rudolph, M.D., Boston University School of Medicine
Abigail Schlesinger, M.D., University of Michigan
Wendy Somerset, M.D., Emory University School of Medicine
Christine Truman, M.D., Cornell University
Tara Yuan, M.D., University of California, Irvine ■

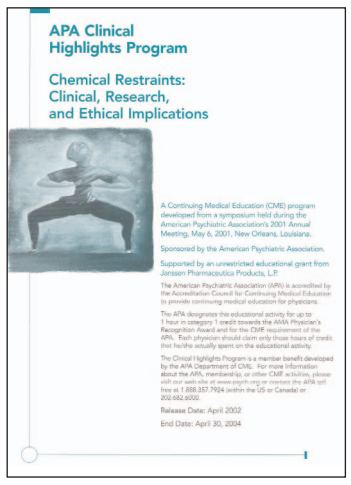
Additions to CME Series Focus on Alzheimer's, Chemical Restraint

APA has released two new editions in its Clinical Highlights series based on industry-supported symposia presentations at the 2001 annual meeting.

BY LAURA BUDASH

APA's Department of Continuing Medical Education has released several new editions in the APA Clinical Highlights program based on industry-supported symposia presented at APA's 2001 annual meeting in New Orleans. APA produced the publications with funds administered by the American Psychiatric Foundation.





Psychiatrists who specialize in the treatment of Alzheimer's disease will find "Psychosis of Alzheimer's Disease: New Knowledge, Developing New Treatment Strategies" a good review for topics such as the psychosis of dementia, the efficacy of antipsychotic agents, the effects of psychoactive medications, and practical strategies for treating psychosis due to dementia.

The second program, "Chemical Restraints: Clinical, Research, and Ethical Implications," describes strategies for preventing psychological trauma following forced medication, long-acting injectable antipsychotics (an alternative to forced medication), historical legal trends and civil liberties related to forced medications, and dealing with the new legal framework for chemical restraints.

Both programs are supported by an unrestricted grant from Janssen Pharmaceutica Products.

Physicians who participate in these programs and wish to receive CME credit can submit a posttest and evaluation form to earn up to one hour of Category 1 credit per course. The CME self-test and evaluation for "Psychosis of Alzheimer's Disease" must be received by March 31, 2004, and for "Chemical Restraints," April 30, 2004. There is a $10 fee for members and a $15 fee for nonmembers for submitting the CME posttest and evaluation.

"APA is pleased to be able to provide wide distribution to our members of high-quality presentations from the annual meeting," said James Thompson, M.D., director of APA's Division of Education, Minority, and National Programs. "These presentations are among the most popular parts of the meeting and contain a great deal of 'cutting-edge' information for the practicing physician. Already, we have received numerous requests for CME credit for these educational materials. We're very pleased that they've been so well received by APA members."

The Clinical Highlights program makes sure members can access the series through a variety of learning media such as monograph, CD-ROM, Internet, and audiocassette.

The Clinical Highlights program draws on data from APA's biennial membership needs assessment, as well as annual meeting evaluation data and other CME programs. This is done to ensure that members are getting current and relevant information presented to them in a style that best suits their learning needs.

All editions in the Clinical Highlights series, including the two new ones, are sent to APA members without charge. PDF versions of the Alzheimer's and chemical restraints programs can be downloaded from the APA CME Web site at <www.psych.org/cme>. In addition, physicians can download PDFs of other Clinical Highlights editions, which are supported by Cephalon Inc. and Ortho-McNeil. ■

Laura Budash is the CME program coordinator in the APA Department of Continuing Medical Education.

District Branch Celebrates Golden Anniversary

The Psychiatric Society of Westchester, a district branch of APA, celebrated its 50th anniversary in late May at the Siwanoy Country Club in Bronxville, N.Y. During the evening's festivities, **Maria Tiamson, M.D.** (right), the society's incoming president, presented a certificate of appreciation to outgoing president **Jeffrey Smith, M.D.** The anniversary celebration also included a dinner dance, a silent auction, and an exhibit titled "Psychopharmacological Progress Over 50 years." The 50-year fellows were honored, as were the members-in-training of the district branch.The proceeds of the silent auction will help support the society's educational and public affairs activities.

history notes

APA and ABPN: The Beginnings

BY LUCY OZARIN, M.D., M.P.H.

Many of today's psychiatrists have passed through the rite of "taking the boards," a process marked by intense preparation and the stress of taking oral and written examinations. Today the examination, administered by the American Board of Psychiatry and Neurology (ABPN), is an integral part of a psychiatrist's education, but its origins 70 years ago were controversial and acrimonious.

In 1928 Dr. Adolph Meyer, in his presidential speech to the APA membership, proposed the creation of a diploma in psychiatry. "The fate of progress depends on minimal standards," he said in recommending that intensive training should lead to the rewarding of a diploma for special proficiency. Qualifying boards in some medical specialties already existed in Great Britain and in the United States. They had been established in ophthalmology (1916) and otolaryngology (1924), and boards in obstetrics and gynecology (1930) and dermatology (1932) came after Dr. Meyer's speech.

For several years after Dr. Meyer's proposal, APA took little action on the matter, although a committee had been appointed to investigate certification. Meanwhile in 1932 the New Jersey Medical Society had begun a state program of specialty certification. Interest was shown by the AMA's Section on Nervous and Mental Diseases and the National Committee for Mental Hygiene (NCMH). Finally, in his APA presidential address in 1933, Dr. James May said that either APA would have to take action on establishing certification or others would make the decision for psychiatry.

Three organizations agreed to meet: APA, the American Neurological Association, and the AMA's Section on Nervous and Mental Diseases, with input from the NCMH. The meetings were controversial. Should psychiatry and neurology have a single board or separate boards? The decision for a single board seemed advisable since the American Neurological Association had limited funds and members. And what should the board be called—should psychiatry or neurology be named first?

The American Board of Psychiatry and

please see ***History Notes*** *on page 26*

Teens Thinking Less of Suicide Yet Continue to Engage in Risky Behavior

Although fewer teenagers in this country are considering suicide than they were a decade ago, teens are still putting their lives at stake by engaging in a number of risky behaviors.

BY EVE BENDER

While suicidal ideation in young people has decreased over the past decade, they are jeopardizing their lives by engaging in other types of reckless behavior, according to the 2001 Youth Risk Behavior Surveillance System report, released in late June.

The study, conducted by researchers at the federal Centers for Disease Control and Prevention (CDC), reveals trends in the extent to which high school students engage in risky behaviors. The study, which the CDC has conducted every other year since 1991, measures how often teens considered or planned to commit suicide, used drugs and alcohol, fought with peers, carried weapons, and engaged in sexual intercourse, among other behaviors.

The CDC report concluded that "too many high school students nationwide continue to practice behaviors that place them at risk for serious acute and chronic health problems."

In 2001 researchers received 13,601 completed surveys from high school students in 150 randomly selected schools across the nation. The data are representative of all high school students nationwide.

Researchers analyzed the students' responses and compared them with those from past years and found that some unhealthy behaviors have decreased in number over the past decade, while others have increased (see graph on page 1).

One piece of good news that emerged is that teens are thinking about and planning suicide less frequently than they were a decade ago. The percentage of teens who seriously considered suicide dropped 10 percent since 1991—from 29 percent to 19 percent in 2001.

