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"see" references appear on pages 1, 2, 5, 8, 9, 16, 21, 26

Candidates Explain Stance On Mental Health Issues

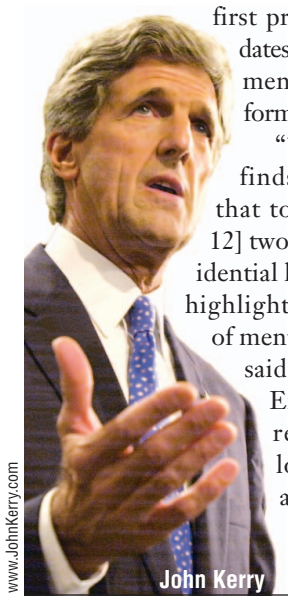
The first of an occasional series on the mental health agendas of presidential candidates, this article focuses on policies supported by Democrats Howard Dean and John Kerry.

Government News

BY CHRISTINE LEHMANN

The Campaign for Mental Health Reform, a coalition of diverse mental health groups including APA, commended Gov. Howard Dean (D-Vt.) and Sen. John Kerry (D-Mass.) for being the first presidential candidates to announce their mental health platforms.

"The campaign finds it heartening that today [September 12] two democratic presidential hopefuls chose to highlight the importance of mental health issues," said coordinator Bill Emmett in a press release. "For too long, the needs of adults and children with mental illnesses have been ignored. It is high time they became a national priority," said Emmett.


www.JohnKerry.com
John Kerry

The campaign's overall goal "is to make access, recovery, and quality in mental health services the hallmarks of our nation's mental health system."

The coalition works on federal policy issues, and its members include the Judge David L. Bazelon Center for Mental Health Law, National Mental Health Association, and National Association of State Mental Health Program Directors.

Dean, an internist, presented his mental health agenda during a speech at the Dartmouth-Hitchcock Medical Center in Lebanon, N.H. Kerry, who has a law degree, released his agenda while the Senate was in session.

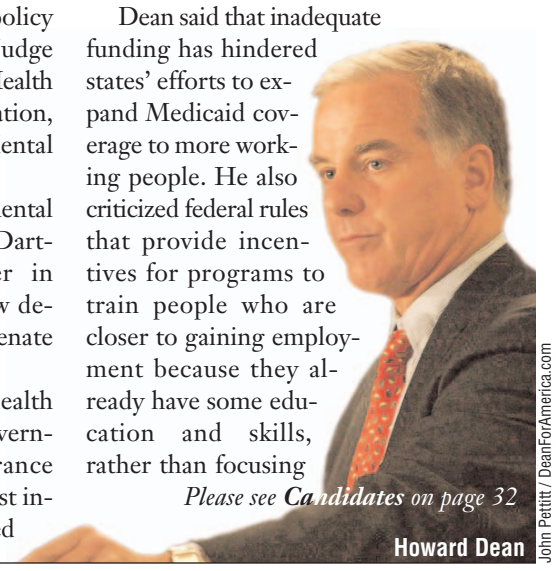
Dean supports parity for mental health insurance coverage. "The federal government should prohibit private insurance companies from discriminating against individuals with mental illness," he stated on his Web site under "mental health reform."

Kerry promised to continue to advocate for "full mental health parity once and for all" in private and public health care insurance programs, especially Medicare.

Kerry supports reforming the Medicaid program. "It makes no sense that the Medicaid program prevents people from working and receiving health care at the same time," he said. He urged Congress to pass the Family Opportunity Act, introduced earlier this year in the omnibus Leave No Child Behind Act (S 448/HR 936). It includes provisions that allow people to keep their Medicaid benefits while working. He also favors expanding Medicaid coverage of community-based care.

Dean said that inadequate funding has hindered states' efforts to expand Medicaid coverage to more working people. He also criticized federal rules that provide incentives for programs to train people who are closer to gaining employment because they already have some education and skills, rather than focusing

Please see ***Candidates*** *on page 32*


John Pettitt / DeanForAmerica.com
Howard Dean

Clinical & Research News

FDA to Require Diabetes Warning On Antipsychotics

Choosing to sidestep the issue of differences in weight gain among the different medications, the new warnings appear to put the entire class on equal footing for risk of diabetes.

BY JIM ROSACK

In a series of letters delivered in mid-September, the U.S. Food and Drug Administration (FDA) disclosed to makers of atypical antipsychotic medications that it will require each drug maker to relabel its product to include warnings regarding risk of hyperglycemia and diabetes mellitus.

Communications between the FDA and drug makers are usually considered privileged and proprietary—those considered to be sensitive are rarely disclosed. However, the receipt of the letters was made public by Eli Lilly and Co., maker of olanzapine (Zyprexa).

The makers of each of the other atypical antipsychotics, clozapine (Novartis's Clozaril), risperidone (Janssen's Risperdal), quetiapine (AstraZeneca's Seroquel), ziprasidone (Pfizer's Geodon), and aripiprazole (Bristol-Myers Squibb/Otsuka's Abilify) all confirmed to *Psychiatric News* the receipt of similar letters requesting the new warning language. None, however, was willing to make copies of its letter available.

The Lilly letter was disclosed in a press release and posted on the company's Web site.

The FDA letter to Lilly, signed by Russell Katz, M.D., director of the agency's Division of Neuropharmacological Drug Products, noted that "after reviewing the available data pertaining to the use of atypical antipsychotic medications and diabetes mellitus adverse events, we have concluded that the product labeling for all atypical antipsychotics should be updated to include information about these events."

The letter continued, "While we acknowledge that the relationship between atypical antipsychotic use and diabetes mellitus adverse events has not been completely described," the agency will require all atypicals to carry the broad new warnings (see box on page 26 for the agency's proposed language for the warnings). "Increased attention to the signs and symptoms of diabetes mellitus may lead to earlier detection and appropriate treatment and thus reduce the risk for the most serious outcomes," the letter advised.

The public release of the letter by Lilly was considered a bold move by pharmaceutical-industry analysts, who regarded the FDA warnings as controversial and having significant potential to alter prescribing patterns. Olanzapine, analysts noted, is tied to reports of weight gain and diabetes more

please see ***Diabetes*** *on page 27*

Candidate Chat Coming Soon

APA's Elections Committee is scheduling two Web chats on APA's Web site for members with the 2004 candidates for president-elect, Steven Sharfstein, M.D., and J. Srinivasaraghavan, M.D. (Ashok Van). The dates have not been set yet, but the first Web chat will occur during the first week of December, and the second during the third week of December. Details about the dates and times and how to access the chat room will be posted on APA's Web site and published in *Psychiatric News.*

Census Finds Insurance Crisis Continues to Grow in U.S.

Health Care Economics

The Census Bureau has reported the largest single increase in a decade in the percentage of Americans without insurance. Their plight puts more demand on a battered Medicaid program.

BY KATE MULLIGAN

A report issued by the U.S. Census Bureau on September 29 states that an estimated 43.6 million people, or slightly more than 15 percent of the population, were without health insurance coverage during the entire year of 2002.

This figure represents an increase of 2.4 million uninsured people, or 14.6 percent, over 2001, the largest increase in a decade.

According to the report, the decrease came about largely because of a drop in the number and percentage of people covered by employer-based insurance. For the second straight year, the proportion of people who received insurance through an employer declined, from 62.6 percent in 2001 to 61.3 percent in 2002.

The number of people with such coverage declined by 1.3 million over the two-year period. Census Bureau data show that in 2002 17 percent of the uninsured worked full time, and 24 percent of them worked part time.

What brought about the decrease in employer-based coverage? From the report, it is impossible to conclude whether it was due to decisions by employers or by employees to drop coverage or by a combination of the two. A third potential cause is the overall increase in unemployment.

Kate Sullivan, director of health care policy at the U.S. Chamber of Commerce, was quoted in the September 30 *Washington Post* as saying, "Employment-based coverage is getting really expensive. Either the company doesn't make it available or individuals are turning down coverage at work because they can't afford it."

Earlier, on September 9, the Kaiser Family Foundation and the Health Research and Educational Trust (KFF/HRET) released the 2003 Annual Survey of Employer Health Benefits (see story on page 5).

That survey reported that between spring 2002 and spring 2003, monthly premiums for employer-sponsored insurance rose 13.9 percent, the third consecutive year of double-digit premium increases and the highest premium increase since 1990.

Premiums increased considerably faster than the rate of inflation, which was 2.2 percent in that time period.

Fifty-one percent of large-firm (200 employees and above) employers reported that they were "very likely" to increase the amount employees pay for health insurance next year. Three percent of such employers planned to restrict employee eligibility for coverage, and 1 percent expected to drop coverage entirely.

Government health insurance programs, particularly Medicaid, helped prevent an even greater spike in the number of uninsured. The number and percentage of people covered by such programs rose from 25.3 percent in 2001 to 25.7 percent in 2002 (see chart).

The enrollment rate for Medicaid coverage went from 11.2 percent to 11.6 percent of the population, while the Medicare enrollment rate decreased by .1 percent to 13.4 percent.

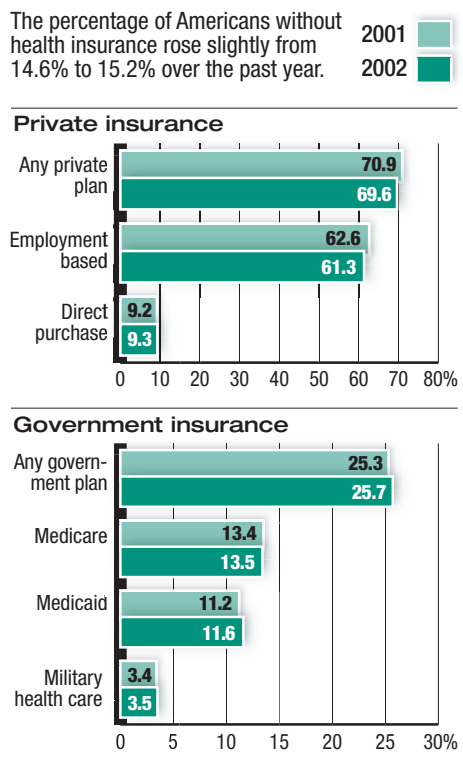
Medicaid itself, however, is under severe cost-containment pressures because of state and federal fiscal constraints (see story on page 9). Every state cut Medicaid costs in some fashion in Fiscal 2003, and all plan additional cuts for Fiscal 2004.

The two most frequently used strategies for cost containment in 2003 were "controlling drug costs" and "reducing/freezing provider payments." Only 18 states made efforts to save money by restricting eligibility, but as the possibility for savings

please see ***Insurance*** *on page 32*

Census Uncovers More Uninsured

The percentage of Americans without health insurance rose slightly from 14.6% to 15.2% over the past year.



Note: The estimates by type of coverage are not mutually exclusive; people can be covered by more than one type of health insurance during the year.

Source: U.S. Census Bureau, Current Population Survey, 2002 and 2003 Annual Social and Economic Supplements

Furthering Access to Integrated Mental Health Care

BY MARCIA GOIN, M.D.

The theme of APA's 2003 Institute on Psychiatric Services (IPS) is "Access to Integrated Mental Health Care." Don't miss it! The IPS, which is being held this year from October 29 to November 2 in Boston, is an annual meeting dedicated to issues surrounding the needs of our most vulnerable, disenfranchised, and difficult-to-serve patients. It is an exciting and dynamic event filled with important happenings.

The theme of this year's IPS highlights our knowledge that the biological, psychological, and social needs of all patients do not occur in isolation, but form an integrated whole. We are determined to provide integrated mental health care that responds to these complex interactions and to do so for all patients.

The IPS Scientific Program Committee has organized a multitude of exciting lectures, symposia, and workshops. Diagnosis and treatment of patients with antisocial personalities, access to care for minorities, treating patients with borderline personality disorder, the use of new technologies, collaboration with primary care, ethics, and split treatment are but a few of the issues that will be addressed. You can take a course on engaging resistant and hostile patients in participatory treatment, an integrative model for treatment of co-occurring substance abuse and other psychiatric disorders, and cultural formulations and treatment and learn about how some have used movie clips and music for therapeutic enhancement.

National and international leaders in psychiatry will give special lectures. Psychiatrist Sir Michael Rutter will present the Marmor Award Lecture, "Using Epidemiology to Test Causal Hypotheses." Francine Bernes, M.D., Glen Gabbard, M.D., John Gunderson, M.D., Arthur Kleinman, M.D., Lisa Mellman, M.D., and Katharine Phillips, M.D., are among the many other extraordinary lecturers.

The mission of the IPS is in concert with the principles expressed in APA's Vision for the Mental Health System. APA's Vision includes in its principles: "Every American with significant psychiatric symptoms should have access to an expert evaluation leading to accurate and comprehensive diagnosis that results in an individualized treatment plan that is delivered at the right time and place, in the right amount, and with appropriate supports such as adequate housing, rehabilitation, and case management when needed. Care should be based on continuous healing relationships and engagement with the whole person rather than a narrow, symptom-focused perspective. Timely access to care and continuity of care remain today cornerstones for quality even as a continuum of services is built that encourages maximum independence and quality of life for psychiatric patients. The physician-patient relationship is central to any reform of the health system. It encompasses confidentiality, continuity of care, and the ethical responsibility always to put the patient's needs first."

At a time when President Bush's New Freedom Commission report on mental health, "Achieving the Promise: Transforming Mental Health Care in America," says what we all know—that the mental health system is in shambles, fragmented, and needs complete restructuring—this meeting is an opportunity to share innovative thinking and creative ideas with colleagues.

Work with patients suffering from such real-life hardships carries its own particular stress. I was talking recently with a psychiatric colleague who interviews some eight to 10 homeless people who are mentally ill. He described the type of effort it took to remain open and hear each person's story. The stories of intense abuse and trauma were each painful and in the aggregate difficult to hear continually. But he knew that it was very necessary to remain engaged if he was to provide appropriate help. During the IPS he and others can meet, talk together, and explore common experiences that are part of our work. A special full-day session titled "Clinical Approaches to Working With Homeless, Mentally Ill Individuals: Challenges, and Rewards" will address some of these issues. There is also the opportunity to attend the special seminar "When the Patient Is Different From You," as well as the workshop "Forming Effective Therapeutic Relationships Under Difficult Circumstances."

All is not work. Boston is a beautiful city with many historic sites and delightful communities, with access to a wide variety of ethnic restaurants to enhance your gustatory integrative experience. A jazz concert with famed jazz guitarist Paul Geremia will take place on Friday night. Boston is a small city, convenient to get around. Take your children for a walk along the Freedom Trail, visit Faneuil Hall (and see if you can pronounce it), walk around North Beach, take a Harbor Cruise, enjoy a morning coffee in a cafe on Newbury Street, and don't miss the statue of Paul Revere in front of the Old North Church and the U.S.S. Constitution. When I was in high school, my family and I lived for a couple of years in Quarters D in the Boston Naval Shipyard. The Constitution was docked within a two-minute walk from our home, and taking visitors on tours of the ship was a continuous activity. So, let me know if you have any questions.

See you in Boston. ■

Division Operates in Background To Support APA's Mission

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

Under the leadership of Terri Swetnam, chief financial officer for APA and its subsidiaries, the Finance, Contracts, and Administrative Services departments provide financial, procurement, and infrastructure support to the five, but separate, entities that make up the APA central office:

- The American Psychiatric Association handles all membership activities.
- American Psychiatric Publishing Inc. (APPI) carries out the scientific, educational, and publishing activities of the affiliated group.
- The American Psychiatric Institute for Research and Education (APIRE) conducts all research work funded by government and private agencies.
- The American Psychiatric Foundation (APF) conducts fund-raising and grant-making activities.
- APA*PAC* (APA's political action committee), established in 2001, raises donations and makes contributions to federal candidates and committees.

The Finance Department has 17 staff members, with an annual budget of $1.9 million. Three accountants are responsible for the accounting operations of each of the entities, ensuring compliance with federal tax requirements and government grant-reporting requirements, and supporting the year-end audit. They ensure that all transactions are properly coded to the correct entity, that intercompany transfers are documented and approved, and that the information in the general ledger system—which is used to prepare financial statements for the Board, finance oversight committees, and auditors—matches information in the subsystems.

The Association has four major components of its financial system—the general ledger system, from which the statements are prepared; the publishing subsystem, in which detailed information about each book transaction is maintained; the advertising subsystem; and the membership system. Each month the accounting staff ensures the information in the general ledger, or finance system, matches the information in the subsystems—a complex task to say the least!