About 19 percent of teens actually planned to attempt suicide a decade ago, and this figure dropped slightly to 15 percent last year.

In addition, the number of teens who carried a weapon (defined as a gun, knife, or club) dropped from 26 percent in 1991 to 17 percent in 2001. While 43 percent of high school students engaged in physical fights in 1991, 10 percent fewer students did so in 2001.

Risky sexual behavior is also on the decline. The percentage of students who ever had sexual intercourse decreased from 54 percent to 46 percent in the past decade, and the percentage of those who had four or more sexual partners decreased from 19 percent to 14 percent of the sample at large.

The study also tracked drug use over the past decade. Researchers found that usage rates of certain drugs have fluctuated. For instance, the percentage of teens who used marijuana at least once in the preceding month rose from 15 percent to 26 percent from 1991 to 1997, and then dropped slightly to 24 percent by 2001. Cocaine use rose from 5.9 percent in 1991 to a little over 9 percent in 2001.

Researchers also ascertained the percentage of teens who used inhalants (15 percent), heroin (3 percent), methamphetamines (10 percent), and steroids (5 percent) but had no comparison data from 1991 since survey questions about these drugs were not asked then.

The percentage of students who had five or more alcoholic drinks within a couple of hours on one or more occasion during the past month has remained constant between 1991 (29 percent) and 2001 (30 percent).

The data from the bienniel survey is used by legislators and policymakers to improve policies and programs that reduce health risk behaviors in teens. The data are also used to measure progress in achieving the national health objectives set by the Department of Health and Human Services in 2000 in its Healthy People 2010 prevention agenda (*Psychiatric News*, January 1, 1999). The agenda lists 467 national health-related objectives to lengthen the lives of Americans and improve their quality of life.

Some of the objectives address reducing drug abuse, physical fighting, and the carrying of weapons by adolescents, for instance.

The results of the Youth Risk Behavior Surveillance Survey are posted on the Centers for Disease Control and Prevention's Web site at <www.cdc.gov/nccdphp/dash/yrbs/info_results.htm>. ■

Analysts Ponder Presence Of ESP and How It Works

Some psychoanalysts wonder whether they have experienced ESP with patients. They also wonder how it might work.

BY JOAN AREHART-TREICHEL

Several years ago, moviegoers may recall, something quite extraordinary occurred in a gracious brown mansion in Philadelphia. A young boy attending a birthday party in the mansion had a paranormal experience that terrified him.

Yes, this was a scene from the movie "The Sixth Sense," and the mansion where the scene was shot still stands on the corner of 22nd and Green streets in Philadelphia.

Thus, it is probably appropriate that only a few blocks away from this mansion some psychoanalysts got together recently to discuss ESP. They were attending the annual meeting of the American Psychoanalytic Association, which was held in Philadelphia's Wyndham Plaza Hotel in May.

The discussion group, titled "Intuition, Unconscious Communication, and Thought Transference," got off to an awkward start. Some 30 psychoanalysts trooped into a large room in the hotel that had been designated for the group and sat down at the long banquet table in the room. One participant quipped that if they were going to be able to communicate with each other under such unwieldy circumstances, they were certainly going to need ESP! However, the chair of the discussion group, Elizabeth Mayer, Ph.D., a psychoanalyst from Berkeley, Calif., circumvented that need and had the participants group themselves at only one end of the banquet table.

"There may be some of us in this room who do not believe that such things as ESP can happen," Mayer challenged her colleagues. But a number of experiments support it, she pointed out. For instance, one researcher arranged for some 1,000 subjects to be called at unexpected times over several weeks either by friends or by strangers. The subjects guessed significantly more often when friends rather than strangers were calling them, suggesting that some form of ESP was occurring between them and their friends. Another investigator found that nursing mothers experienced let-down reflexes at the times when their infants, several miles away, experienced accidents or other mishaps. In another study, youngsters guessed significantly more often when they were being stared at than when they were not.

Also, Mayer continued, "I have found that many scientifically trained people have had an experience along the lines of ESP that they cannot explain. And I have, too."

Some of her experiences, she said, have occurred with patients. For instance, a patient once told Mayer that she had dreamed that Mayer was going to Arizona. "That is amazing!" Mayer said. "I *am* going to Arizona. How did you know?" The patient replied, "I have dreams like this a lot, and they terrify me." Mayer said that as far as she knew, she had given the patient no clues that she was planning to go to Arizona.

Another psychoanalyst reported that he too had what seemed to be an ESP experience with a patient. One evening, following a session with a depressed patient, he dreamed that someone committed suicide. The patient's roommate called him shortly after to tell him that the patient had tried to kill herself. The patient's diary later revealed that she had been planning to commit suicide when she visited him, but as far as he could tell, she had not given him any indication of it.

Yet if ESP can truly occur between two people, and especially between analyst and patient, how might it occur? "We need a scientific explanation for how this happens," asserted Sydney Pulver, M.D., a Philadelphia psychoanalyst. "But I do not know where we are going to find it."

When monks meditate, the parietal lobes in their brains are especially active, Mayer pointed out. So perhaps the parietal lobes are involved in ESP, she speculated.

In fact, Mayer suggested, perhaps analysts can cultivate a state of mind that allows ESP-type communication between analyst and patient, and that such cultivation might consist of meditating a few minutes before seeing a patient. "After all," Mayer asked, "isn't the analytic mind a quiet state of mind?"

To which another analyst replied: "Yes, and in the process we get closer to the patient."

Mayer also suggested that analysts start collecting anecdotal evidence about their ESP experiences with patients. "I think it would be good for our field if people well established in it pulled such data together," she asserted.

Another analyst took issue with this idea, however. "That clarity of consciousness that occurs on a good day between analyst and patient is certainly of interest. But if we really take this up as a *cause célèbre*, it is going to hurt our reputations as analysts since analysts have a fringe reputation already."

To which Mayer replied: "I disagree. I think we could have a dialogue with physicists about it."

"I don't think modern physics can explain ESP," Pulver commented. ■

New Class of ADHD Drugs Awaits FDA Approval

A new medication option for ADHD is awaiting final FDA approval, and in some ways it looks almost too good to be true. If the data are verified, it could be a major treatment advance.

BY JIM ROSACK

What more could you ask for? A medication that effectively and safely relieves many of the symptoms of attention-deficit/hyperactivity disorder (ADHD) and is not a stimulant shows little potential for abuse and can be given as a single morning dose to avoid the need for potentially stigmatizing dosing during school or work.

Eli Lilly and Company believes it has found all of that and possibly more in its new ADHD drug, atomoxetine. Lilly expects to gain approval from the U.S. Food and Drug Administration (FDA) in the first quarter of 2003 to market the drug for treatment of the symptoms of child, adolescent, and adult ADHD.

If approved, it would be the first drug approved for treatment of the disorder in adults.

The proposed trade name for the drug, pending FDA approval, is Strattera. The drug, which originally carried the generic name tomoxetine, had the leading letter 'a' added (at the suggestion of the FDA) to help avoid confusion with the cancer drug tamoxifen. According to Lilly research scientist Cal Sumner, M.D., atomoxetine is a highly specific inhibitor of the norepinephrine reuptake transporter, resulting in significant increases in availability of the neurotransmitter in brain synapses.