Five staff handle disbursements—including payroll, vendor invoices, and travel reimbursements. Each year, staff prepare more than 6,500 payroll transactions and 11,000 other disbursements. Requests for vendor checks and travel reimbursements are prepared and approved within the department. They are then sent to the disbursements staff, who verify that the request is consistent with the Association's policies. The department is committed to mailing out checks within 15 calendar days from receipt of the request.

Three staff are responsible for the budget, cash, and investment-management activities of all five entities. The budget process starts in March with the first Finance and Budget Committee meeting. A budget call goes out to staff in May or June, with information regarding budgetary limitations, inflationary factors, and so on. Budgets are submitted by the departments in July, and the budget staff analyzes and prepares several perspectives for the executive staff. Inevitably, there is a gap between the revenue forecasts and the spending requests for the coming year. The budget staff, working with the budget coordinators in each division, work toward a proposed and balanced budget for the executive team's review. Once approved by the medical director, the budget goes to the Finance and Budget Committee at its fall meeting.

In addition to the budget, staff monitor the Association's investment portfolio, working closely with our investment advisors and the Investment Oversight Committee to ensure a balance between protecting the principal of the portfolio and experiencing a positive return.

Finally, the budget team is responsible for monitoring the cash balance of the Association. This involves knowing how much is in each of the 11 checking accounts daily, forecasting what checks will clear the accounts that day, and transferring funds between accounts as is appropriate to ensure that no accounts are overdrawn.

The finance department has six staff who oversee cash receipts—three of these staff are integrated into the Membership Department and are responsible for ensuring that dues for 28,000 members are allocated to the correct member and for responding to member billing inquiries; three support the cash receipts for all other areas (publishing, annual meetings, advertising revenue, and mailing-list sales).

Payments for advertising, annual meeting registrations, and member dues are sent to a post-office box—which is a "lockbox" managed by our bank. Funds are deposited into one of the Association's 11 checking accounts, and staff are responsible for ensuring the detailed information from the bank matches the bank statements and is properly recorded into the financial system.

The finance department, in conjunction with staff members of the subsidiaries, is responsible for ensuring that the financial information is well documented, controlled, and accessible for the external auditors each year. The auditors perform a consolidated audit of APA, with individual audits for APPI, APIRE, APF, and APA*PAC*. In addition, staff support the audit required by the government for its awards audits of the employee benefit plans and prepares tax returns for all entities. In 1999 the auditor's letter to management contained 44 "findings" (instances of internal-control weaknesses); in 2002 there were no internal-control weaknesses and only two unresolved recommendations and one new recommendation.

Contracts Department

The Contracts Department, with one staff person and a budget of approximately $100,000, is responsible for implementing policies and procedures related to procurement and contracting and ensuring that contractual terms and conditions (both with organizations and individuals) are consistent with internal policies and are negotiated to protect the business and financial interests of the Association. In addition, the department establishes policy for major procurement activities, prepares solicitations for outside vendor consideration, and manages the American Express corporate credit card program. The Association has 37 vendors of $100,000 or more and approximately 145 contract agreements.

Administrative Services

The Office of Administrative Services, under the direction of Terry Hilmer, consists of seven staff members with an annual budget of $600,000. It is responsible for all space-related functions—including maintenance and repairs, security, safety, parking, mailroom, and printing services. This office is the primary liaison with building management for day-to-day coordination of services. In addition, staff in this office coordinate and monitor the Association's insurance policies and telecommunication requirements, office-supplies purchasing, and furniture and equipment maintenance.

Administrative Services staff also are responsible for meeting-room reservations and setup, and ordering and serving meals for more than 2,000 meetings a year in the Association's conference rooms.

In the course of a year the department purchases 1,700 cases (two tractor-trailer loads) of copy/printing paper. A portion of this paper is used to produce approximately 5 million pages of printed matter in the print shop.

Each month the mailroom sends out an average of 15,000 letters and 550 packages and receives and delivers an average of 1,000 parcels and 16,000 pieces.

Although operating largely behind the scenes, the staff in the departments of Finance, Contracts, and Administrative Services manage the logistics, finances, and business relationships that enable the other, more visible areas of the Association to do what they do best—support our members.

Feel free to forward your ideas, comments, and/or suggestions to me at medicaldirector@psych.org. ■

Employers Discover Loopholes, Keeping Parity An Elusive Goal

Many employees attempting to use mental health benefits still face inequities, in spite of nearly a decade of parity laws being enacted.

BY KATE MULLIGAN

At first glance, the big picture about eliminating discriminatory coverage of mental illness looks good, according a study reported in the September-October *Health Affairs*.

But lead author Colleen Barry and her colleagues ultimately concluded that without "broader parity laws, progress toward benefit parity could prove difficult to achieve."

The authors used data from the 2002 national survey about health care benefits conducted by the Henry J. Kaiser Family Foundation and Health Research and Educational Trust (KFF/HRET) of 2,014 randomly selected public and private firms. Since firms are selected randomly, statistical weighting enables researchers to draw both national conclusions and conclusions about various subsets of data, such as benefits related to firm size and region of the country.

The authors tracked trends by comparing results from previous studies with the KFF/HRET results.

Ninety-eight percent of workers with employer-sponsored health insurance had coverage for mental health care in 2002, according to the KFF/HRET survey.

Large firms were significantly more likely than small ones (those with three to 199 workers) to offer mental health benefits.

From 1991 to 2002, the proportion of covered workers offered mental health benefits increased, according to a comparison of data from three surveys. For outpatient care, the respective percentages for 1991, 1995, and 2002 were 86 percent, 92 percent, and 98 percent covered.

The authors noted, however, that firms continue to place special limits on mental health benefits. Loopholes in federal and state parity laws permit "persistent differences in coverage between mental health and general medical benefits."

The Mental Health Parity Act (PL 104-204), for example, prohibits annual or lifetime dollar limits on coverage for mental illnesses unless equal dollar limits apply to other medical services. It does not, however, mandate nondiscriminatory coverage for day and visit limits and copayments.

The authors cited a study by the General Accounting Office (GAO/HEHS-00-05) that found that about two-thirds of employers who complied with the law made at least one other mental health benefit design feature more restrictive.

According to the KFF/HRET survey, the majority of covered workers in 2002 were still subject to day and visit limits for mental illness. Seventy-four percent of covered workers were subject to an annual outpatient-visit limit, and 64 percent were subject to an annual inpatient-day limit.

In fact, it appears that day and visit limits for mental health benefits have increased. The proportion of covered workers subject to outpatient-visit limits increased from 65 percent in 1999 to 74 percent in 2002. Fifty-seven percent of covered workers had inpatient-day limits in 1999, compared with 65 percent in 2002. A higher number of firms reported "don't know" in 1999, complicating the comparison (see chart).

Cost sharing represents another tool by which employers control costs for benefits. According to the authors, the federal Bureau of Labor Statistics found that a majority of enrollees in medium and large firms during the 1980s paid a 50 percent coinsurance rate for outpatient mental health care, rather than the usual 20 percent paid for other illnesses.

The 2002 KFF/HRET survey data showed a decrease to 22 percent of covered workers with higher cost sharing for mental health benefits.

Barry and her colleagues speculated that people covered for mental illness under HMOs or through carveouts might be less likely to be subjected to cost sharing and benefit limits than those who are not in HMOs or subject to carveouts.

Their reasoning was that managed care, in theory, was intended to produce savings that could be used to expand benefits.

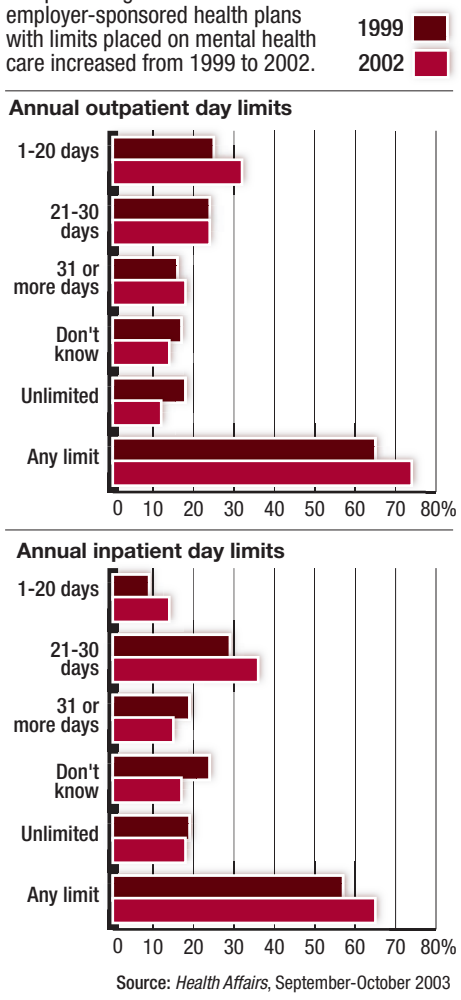
The authors found, however, that "nominal benefits under HMOs and carveouts tend to be at least as restrictive as conventional plans."

They speculated that "benefit restrictions could be motivated by a health plan's desire to avoid enrollees with a propensity to avail themselves of mental health care."

"Design of Mental Health Benefits: Still Unequal After All These Years" can be accessed for a fee at the Web site of* Health Affairs *at <www.healthaffairs.org>; access is free to subscribers. ■

Limits on MH Care Increasing

The percentage of workers who had employer-sponsored health plans with limits placed on mental health care increased from 1999 to 2002.



Source: *Health Affairs*, September-October 2003

community news

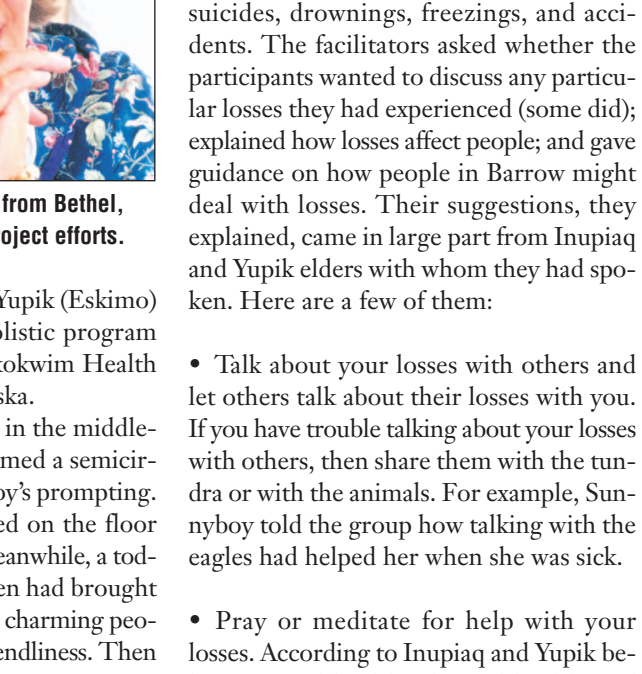
Alaska Natives Help Peers Cope With Grief, Loss

Two Alaska Eskimo women help people in the far northern town of Barrow to heal from their losses as part of a NAMI-Alaska project.

BY JOAN AREHART-TREICHEL

August 14 was a typical day weatherwise in the Alaska town of Barrow—the northernmost town in North America and arguably the highest town in the world. Icy winds swept in from the Arctic Ocean, pummeling people's bodies; snow whirled over the gray landscape and muddy roads.

The day was atypical, however, in that some 20 people met in the Hopson Middle School, on the corner of A and C avenues in Barrow, to engage in a group-grieving ceremony. It had been organized by Augusta Reimer, an Anchorage Inupiaq (Eskimo) woman who leads up a project for NAMI-Alaska (the Alaska chapter of the National Alliance for the Mentally Ill) called the Mental Health Consumer/Family Leadership Development and Training Project. The project in turn is funded by the Substance Abuse and Mental Health Services Administration. The ceremony was conducted by Liz Sunnyboy, a Yupik (Eskimo) woman and community holistic program coordinator at Yukon-Kuskokwim Health Corporation in Bethel, Alaska.



Augusta Reimer, an Inupiaq woman from Anchorage, heads up the NAMI project to help Alaska Natives deal with mental health issues.

Liz Sunnyboy, a Yupik woman from Bethel, assists Reimer in her NAMI project efforts.

Once the people arrived in the middle-school auditorium, they formed a semicircle at Reimer's and Sunnyboy's prompting. A box of Kleenex was placed on the floor in front of the semicircle. Meanwhile, a toddler whom one of the women had brought along darted here and there, charming people with his curiosity and friendliness. Then the grieving ceremony began.

One by one, individuals came forward from the semicircle to take a long-stemmed rose from Reimer and to dedicate it to someone they had loved and lost—for example, "I dedicate this rose to my husband and son, who killed themselves," "I dedicate this rose to my sister, who has a drinking problem," "I dedicate this rose to my sister, wherever she may be."

As the individuals dedicated their roses, emotions started to be released and tears to flow. Before those present could reach down to the Kleenex box for a tissue, however, the toddler sensed their emotional pain. He trotted over to the box, stooped down on his pudgy little legs, pulled tissues out of the box, and distributed them to those present.

Then all of the adults in the semicircle, at Sunnyboy's instruction, formed a complete circle and hugged each other.

"I feel better," said the young man who had lost his sister.

The grieving ceremony was only part of Reimer's and Sunnyboy's efforts to help people in Barrow recover from loss. On August 14 and 15, about 30 people attended sessions where they discussed some of the losses experienced by the Inupiaq and Yupik peoples in recent years, such as homicides, suicides, drownings, freezings, and accidents. The facilitators asked whether the participants wanted to discuss any particular losses they had experienced (some did); explained how losses affect people; and gave guidance on how people in Barrow might deal with losses. Their suggestions, they explained, came in large part from Inupiaq and Yupik elders with whom they had spoken. Here are a few of them:

- Talk about your losses with others and let others talk about their losses with you. If you have trouble talking about your losses with others, then share them with the tundra or with the animals. For example, Sunnyboy told the group how talking with the eagles had helped her when she was sick.

- Pray or meditate for help with your losses. According to Inupiaq and Yupik beliefs, mental health, physical health, and spiritual health are all connected. When you meditate, concentrate your thoughts on what you consider a "safe place."

- Forgive those who may have been responsible for your losses. That person may be yourself. Forgiveness is healing.

- Try to heal from your losses as a community, such as in a ceremony like the one described above. "For too long our people have taken this journey to recovery alone," Sunnyboy declared.

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School-Based Program Targets Minds Scarred by Violence

Students throughout Los Angeles benefit from a group intervention that is helping students in impoverished areas cope with community violence and develop stronger relations with family and friends.

BY EVE BENDER

As gang shootings and other types of community violence in Los Angeles mushroomed in the late 1980s, Marleen Wong, M.S.W., who was director of mental health services for the Los Angeles Unified School District (LAUSD), turned her thoughts to the students. How many had witnessed life-threatening violence, she wondered, and how did it impact them?

Years later, her quest for answers would lead to the implementation of a school-based screening and intervention program that is helping students cope with the trauma that results from witnessing the kind of violence most people see only in movies.

One of Wong's tasks was to organize school-district crisis teams of school administrators and school mental health clinicians to help students cope with violence in or around the school.

"Each year in the late 1980s, we had 800 to 900 incidents of gang violence around the city," she told *Psychiatric News*. "Students would see their fathers and brothers shot and killed in front of them."

Realizing that many Vietnam veterans were at increased risk for posttraumatic stress disorder (PTSD) due to their exposure to life-threatening violence, she wondered whether some Los Angeles school students were at similar risk.

Lessons From Immigrant Children

When Wong became director of crisis counseling for LAUSD, she began working with immigrant students through the Emergency Immigrant Education Program (EIEP). This program was created in 1999 to help children who had been in the United States fewer than three years adjust to school. Among the services that the children received were tutoring, language classes, and mental health counseling.

During the project, Wong noted that many of the immigrant children—most of whom were Latino—had witnessed life-threatening violence in their countries of origin and benefited from individual counseling. "Their fear and anxiety would subside after they had a chance to talk about their traumatic experiences," she said.

But she quickly realized that helping one child at a time wasn't going to work, especially for a school district with 748,000 children.

Her desire to find a more practical way to help students who had witnessed life-threatening violence was soon fulfilled through a collaboration with researchers at the RAND corporation and the University of California at Los Angeles.

Intervention Launched

As part of the immigrant project, Wong began in 1999 to implement the Cognitive-Behavioral Intervention for Trauma in Schools (CBITS) program in 11 East Los Angeles schools.

CBITS is an early intervention developed by RAND researcher and psychologist Lisa Jaycox, Ph.D., for students who experience symptoms of PTSD, depression, and/or anxiety in relation to exposure to violence in the community.

Jaycox told *Psychiatric News* that she developed the group intervention with three goals in mind: to reduce symptoms associated with trauma in students, build resilience so students can cope with future trauma, and build parent and peer support.

"One of the things we teach students is that it's OK to feel fear and anxiety," Jaycox said, and "that it's not necessary to avoid thinking or talking about the trauma."

The10-session intervention is designed so that students learn about common reactions to trauma and the link between thoughts and feelings, receive relaxation training, learn how to problem-solve, and discuss their traumatic experiences in a safe environment.

School social workers typically lead the groups, which usually have five to eight students. Students and their parents are also allotted a certain number of individual sessions with the social worker.

Many of the participating children, said Jaycox, have witnessed the shooting or stabbing death of someone in their neighborhood.

It is not uncommon for children to blame themselves for such an event, according to

please see ***Violence*** *on page 32*

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continued from facing page

The sessions were attended not just by Barrow residents who had experienced losses, but also by some mental health workers in Barrow. One was Michael Danner, who runs a home in Barrow for youngsters who have been separated from their parents by court order or for other reasons. The sessions helped him better understand the emotions that people feel when they grieve over losses, Danner told *Psychiatric News*—in other words, the types of emotions that youngsters in his home often feel.

As part of the NAMI Alaska project, Reimer and Sunnyboy have also helped people in some other towns and villages deal with mental health issues. ■

Children Who Witness Violence Respond To Cognitive-Behavioral Intervention

Students at two primarily Latino middle schools in Los Angeles report witnessing six instances of life-threatening violence in the past year and being the victims in two such events.

BY EVE BENDER

A group cognitive-behavioral intervention reduces the number of symptoms associated with posttraumatic stress disorder (PTSD) and depression among middle-school students in Los Angeles who witnessed or directly experienced life-threatening violence, a new study shows.

Researchers with the RAND Corporation and the University of California at Los Angeles screened 769 sixth graders at two middle schools in East Los Angeles, a poor, mostly Latino section of the city, during the 2001-02 academic year.

To determine study eligibility, researchers asked the students whether they had directly experienced or witnessed life-threatening violence, such as a shooting or stabbing. They also used the Child PTSD Symptom Scale (CPSS) to assess trauma-related symptoms.

Students were eligible for the study if they reported being exposed to three or more violent events either as a victim or witness, showed clinically significant levels of PTSD on the CPSS, and were willing to discuss their traumatic experiences and related symptoms among a group of peers.

Of the 769 students, 159 met eligibility criteria, and 126 chose to participate in the study with parental consent.

Researchers randomized the 126 students into two groups. One group of 61 students received the Cognitive-Behavioral Intervention for Trauma in Schools (CBITS) (see story on page 7); the other students were placed on a waiting list to receive the intervention.

Students participating in the group intervention met with a school social worker and five to eight other students for 10 sessions, during which they learned about common reactions to trauma exposure, the link between thoughts and feelings, and how to approach anxiety-provoking situations.

Researchers assessed both groups and their families at baseline, three months, and six months with the CPSS, the Child Depressive Inventory (CDI), and the Pediatric Symptom Checklist.

At baseline, both groups of children reported being the victims of an average of 2.8 violent events and witnessing an average of 5.9 such events during the preceding year.

"Violence was endemic in these communities," said the study's principal investigator, Bradley Stein, M.D., Ph.D.

Stein is also lead author of an article based on the study, "Mental Health Intervention for Children Exposed to Violence" in the August 6 *Journal of the American Medical Association*.

Baseline assessments showed that the average CPSS score for both groups of children was 24 on a scale of 0 to 51, indicating moderate to severe levels of PTSD. The mean CDI score was 17 on a scale of 0 to 52.

At the three-month mark, children receiving the group intervention reported significantly lower mean scores on the trauma scale than had their counterparts (8.9 versus 15.5).

According to the report, 86 percent of children who received the intervention had fewer symptoms of violence-related distress than would be expected with no intervention.

Mean scores on the depression scale were also lower for children who participated in the groups (9.4 versus 12.7). The report noted that 67 percent who received the intervention had fewer symptoms of depression at the three-month mark than what would be expected with no intervention.

A large majority of parents (78 percent) also reported improvement in their children's levels of psychosocial dysfunction after receiving the intervention.

By the six-month evaluation, the second group of students had received the CBITS intervention, and their scores closely matched those of the first group on all measures.

Stein said that he found the results "promising" and that further research may compare the CBITS intervention with another controlled condition, such as individualized supportive therapy.

An abstract of the article, "Mental Health Intervention for Children Exposed to Violence" is posted on the Web at <http://jama.ama-assn.org/cgi/content/full/290/5/603>. ■

Association News

Support the Foundation

Do you buy electronics, clothes, and airline tickets online? Do you shop with retailers such as Best Buy, Travelocity, Expedia, Hotwire, Priceline, Gap, Dell, Kenneth Cole, Old Navy, Petco, and 1-800-Flowers?

If you do, then you can support the American Psychiatric Foundation at the same time by making one extra click that connects with these retailers through BuyForCharity.com at <www.buyforcharity.com/allcategories.asp>.

A percentage of each sale will be contributed to the foundation. The funds will be used to support the foundation's programs in education and research that are raising awareness of mental illness and increasing access to quality care.

More information is available by contacting Meghan Sayer at the foundation at MSayer@psych.org.

Experts See No Relief From Medicaid Cost Cutting

Every state has enacted cost-containment measures directed at Medicaid, but fiscal woes are worsening.

BY KATE MULLIGAN

States' spending growth on Medicaid has slowed, but reports from the Kaiser Commission on Medicaid and the Uninsured (KCMU) suggest that the program's troubles are becoming more complicated and intractable.

In late September, KCMU released its third annual survey concerning states' actions related to the cost of Medicaid. States reported that the average spending growth for Medicaid in 2003 was 9.3 percent, down from 12.8 percent in 2002. This figure marks the first time since 1996 that the growth rate has decreased.

The survey was conducted by Health Management Associates for KCMU in June 2003, which is the end of the fiscal year for most states.

The two most frequently used strategies for cost containment were "controlling drug costs" and "reducing/freezing provider payments" (see chart).

Robert Day, director of Medicaid and Medicaid Policy for Kansas, said at a press conference on September 22 announcing the survey and related reports, "We can control pricing because generally. . . . Medicaid's the worst payer in the business. . . . We pay physicians poorly."

Susan Fleischman, M.D., director of the Venice Family Clinic in Los Angeles, said that the California state legislature had enacted a 15 percent cut to providers over three years.

She told the audience, "[F]ive years ago, there were 42 providers who saw Medicaid patients in my part of Los Angeles. Now there are 22. . . . Most of them are closed to new Medicaid patients."

The complexity and likely longevity of the problems concerning Medicaid are indicated in a companion report issued by KCMU, "The Current State Fiscal Crisis and Its Aftermath."

That report, which was prepared for KCMU by Donald Boyd, Ph.D., director of the Fiscal Studies Program of the Nelson Rockefeller Institute of Government, found a dramatic decline in state tax revenue. In fact, Boyd found that measured as a share of the economy, the falloff was twice as steep as the state revenue declines that occurred during the recessions of 1990-91 and 1980-82.

He reported that "the fiscal crisis facing states is far worse than the condition of the nation's economy." The main reason state tax revenue fell so sharply, Boyd claimed, is that it had been propped up in the late 1990s by "unsustainable forces—especially the run-up in the stock market—which have unraveled rapidly in recent years."

"[The situation] doesn't just sound bad. It is bad," Boyd said.

Although state spending on Medicaid has increased every year since 1996, that increase has played a relatively small role in creating the states' fiscal difficulties. In Fiscal 2002, the growth in Medicaid spending contributed an estimated $6.9 billion to state budget shortfalls, while the drop in revenue collections contributed $61.8 billion to the gap, according to Boyd.

The result is that although further cost-containment measures will be directed at Medicaid, those measures cannot resolve or do much to alleviate state budget crises. Pressures for further cost cutting likely will result.

Boyd pointed out other factors that contribute to a bleak outlook for state budgets. Many states used now-depleted reserve funds to fill gaps in budget shortfalls or addressed the problem with measures, such as bond issues, that will exacerbate problems in the future.

He wrote that "prospects for substantial and sustained increases in federal aid to states appear dim."

Boyd cited projections from the Congressional Budget Office that the federal budget deficit will amount to $1.4 trillion for the period 2004 through 2008 and noted that "these projections do not reflect most of the costs of Iraq and its aftermath"; they also assume that Congress will not enact a Medicare prescription drug benefit.

A second study, prepared by the Urban Institute and issued by KCMU, "Medicaid Spending Growth: 2000-2002," found that spending on the "disabled" was the largest contributor to Medicaid expenditure growth in terms of enrollment category.

During the period 2000-02, expenditures on disabled individuals accounted for 34.3 percent of expenditure growth. The "aged" ranked second at 24.3 percent.

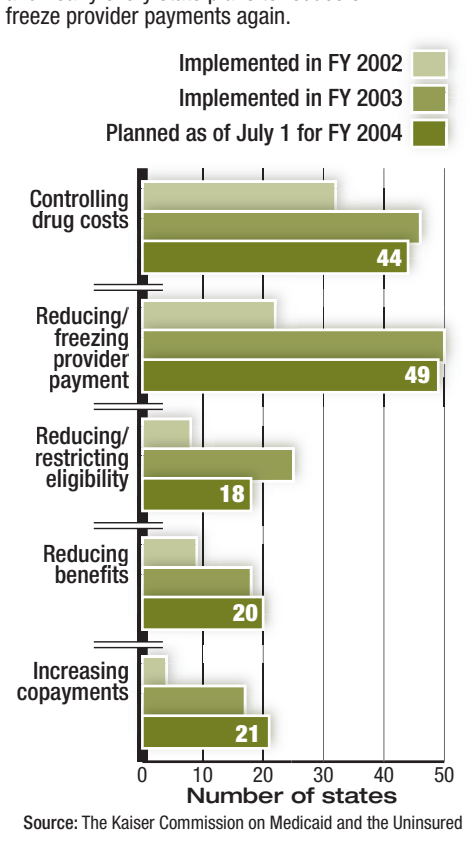
Lead author John Holahan, Ph.D., wrote, "Increases in enrollment of the aged and disabled far exceeded growth in the population, and this growth [trend] is likely to continue for some time."

He cited the "high use of prescription drugs" by those two categories of enrollees as a source of expenditure growth.

"Medicaid Spending: What Factors Contributed to the Growth Between 2000 and 2002?" is posted on the Web at <www.kff.org/content/2003/20030922/presentslides.pdf>. "The Current State Fiscal Crisis and Its Aftermath" is posted at <www.kff.org/content/2003/4138/4138.pdf>. ■

States Try to Contain Medicaid Costs

For Fiscal 2004, more states are planning to reduce benefits and increase copayments, and nearly every state plans to reduce or freeze provider payments again.



Source: The Kaiser Commission on Medicaid and the Uninsured

Psychiatric Hospitals Could Gain Right to Medicaid Reimbursement

Federal law requires hospitals to stabilize emergency room patients regardless of insurance status or ability to pay. Yet many general hospitals lack space, leading to patients' being transferred to nonpublic community psychiatric hospitals.

BY MARK MORAN

Legislation enabling nonpublic psychiatric hospitals to receive Medicaid reimbursement for stabilization of medication-eligible patients transferred from public hospitals was introduced in Congress last month.

The Medicaid Psychiatric Fairness Act, introduced by Sen. Olympia Snowe (D-Maine) and Sen. Kent Conrad (D-N.D.), addresses a conflict in existing federal laws and regulations that has resulted in nonpublic psychiatric hospitals having to provide uncompensated care to patients who are eligible for Medicaid.

The bill is supported by APA and by the National Association of Psychiatric Health Systems, among others.

Michael Strazzella, deputy director for congressional relations in APA's Division of Government Relations, explained that the conflict is between the legal requirements of the Emergency Medical Treatment and Labor Act (EMTALA) and a Medicaid regulation governing reimbursement for care of psychiatric emergency patients transferred to nonpublic hospitals.

Under EMTALA, hospitals are required to stabilize an emergency room patient regardless of insurance status or ability to pay. For psychiatric patients, especially, stabilization is likely to require admission. Yet many general hospitals do not have psychiatric beds because reimbursement rates are so low, while others are too full to take patients.

As a result, emergency patients are being transferred from general hospital emergency rooms to nonpublic community psychiatric hospitals, Strazzella said.

But while a general hospital is reimbursed for inpatient psychiatric care provided to Medicaid-eligible EMTALA patients, a psychiatric facility is not. That's because of the Institution for Mental Diseases (IMD) exclusion in the Medicaid laws prohibiting a psychiatric facility from claiming reimbursement for any services rendered to a patient who is a Medicaid beneficiary between the ages of 21 and 64.

The IMD exclusion was enacted in 1965 to prevent states from transferring financial responsibility for long-term-care patients in state psychiatric hospitals to the Medicaid program.

But Strazzella said that the delivery of mental health services has changed radically since that time, and that nonpublic community psychiatric hospitals are now the safety net for many who have serious mental illness. The EMTALA/Medicaid conflict puts these hospitals in the position of having to provide care for these patients without compensation, even though the patients are eligible for Medicaid.

In letters to Snowe and Conrad, APA President Marcia Goin, M.D., expressed the Association's support of the bill. "Your legislation will allow nonpublic psychiatric hospitals from receiving Medicaid reimbursement for Medicaid patients between the ages of 21 and 64 that have required stabilization as a result of EMTALA," Goin wrote. ■

Medicare Agency to Grant Reprieve From HIPAA Electronic-Claims Rule

A new contingency plan to accept Medicare "legacy claims" after the October 16 deadline for compliance with HIPAA standards appears to be in response to concerns raised by APA, the American Medical Association, and other medical groups.

BY MARK MORAN

The Centers for Medicare and Medicaid Services (CMS) has announced implementation of a contingency plan so that the Medicare fee-for-service program continues to accept electronic claims that are not compliant with the Health Information Portability and Accountability Act (HIPAA) now that the October 16 deadline has passed.

This plan ensures continued processing of claims from thousands of providers who were not able to meet the deadline and otherwise would have had their Medicare claims rejected, according to CMS.

"Implementing this contingency plan moves us toward the dual goals of achieving HIPAA compliance while not disrupting providers' cash flow and operations, so that beneficiaries can continue to get the health care services they need," said CMS Administrator Tom Scully.

The decision appears to be in response to concerns voiced by APA, the American Medical Association and other medical groups, and government and AMA surveys showing that many physicians are not completely ready for the new standards.

CMS announced its contingency plan on September 11, but did not announce whether the plan would be implemented until September 23.

*please see **Electronic Claims** on page 10*

California Law Mandates Employer-Sponsored Coverage

The controversial legislation is indicative of growing anxiety among states about the uninsured. An estimated 6 million Californians are without health insurance for all or part of a year.

BY MARK MORAN

California Gov. Gray Davis signed a bill earlier this month requiring some employers in the state to purchase health insurance for workers or pay into a state fund for that coverage.

The legislation (SB 2, sponsored by state Sen. John Burton, a Democrat), requires employers to provide health care coverage for employees and dependents that is equivalent to coverage required under California's public health insurance programs—including dental, vision, and mental health benefits—but that also includes coverage for basic prescription drugs.

If an employer chooses not to purchase health insurance for its workers, it must pay into a state fund providing such coverage.

The measure, which exempts small employers, is an indicator of increasing anxiety on the part of states about the uninsured. The Center for Health Policy Research at the University of California, Los Angeles, estimates that more than 6.3 million Californians (out of a population of about 35 million) were without insurance for all or part of 2001 and 2002.

Under the bill, large employers—those with 200 or more employees—are required to comply with the law by January 1, 2006. "Medium" employers—those with more than 50 employees but fewer than 200—would be required to comply by January 1, 2007. Employers with fewer than 20 workers would be exempt from the law, and those with 20 to 49 workers would be exempt from the law unless the state provides tax credits to help offset the cost of health benefits.

At press time, opponents planned to file paperwork to start a referendum that would block the law. A Washington, D.C., think tank released a study concluding that "SB 2 will indirectly cost residents $11.4 billion in lost jobs, lower wages and reduced benefits," according to the October 6 *Los Angeles Times*.