Current best-guess theory says that ADHD is a constellation of symptoms resulting from a "combination of norepinephrine and dopamine dysfunction," Sumner explained. "Actually, attention deficit is probably a huge misnomer. This is an organizational dysfunction of the brain, probably affecting multiple areas of the brain. And it is an enduring brain pathology with different signs and symptoms across the life span, depending on [a patient's] developmental stage, experience, and external support system."

For decades, the focus has been on stimulant medications such as amphetamines and methylphenidate. These medications, Sumner agreed, have been very useful in treating what he termed the "externalized symptoms" of the disorder—for example, the child who simply cannot sit still, bounces around the room, is impulsive, and is unable to focus and maintain attention—symptoms frankly observable by others.

"Atomoxetine came about as people revisited the point of view that if you could affect only norepinephrine," Sumner explained, "you might not only get the benefits that you see with the existing stimulant medications, but you might get them at less cost.

"When people ask me about the mechanism of action of this drug, I can easily tell them what the mechanism is. What happens after that initial action is where we start to get into a fuzzier area."

Because atomoxetine is a "fairly clean" norepinephrine modulator, Sumner believes that the drug is primarily impacting information before it even gets to higher organizational centers, allowing "better information" to reach those organizing centers in the brain. "We are also impacting the organizational centers themselves, modulating neurotransmitter function in the frontal cortex," which, he noted, impacts the pathology early on in the pathway of the neurotransmitter dysfunction.

"Atomoxetine improves the efficiency of organization and also improves some of the clarity of the brain's signals," Sumner said.

In clinical trial data submitted as part of the new drug application and presented at APA's 2002 annual meeting in Philadelphia in May, atomoxetine was associated with significant improvement in the core symptoms of ADHD, and surprisingly, said Sumner, appears to be equally beneficial in improving core symptoms in the inattentive subtype as well as the hyperactive/impulsive subtype. The efficacy appears to be as good in adults as it is in children and adolescents.

Studies have compared once-a-day dosing with twice-a-day dosing and found that once-a-day dosing is as effective as taking the drug twice a day. The new drug application lists once-a-day dosing, in the morning, with no requirement to take the medication with or without food.

In four short-term (fewer than 10 weeks) clinical trials in children, the only treatment-emergent side effects associated with atomoxetine that are different from those associated with placebo were headache and appetite suppression. In longer studies, appetite suppression has resulted in a mild decrease in weight upon starting the medication; however, over one year, children on atomoxetine showed no significant difference in trends on weight or height curves. In addition, the drug had no affect on sleep.

Atomoxetine does not appear to be associated with the adverse cardiac effects, such as hypertension and tachycardia, associated with other drugs that modulate norepinephrine (venlafaxine or certain tricyclic antidepressants, for example).

"We have a huge unmet need in the understanding of this disorder across the life span, as well as in understanding the impact of medication on this disorder," Sumner said. "But when something sounds too good to be true, you can just think of it as being true, or you can go back and double your efforts and find the holes in it."

Holes will undoubtedly appear, Sumner acknowledged, especially given the complexity and comorbidity associated with ADHD. While previous studies excluded patients with comorbidity, studies of patients with other disorders and ADHD are under way.

"At least we hope to find that comorbidities in patients with ADHD are not getting worse on atomoxetine," Sumner said. "And at best, we'll be able to say that not only is atomoxetine helpful for ADHD but for other symptoms as well." ■

High-Fat Diet May Affect Absorption Of Once-Daily ADHD Medications

What patients with ADHD eat for breakfast could drastically affect the day-to-day reliability of their medication, new research indicates.

BY JIM ROSACK

The absorption of the two long-acting medications used to treat symptoms of attention-deficit/hyperactivity disorder (ADHD) is differentially affected by the presence of food in the stomach, especially if that food is high in fat, according to a new study.

The data, reported in the July issue of *Current Medical Research and Opinion*, indicate that serum levels of methylphenidate in individuals taking the long-acting medication Concerta are not substantially different when the medication is taken with food or on an empty stomach.

In contrast, individuals in the study who took Adderall XR, an extended-release formulation of mixed amphetamine salts, displayed drastically lower early blood levels when taking the medication with food compared with taking it on an empty stomach.

The study was conducted by researchers at McNeil Consumer and Specialty Pharmaceuticals, which markets Concerta. Adderall is marketed by Shire Pharmaceuticals Group.

The study compared the effect of eating a high-fat breakfast on the absorption and distribution of a typical morning dose of each medication (36 mg of Concerta or 20 mg of Adderall) in 36 healthy adults. Breakfast consisted of eggs, buttered bread, bacon, hash-brown potatoes, and eight ounces of whole milk. Blood samples were taken 18 times over the ensuing 28-hour period. Subjects received either Concerta or Adderall following either an overnight fast or 15 minutes after eating the high-fat breakfast.

Blood levels of methylphenidate in subjects who received Concerta varied only about 3 percent between the fasting and post high-fat-meal dosings. Subjects who took Adderall after the high-fat meal, however, had on average a 55 percent decrease in their blood levels of amphetamine during the first four hours following dosing, compared with those who took Adderall after fasting.

When a drug's absorption is significantly affected by food intake, its label usually says it is best taken either one hour before or two hours after a meal. The current approved labeling for Adderall does not address any need to take the medication on an empty stomach.

Requests by *Psychiatric News* for comment about the data from Shire Pharmaceuticals Group were not answered by press time. ■

Can Antidepressants Lower Coronary Disease Mortality?

Just as many physicians have long suspected, research shows a link between affective disorders and heart disease—a link that just might dramatically affect survival.

BY JAMES ROSACK

Numerous studies have demonstrated that adding depression to existing cardiovascular disease significantly increases patients' chances of dying within five years of diagnosis. However, new research presented in May at APA's 2002 annual meeting indicates that adequate treatment of the patients' depression may significantly improve their prognosis.

The apparent link between heart disease and depression appears to be a two-way street. Recent studies have provided compelling evidence that otherwise healthy, middle-aged individuals with depression have an increased risk of developing ischemic heart disease compared with individuals without depressive symptoms. Indeed, one recent study documented that in some individuals even "mental stress"—not necessarily anxiety or depression—can trigger decreased blood flow to the heart, leading to ischemia. Individuals with stress-induced ischemia were three times more likely to die within five years compared with people without ischemia brought on by mental stress, the study concluded.

Similarly, those individuals who have known coronary artery disease (CAD) and suffer a heart attack or undergo coronary artery bypass surgery and then subsequently develop depression have been shown to have a worsened prognosis compared with those who do not become depressed, according to a review of related research. Studies have reported that around 20 percent of persons with coronary artery disease have depression that meets *DSM* criteria for major depressive disorder, and as many as 30 percent to 40 percent of patients with CAD have less-severe symptoms. Recently, researchers reported that in a study of more than 900 people with CAD, followed for a minimum of nine years, patient scores on the Beck Depression Inventory (BDI) were predictive of mortality over a five-year period. Anxiety, anger, and social support were found not to be predictive of mortality, but subjects with higher BDI scores had an increased risk of death that was 3.5 times greater than that of the subjects with low BDI scores.

"The crucial remaining question," said Alexander Glassman, M.D., a clinical professor of psychiatry at Columbia University, "is whether treating depression after a heart attack or stroke can decrease the risk of dying" from that event.

SADHART Established

Several years ago, Glassman and his colleagues set out to attempt to answer that question with SADHART—the Sertraline Antidepressant Heart Attack Randomized Trial.

"Our biggest initial problem was figuring out how large a sample size we'd need in order to show any effect," Glassman said at the annual meeting session. They wanted to establish the safety and efficacy of using an antidepressant in cardiovascular disease. To do so with enough power to detect any statistically significant differences, "we were looking at enrolling an absolutely huge number of subjects." The group settled on enrolling 200 patients in each arm of the prospective study, one group treated with sertraline (Zoloft) and the other treated with placebo.

"Previous work had been done with stable disease and things like Paxil and Prozac," Glassman noted, "but nobody had done anything with unstable cardiovascular disease."

Glassman coordinated a multicenter trial that eventually screened 11,500 patients who had suffered an acute myocardial infarction (MI). Slightly more than 3,300 met eligibility requirements with some symptoms of depression. The subjects had not sought treatment for depression and had generally mild symptoms. However, around 1,800 of those met criteria for major depression, and slightly fewer than 900 met the full inclusion/exclusion criteria. In the end, 186 were randomized to sertraline, and 183 were randomized to placebo for 26 weeks.

"There you see the relevance of statistical empowerment," Glassman said. "In order to end up with 200 patients in each arm of the study, we had to screen nearly 12,000."

The study used a measure of cardiac-pumping power to follow cardiac function following the MI and *DSM* criteria for depression to follow the patients' major depression.

The results, now available in preliminary form, Glassman said, were interesting—not quite what he expected, but very significant. Publication of the complete data from the trial is expected around the end of the year.

Three Groups Assessed

The researchers broke the subjects into three groups for analysis in each arm of the trial: those patients who experienced their first episode of depression following their MI, those patients who had one prior episode of depression, and those patients who had two or more episodes of depression that the researchers categorized as "severe" depression.

"Overall, response rates [for depression] were 66 percent for those taking sertraline and 53 percent for those on placebo," Glassman said. "But what is very interesting is when you look at response rates within the three different groups." For those patients with their first episode of depression, there was no statistically significant difference in the response rates between sertraline and placebo (59 percent versus 55 percent, respectively). With one prior episode of depression, the difference was very significant, 72 percent for those on sertraline versus 51 percent for placebo. And for the "severe" category, 78 percent of those taking sertraline were responders compared with 45 percent of those taking placebo.

"These results, though, were really tied to the recurrence of the depression, not necessarily to the severity of depression," Glassman noted. There were not statistically significant differences between higher versus moderate scores on the Hamilton Rating Scale for Depression.

The adverse-event profile also varied between the placebo and sertraline group, consistent with known side effects of the drug. The most common side effects were nausea and diarrhea.

Interestingly, the cardiac-complications profile also differed between the groups. "It looked like those taking sertraline had decreased risks for most major cardiac events," Glassman said, including risk of having another MI, arrhythmias, or sudden cardiac death. However, while these differences did not reach statistical significance, there was a consistent trend for those taking sertraline to have lower rates of death within the study period, as well as lower rates of severe chest pain, arrhythmias, and stroke.

"I suspect that if we had a larger patient base, we might have seen these reach statistical significance," Glassman noted, "but then we would have to have screened maybe 50,000 or 100,000 patients.

"In the end, what we saw was that sertraline was indeed safe and effective at treating recurrent depression following an MI, but not in first-episode depression." ■

Fine Line Separates Personality Quirks From Personality Disorder

What makes people tick? When do quirky personalities constitute personality disorders? And what can be done to help people with borderline personality disorder? An authority answers these questions.

BY JOAN AREHART-TREICHEL

Hundreds of psychiatrists attending APA's 2002 annual meeting in Philadelphia in May packed a large room to hear a lecture by a psychiatrist renowned for his knowledge of human personality.

The psychiatrist was John Oldham, M.D., director of the New York State Psychiatric Institute and chair of the APA work group that developed the Practice Guideline for the Treatment of Borderline Personality Disorder (*Psychiatric News*, August 3, 2001).

John Oldham, M.D., says a lot can be learned about personality disorders from the *New Yorker.*

Oldham warmed his audience up with the question: "What is the best journal of personality traits, styles, types, and disorders?" His answer: "The *New Yorker* magazine. I have a representative cartoon for every single one, and they are wonderful!" His audience broke into laughter.

The *New Yorker*, he continued, once ran a cartoon that showed a woman looking at her husband and asking, "Why are you the way you are?" This question, Oldham said, is of vital interest to psychiatrists. In essence, is personality inherited or is it acquired? "I think it is both," he declared. "It is both a bit of the way we are and a bit of something we get."

In short, personality is composed of both temperament and character, he explained. Temperament is the largely heritable contribution to personality; character is greatly impacted by life events. For instance, novelty seeking, harm avoidance, reward dependence, and persistence are temperament traits, moderately heritable, and probably not particularly influenced by environmental events, whereas self-directedness, cooperativeness, and self-transcendence are character traits that are mostly influenced by environment and only weakly, if at all, heritable.

So what is the difference between personality traits and personality disorders? "There is no bright line that distinguishes one from the other," Oldham stated. Nonetheless, just as both genes and environment undoubtedly contribute to healthy personalities, the same is indubitably true of unhealthy ones.

Personality disorders may be more widespread than most psychiatrists realize, Oldham continued. A study published last year of some 2,000 individuals in the community suggested that the overall prevalence of personality disorders may be as high as 13 percent. What's more, 2.4 percent of the subjects studied were found to have paranoid personality disorder, which "was surprising to me," Oldham admitted. "We think of schizophrenia as being a 1 percent disorder. We don't usually think of paranoid personality disorder as being twice as prevalent."

Even more of the subjects were found to have histrionic personality disorder or obsessive-compulsive disorder, and a surprising 5 percent were discovered to have avoidant personality disorder, he said.

True, borderline personality disorder does not seem to be as widespread as the above disorders, which afflicted about 2 percent of the population, Oldham said. Yet it is the personality disorder of paramount interest to psychiatrists because individuals with borderline disorder are often very disabled.

Borderline personality disorder, he explained, lies between the neuroses and the psychoses—"You will have periodic transient fuzziness or loss of reality, but you maintain reality testing overall," he said. Yet there are many different types of borderline disorder.

For instance,the affective type is moderately heritable and precipitated by environmental stress. The impulse dyscontrol type is also moderately heritable and triggered by stress. The aggressive type is due to a moderately heritable aggressive temperament and a reaction to early trauma. "Trauma is not inevitable in patients with borderline personality, but is common," Oldham said.

Then there are a fourth type—the dependent type—and a fifth type in which a person has chronic feelings of emptiness and identity disturbance. "You can readily see that this last type would be a very different type of borderline patient from the impul-

please see ***Personality*** *on page 29*

Discussion Groups Promise To Get You Talking

You never have to take a back seat at APA's fall meeting. Come to Chicago and share what's on your mind with the experts in an exciting series of discussion groups.