The California Psychiatric Association (CPA) supported the bill. "We have a real interest in any measure that improves general access to medical care because of its obvious implications for those with mental illness," Randall Hagar, director of government relations for CPA, told *Psychiatric News*.

"Both because of our public-entitlement programs and because of our mental illness insurance parity statute, we believe that SB 2 will mean that those who don't qualify currently for public mental health services and are not privately insured will now have access to mental health services for the first time through either employer- or state-provided insurance."

The California Medical Association (CMA) is a cosponsor of the bill.

"This unprecedented legislation strikes a fair balance of constructive change and compassion for the plight of the uninsured that is desperately needed in our health care system," said Ronald Bangasser, M.D., president of the CMA and a family practitioner.

Every day "in my wound-care clinic," he said, "I see firsthand the increasing costs [that being uninsured] passes on, affecting the prices businesses that provide health insurance must pay, leading to overcrowded and underfunded trauma-care systems and emergency rooms."

The text of the bill is posted on the Web at <http://info.sen.ca.gov/pub/bill/sen/sb_0001-0050/sb_2_bill_20030913_enrolled.html>. ■

Support for Psychiatry Ally

David Fassler, M.D. (right), and **Andrew Siegel, M.D.** (left), present **Rep. Bernard Sanders** (I-Vt.) with a contribution from APA's political action committee, APA*PAC*. The presentation was made in Vermont.

Fassler is treasurer of the Vermont Psychiatric Association (VPA), a member of APA*PAC* Board of Directors, and an APA trustee-at-large, and Siegel is VPA's deputy representative to the APA Assembly. Sanders is a member of the House Government Reform Committee and of the Mental Health Caucus. He is also a co-sponsor of the 2003 parity and privacy bills that APA supports.

The visit is part of an ongoing program at APA—through APA*PAC*—in which APA members educate federal and state legislators and policymakers about mental health issues.

NIH Hopes Loan-Repayment Aid Will Attract Future Researchers

A National Institutes of Health program is trying to lower a barrier that is keeping young physicians from choosing research careers.

BY KEN HAUSMAN

In an effort to reverse a decline in the number of young researchers, the National Institutes of Health (NIH) is making future medical researchers an offer it hopes they can't refuse.

In September the federal agency started to accept applications for its Loan Repayment Programs through which it will repay up to $35,000 in educational debt owed by health professionals who pledge to pursue careers in clinical, pediatric, contraception and infertility, or health disparities research.

The programs also cover "federal and state tax liabilities," according to NIH.

The conditions NIH places on the program participants are that they must have completed a doctoral-degree program and be devoting at least 50 percent of their time to research funded by a nonprofit organization or federal, state, or local government agency. In addition, participants must have accumulated education-loan debt "equal to or exceeding 20 percent of their institutional base salary."

The program is limited to citizens and permanent residents of the United States, and full-time federal government employees are not eligible.

NIH offers five programs within the overall loan-repayment program. They are the Clinical Research Loan Repayment Program (LRP), Clinical Research for Individuals From Disadvantaged Backgrounds LRP, Contraception and Infertility Research LRP, Health Disparities Research LRP, and Pediatric Research LRP.

Ruth Kirschstein, M.D., senior advisor to the NIH director, described that repayment programs as "one of our nation's most significant efforts to ensure a solid foundation of clinical, pediatric, and health-disparities research professionals for the next generation. These programs provide a means for health professionals to launch their research careers unfettered by the burden of student-loan debt."

Darrel Regier, M.D., director of the American Psychiatric Institute for Research and Education and APA's Division of Research, also finds the program to be a valuable tool for recruiting the next generation of researchers.

"Given the dwindling number of qualified psychiatrists going into research after they complete their clinical training," he told *Psychiatric News*, "this program will reduce some of the economic pressures of repaying student loans for psychiatrists who choose to go into relatively low-paying research fellowship positions."

Completed applications for 2004 awards must be submitted online no later than 5 p.m. on December 31.

Applications and additional information about the NIH Loan Repayment Programs are posted on the Web at <www.lrp.nih.gov> and available by phone through the LRP Helpline at (866) 849-4047. ■

Electronic Claims

continued from page 9

The AMA has also urged private-sector health plans to do the same. A coalition letter urging the implementation of a contingency plan was sent to Karen Ignani, president and chief executive officer of the American Association of Health Plans, on September 12 and was signed by 50 medical societies and organizations including APA.

HIPAA requires national standards for electronic health care transactions and national identifiers for providers, health plans, and employers. It also addresses the security and privacy of health data. Adopting these standards is expected to improve the efficiency and effectiveness of the nation's health care system by encouraging the widespread use of electronic data exchange in health care.

"The AMA will continue its work with CMS and private payers up to and beyond the deadline to ensure that claims are processed promptly and the transition to standardized electronic claims processing functions smoothly," the AMA said in a press statement. "The only way the medical community can avoid disruption in medical-claims processing is if stakeholders—physicians, government, and private payers—each [does its] part toward the common good of a smooth transition to the new transaction standards."

APA has posted a range of HIPAA education materials on APA's Web site at <www.psych.org/pub_pol_adv/hipaa/index.cfm>. These include compliance guidelines, frequently asked questions, and other resource links. In the Members Corner section of the Web site, APA members can also access a HIPAA Bulletin Board to ask HIPAA-related questions, view previously posted questions and answers, and read responses prepared by HIPAA experts. HIPAA staff training and additional compliance materials are also available. ■

Bill Targets Rx Drug Advertising

Rep. Pete Stark (D-Calif.) introduced the Fair Balance Prescription Drug Advertisement Act of 2003 (HR 3155) in late September.

The legislation would eliminate the corporate advertising tax deduction for direct-to-consumer prescription-drug advertisements that do not present the benefits and risks of the medications they promote "in a fairly balanced manner," according to a September 23 press release.

The act would require that print advertisements display a drug's pros and cons in same-sized typeface and space and on the same or facing pages. Risk and benefit descriptions would be allotted equal airtime for television and radio advertisements.

The California Public Employees' Retirement System, which provides health benefits to more than 1.3 million members, endorsed the proposed legislation.

More information about the bill is posted on the Web at <www.house.gov/stark> under "Legislation." ■

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State MH Inspector General Shifts to Federal Arena

After a four-year stint as inspector general for Virginia's mental health system, Anita Everett, M.D., begins a new chapter in her career advising the administrator of a federal agency.

BY CHRISTINE LEHMANN

Psychiatrist Anita Everett, M.D., ended her tenure as Virginia's first inspector general (IG) for the public mental health system on September 15. She is moving from Richmond to the Washington, D.C., area to advise the head of the Substance Abuse and Mental Health Services Administration (SAMHSA) about psychiatric issues.

Her new job title is senior medical advisor to SAMHSA Administrator Charles Curie at the agency's headquarters in Rockville, Md.

Curie commented on the new position in an interview with *Psychiatric News*, "I look forward to working with Dr. Everett, who will be a critical member of our leadership team at SAMHSA."

Everett will focus on several areas, Curie noted, including improving the assessment and treatment of people with co-occurring disorders and promoting evidence-based psychiatric services.

"With her career in community psychiatry [*Psychiatric News*, May 2], Anita is in a unique position to shape public policy and the role of psychiatrists in community interventions. She will serve as a liaison between SAMHSA and a range of trade associations, including APA and AMA," said Curie.

Everett will collaborate with Kathryn Power, M.Ed., director of the Center for Mental Health Services, in reviewing, identifying, and finalizing information on evidence-based practices and developing an action agenda, added Curie.

As inspector general for Virginia's mental health system, Anita Everett, M.D., took steps to make the system more accountable to taxpayers.

Curie also plans to tap Everett's expertise on a federal initiative to reduce and eventually eliminate the use of seclusion and restraint in state psychiatric facilities.

As to who will replace Everett as Virginia's mental health IG, James Reinhard, M.D., commissioner of the Virginia Department of Mental Health, Mental Retardation, and Substance Abuse Services favors filling the IG position with another psychiatrist, said Everett. She would like to see the term of the IG position expanded to six years rather than tied to the governor's four-year term of office. She was appointed in 1999 by then-governor James Gilmore.

"It's critical that the position be independent from [the mental health department]. I reported directly to the governor on conditions at state mental health facilities. We issued 86 reports on 15 state mental health and mental retardation facilities, with an average of 10 recommendations per report. The reports and any corrective actions taken by the department or us were publicized on the Web site [of the IG's office], which made the public mental health system more accountable to the taxpayers," said Everett in an interview with *Psychiatric News*.

She also instituted a rigorous peer-review process examining adverse events at the 15 state facilities. "This was done for all unexplained deaths, including suicides, to determine what could have better managed and prevented," said Everett.

Reports filed during Everett's tenure as IG are posted on the Web at <www.oig.state.va.us/OIG_Reports.htm>. ■

Update on Drug Reimports

Iowa Gov. Tom Vilsack (D) and Illinois Gov. Rod Blagojevich (D) have asked aides to draft plans that would enable state insurance programs to buy prescription drugs from Canadian suppliers, according to a story in the *Washington Post* on September 24.

The two governors join Mayor Michael J. Albano (D) of Springfield, Mass., who became the first government official in the United States to establish a drug-reimportation program.

In the U.S. Congress, 142 House Democrats sent a letter to members of the conference committee that is trying to work out differences between House and Senate versions of a Medicare bill (HR 1/S 1) suggesting that they are "unlikely to support a Medicare drug benefit that does not include" language making it legal to buy FDA-approved drugs from Canada.

In July 243 House members voted for legislation permitting reimportation of FDA-approved drugs from Canada and specified European countries *(Psychiatric News*, August 15). That bill became part of HR 1.

Influential lawmakers are divided on the reimportation proposal. Senate Finance Committee Chair Charles Grassley (R-Iowa) supports reimportation, but House Ways and Means Committee Chair Bill Thomas (R-Calif.) does not. The Food and Drug Administration opposes the legislation. ■

State Hospital to Lose Beds In Major Funding Shift

State mental health departments are under increasing pressure to control costs and are downsizing psychiatric hospitals. Virginia's plan to downsize and divert funds into community-based services has drawn fire from some psychiatrists.

BY CHRISTINE LEHMANN

About 25 staff psychiatrists at Eastern State Hospital in Williamsburg, Va., are opposing the state-backed plan to downsize their acute services admissions unit. Despite meetings with legislators and the state mental health commissioner earlier this year, the plan to close 43 beds this year and eventually close the entire unit is proceeding. Once the unit is closed, patients will be diverted to private psychiatric hospitals in their communities for acute care.

"Because we are committed to caring for our patients, we will not stage a walkout or formal protest," staff psychiatrist Mahmood Rahman, M.D., told *Psychiatric News*. "And, next month, we will stop admitting new patients, as asked. But we will discharge only those patients who are ready and have appropriate community placements."

The plan for Eastern State Hospital was proposed by its hospital administrator with input from local government agencies responsible for community-based services.

Psychiatrists Oppose Plan

The medical staff at Eastern—from psychiatrists to clinical social workers—contend that they were not asked for input until after the plan was developed. Their main criticisms of the plan are the existing shortage of public and private psychiatric beds, inadequate funding, and lack of intensive and comprehensive services to meet the needs of the seriously mentally ill population they treat.

"We already don't have enough psychiatric beds in our region," said Rahman. "Last year, there were 1,295 admissions to our 90-bed admissions program. With a service population of 1.7 million in our region, and only about 280 acute adult private beds, we cannot afford to close any acute beds. We also have a waiting list of patients to be admitted at Eastern."

"Just last month, when our admissions unit was full, we found that yet again there were no available beds to buy in the community."

Rahman and 24 other psychiatrists expressed their concerns in a July letter to James Reinhard, M.D., commissioner of the state's Department of Mental Health, Mental Retardation, and Substance Abuse Services. Reinhard is a former director of a community-based psychiatric hospital and a member of the Psychiatric Society of Virginia (PSV).

Rahman added, "We routinely admit patients that are acutely psychotic, violent, and destructive from jails, private psychiatric hospitals, and sometimes the streets. Our experience is that most private psychiatric facilities aren't equipped to provide the comprehensive services these patients need."

Commissioner Responds

Eastern—the oldest public psychiatric hospital in the United States—is one of five state facilities being downsized over a two-year period to divert funds to community-based services (see box), said Reinhard in an interview with *Psychiatric News*.

He proposed the reinvestment concept to Gov. Mark Warner (D) last year after being told to cut his agency's budget.

Virginia's budget deficit in Fiscal 2004 is $1.5 billion, according to the governor's Web site.

"I was pleased that the governor approved the proposal, which is budget neutral and minimizes the impact on direct patient care and hospital staff," said Reinhard.

"Virginia ranks seventh in the nation in spending per person on inpatient psychiatric beds, yet we rank 41st in spending per person on community mental health services," Reinhard noted. "It makes sense to reinvest a portion of the resources at Eastern State and try to serve those and even more patients in the community."

He estimated that in January about $6 million in funds for Eastern will be diverted during Fiscal 2004 and available for reinvestment.

"Similar reinvestment projects have been very successful in other regions of Virginia [see story below]. I am confident that the same success in maximizing state hospital

please see ***Virginia Plan*** *on facing page*

Virginia Plan's Fine Print

Here are some of the key details of Virginia's Community Reinvestment Project:

- Five state psychiatric facilities will be downsized, and the savings will be invested in community-based services identified by regional planning committees.
- About $34 million in the state-facilities budget will be transferred in Fiscal 2004 and Fiscal 2005 to local community-service boards to buy services for people who have mental illness and would have been hospitalized previously.
- About 261 beds will be closed at five state inpatient facilities during Fiscal 2004 and Fiscal 2005, which equals about 15 percent of 1,798 total beds now available.

Here is a breakdown of the plan's projected bed closures by population and facility:

- 86 acute-care beds will be closed at Eastern State Hospital
- 32 acute-care beds will be closed at Southwestern State Mental Health Institute
- 63 civil and forensic beds will be closed at Central State Hospital
- 49 dual-diagnosis (mental illness and mental retardation) and long-term psychiatric beds will be closed at Western State Hospital
- 31 beds at Northern Virginia Mental Health Institute will be closed

Psychiatrists Have Diverse Views Of Community MH Funding Plan

The medical director of Virginia's Central State Hospital says its experience with a funding experiment similar to one at Eastern State Hospital is positive. But critics say the loss of beds has hurt patient care.

BY CHRISTINE LEHMANN

Virginia's Central State Hospital in Petersburg has a community reinvestment project under way to close two wards and fund new community-based services instead. The project is part of a state-backed plan to close 261 inpatient psychiatric beds eventually and divert more resources into community-based services (see box).

The project at Central builds on its Acute Care Project, which is viewed as a successful model for Eastern State (see story above) by its directors and mental health commissioner James Reinhard, M.D.

Central closed its 60-bed, acute-care admissions unit over a four-year period beginning in 1999. Patients qualified to be discharged were placed in community-based residential settings. Private psychiatric hospital beds were contracted at $500 a day to provide crisis-stabilization services, Central's immediate past director, Larry Latham, Ph.D., told *Psychiatric News*.

Central State Hospital in Petersburg, Va., closed its admissions unit a few years ago and is now downsizing civil and forensic units to invest more funds in community-based services.

"We found that more people were served for less money than in our admissions unit," he said.

According to Reinhard's office, these are among the results of the Acute Care Project, although no comment was made with regard to quality of care:

- In Fiscal 2002, 855 people received acute care services in their communities compared with 257 in Fiscal 1999—before the funding reallocation—at Central State.
- The average inpatient stay dropped from 67 days to just under seven days.
- The annual cost of psychiatric care per patient dropped from $38,592 to $2,615.
- The rate of monthly readmissions has dropped from 9 percent to 6 percent.

"Our experience with the project has been excellent. We work closely with the community service boards in the assessment process and finding treatment in the community," said Central's medical director Charles Davies, M.D., in an interview with *Psychiatric News*. He is a former medical director of Eastern State Hospital. He did not believe that quality of care was compromised.

"About five to 10 patients a month are admitted [to Central State] now, compared with 30 to 40 patients a month before the project began. We now see a more chronic and treatment-resistant population," said Davis.

The patient population served by Eastern is larger and more diverse than that at Central and may require a more complex plan than the Acute Care Project, he added. Both he and Latham acknowledged that finding enough beds can be challenging.