BY RICHARD BALON, M.D.

APA's 2002 Institute on Psychiatric Services (IPS), which will be held at the Palmer House Hilton in Chicago from October 9 to October 13, promises to deliver a very informative, interesting, and entertaining program. The institute has always been a forum for those interested in clinical and public psychiatry issues in the friendly and relaxing atmosphere of a small meeting.

One of the more popular formats has been the discussion groups. Discussion groups allow for lively debates of hot topics and controversial issues in clinical and public sector psychiatry. Each year the institute's Scientific Program Committee chooses prominent experts and mentors to lead the discussion groups. These experts guide attendees through dynamic, informed, and useful interactions. The discussion groups also include valuable contributions by the APA/Bristol-Myers Squibb Fellows and APIRE/Janssen Fellows. This year's topics and facilitators promise entertaining, at times controversial, and always interesting exchanges.

The first discussion group, on October 9 from 1:30 p.m. to 3 p.m., will be led by H. Steven Moffic, M.D., and Timothy Florence, M.D., and is titled, "How Can We Resolve the Ethical Challenges of Public Sector Managed Care?" Even health care experts and managed care proponents are starting to recognize that managed care has failed.

In the discussion group on October 10 from 1:30 p.m. to 3 p.m., Jeanne E. Greenblatt, M.D., M.P.H., and Jess Shatkin, M.D., will guide the audience through a discussion on "Models of Providing Child and Adolescent Psychiatric Services in Underserved Areas." This should yield useful insights and information at a time when child mental health care is being compromised by a serious child/adolescent psychiatrist shortage, a growing number of underserved areas, and limits on immigrant visas.

"Addressing Trauma in the Context of Ongoing Domestic Violence: Practice, Policy, and Collaboration," led by Paula Panzer, M.D. (chair of the institute's Scientific Program Committee), Carole Warshaw, M.D., Intikhab Ahmad, M.D., and Sata Chandragiri, M.D., will be another lively interchange on an important clinical and public mental health issue. This discussion group will be held October 11 from 3:30 p.m. to 5 p.m.

"Unfunded Mandates: The Latest Challenge for Community Mental Health Clinics" will be led by Julia Eilenberg, M.D., and Jennifer Coffman, M.D., on October 12 from 10 a.m. to 11:30 a.m. With most states facing serious budget cuts, this discussion will be helpful to many.

"Psychoeducation: Liability or Asset?" will be held October 12 from 1:30 p.m. to 3 p.m. Larry S. Baker, M.Div., Karen Landwehr, M.C., Katherine Watkins, M.D., and Alison M. Barnes, M.D., will address an important clinical issue in the management of severely mentally ill patients, the usefulness of psychoeducation.

Other discussions groups include "Leading Large-Scale System Change, Confidentiality in Psychiatric Treatment: HIPAA and Beyond," led by APA President Paul Appelbaum, M.D., and "Mental Health in Corrections," led by the president of the American Association of Community Psychiatrists, Jacqueline Maus Feldman, M.D.

All discussion groups will offer a great opportunity to exchange ideas with experts and leaders in the field and with colleagues in a comfortable, relaxed setting, appropriate for conversation, debate, discussion, and opinion exchange.

Mark your calendar to attend the 2002 institute and participate in its exciting, timely, and controversial discussions in the hospitable and friendly city of Chicago. Registration information appears below. ■

Dr. Balon is vice chair of the Scientific Program Committee of the 2002 Institute on Psychiatric Services.

Register Now!

There are two easy ways to register for APA's Institute on Psychiatric Services, which is being held in Chicago October 9 to 13:

- Register online on APA'S Web site at <www.psych.org/sched_events/ips02/index.cfm>
- Request a preliminary program from the APA Answer Center at (888) 357-7924. The program contains hotel information and registration forms.

Save on fees by registering before September 9.

apa institute

Want to See Real Chicago? Then Hop on the El!

APA members will be coming to Chicago in the fall for one of the Association's premier educational meetings, but it's also a good time to get an insider's view of one of the country's leading cities.

BY MARK MORAN

APA members visiting Chicago for this year's Institute on Psychiatric Services can count on plenty of the usual fare—bus tours and boat rides—to see the town.

But one of the best and cheapest ways to get an introduction to Chicago (at least its North Side and downtown) is to take a ride on the Ravenswood Elevated train. For three years, when I lived in Chicago, I commuted downtown by catching the Ravenswood El (also known as the Brown Line) at Addison. While it was for me—as for thousands of daily commuters—principally a way to get to work, it was also an inspiring, daily reminder of the vastness and variety of the city.

And when visitors who wanted a relaxing way to get a feel for Chicago but who didn't have time for lengthy tours (or the patience for city traffic), I always told them to hop the Ravenswood line.

APA members staying at hotels in or near downtown will find stops at the Merchandise Mart or any of several stations in a circular path around "the Loop." Traveling north, the Ravenswood intersects with other train lines for easy access to North Side landmarks, restaurants, and parks.

As the editors of *Sweet Home Chicago: The Real City Guide* (Chicago Review Press, 1993) note, a ride on the Ravenswood El is not unlike taking a double-decker tour bus in London—but without the tour fee. For the price of a CTA fare card ($1.50) you can conduct your own tour, with a vista of the city both east and west, riding above the noise and traffic of the city.

The *Real City Guide*, taking the reader on a ride from north to south, captures it well: "Starting out at almost any station on the North Side, you'll pass blocks of typical Chicago residential streets. Loop-bound between Belmont and Armitage, the buildings get increasingly elegant; the view in both directions at the Armitage stop shows gracious two-flats with ornamentation just about at eye level. Looking forward, you get a good glimpse of the approaching Chicago skyline, with the John Hancock building off to the left and the Sears Tower straight ahead. Between the Armitage and Sedgwick stops, the track takes a few twists and turns, so you get a little roller-coaster action along with the sightseeing experience."

The track straightens and heads south after Sedgwick, with the River North gallery district immediately ahead, Old Town and the high-priced Gold Coast to the left, and the Cabrini-Green housing project to the right. After the Chicago stop, the train heads straight for the mammoth Merchandise Mart.

"Above the broad brick expanse of the mart you'll see a sliver of green glass, the 333 West Wacker Building, and on top of that hovers the Sears Tower. Three generations of Chicago architecture in a single slice."

And then, as the *Real City Guide* notes, comes the best part of the ride: crossing the Chicago River into the urban canyon that is the Loop. On a bright day, with the sun illuminating the bridges and buildings, the view of the river from the train can be truly impressive. To the left are the twin towers of Marina City (known locally as the corn-cob towers), one of the city's distinctive landmarks. To the right, 333 Wacker reflects the river's gentle curve.

Once in the Loop, the train makes a turn east at Van Buren and passes the Harold Washington Library. To the left along Van Buren are two venerable old Chicago office buildings, the Fisher and the Monadnock. The train loops back north on Wabash Avenue, where it runs close enough to the buildings to allow visitors a peek inside the windows. (Mystery readers take note: the fictional Chicago private eye V.I. Warshawski, the leading character in dozens of novels by author Sara Paretsky, has her offices somewhere in here.) Heading back west on Lake Street, the train passes the Chicago Theatre on the left and the State of Illinois Building.

Then, it's back over the river heading north again. ■

Find Your Voice in APA

The APA Special Caucus Program Was Designed for You

The APA Caucus Program was developed by members, for members to explore and focus on concerns and challenges in special practice settings. Through twice-yearly meetings, list serves, and newsletters, the caucus program offers an opportunity for practitioners to come together and share information. Six caucuses report to the Council on Social Issues and Public Psychiatry—for psychiatrists working in state hospital, VA, rural, and correctional settings and psychiatrists who treat patients with mental retardation and developmental disabilities and those with eating disorders. The Caucus for Psychiatrists Treating Patients Covered by Managed Care reports to the Council on Healthcare Systems and Financing.

All seven caucuses will meet during APA's Institute on Psychiatric Services in Chicago. Participants do not have to be registered for a caucus to attend a caucus meeting; however, one must be an APA member to join a caucus.

All meetings will be held at the Palmer House Hilton.

Friday, October 11

8:30 a.m.-11:30 a.m.
Caucus of State Hospital Psychiatrists
Salon V, Third Floor

2 p.m.-5 p.m.
Caucus of VA Psychiatrists
Salon III, Third Floor

Saturday, October 12

8:30 a.m.-11:30 a.m.
Caucus of Rural Psychiatrists
Salon V, Third Floor

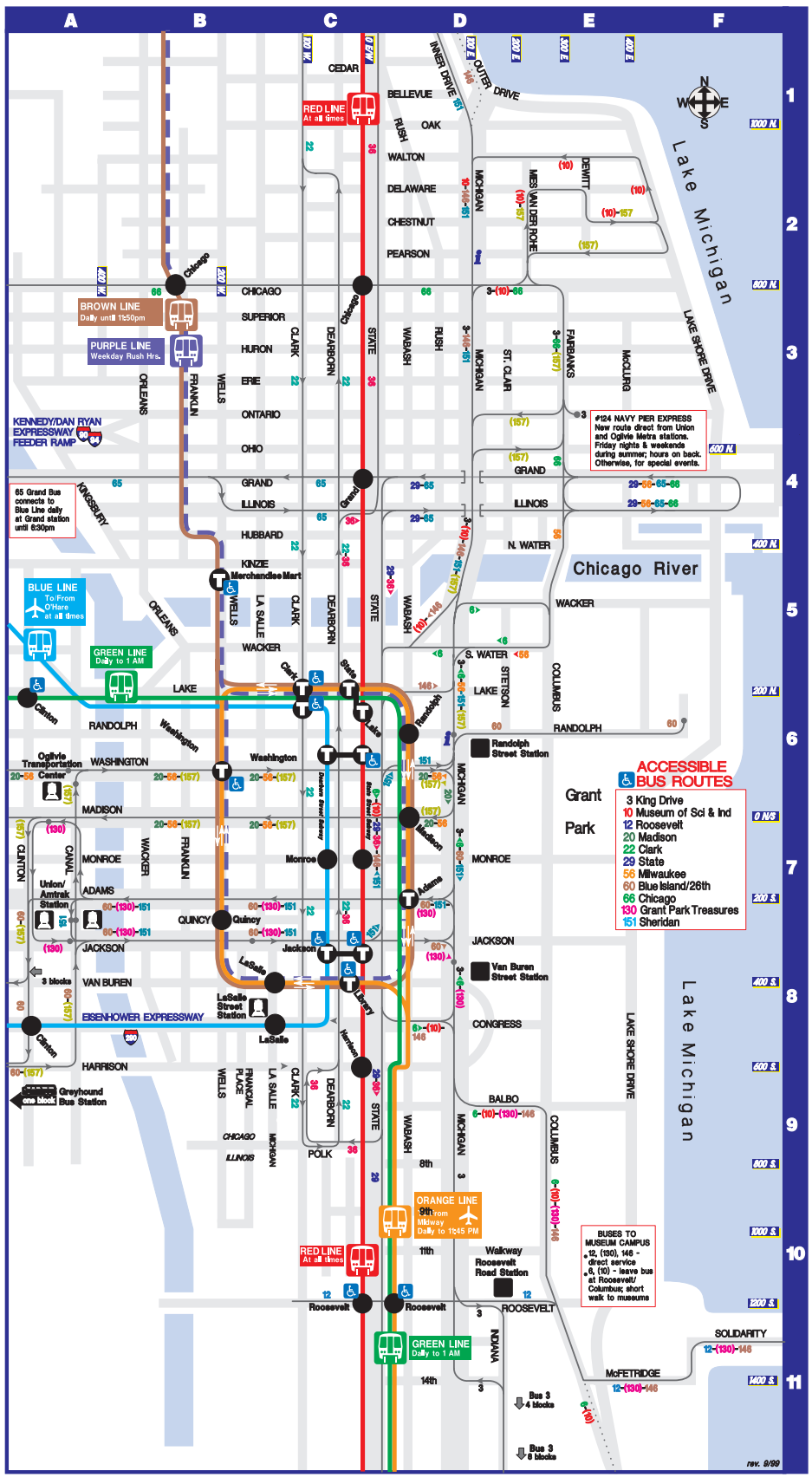
10 a.m.-11:30 a.m.
Caucus for Psychiatrists Treating Persons With Eating Disorders
Cresthill Room 11, Third Floor

1:30 p.m.-3 p.m.
Caucus of Psychiatrists Treating Patients Covered by Managed Care
Salon III, Third Floor

2 p.m.-5 p.m.
Caucus for Psychiatrists Treating Mental Retardation/Developmental Disabilities
Cresthill Room 11, Third Floor

Caucus of Psychiatrists Practicing in Criminal Justice Settings
Salon V, Third Floor

More information on the State Hospital, VA, Rural, Correctional, Eating Disorders, or MR/DD caucuses is available from Chris Druhan at (202) 682-6092; more information on the Caucus of Psychiatrists Treating Patients Covered by Managed Care is available by contacting Karen Sanders at (202) 682-6108.



JANSSEN RISPERDAL

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letters to the editor

More to the Story

The article "Serotonin Receptors Offer Clue to Teen Suicide Risk" in the May 3 issue underscores the finding of increased serotonin-receptor density in the prefrontal cortex of teenage suicidal victims, as also occurs in adults. This is an important finding.

Neither the reporter nor Ghanshyam Pandey, Ph.D., however, hook this up with the established fact of lower levels of 5-hydroxy-indole acetic acid, a metabolic product of serotonin, in the cerebral spinal fluids of victims of violent suicide. An up-regulation of 5HT receptors would be expected in a serotonin deficit.

Other clinicians and I have discovered that specific serotonin reuptake inhibitor antidepressants often ameliorate both irritability and impulsivity in patients who may be exhibiting no other clinical signs of depression, including personality-disordered patients.

The findings of the study, therefore, bear important implications for treatment planning. One wonders, indeed, what might be the prefrontal 5HT receptor density in patients suffering from personality disorders. Might these disorders be, in part, adaptations to lifelong depressive disorder?

FRANCIS J. DURGIN, M.D.
Fayetteville, N.Y.

Better System for Future?

This communication was stimulated by the headline on page 2 of the May 17 issue: "Angry Response Follows Appointment of Psychologist to Head Yale Center."