Richard Kaye, D.O., medical director of behavioral medicine at Obici Hospital, a private psychiatric hospital in Suffolk, Va., and immediate past president of the Tidewater Academy of Psychiatry, commented to *Psychiatric News*, "If the mental health department can contract with private facilities at $500 a day, it will have to shorten the stay [in those hospitals] dramatically in order to obtain any savings. Although our average length of stay is five to six days for acute-care patients, committed patients typically take longer to stabilize. The mean length of stay in the acute-care unit at Eastern is 14 days."

He added, "In many cases, this even is too short, and many discharged patients relapse."

Shortly after diversion to private psychiatric hospitals began at Central State Hospital, Kaye pointed out, two private contracted hospitals dropped out because of the low reimbursement rate, and the beds haven't been replaced.

"The numbers cited by the mental health commissioner do not reflect improved community care but the shortage of available psychiatric beds," said Kaye.

Central also refers violent and acutely ill patients to Obici for commitment when patients' local hospitals won't accept them.

"If we accept them," said Kaye, "they have to stay until it's safe to discharge them, although they belong in extended-care facilities. Their HMO Medicaid insurance won't cover our costs, which means that the state is essentially transferring the costs of care to us when we are already losing money on psychiatric services." ■

Virginia Plan

continued from facing page

resources can occur in the region around Eastern State Hospital."

Rahman responded that Eastern's plan doesn't have the same level of funding or intensive services being implemented at Central State Hospital, which Reinhard promoted as a model.

Opposition Grows

At a town-hall meeting at Eastern State Hospital in April, private hospital nurses and physicians told officials that the acute-care admissions beds were vital for providing adequate care to the indigent mentally ill, according to a June 6 *Associated Press* article.

James Reinhard, M.D., believes that the Virginia plan "minimizes the impact on direct patient care and hospital staff," despite being budget neutral.

Richard Kaye, D.O., medical director of behavioral medicine at Obici Hospital, a private psychiatric hospital in Suffolk, Va., and immediate past president of the Tidewater Academy of Psychiatry, has been an outspoken critic of the reinvestment plan.

He told *Psychiatric News*, "Deinstitutionalization is neither cost-effective nor does it improve services. The results are that the chronically ill end up homeless, in jail, or die. It is the threat to human life that is most troubling."

"We believe that we can and should provide better care than the current system allows."

These concerns were echoed by Valerie Marsh, executive director of the National Alliance for the Mentally Ill-Virginia. She told *Psychiatric News* that she believes "the funds allocated to reinvestment are grossly inadequate. The amount of state funding is not comparable to what other states have allocated to transition from facility care to community care."

She was referring to the approximately $500,000 in "bridge money" each region received from the state mental health department.

"The reinvestment plans seem to focus on inpatient and emergency care. I thought the whole point was to prevent inpatient care and intervene with adequate treatment and supports. Changing beds from public to private or from long term to short term is not true investment," said Marsh. She also complained that consumers and families were not consulted until long after the planning had begun.

Founded in 1773, Eastern State Hospital in Williamsburg, Va., was the first public facility in the United States constructed solely for the care and treatment of the mentally ill. With the growth of Colonial Williamsburg, by the mid-1960s many patients had been moved from the hospital's downtown site to a site three miles west at Dunbar Farms. In 1985 a replica of the original hospital was built on its original site and today gives visitors an idea of what it was like to be mentally ill in colonial times.

Supporters Speak Out

Community psychiatrists who favor the reinvestment plan include James Krag, M.D., president of the Virginia Association of Community Psychiatrists, which represents more than 200 psychiatrists working in the state's 40 community mental health centers.

Krag commented to *Psychiatric News*, "We believe that we can and should provide better care than the current system allows. Continuity of care is often lost as the person is transferred from one hospital unit to the next and then finally discharged to a community team that had little say during the person's hospital stay."

Krag added that community psychiatrists are concerned about the state shifting patients to them without redirecting the dollars from closed state hospital beds into community care.

Mary Ann Bergeron, executive director of the Virginia Association of Community Services Boards (CSB), said, "New funds are needed to create a broad array of mental health services." She plans to propose increasing the CSB budget by $18 million for Fiscal 2005 and $21 million for Fiscal 2006.

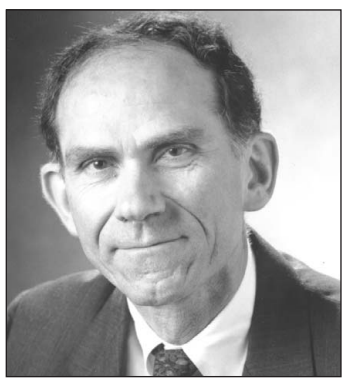
Reinhard said that Medicaid will relieve some of the state's cost burden for community-based services, which wasn't an option when patients stayed in state hospitals. Medicaid does not pay for state psychiatric hospital care. Virginia officials are, however, considering substantial cuts in Medicaid funds.

Reinhard emphasized that the reinvestment project moves Virginia closer to complying with the 1999 Supreme Court decision in *Olmstead v. L.C.* The ruling upheld the constitutional right of people with mental illness to live and receive treatment in their communities if there are adequate placements and services, among other conditions.

A description of Virginia's restructuring process, including the "community reinvestment project" and regional updates, is posted on the Web at <www.dmhmrsas.state.va.us./R&R/defaultR&R.htm>. ■

Office-Based Patient Safety: We're All Responsible

BY AL HERZOG, M.D.



Julie (not her real name, but the scenario is real) came to see me for help with depression. She was single, in her mid-20s, still living at home with her parents, and a well-liked, much-respected administrative assistant at a local business. In our initial interview, she described classic neurovegetative symptoms of depression but denied suicidal ideation or intent.

I saw her weekly, felt I had developed good rapport with her, and started her on imipramine, building up to 150 mg a day. I gave her a two-week supply at a time. (This occurred a good decade before the first SSRI was on the market.) By the sixth week, her mood was markedly improved. Sometime during the eighth week of contact with me, she drove out to an isolated path in the woods and, when discovered a day later, was found dead in her car with the recently refilled but now empty container of imipramine next to her. The coroner ruled Julie's death "suicide, secondary to an arrhythmia from an imipramine overdose."

I felt enormous guilt for what I felt were errors in judgment—not asking often enough about possible suicidal feelings once she trusted me more and for giving her a two-week supply of a potentially lethal amount of medication. I met with her family several times, was honest about my errors, and dealt with their anger as best as I could.

Julie's parents ended up not suing me. However, I remember feeling even then—25 years ago—that I owed myself, and certainly Julie and her parents and all of my patients, more than self-blame and guilt. I owed all of us a way of practicing psychiatry in the safest possible way, realizing that the practice of medicine/psychiatry, like most human endeavors, involves risks for patients and for caregivers. However, our task, as clinicians, is to reduce the number of errors to an absolute minimum.

Much has happened to patient safety in the intervening 25 years. We realize that our mindset about patient safety needs to change from one of blame, guilt, or both to creating safe systems of care, or, to put it in the language of patient safety, processes of care that incorporate best practices and reflect systems of independent redundancies. Put simply, what that says is that if I make a mistake, someone (or something/a device, etc.) looking at the care process independently will catch my mistake and correct it.

Some of this may apply more easily to those of you who practice in hospital settings. Other clinicians are more easily available to "double-check" care processes—residents, attendings, nurses, social workers, and pharmacists, as well as technologic aides (various order/entry systems, etc.).

The office practice of psychiatry, where there are often only two people involved—the psychiatrist and the patient—presents particular challenges to practicing safe care. Here are some, but by no means an exhaustive list of, approaches. We know from research that a potentially suicidal patient may not tell us up front about his or her suicidal feelings. We know suicide risk increases (1) whenever a dramatic change in mood occurs and (2) whenever the patient's treatment status changes (inpatient to partial hospitalization, inpatient to outpatient, etc.). Therefore, we need to make it a point, especially with any relatively new patient, to assess the patient's suicide status often and especially at any high-risk times.

Most of us who treat outpatients (and, of course, inpatients) deal with the prescribing and managing of psychiatric medications daily. This is especially true in the managed care era of "med-check" office visits. Keeping in mind the principle of safety from redundant systems, we should actively involve (whenever possible) the patient in the medication process. For instance, I have gotten into the habit of having the patient read back to me the prescription(s) I have just handed to him or her. I quickly learned a lot about improving my safe practices—writing more legibly, being clearer about the specifics of my instructions. Likewise, we need to discuss more clearly with the patient the possible interactions of not just what we prescribe, but also interactions with the other medications the patient may be taking. None of us has an excuse not to take out our *PDR*, but best practice in 2003 almost dictates our routine use of PDAs (and programs such as e-Pocrates or whatever your favorite is) to help us discuss possible medication interactions with our patients.

In the year ahead, the APA Patient Safety Committee has planned a series of educational activities, at the national and district branch levels, to increase patient-safety consciousness in our daily clinical activities. In addition, *Psychiatric News* will publish a series of articles on patient safety.

Some of you will say, "What is the big deal; this is all common sense!" While that may be partially true, I have been struck by how often (myself included) common sense is practiced uncommonly. Please join us in truly making patient safety an everyday practice. ■

Dr. Herzog is chair of APA's Committee on Patient Safety and a private practitioner and vice president for medical affairs at Hartford Hospital in Hartford, Conn.

The Night the Lights Went Out

BY DIANA GRAHAM, M.D.

"Gee, this has never happened before." My boss's words hung in the air as the lights flickered and went out on August 14. We were in the middle of a chaotic shift change in the Comprehensive Psychiatric Emergency Program (CPEP) at Bellevue Hospital in New York City and had no way of knowing that millions of Americans had been thrust into a similar blackness due to a major power blackout spanning much of the East Coast and Midwest.

I had finished my residency this June, and that overnight shift was my seventh as the CPEP attending psychiatrist. The 15 clinicians and trainees who were crowded into our doctors' station froze in the darkness. Half the lights came back up as the generator kicked in. Word quickly spread about the extent of the blackout.

"This can't be an accident." I spoke without meaning to, and heads whipped around. "OK, you're in charge," I reminded myself. "Be the grownup. Keep it cool."

The ER complex went on disaster alert. We were told to move patients out of the CPEP, either by discharging them or admitting them to inpatient psychiatry. The laboratories were not functioning in the outage. We'd have to do old-fashioned medical clearances based on histories and physicals.

Around 10:30 p.m., the lights began to flicker again, and then we were plunged into darkness. This time, the lights did not come back up: our backup generator had failed. I could hear the voices of the staff begin to rise anxiously. "OK, everybody!," I shouted. "Nobody panic. We're all right."

Now what? I'd been through four years of medical school, four years of residency, and a full six weeks (!) of attending life, but nowhere could I recall being trained in what to do when you find yourself in charge of one of the busiest and most acute psychiatric emergency rooms in the world during a complete power failure.

"Be the grownup," said the voice in my head again. "Think safety. Are the patients safe?"

"We need staff with the patients," I said out loud. "Let's get flashlights and visualize all the patients."

Staff were already in motion, locating patients and shifting them into one area where we could easily communicate with everyone.

Eventually half the crew either fell asleep or were lying calmly on gurneys. The group was unfazed by the darkness and seemed to need little reassurance. Nonetheless, I was nervous. We had some acutely psychotic patients in our care. What if someone became agitated? How would we coordinate restraints in the dark?

One man approached me. "Is it time for my pill yet? I'm not feeling well."

His hands were tremulous. He was in alcohol withdrawal and due for his medication.

"No Librium, doc," the nurse in charge informed me. "We can't get into the Omnicell."

I realized with a groan that all our oral medications were dispensed from an electronic cart. Without power, they were inaccessible. We went to the medication refrigerator for IM Ativan, only to find that the controlled-substance lock was inexplicably jammed. We were a psychiatric ER without benzodiazepines! Fortunately, the medical ER was operating under full generator power and provided us with several vials of Ativan. Withdrawal crisis averted. We ran the CPEP on flashlight power for about 90 minutes. Having to forage for benzos was our only major misadventure.

The quiet, dim atmosphere served us well. There was minimal stimulation for the patients, who mostly slept. For once, we had virtually nothing to do. Around midnight, the generator kicked back in. We went back to work.

As I watched our staff work together throughout the night, my sense of admiration grew. During a tense, terribly uncertain situation, the team remained calm.

Each of us found ourselves doing things well outside our job description. The good humor and creativity were contagious. Everyone seemed to delight in coming up with new ways to solve the problems we faced. No one became upset or complained, even as the nurses' double shifts rolled into triples.

I stepped out the back door around 3 a.m. in hopes of taking in some fresh air and gazed around. The normally creepy, rundown alley was transformed. The nondescript highrise across the highway was almost cathedral-like, bathed from inside with the shimmering glow of candles. I looked up and saw what I never thought I'd witness—hundreds of stars blinking over Manhattan.

The blackout had deprived us of many necessities but brought some magic with it. I returned to the same spot a few hours later and watched the sun blaze into view over the East River.

At last, light in New York City. ■

Dr. Graham finished her psychiatry residency in June at the Comprehensive Psychiatric Emergency Program at Bellevue Hospital, where she is now an attending psychiatrist.

Atypical Depression: What's in a Name?

The existence of a subgroup of atypical depressed patients—distinguishable in terms of symptoms, drug response, and possibly even underlying neurobiology—suggests that "depression" is less a disease than a description, encompassing a variety of subtypes.

BY MARK MORAN

Twenty-five years ago a depressed patient told researchers at Columbia University College of Physicians and Surgeons, "You know those people who run around the park with lead weights? I feel like that all the time. I feel so heavy and leaden [that] I can't get out of a chair."

The statement graphically portrayed a symptom peculiar to a subset of depressed patients first described by English psychiatrists a generation earlier as "atypical." The Columbia researchers, seeking to define the group more rigorously, incorporated that symptom—which they called "leaden paralysis"—into the criteria that currently serve as the basis for a diagnosis of "depression with atypical features."

That diagnosis depends on the presence of "mood reactivity"—depressed mood that can brighten readily at a positive turn of events—in conjunction with any two of the following: hypersomnia, hyperphagia, leaden paralysis, and interpersonal rejection sensitivity.

But while experts agree that the definition roughly describes a subgroup of people who are different from those with classic melancholic depression, much about the description, including the centrality of mood reactivity, is debated.

Even researchers involved in developing the original Columbia University criteria agree that the diagnosis requires refinement.

"There is something out there that we can call atypical depression, but the problem is that the *DSM* criteria are too broad," said Jonathan Stewart, M.D., a professor of clinical psychiatry at Columbia and a research psychiatrist at the New York State Psychiatric Institute.

"It's clear to me that even though it captures most of the people who have the disorder—whatever it is—it probably captures a lot who have something else."

Not Like Melancholic Depression

As Stewart recounted, almost 50 years ago the English psychiatrists West and Dally first described a subset of patients who were depressed but whose clinical symptoms differed from those of classic melancholic depression. Moreover, while this group did not respond to tricyclic antidepressants, it did respond to monoamine oxidase inhibitors (MAOIs).

Stewart said the Columbia research in the 1980s confirmed the latter, identifying a group of depressed patients who preferentially responded to the MAOI phenelzine sulfate. The treatment studies also validated criteria for atypical depression that originating certain symptoms that are part of a more general condition?"

Reverse Vegetative Symptoms Give Clue

A recent analysis of depressed patients with atypical features emphasizing the reverse vegetative symptoms—overeating and oversleeping—suggest that those two symptoms alone might serve as important markers of atypical depression for primary care physicians who might not otherwise look for the disorder.

The study, appearing in the September *Archives of General Psychiatry*, used the two symptoms to identify 836 patients with major depression, 304 of whom had atypical features and 532 who did not, in the National Comorbidity Survey.

Study author Louis S. Matza, Ph.D., told *Psychiatric News* that the analysis suggests that the simpler criteria emphasizing overeating and oversleeping could be readily used by primary care physicians to identify depressed patients who are liable to have a different clinical course and possibly a different response to treatment.

He noted that the study found that the patients who fit the criteria had an earlier onset of illness. They also reported higher rates of depressive symptoms, suicidal thoughts and attempts, psychiatric comorbidity, drug dependence, and a history of paternal depression, childhood neglect, and sexual abuse.

Matza is with MEDTAP International of Bethesda, Md. MEDTAP is a research organization specializing in health outcomes research.

Stewart, a co-author of the study, noted that the earlier age of onset found among the patients identified by the NCS is "exactly what we see in patients with atypical depression as diagnosed according to the full *DSM-IV* criteria."