As I look back on my decades in medical education, I recall medical school quotas for women, African Americans, and Jews. After correcting those, a historical relic was that to do psychotherapy in the United States, one had to be a licensed physician. There were a few exceptions, such as distinguished products of European psychoanalytic education, which credentialed nonphysicians. The only other exceptions were psychologists who conducted testing and social workers who were employed by clinics and a handful of enterprising physicians for what was called casework. It was not uncommon that those professionals performed psychotherapy under the supervision of the physician.

This was the era when intravenous punctures had to be done by physicians; nurses not permitted. Hence, if an intravenous needle got out of vein in the wee hours of the morning, the intern had to be awakened to reinsert it. (I won't burden you here with my grateful stories of experienced, thoughtful nurses who made a deal with me that they would let me sleep and reintroduce dislodged needles providing I took responsibility if complications ensued.)

Change began in the 1960s with the report of the Joint Commission on Mental Illness and Health, which had been created by Congress and encompassed 36 organizations. The process of change was slow in evolving eventually to where the landscape is littered with nonphysician psychotherapists. Indeed, psychiatry residencies debate whether and the extent to which residents should have learning experience in psychotherapy.

I predict that eventually the inherent irrationality of today's medical-education hierarchical systems at various levels of expertise will be replaced by interlocking systems of permeable hierarchies of competence and certification.

SAUL I. HARRISON, M.D.
Marina Del Ray, Calif.

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.

Opinions expressed in letters do not necessarily reflect the views of APA or the editors. Clinical opinions are not peer reviewed and thus should be independently verified.

history notes

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Neurology was established in 1934, and the first examination was held in 1935. There were 31 applicants. Nine were certified in both psychiatry and neurology, 10 in psychiatry alone, and two in neurology alone; 10 failed.

Controversy again erupted in 1970 when the ABPN abolished the internship incorporating six months of general medical experience within a four-year psychiatry residency. Despite opposition from chairs of psychiatry departments and the APA Assembly, the decision remains.

In an anecdotal history, Dr. Francis Braceland (a psychiatrist and secretary of the ABPN from 1947 to 1951) wrote that during the early years, the neurologists made several unsuccessful attempts to establish a separate board. The psychoanalytic groups made a serious bid to become a subspecialty within the board, but after several years of discussion and disagreements, they withdrew the request.

Other groups within psychiatry and neurology began to press for subspecialty certification. In 1960 the first examination in child and adolescent psychiatry was held, and an examination for child neurology followed. Since then, subspecialty certificates for diplomates in psychiatry were added for addiction psychiatry, clinical neurophysiology, forensic psychiatry, geriatric psychiatry, and pain management.

As of 2000, the ABPN has granted 37,967 certificates in psychiatry and 9,745 in neurology.

Today the ABPN consists of 16 members. The nominating organizations for psychiatry are APA, American College of Psychiatrists, and the AMA; for neurology, they are the American Neurological Association and the American Academy of Neurology. Each of these organizations proposes nominees to serve on the ABPN. The ABPN is independently incorporated. ■

AMERICAN PROFESSIONAL AGENCY P4C

Bullying

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lying, along with CSA member Mary Anne McCaffree, M.D., a pediatrician from Oklahoma. AMA staff member James Lyznicki, M.S., M.P.H., assisted the council members in preparing the report.

Carolyn Robinowitz, M.D.: "Bullying is a sign of potential psychiatric illness, in both the bully and the victim."

Implications

"There were several implications for physicians that were important to have in the report," Robinowitz told *Psychiatric News*. "First of all, bullying is a sign of potential psychiatric illness, in both the bully and the victim. We know from our literature review that bullies have a significant incidence of physical and emotional abuse in their past and that they have a higher incidence of adjustment and conduct disorders, and bullying could be a sign of more severe disorders as well.

"Second, we know that bullies are more likely to have long-lasting psychiatric consequences" from their bullying behavior.

Robinowitz added that victims often develop anxiety and depressive disorders as a result of traumatization. "But it is important to note that bullying may not be the standard physical form that everyone thinks of; it is often combined with psychological bullying and can be harder to detect if it is occurring only on the psychological level," she explained.

Another significant implication for physicians, she noted, is that teachers, caregivers, and often parents are slow to pick up on signs and symptoms of bullying, relying somewhat on the old thinking that "kids will be kids," often with disastrous outcomes. That makes the issue all the more important for physicians to be aware of, so they can identify signs and symptoms early on and try to prevent further damage from occurring, Robinowitz said.

"I am pleased that the problem of bullying is finally receiving increased attention," APA Trustee-at-Large David Fassler, M.D., told *Psychiatric News*. Fassler, the AACAP delegate to the AMA, was one of the authors of the original resolution asking the AMA to conduct the study.

"As psychiatrists," Fassler continued, "we treat both children and adults whose lives have been devastated by the trauma of bullying."

The full report, which was adopted by the House of Delegates without amendment, concludes that the complex behavior of bullying involves a pattern of repeated aggression with a deliberate intent to harm or disturb a victim despite apparent victim distress, and a real or perceived imbalance of power allowing the more powerful child (or group of children) to attack a physically or psychologically vulnerable victim.

"It is important to note that bullying may not be the standard physical form that everyone thinks of."

Recommendations

"Efforts to prevent or reduce bullying," the report states, "require involved and motivated parents, school administrators, teachers, and other adults with a positive interest in addressing the problem."

Firm and clear limits for unacceptable behavior, elimination of risk factors promoting bullying, and clearly defined consequences for bullies are also absolutes, according to the report. The report then outlines a series of six recommendations for physicians and the AMA to help combat bullying (see box above.)

"While we know there are no simple solutions, the report highlights promising intervention and prevention initiatives," Fassler noted. "The conclusions and recommendations will also enhance public awareness of the issue and help encourage ongoing research into the causes and consequences of bullying."

The report on bullying is awaiting publication in the* Journal of the American Medical Association, *after which the complete text will be available on the AMA's Web site. A summary of the conclusions and recommendations is posted at <www.ama-assn.org/ama/pub/article/2036-6398.html>. ■

AMA's Recommendations on Bullying

The report on bullying that the AMA adopted in June contains the following conclusions and recommendations:

- The AMA recognizes bullying as a complex and abusive behavior with potentially serious social and mental health consequences for children and adolescents.
- The AMA will advocate for federal support of research to develop and test programs to prevent or reduce bullying.
- The AMA urges physicians to be vigilant for signs and symptoms of bullying and screen for psychiatric comorbidities in at-risk patients.
- The AMA will advocate for federal, state, and local resources to increase the capacity of schools to provide safe and effective educational programs by which students can learn to reduce and prevent violence.
- The AMA will advocate for expanded funding for programs for assessment, consultation, and intervention services for bullies and their victims.
- The AMA urges parents and other caretakers of children and adolescents to be actively involved in their child's school and community activities and teach children how to interact socially, resolve conflicts, deal with frustration, and cope with anger and stress.

Medicaid

continued from page 1

medication after release from a hospital. Callers could identify the health problem of the patient. The category with the problem most often identified was mental health/neurological, with 62 mentions.

Ninety-five medical personnel called the hotline. More than half of them cited as a primary complaint problems related to the time required to seek authorization and confusing administrative procedures.

One health care professional said, "Most of our patients are on psychotropic drugs. We now have to get approval for these from Medicaid HMOs. It's like a circus with this stuff, going around and around in circles, trying to find out who is supposed to be responsible for preauthorizations."

Geralyn Lasher, spokesperson for Michigan's Department of Community Health, told *Psychiatric News* that the program is working well and that there is no evidence of physicians refusing to treat Medicaid patients because of the new procedures.

She said that the program is generating about $800,000 in savings each week and that the number of prescriptions written has not declined.

Reinstein replied that many physicians do not understand the process by which a prescription can be judged medically necessary. "The state," he said, "has done a terrible job in making known to consumers and providers what their options are in terms of appeals."

Two MPS members, Oliver Cameron, M.D., Ph.D., and Jonathan Henry, M.D., commented on the formulary program to *Psychiatric News*.

Cameron, a professor of psychiatry at the University of Michigan and a member of the state's pharmacy and therapeutics committee, said, "My sense is that the preferred drug list has expanded and improved somewhat as a result of negotiations and might be 'workable.' However, serious problems persist with the administrative aspects of the program."

Henry, medical director of the Clinton-Eaton-Ingham Community Mental Health Board, said that the cost savings claimed by the state do not reflect the real costs of the program.

"The medical directors of the community mental health board uniformly report that their nursing staffs are bogged down with the paperwork required for prior authorization," he said. That stress on staff could be exacerbated by projected layoffs in the Medicaid program.

Efforts to rescind or modify the drug formulary program are taking place at several levels, according to Reinstein.

The MHA in Michigan has issued a series of reports on problems identified by the hotline, including excerpts of comments from patients. According to the July 2 *Wall Street Journal*, as a result of those reports, one "powerful early backer of the drug list," Sen. Alma Wheeler Smith (D), said that she plans to support a bill to gut the program.

Reinstein commented that although such a bill had not yet been introduced, another bill (S 1193), which codifies procedures for drug utilization, offers opportunities for advocates to add language that would improve administration of the drug formulary.

The MHA of Michigan, MACED, Alliance for the Mentally Ill of Michigan, and Michigan Protection and Advocacy Service Inc. filed suit in December 2001 in Ingham County Circuit Court to prevent implementation of the program.

The organizations charge that the method by which the program was passed by the legislature violates the state's constitution and that the state has no authority to insist upon rebates in addition to those mandated by the federal Medicaid law.

In his January 9 ruling, Judge Lawrence Glazer supported a third argument by the plaintiffs. He wrote, "The system of telephone appeals to a technician and then to a pharmacist and then to a physician, only during business hours, will undoubtedly result in delays in the dispensing of the medications [that] physicians judge to be medically necessary. . . .To me this constitutes irreparable harm to those patients who would be so affected."

On January 18 the Court of Appeals lifted the injunction issued by Judge Glazer. The decision is being appealed. Henry said, "If there is one macro-message I would like to get to your readers, it is that psychiatric societies must involve themselves as early as possible in the process of developing and implementing drug formularies." ■

from the president

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only a few of the many issues with which our delegation was actively involved.

Why does all this matter? Of what concern is it to us whether the AMA or state medical societies support the positions we take? The answer is that, if our advocacy efforts are to be something more than quixotic crusades, it is critical that we have the support of our colleagues in the rest of medicine. Psychiatrists represent somewhere between 5 percent and 10 percent of practicing physicians in the United States. When our efforts are reinforced by our medical colleagues, our strength is multiplied 10- to 20-fold. In some states with few psychiatrists and small APA district branches, the only effective advocacy voice for any part of the medical profession is the state medical society, and only with the help of our medical colleagues can we have any chance of success at all.

Moreover, the support of the rest of medicine is often essential for the credibility of our arguments. In New Mexico the district branch's opposition to psychologist prescribing was severely undercut when the state medical society—for inadequate reasons of its own—declined to oppose the psychologists' bill. What were New Mexico psychiatrists to respond when asked by the governor and legislators a question that went something like this: "If this bill would allow psychologists who are not properly trained in medicine to engage in medical practice, and thereby endanger patients as you say, then why is the state medical society not opposing it?" Even the assistance of the state's family practitioners, who stood with their psychiatric colleagues, was insufficient to overcome the setback associated with the defection of the medical society.

If this all makes sense to you, there are some very important things that you can do to reinforce the alliance between psychiatry and the rest of medicine. Indeed, only you can help us accomplish that goal. Join the AMA and your state medical society. There's nothing like having proportionate representation of each state's and the nation's psychiatrists in these groups to motivate them to fight for those issues of greatest importance to us. If you have the time, don't just be a member—be a vocal and active member. Write to your representatives in organized medicine to urge them to support issues affecting psychiatrists and their patients. Better yet, become one of those representatives yourself. The number of psychiatrists who are now or have recently been presidents of their state medical societies is a very heartening development and one that bodes well for the future.

Of course, we all face limits on resources and time. There are just so many dues bills we can pay, and just so many meetings we can attend. That is an argument, however, for making our dollars and our time count. I'd suggest to you that one of the best ways of doing that is by actively involving ourselves in the broader house of medicine. ■

clinical & research news

Personality

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sive, self-mutilative kind of patient," said Oldham. "Yet they are both quite diagnosable using our *DSM* prototypic method."

Psychiatric investigators are starting to get some brain-imaging and neurological information about persons with borderline personality disorder, Oldham reported. There seems to be a generalized reduction in frontal cortex metabolism, an abnormally small hippocampus, and a somewhat smaller-than-normal amygdala. There may also be a reduced integration of parietal lobe function with the rest of the brain. And persons with borderline disorders have an increased pain threshold, so that they do not seem to experience pain the same way that persons without the disorder do.

Psychiatric researchers are also learning some other interesting things about individuals with borderline personalities, Oldham pointed out. For instance, patients with borderline disorders use considerably more psychiatric residential treatment than do patients with schizotypal, avoidance, and obsessive-compulsive personalities or with major depressive disorder. The same goes for the use of medications. Also, about 8 percent of borderline patients eventually commit suicide, which is about 400 times higher than the general population. A surprising number, however, seem to do well over the long run (*Psychiatric News*, June 7).

"The core recommended treatment," he said, "is psychotherapy with adjunctive symptom-targeted pharmacotherapy. We don't recommend in the practice guideline one particular kind of psychotherapy but rather suggest that psychotherapy is the treatment of choice."

In doing psychotherapy with borderline patients, Oldham asserted, the therapist must take an active role, whether it is a cognitive-behavioral or a psychodynamic approach. "You can't just sit there quietly and say 'Ummm' whenever the patient says anything. . . .You need to say to someone, 'Look, if I had had your early life, and if I had been traumatized, as you clearly were, I understand how hard it would be to trust me, to trust anyone in the world. I think I would have the same kinds of feelings that you have. But the world isn't the same one you experienced when you were little. And people aren't going to expect you to treat them with the level of mistrust that you carry around with you. And you are going to have to learn to remember that and act differently, whether you feel like it or not.' "

Oldham concluded, "We can't treat these patients quickly, whatever the managed care organizations would like to say. [Yet] if we keep them in treatment for a reasonably substantial period of time, we think that there is a persuasive case that they will do better, and many of them will respond very well." ■