Experts React

Experts who reviewed the study for *Psychiatric News* found compelling the use of the reverse vegetative symptoms to identify atypical depression in such a large national sample.

Carpenter agreed that hypersomnia and hyperphagia are prominent. "A person with atypical depression is usually slowed down, as opposed to agitated and moving around a lot," she said. "They will tell you they are oversleeping and overeating—that is sort of a classic characteristic. If you had to say what jumps out when you see these patients, that would be it."

But she and others expressed surprise, and some skepticism, about the finding of an increased-risk profile for suicide and comorbid psychiatric disorders among people with atypical depression.

"There have been plenty of typically melancholic depressed patients who are significantly ill," said Mark Frye, M.D., director of the bipolar research program at the University of California, Los Angeles. "The idea that [atypical patients] have more drug use is remarkable as well. I am not sure I have seen that. It makes me think that many of these patients are covert bipolars."

Miller, too, expressed surprise at the finding and—underscoring the complicated picture of atypical depression—wondered whether the increased risk found among the sample could reflect the confluence of personality disorders.

All the clinicians interviewed by *Psychiatric News* agreed that reverse vegetative symptoms cannot be used as criteria to start patients on MAOIs as a first-line treatment.

"Why force someone into following an MAOI regimen with its side-effect problems until you have demonstrated that less problematic treatments are not going to work?," Stewart asked.

Distinct Biological Disorder?

Stewart told *Psychiatric News* that he and colleagues have refined their definition of atypical depression, focusing on early onset and chronic course as critical features.

"If you sort the patients who meet the criteria [for atypical depression] into those who have early-onset chronic illness and those who have later-onset or nonchronic illness, those two groups look entirely different," he said.

Moreover, the "true" atypical patients with early onset and chronic course differ from both late-onset nonchronic patients and from patients with classic melancholic depression on cortisol testing and auditory perceptual processing, as well as on their response to tricyclic antidepressants.

"The patients with melancholic depression and late-onset atypical depression lie on the same side of normal controls on cortisol testing and perceptual processing, while these early-onset chronic patients lie on the opposite side of normal controls," Stewart said. "This demonstrates to me that they have biologically different disorders. It argues against the notion of depression as a continuum and in favor of the idea that these categorical distinctions make some sense, that they are biologically distinct disorders."

More generally, experts said, the stubborn existence of a subgroup of atypical depressed patients—distinguishable in terms of symptoms, drug response, and possibly even underlying neurobiology—points to the possibility that "depression" itself is less a disease than a description, encompassing a variety of subtypes.

"As we learn more about the biology of depression—not just the phenomenology, but the biological markers—we will be able to lump less and split more," Carpenter said. "The nosology will reflect more subtypes as we have greater understanding of the biological, genetic, and psychosocial contributions."

An abstract of the study, "Depression With Atypical Features in the National Comorbidity Survey: Classification, Description, and Consequences," is posted on the Web at <http://archpsyc.ama-assn.org/cgi/content/abstract/60/8/817?>. ■

Linda Carpenter, M.D.: "As we learn more about the biology of depression—not just the phenomenology, but the biological markers—we will be able to lump less and split more."

Association News

New Discount For MITs!

In response to the very popular Sunrise Special Sale at APA's annual meeting for members-in-training (MITs), American Psychiatric Publishing Inc. (APPI) is now extending those sale prices year-round. Thus, MITs are now eligible to receive a 25 percent discount when they purchase books and journals from the APPI Web site at <www.appi.org>. When ordering, they should use PRIORITY CODE APAWEB3.

Urgent Alcohol Treatment Eludes Thousands in Need

Despite the denial and stigma that prevent so many people with alcohol problems from seeking help, tens of thousands of people turned up at screening sites across the country for National Alcohol Screening Day.

BY EVE BENDER

Almost half of the 18,000 people who completed screening forms in conjunction with the 1999 National Alcohol Screening Day (NASD) engaged in problem drinking behaviors, a new study finds. In addition, about 15 percent of respondents had a score on an alcohol-abuse screening instrument that indicated the need for immediate intervention.

The study results appeared in the September *American Journal of Psychiatry* and offer a first-ever glimpse of who attended the nationwide screening.

Screening for Mental Health Inc., a nonprofit agency based in Wellesley, Mass., has organized the screening each year since 1999.

The first NASD took place in April 1999 at more than 1,200 community sites, most of which included general and psychiatric hospitals, and 500 college campuses across the nation. In addition to the 18,000 people who participated in the screening, more than 14,000 came to the sites just to get information for themselves or a loved one, the report noted.

People who wanted to be screened completed the Alcohol Use Disorders Identification Test (AUDIT), developed by the World Health Organization (WHO) to identify those who engage in "hazardous" or "harmful" drinking. Scores on the 10-question survey range from 0 to 40, and a trained clinician discusses individual screening results with participants on site.

Hazardous drinking is defined by WHO as a pattern of drinking in which people are at risk for significant health problems. Harmful drinking, which is considered to be more serious, describes those who have already experienced drinking-related health problems but are not yet dependent on alcohol.

Researchers found that 43 percent of the 18,043 respondents scored 8 or above on the AUDIT, indicating harmful or hazardous drinking, and 15 percent scored at or above 19, indicating the need for immediate treatment, according to the report. Clinicians at the screening referred a third of the respondents, or about 6,000 people, to services in their community for further evaluation and possible treatment.

"We know it's difficult for people to recognize they have a problem with alcohol and seek help," said lead researcher Shelly Greenfield, M.D., M.P.H. "Yet this event was embraced by college campuses and the community at large."

Greenfield is an assistant professor of psychiatry at Harvard Medical School and medical director of the Alcohol and Drug Abuse Ambulatory Treatment Program at McLean Hospital in Belmont, Mass.

During the screening process, participants were informed of the opportunity to participate in a study in which researchers would evaluate their AUDIT scores and contact them by telephone about six months later for a follow-up interview.

Of those who volunteered and were eligible to participate, researchers successfully followed up with 704 people in November 1999. Of the sample, 337 respondents had originally been screened at a site in the community and 367 on a college campus.

The follow-up survey revealed that among the sample of 704 people, 59 percent (418) had an AUDIT score of 8 or above, indicating harmful or hazardous drinking (273 at community sites and 145 at college sites). About 24 percent of that subgroup (169) needed immediate intervention (126 at community sites and 43 at college sites).

Overall, Greenfield said, those who came to community sites had more serious drinking problems than those who came to college sites.

When researchers questioned the smaller sample in November, they learned that 22 percent of the subgroup said they no longer drank, and 41 percent reported cutting back on their drinking. Researchers also compared how people altered their drinking behavior in the months after the screening by type of site (see chart).

Of the people in the community who were advised to see a health care professional for a follow-up visit (136), about 50 percent complied with the recommendation, according to the report. Of those at college sites who received the same advice (35), just 20 percent complied. Reasons cited for noncompliance included denial that there was an alcohol problem and the decision to handle the problem alone.

Since the 1999 screening event, NASD has grown considerably, according to Joelle Reizes, M.A., who is director of external relations for Screening for Mental Health Inc. and a co-author of the article.

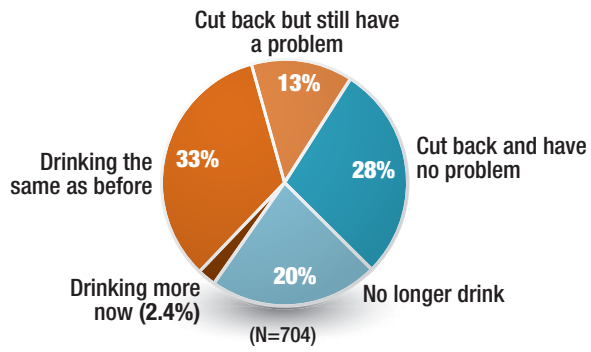
Reizes said that 102,000 people participated in the 2003 NASD—62,000 people were screened, and 40,000 came to get information for themselves or for a loved one. More than 3,000 sites offered the screening this year. "We're on the right track," she said of the screening.

The study was funded by the National Institute on Alcohol Abuse and Alcoholism, Robert Wood Johnson Foundation, National Institute on Drug Abuse, and the Dr. Ralph and Marian C. Falk Medical Research Trust.

More information about National Alcohol Screening Day is posted on the Web at <www.mentalhealthscreening.org/alcohol.htm>. "Who Comes to Voluntary, Community-Based Alcohol Screening? Results of the First Annual National Alcohol Screening Day, 1999" is posted at <http://ajp.psychiatryonline.org/cgi/content/full/160/9/1677>. ■

Screening Worth the Effort

Nearly half of the respondents in a survey conducted six months after the 1999 National Alcohol Screening Day reported no longer having a drinking problem.



Source: *American Journal of Psychiatry,* September 2003

Trauma of Having Cancer May Alter Brain Structure

Cancer patients who experience one of the symptoms of posttraumatic stress disorder have been found to have a small left amygdala. This discovery suggests that the psychological stress of having cancer may alter this brain structure.

BY JOAN AREHART-TREICHEL

The notion that psychological stress, and especially posttraumatic stress disorder, can damage the architecture of the human brain is a disturbing notion.

But there is scientific evidence to support it—and the evidence is growing.

During the past few years, for example, various scientists have reported that PTSD patients have smaller hippocampi than normal. These findings suggest that the psychological stress of PTSD is powerful enough to shrink the hippocampus. Smaller hippocampi have also been noted in depressed persons, which in turn may possibly be due to stress as well *(Psychiatric News*, May 19, 2000).

And now Yutaka Matsuoka, M.D., Ph.D., head of adult mental health at the National Center of Neurology and Psychiatry in Kohnodai, Ichikawa, Japan, and colleagues have found that cancer survivors who experience only one of the symptoms of PTSD—intrusive recollections—have a smaller left amygdala. The investigation was reported in the October 1 *Biological Psychiatry*.

"This is an intriguing study," David Spiegel, M.D., associate chair of psychiatry at Stanford University School of Medicine, told *Psychiatric News*. "It is novel to have differences in amygdala volume related to PTSD symptoms in cancer patients."

Breast Cancer Subjects Used

Matsuoka and his coworkers first recruited 76 subjects who had already survived more than three years since breast cancer surgery. They then took a question regarding PTSD intrusive recollections from the Structured Clinical Interview for *DSM-IV* Axis I Disorders and modified it slightly so that it was more appropriate for cancer survivors.

The question was this: "Did you think about cancer-related events when you did not want to, or did thoughts about cancer-related events come to you suddenly when you did not want them over a period of four weeks or more?"

They then asked this question of their 76 subjects: 35 (46 percent) answered yes, and the remainder (54 percent) answered no.

The researchers then used magnetic resonance imaging to measure total amygdala volume and volume of the left amygdala and of the right amygdala in each of the subjects. The total amygdala volume was significantly smaller in the subjects who had experienced intrusive recollections than in the subjects who had not, the investigators found. What's more, this significantly smaller total amygdala volume appeared to be due to a smaller left amygdala, not to a smaller right amygdala. These findings continued to be statistically significant even after the scientists took possibly confounding factors such as age, height, handedness, and a history of major depressive disorder into consideration.

"These results suggest a difference in volume of the amygdala of cancer survivors according to whether they have cancer-related intrusive recollections," the researchers concluded in their study report. The results also suggest, but certainly do not prove, that the psychological stress of having cancer might be enough to shrink the left amygdala.

And how might psychological stress shrink the left amygdala? Conceivably through intrusive recollections because, as the researchers pointed out in their report, "the amygdala is critically involved in the formation of enhanced explicit memory for emotionally arousing events." Still, the psychological stress of having cancer might shrink the left amygdala via some other means, and a diminished amygdala might then lead to intrusive recollections.

"It is more likely that the volumetric alterations of the amygdala precede the cancer-related intrusive recollections," the scientists speculated.

Clinical Implications

These findings do not have any immediate implications for clinical psychiatrists, Matsuoka told *Psychiatric News*. But they do have a possible future one, he pointed out—"I think that the left amygdala may become a possible target for the development of a treatment strategy against intrusive recollections in cancer survivors."

Moreover, he said, the findings "represent an important step in integrating medical illness [such as cancer] with a field that was previously the domain of neuropsychiatry."

The study was financed by the Japanese Ministry of Health, Labor, and Welfare; the Japanese Ministry of Education, Culture, Science, and Technology; and the Foundation for Promotion of Cancer Research in Japan.

An abstract of the study, "A Volumetric Study of Amygdala in Cancer Survivors With Intrusive Recollections," is posted on the Web at <www-east.elsevier.com/bps>. ■

For Schizophrenia Patients, Faces Are a Difficult Read

Schizophrenia patients tend to do just as well as the rest of us in recognizing happy, sad, or angry expressions. They do less well, however, in reading fear or disgust or in interpreting neutral expressions.

BY JOAN AREHART-TREICHEL

Welcome to the art of face reading—the ability to interpret emotions in other people's faces correctly. It's probably harder than most people think. They tend to make correct interpretations only 71 percent of the time.

But for individuals with schizophrenia, correctly interpreting emotions in other people's faces is even more challenging. They tend to get the emotions right only 64 percent of the time—a highly significant difference statistically.

What's more, persons with schizophrenia are especially likely to err when faces express fear or disgust or are emotionally neutral. Interestingly, however, they tend to do just as well as persons without mental illness in recognizing happy, sad, or angry expressions.

These revelations come from a study conducted by Christian Kohler, M.D., clinical director of neuropsychiatry at the University of Pennsylvania, and coworkers; the results of their study appeared in the October *American Journal of Psychiatry*.

The study included 61 persons without mental illness and 28 persons with stable schizophrenia. The subjects competed with each other on an emotion-recognition test that Kohler and his team developed. The test included 96 computer-based, three-dimensional color faces expressing any of five emotions—happiness, sadness, anger, fear, or disgust—or neutrality. The emotions expressed were designed to be either mild or intense. Half of the faces were male, half were female. Fifty-nine of the faces were Caucasian, and 37 were non-Caucasian.

Kohler and his colleagues believe that their findings have practical implications for persons with schizophrenia and for those who care for them. For instance, both mentally healthy and schizophrenia subjects were found to interpret emotions better when they were displayed more intensely. The schizophrenia subjects, however, benefited less from emotions that were intensely displayed than the other subjects did. Thus, exaggerating one's facial expressions may not help an individual with schizophrenia correctly interpret the meaning of those expressions.

The researchers also pointed out that one of their findings—that schizophrenia subjects tend to be as good at recognizing angry faces as subjects without mental illness—surprised them. The reason? They expected that schizophrenia patients, who are often prone to paranoid thinking, and hostility would also be likely to misinterpret anger.

Source: *American Journal of Psychiatry*, October 2003

Study subjects were asked to identify the emotions suggested in these and other photos. The top photos depict (from left) neutral, mild-intensity happy, sad, angry, fearful, and disgusted expressions. The bottom photos depict neutral, extreme-intensity happy, sad, angry, fearful, and disgusted expressions.

The study was financed by the National Institute of Mental Health.

The study, "Facial Emotion Recognition in Schizophrenia: Intensity Effects and Error Pattern," is posted on the Web at <http://ajp.psychiatryonline.org/cgi/content/full/160/10/1768>. ■

Applicants Invited

Psychiatry residents are invited to apply for the APA/Shire Child and Adolescents Psychiatry Fellowships for 2004-05. There will be five residents chosen to participate in this two-year program.

Each fellow will be assigned to work with a mentor. Also, the fellows will be able to attend APA's 2004 and 2005 annual meeting with travel and meeting expenses paid. At those meetings, the residents will be able to network with the field's leading lights and attend sessions on various aspects of child and adolescent psychiatry; they will present a workshop at the 2005 annual meeting in Atlanta.

The fellowship is open to psychiatry residents in their PGY-1 to PGY-3 years. They must be in a psychiatry residency program during both years of the fellowship.

Financial support for the fellowship comes through an unrestricted educational grant from Shire Pharmaceuticals.

The deadline for applications is November 12. Applications and information can be obtained on the Web at <www.psych.org/med_ed/Shire_brochure_04.pdf> or from Jane Edgerton by phone at (703) 907-8579 or e-mail at kids@psych.org. ■

ASTRAZENECA SEROQUEL (AKATHISIA) P4C

More Medication Doesn't Mean More Improvement

Schizophrenia patients who received dosages in excess of 1,000 chlorpromazine mg equivalents had poorer outcomes than those who received standard dosages, even after adjusting for baseline severity.

BY MARK MORAN

Patients with schizophrenia discharged from the hospital receiving antipsychotic medication in dosages within recommended ranges show improvement in some critical short-term outcomes compared with patients receiving higher dosages.

Individuals who were given high dosages of antipsychotic medication at hospital discharge (defined as more than 1,000 chlorpromazine mg equivalents) had greater severity of symptoms three months after discharge—as measured by the Brief Psychiatric Rating Scale (BPRS)—than patients who were given dosages recommended by the Patient Outcome Research Team for Schizophrenia (PORT) (300 to 1,000 chlorpromazine mg equivalents), according to a study in the September *Psychiatric Services*.

Those patients who were given low dosages at discharge (defined as less than 300 chlorpromazine mg equivalents) were less likely to report side effects but were slightly more likely to be nonadherent, according to the study.

"When patients with schizophrenia are leaving the hospital, higher dosages that exceed PORT guidelines are not necessarily associated with better outcomes," study coauthor Mark Olfson, M.D., M.P.H., told *Psychiatric News*. "Patients who received dosages in excess of 1,000 chlorpromazine mg equivalents had poorer outcomes than those who received standard dosages even after adjusting for baseline severity and other measures."

Olfson is a professor of psychiatry at Columbia University College of Physicians and Surgeons in New York City.

Study Methodology

Data for the study were collected as part of the Rutgers Hospital and Community Survey, 1995-97. A total of 264 patients completed a three-month follow-up interview, with data available on discharge medication dosage for 246 patients.

The study patients were interviewed within three days of discharge using the Structured Clinical Interview for *DSM-III-R*. Clinical symptoms were assessed using the BPRS, and social engagement was assessed using a four-item scale derived from the schizophrenia PORT project measuring frequency of interaction with friends.

The patients were interviewed again using the same instruments at three months postdischarge.

Of the 246 patients, 161 were prescribed antipsychotic medication within the recommended range, 50 received high dosages, and 35 received low dosages.

Since data were collected from 1995 to 1997, before PORT recommendations were released, so the study does not speak to clinicians' adherence to treatment guidelines.

Findings Difficult to Interpret

Despite the finding of more severe symptoms at follow-up among patients receiving higher dosages at discharge, the study found no significant differences in outcome on social and occupational functioning related to dosage level at hospital discharge. Moreover, patients who received low dosages did not show poorer outcomes.

But lead author Nancy L. Sohler, Ph.D., M.P.H., told *Psychiatric News* that the follow-up period may have been too short to detect a relationship between low dosages and poorer outcomes. Sohler is with the department of epidemiology and population health at Montefiore Medical Center and Albert Einstein College of Medicine, New York.

"Those patients prescribed low dosages were, however, slightly less likely to be adherent during the three-month follow-up period," said Sohler.

This was true despite the fact that they were also less likely to experience adverse side effects, she said.

Olfson said the finding of nonadherence among patients prescribed lower dosages is difficult to interpret. It could be an artifact of treatment history—these patients may have had a history of noncompliance, leading psychiatrists to prescribe lower dosages. Or the lower dosages could be less effective, causing patients to "make a reasoned choice" to discontinue medication, Olfson said.

Sohler told *Psychiatric News* that social and occupational functioning is likely to be influenced by too many other factors for medication dosage alone to produce an effect. "We believe appropriate treatment that includes recommended antipsychotic dosing should impact social and occupational functioning and service utilization," she said. "However, these outcomes are generally associated with a complex interplay among social context, resource availability, and treatment decisions, in addition to medication use. Adherence to medication dosage guidelines alone is not likely to result in strong effects on these outcomes. It is also likely that a longer follow-up period is needed to detect changes in these outcomes."

John Kane, M.D., executive director of the Zucker Hillside Hospital in New York, emphasized the difficulty of interpreting both the surprising findings of greater nonadherence and fewer side effects among patients receiving low dosages, as well as the poorer outcomes among those receiving higher dosages.

"Nonadherence is a difficult thing to evaluate in terms of what causes it," he told *Psychiatric News*. "This study demonstrates just how complicated adherence is—we shouldn't just assume that if we diminish side effects, we will improve adherence."

Because the patients in the study were not randomly assigned to the different dosage levels, Kane said, it is likewise difficult to interpret the finding of greater symptom severity among patients receiving the higher dosage.

"It is possible that the patients who were given the higher dosages needed those dosages to achieve the same clinical status at discharge as those who received the lower dosages," Kane said. "Those patients who required the higher dosage at discharge had higher BPRS scores at follow-up. But it is difficult to tease out a cause and effect. Can we say they had higher scores because they were receiving higher dosages? Or were they a subgroup that required the higher dosage and even with that higher dosage experienced more severe symptoms?"

Kane said the latter supposition is supported by the fact that those patients were more likely to have frequent hospitalizations and to be receiving both oral and depot medications.

"It just shows that these are not simple relationships," Kane said. "In order to understand all the variables that may explain these relationships, we need randomized trials where the variables can be controlled and manipulated."

Kane added that clinical research data on how to manage patients who are more severely ill and less responsive to treatment are lacking.

"Certainly, guidelines are useful and should be the rule rather than the exception," Kane said. "One of the things the study shows is that there are no advantages to higher dosages, though they may be necessary for some patients."

Sohler also noted that the study was undertaken before second-generation antipsychotic medications became widely available. "It will be important to monitor how the newer generation of antipsychotic medications impacts a number of patient outcomes across a range of domains over time," she said. "A systematic evaluation of long-term treatment outcomes across different patient groups is very important to help clinicians, patients, and their families understand better their treatment options.

"Understanding why deviations occur in recommended dosing regimens needs further study," she added. "Clinical decision making must consider patient preferences, family and residential staff considerations, treatment resistance, as well as psychiatrists' judgments of dosage related to issues of symptom control, safety concerns, and optimal functioning."

The study, "Antipsychotic Dosage at Hospital Discharge and Outcomes Among Persons With Schizophrenia," is posted on the Web at <http://ps.psychiatryonline.org/cgi/content/full/54/9/1258?>. ■

Schizophrenia, Bipolar Disorder May Share Malfunctioning Gene

Two very different mental illnesses may share some of the same genetic flaws, namely the warped expression of genes that make myelin.

BY JOAN AREHART-TREICHEL

Could two mental illnesses with quite different symptoms—schizophrenia and bipolar disorder—share some of the same genetic flaws? Mounting evidence bolsters just such a hypothesis.

A protein known to interact with dopamine receptors was found to demonstrate abnormally high activity in the prefrontal cortex region of brains of deceased persons who had been diagnosed with schizophrenia and of deceased individuals who had had bipolar disorder (*Psychiatric News*, February 7).

In May Elliot Gershon, M.D., a professor of psychiatry and human genetics at the University of Chicago, and coworkers reported that two genes on chromosome 13 with undetermined functions appeared to increase the risk for both schizophrenia and bipolar disorder.

And now Sabine Bahn, M.D., Ph.D., a clinical lecturer in psychiatry at the University of Cambridge in England, and colleagues have found that some genes that do not express themselves properly in the brains of schizophrenia patients also do not express themselves correctly in the brains of bipolar disorder patients. The genes in question help make the myelin sheaths that insulate brain nerve cells. The findings were published in the September 6 *The Lancet*.

A number of studies from various scientists had already suggested that certain genes that make nerve-cell myelin are abnormally expressed—that is, engage in abnormal messenger RNA transcription—in the brains of schizophrenia patients. So Bahn and her team decided to see whether this might be the case for brains from bipolar disorder patients as well.

To explore this, they took prefrontal cortex material from 15 deceased persons who had had schizophrenia, from 15 who had had bipolar disorder, and from 15 who had had neither illness. They then used three high-technology techniques to measure the expression of myelin-producing genes present in the brain material for the three groups. The techniques were differential display polymerase chain reaction, real-time quantitative polymerase chain reaction, and microarray analysis. (Differential display PCR is a method whereby two populations of RNA are compared. Real-time quantitative PCR is a method that measures specific amounts of DNA that have been reverse-transcribed from RNA. Microarray analysis is a method that allows for the measurement of mRNA in a sample on a massive scale.)

The researchers found a highly statistically significant reduction in the expression of a number of myelin-producing genes in schizophrenia brain material compared with control brain material.

They also found a highly statistically significant reduction in the expression of a number of myelin-producing genes in bipolar brain material compared with control brain material.

"The high degree of correlation between expression changes in schizophrenia and bipolar disorder provides compelling evidence for common pathophysiological pathways that may govern the disease phenotypes of schizophrenia and bipolar affective disorder," the researchers concluded.

"The observation that at least some myelin-related gene-expression deficits are common between individuals with schizophrenia and bipolar disorder is intriguing because schizophrenia and bipolar disorder have different symptom profiles and require treatments based on quite different neurotransmitter systems." So wrote Kenneth Davis, M.D., chair of psychiatry, and

please see ***Malfunctioning Gene*** *on page 28*

ASTRAZENECA SEROQUEL
P4C

FDA's Proposed Diabetes Warning

The FDA has proposed the following language be added to the labels for atypical antipsychotics, under the section regarding warnings. The final wording of any warning is subject to negotiation and agreement between the individual companies and the FDA.

Hyperglycemia and Diabetes Mellitus

Hyperglycemia, in some cases extreme and associated with ketoacidosis or hyperosmolar coma or death, has been reported in patients treated with atypical antipsychotics including [insert drug name]. Assessment of the relationship between atypical antipsychotic use and glucose abnormalities is complicated by the possibility of an increased background risk of diabetes mellitus in patients with schizophrenia and the increasing incidence of diabetes mellitus in the general population. Given these confounders, the relationship between atypical antipsychotic use and hyperglycemia-related adverse events is not completely understood. However, epidemiological studies suggest an increased risk of treatment-emergent hyperglycemia-related adverse events in patients treated with the atypical antipsychotics studied. Precise risk estimates for hyperglycemia-related adverse events in patients treated with atypical antipsychotics are not available. The available data are insufficient to provide reliable estimates of differences in hyperglycemia-related adverse-event risk among the marketed atypical antipsychotics.

Patients with an established diagnosis of diabetes mellitus who are started on atypical antipsychotics should be monitored regularly for worsening of glucose control. Patients with risk factors for diabetes mellitus (e.g., obesity, family history of diabetes) who are starting treatment with atypical antipsychotics should undergo fasting blood glucose testing at baseline and periodically during treatment. Any patient treated with atypical antipsychotics should be monitored for symptoms of hyperglycemia including polydipsia, polyuria, polyphagia, and weakness. Patients who develop symptoms of hyperglycemia during treatment with atypical antipsychotics should undergo fasting blood glucose testing. In some cases, hyperglycemia has resolved when the atypical antipsychotic was discontinued; however, some patients required continuation of antidiabetic treatment despite discontinuation of the suspect drug.

Study Questions Pancreatitis Link To Antipsychotics

A new study has identified rare cases of pancreatitis in patients taking atypical antipsychotics.

BY JIM ROSACK

Amid the controversy surrounding warnings of increased risk of patients developing diabetes while taking atypical antipsychotic medications (see article on page 1), a report focusing on a potential rare risk of pancreatitis associated with the same medications garnered little attention.

The report by former Food and Drug Administration (FDA) staff member Elizabeth Koller, M.D., now an assistant professor of internal medicine at the University of Nebraska Health Sciences Center, and her colleagues was published in the September *Pharmacotherapy*. The study was completed with no outside sources of funding.

Koller and her associates conducted a systematic review of the FDA's MedWatch database of adverse-event reports for cases of pancreatitis in patients taking clozapine (Clozaril and generics), olanzapine (Zyprexa), or risperidone (Risperdal). They used haloperidol (Haldol and generics) as a "control" representing an older typical neuroleptic. The MedWatch data spanned the period from January 1981 through February 2002. In addition, a MEDLINE search was conducted for any published reports of antipsychotic-associated pancreatitis during the same period.

The researchers found 177 reports of pancreatitis associated with the four antipsychotic medications. In addition, they noted 31 cases where patients were taking more than one of the medications, most often a combination of one atypical plus haloperidol.

Of the cases occurring in patients on monotherapy, 72 cases (40.7 percent) were associated with clozapine, 62 cases (35 percent) with olanzapine, 31 cases (17.5 percent) with risperidone, and 12 cases (6.8 percent) with haloperidol.

Most cases occurred within the first six months of therapy; however, there was no association between daily dose of any of the four medications and the time to diagnosis of pancreatitis. Of the patients who developed pancreatitis, 22 died. Deaths did not differ significantly between the four medications.

The investigators stressed that the presentation of pancreatitis in patients taking an atypical antipsychotic is very rare and that causality cannot be proven by methods such as theirs. Sedentary lifestyle, obesity, weight gain, diabetes, alcoholism, hyperlipidemia, and gall stones are all risk factors for pancreatitis, they noted, and all are common in patients with schizophrenia.

Koller's team concluded that it is reasonable to entertain a diagnosis of pancreatitis as a differential for any schizophrenia patient with unexplained abdominal pain. While clinicians should be aware of adverse-event reports, the researchers called for more definitive prospective studies to determine whether a clear causal link exists.

An abstract of "Pancreatitis Associated With Atypical Antipsychotics: From the Food and Drug Administration's MedWatch Surveillance System and Published Reports" is posted on the Web at <www.accp.com/pharmacotherapy/pharm2309.php#5>. ■

Diabetes

continued from page 1

often than are other atypical antipsychotics.

The issue is certainly not a new one. Case reports of diabetes and diabetic complications associated with atypical antipsychotics have been known for many years. However, significant debate has occurred in both the research and clinical arenas as to how strong the association is, and what factors—if any—are likely to predict which patients will be at increased risk.

One central issue in the controversy is the role played by weight gain as a factor in increasing a patient's risk for developing diabetes. Endocrinologists have long held that obesity is a key factor increasing the risk of diabetes in the general population. A significant body of epidemiological research has attempted to answer the question in patients taking antipsychotics, with somewhat conflicting results.

Many psychiatrists familiar with the issue now believe that weight gain fostered by antipsychotic medications does play a central role in elevating the risk of diabetes in their patients.

"Both case-report literature and published FDA MedWatch analyses indicate that about 75 percent of the cases of new-onset type II diabetes associated with drugs like clozapine and olanzapine occur in the setting of obesity and substantial weight gain," said John Newcomer, M.D., an associate professor of psychiatry at Washington University School of Medicine in St. Louis.

"That leaves 25 percent, though," Newcomer told *Psychiatric News*, "who develop diabetes without weight gain, and these are the difficult cases to figure out."

Newcomer has published several research studies on the risk of diabetes in patients taking atypical antipsychotics.

Several studies have indicated that patients gain the most weight on olanzapine and clozapine, while patients taking risperidone and quetiapine gain less. Patients taking ziprasidone or aripiprazole generally do not gain weight, and may even lose weight.

While cases of diabetes have been reported among patients taking all of the six medications in question, some studies indicate that the highest number of cases appears to be in patients taking olanzapine and clozapine.

Olanzapine maker Lilly several years ago acknowledged that weight gain is a known risk factor for diabetes and began a line of research geared to help patients reduce the amount of weight they gain while on the drug—either through pharmacological means or via diet and exercise. Some data have been published that suggest that weight gain can be limited in patients with schizophrenia taking olanzapine.

FDA's Stance

"The FDA was in a very difficult position," Newcomer noted. If the agency had done nothing, it would have been accused of being nonresponsive. If the FDA ordered selective labeling—only certain drugs within the class—then the agency "would really have been on the spot to justify that position."

In ordering warnings across the entire class of atypicals, however, Newcomer believes the agency may have been trying for the middle ground—not wanting to single out one medication. Yet by avoiding the weight issue, he said, the FDA appears to have caught the ire of a number of specialists familiar with the issue.

"Clearly, the NIH [and] the [American Diabetes Association] say that weight gain is a major risk factor for diabetes mellitus and that it should be watched. Yet there is little mention of it in the FDA warning," Newcomer said.

In addition, he maintains that the warning could have been more specific on what physicians should do if a patient develops serious diabetic complications, as well as how patients taking atypical antipsychotic medications should be monitored to catch any impairment in glucose control early. Newcomer also believes that "the FDA could have identified that there are differences in short- and long-term weight gain among the individual medications that are already detailed in the package inserts and should be considered as part of monitoring and treatment decisions."

Looking for Answers

In its letter to Lilly, the FDA "acknowledge[s] that additional labeling changes may be required as new information becomes available. Areas that require additional research include, but are not limited to, identification of subpopulations at greatest risk for diabetes mellitus adverse events, exploration of the relative risk for diabetes mellitus adverse events among the different antipsychotics, and evaluation of potential mechanisms of action."

Each of the companies involved continues to pursue these and other research questions in an attempt to resolve the issue, and most of the companies told *Psychiatric News* that they will review the requested labeling changes and work out final language with the FDA.

Endocrinologists are intimately involved in attempting to answer key questions as well. The American Diabetes Association (ADA) has scheduled a November 19 consensus development conference to address the relationship between antipsychotic medications and diabetes.

Newcomer is a member of the ADA consensus panel's planning committee. (He noted that the final consensus committee will be made up of endocrinologists and senior psychiatrists who—like himself—have no research or financial interest in the companies that make the medications at issue.) The ADA conference is currently targeted at primary care physicians and endocrinologists, Newcomer said, who have not yet heard much about the diabetes problems that psychiatric patients are encountering. However, the results of the conference will have obvious relevance beyond those fields.

APA is also working on the issue, having established an antipsychotics and diabetes subcommittee under the Corresponding Committee on Research on Psychiatric Treatments. Newcomer also is on this subcommittee.

"What remains to be seen is whether the ADA comes out with a consensus statement that is in line with or different from the FDA's language," Newcomer said. "Will there be any clarity to the monitoring and treatment recommendations? APA's subcommittee will watch this very closely and will be in a position to add to or clarify the ADA statement, so that we get the most accurate and complete information out in a timely manner."

The FDA's letter to Lilly is posted on the Web at <www.lilly.com/pdf/2003_9_17_fda_letter.pdf>. ■

Discussing Depression Helps Families Cope

Parental depression can wreak havoc on families, but recent findings show that when parents and children learn about and share their experiences of depression with one another, family relations improve.

BY EVE BENDER

A family-based intervention targeting depressed parents and their children helped children to understand parental depression better, improved family functioning, and led to fewer depressive symptoms in the children, according to a study in the August issue of *Pediatrics*.

"Currently, there is not enough attention paid to the needs of children whose parents are depressed," William Beardslee, M.D., told *Psychiatric News*. Beardslee, the study's lead author, is psychiatrist in chief at Children's Hospital in Boston and the Gardner Monks Professor of Psychiatry at Harvard Medical School.

Beardslee and his colleagues recruited 93 dual- and single-parent families with 121 children throughout the early to mid-1990s in the Boston area in which at least one parent was depressed and randomized them to one of two interventions.

The first was a family-based approach to an intervention in which a nonmedical mental health clinician delivered two lectures to depressed parents about mood disorders and their effect on family functioning in general. During the lectures the clinician encouraged parents to talk with their children about their depression.

Beardslee developed the other intervention, known as the "family-based preventative intervention," in the late 1980s while treating depressed parents and their children.

During the intervention, which typically lasts for six to 11 sessions, nonmedical mental health clinicians held individual and group meetings with parents and children.

Although psychologists, nurses, and social workers conducted the sessions, Beardslee described both interventions as "public health approaches" designed to be administered by a wide range of practitioners, including nonmedical mental health practitioners, psychiatrists, primary care practitioners, and pediatricians.

In the meetings, parents and children were taught about mood disorders and their effects on family functioning, and these effects were linked to families' specific experiences. In addition, the clinician encouraged parents to assure children that they were not to blame for their parents' depression.

The clinician also worked with parents to encourage children to pursue interests, relationships, and activities outside the home.

When the researchers assessed the families at four points up to 2.5 years after the interventions, they linked both interventions to a decrease in children's depressive symptoms as evidenced by a drop in scores on the Youth Self-Report. However, the family-based intervention had more impact in other areas of functioning.

Beardslee found, for example, that for families that participated in the more intensive, family-based intervention, parents reported, on average, a greater number of positive changes in "child-related behavior and attitudes"— in other words, the ways in which parents interacted with their children.

For example, the parents in the family-based intervention reported better overall communication with their children or had more discussions about depression with their children than those in the lecture-based intervention. In addition, when such reports of child-related behavior were removed from the statistical analyses, children in the family-based intervention reported more change in their understanding of parental illness than had those in the lecture group.

As one child reported about his mother, "[I]t's good to know that part of [the depression] is physical. It helps me to understand that she is ill."

There was also a strong positive association between the amount of change children reported in their understanding of parental depression and the number of positive parent-child interactions. "Our intervention had a positive overall effect on family interactions, and that was our aim," Beardslee told *Psychiatric News*.

The study was funded by grants from the National Institute of Mental Health and the William T. Grant Foundation.

"A Family-Based Approach to the Prevention of Depressive Symptoms in Children at Risk: Evidence of Parental and Child Change" is posted on the Web at <http://pediatrics.aappublications.org/cgi/content/full/112/2/e119>. ■

NIMH Research Effort to Focus On Genetics of Schizophrenia

The National Institute of Mental Health launches an intramural research program to investigate the roles of genetics and neurobiology in schizophrenia.

BY CHRISTINE LEHMANN

How does a gene variant encode for schizophrenia? A new intramural research program at the National Institute of Mental Health (NIMH) will focus on answering that complex question over the next six to eight years.

Daniel Weinberger, M.D., chief of the NIMH Clinical Brain Disorders Branch, will direct the new program, which will look at the genetics and neurobiology of cognition and psychosis. Weinberger is a psychiatrist and neurologist.

Multidisciplinary teams will use mouse, fruit-fly, and cell-culture models; clinical studies; and brain imaging to understand how genetic variations express themselves in cells, molecules, and neurobiological systems.

"Genes don't directly encode for the hallucinations, delusions, and blunted affect of schizophrenia," said Weinberger in a press release announcing the project. "Rather, there is a very complicated path between a gene's influence on the regulation and function of a protein and such psychiatric phenomena."

At least six genes are considered candidates worthy of further research, with each contributing about 3 percent to 4 percent of the variance in vulnerability to schizophrenia, according to Weinberger. "The new studies may identify biological tests and ways to turn on or off genes that could lead to strategies to prevent or treat schizophrenia," he said.

"Such findings will serve to stimulate spin-off studies by extramural or grant-supported researchers," said NIMH director Thomas Insel, M.D.

The new intramural program has a budget of at least $6 million annually over the eight to 10 years over which it will extend. The funds will be derived mainly from other intramural funds, according to NIMH spokesperson Jules Ascher.

A panel of advisors to the project includes Christopher Austin, M.D., a senior advisor at the National Human Genome Research Institute; David Goldman, M.D., chief of the Laboratory of Neurogenetics of the National Institute on Alcohol Abuse and Alcoholism; Jeffrey Lieberman, M.D., psychiatry professor and vice chair for research at the University of North Carolina; and Eric Nestler, M.D., professor and chair of the psychiatry department at the University of Texas Southwestern Medical Center at Dallas.

The NIMH press release is posted on the Web at <www.nimh.nih.gov/events/schizgeneleads.cfm>. ■

Scientists Try to Unravel Mysteries of Human Biology

Two new NIH "centers of excellence" will study how living systems make decisions at the cellular level—a concept at the core of neuroscience research.

With grants totaling more than $31 million over the next five years, the National Institute of General Medical Sciences (NIGMS) has established two new centers for excellence in research at Harvard University and the Massachusetts Institute of Technology. The two centers are set to explore key concepts directly applicable to neuroscience.

The Bauer Center for Genomics Research at Harvard received an initial grant of $3 million—the first installment of an anticipated total of $15 million—to explore topics related to "modular biology."

Lead investigator Andrew Murray, Ph.D., director of the center, will team with collaborators at Stanford University, Canada's University of Calgary, the California Institute of Technology, and Israel's Weizmann Institute for Science and Hebrew University in Jerusalem to study how collections of genes or proteins work together to carry out particular biological functions.

The team will test the hypothesis that such collections "behave as discrete functional modules," each of which performs a specific function essential to an organism's survival and reproduction. The concept has been at the core of neuroscience research for many years as researchers struggle to decipher the living physiology behind behavior and personality traits.

At MIT, the Computational and Systems Biology Initiative, led by executive director Brigitta Tadmor, Ph.D., will focus on projects related to the emerging field of systems biology—a study of the interface between biology and engineering. Experts in computer science, basic biology, cancer research, biological engineering, environmental health, chemical engineering, and microsystems research will team up to explore "biological circuits" in human cells and tissues. By combining research methods in computer-based analysis and living-cell modeling, researchers hope to predict how biological circuits function under normal circumstances and how they go awry in disease states.

The function of the human brain is centered in the concept of biological circuits—the combination of individual groups of neurons that team up to perform specific tasks leading to behavior and cognition.

More information on these research projects is posted on the Web at <www.nigms.nih.gov/funding/complex_systems.html>. ■

Malfunctioning Gene

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Vahram Haroutunian, Ph.D., an associate professor of psychiatry and neurobiology at Mount Sinai School of Medicine in New York City, in an editorial accompanying *The Lancet* report.

"I have seen the study [report from Bahn and team]," Gershon told *Psychiatric News*. "It is quite important. . . ."

In contrast—and not surprisingly—increasing evidence also shows that the genes underlying schizophrenia are not always those that underlie bipolar disorder.

For example, Bahn and her colleagues reported in 2002 that three genes that make lipoproteins (which in turn play a central role in cholesterol transport) appear to be overly expressive in the brains of persons with schizophrenia, but not in the brains of persons with bipolar disorder (*Psychiatric News*, April 19, 2002).

The recently reported study by Bahn and her team was funded by the National Alliance for Research on Schizophrenia and Depression, Britain's Biotechnology and Biological Sciences Research Council, and the Stanley Medical Research Institute.

A summary of the study report, "Oligodendrocyte Dysfunction in Schizophrenia and Bipolar Disorder," is posted on the Web at <www.thelancet.com>. ■

When Can You Treat Minors Without Parental Consent?

Q. I treat children and adolescents in my psychiatric practice. Recently, an older adolescent requested treatment but does not want his parents to know. Who may consent to treatment for a minor? Does it make a difference if the adolescent is over 16 years of age?

A. Traditionally, the law has considered minors to be incompetent to give consent to medical treatment. Most states have statutes that govern who may consent to mental health treatment and under what circumstances. Generally, a parent or legal guardian must consent to the treatment of a minor. There are various statutory and judicial exceptions to the rules of who may consent.

Minors of a certain age have been granted the right to consent to specific types of treatment in some states. For example, minors may have the right to consent for themselves to treatment for sexually transmitted diseases or health services for birth control or pregnancy. Several states permit minors to obtain psychiatric treatment and/or substance abuse treatment without parental consent. Even states that permit minors over a certain age to consent to mental health treatment usually do not allow minors to give informed consent for psychotropic medications.

Most states allow emancipated minors or "mature minors" to give consent for mental health treatment. State law establishes the criteria for being considered an emancipated or mature minor.

Do not treat a minor under an exception to the consent law unless you have confirmed that the exception is valid and applies to the particular situation under the laws of your jurisdiction. Documentation in the medical record should support treatment under the exception.

Know your state statutes about who may consent to a minor's psychiatric treatment or admission to a mental health treatment facility before treating a minor. Written consent for treatment should be obtained from the parent(s) or legal guardian and maintained in the child's medical record. Consent given by one who does not have the legal authority to give consent is no consent. Individuals who do not have the legal authority to consent to treatment often present children for treatment (grandparents, babysitters, stepparents, siblings, and so on). In a nonemergency situation, the psychiatrist must determine who may legally consent and obtain that person's written consent before beginning treatment.

In an emergency, treatment may be provided without consent. Some states have passed laws applicable to minors and emergency consent; they vary as to the immediate and probable harm that must be present for treatment to be provided under this exception. The psychiatrist must make a clinical decision about whether treatment is appropriate when a minor is presented for psychiatric treatment under the emergency exception. Physicians should be familiar with the minor consent laws in their states. In any case, the documentation in the medical record should include the clinical rationale for a decision to treat under an emergency exception.

Child-custody situations complicate the issue of who has authority to consent to a child's psychiatric treatment. Program participants are encouraged to call the Risk Management Consultation Service at (800) 245-3333 for more information about this circumstance and other risk management issues related to treating children and adolescents. Risk management articles about this topic are also available in our Online Risk Management Library in the "For Participants Only" section of <www.psychprogram.com>.

Q. I am considering reducing my hours and would like to know how part-time discounts are calculated with the Psychiatrists' Program.

A. The Psychiatrists' Program offers a premium discount of up to 50 percent for part-time practice. Part-time hours are calculated based on the weekly total hours of all covered professional activities at all covered locations. Should your hours slightly fluctuate from week to week, it is acceptable to average the hours over a longer period, for example, six months. The discount is based on a range, as follows (except in New York, where the part-time discount is 50 percent for 20 hours or fewer):

- **1 to 10 hours weekly:** 50 percent
- **11 to 15 hours weekly:** 40 percent
- **16 to 20 hours weekly:** 30 percent

Weekly hours are determined by calculating not only direct patient care but also other activities your policy covers, such as records management, consultations, peer review and utilization review activities, and hospital rounds. Please note that when seeking coverage for on-call work, the on-call hours are used to calculate total practice time in the context of actual hours worked during the on-call period.

If your hours have changed, contact your underwriter by phone at (800) 245-3333 or by e-mail at customercare@prms.com so that your next premium can be calculated accurately.

This column is provided by PRMS, manager of the Psychiatrists' Program, for the benefit of members. More information is available by visiting the Program's Web site at <www.psychprogram.com>; calling (800) 245-3333, ext. 389; or sending an e-mail to TheProgram@prms.com. ■

letters to the editor

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,* APA, Suite 1825, 1000 Wilson Boulevard, Arlington, Va. 22209; fax: (703) 907-1094; 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.

Sticky Business

The July 4 issue of *Psychiatric News* featured several highly salubrious signs of critical thinking, but one tiny indication that the sickness within APA lingers.

The healthy signs were articles that reported on unbiased studies presented at APA's 2003 annual meeting that compared conventional antipsychotics with the costly, much-hyped atypicals. It is a sign of hope that these presentations were sponsored and published by APA, not by the pharmaceutical industry.

In that same issue, however, the ominous symptom of lingering illness was the bulky inserts advertising those same high-priced antipsychotics. Most ominously, the rubbery, gelatinous glue affixing them to adjacent pages was more tenacious and adhesive than before. It used to crumble off easily, like a week-old scab. Now it infiltrates and binds to the page, like a penetrating sore. Does this hint at APA's underlying fatal acquired immune deficiency to drug company cash?

WILLIAM HOUGHTON, M.D.
Milwaukee, Wis.

GID Not 'Phantom Disorder'

An article in the July 18 issue summarized some of the putative controversy regarding the gender identity disorder (GID) diagnosis, including its use with children, as discussed at the APA annual meeting in San Francisco. Dr. Hill's critique of GID is replete with inaccuracies.

He asserts that "gender roles are not clearly dichotomous, like *DSM* suggests they are." Almost no behavior is completely dichotomous between two groups, but the phenomenology of the GID criteria is based, in part, on very strong mean differences between the behavior of boys and girls that play a strong role in how one's gender is subjectively constructed. Hill's disavowal of such differences reflects a lack of awareness of a large empirical research literature on children's gender development.

His claim that there are no validity studies on GID in children is incorrect. Our group at the Child and Adolescent Gender Identity Clinic at the Centre for Addiction and Mental Health in Toronto has conducted several diagnostic studies of children with GID, with siblings, clinical controls, and nonreferred controls serving as comparison groups. All of these studies demonstrated substantial evidence for discriminant validity.

Hill also stated that "[t]here is little evidence of pathology." By this, he is referring to the presence of other behavioral/emotional problems in children with GID. Hill is wrong. Using a well-standardized parent-report measure of child and adolescent behavior problems, the Child Behavior Checklist, we have published several studies showing that both children and adolescents with GID have, on average, as many general behavioral and emotional problems as demographically matched clinical control children and significantly more problems than nonreferred children.

Hill's primary beef, however, is that he does not really accept the possibility that children can experience marked discomfort with their gender (gender dysphoria), other than seeing it as secondary to the reaction of others. In my view, this is a simplified understanding of the complexity of gender development. Consider, for example, a 3-year-old girl who repeatedly states that she is a boy or that she wants to be a boy. Her parents reply by telling her that she is a girl, and the child's reaction is to cry and insist otherwise. Hill's interpretation of such distress is that it is merely the result of the parents' reaction, not the possibility that the child is also struggling with a complex feeling state. Of course, if the parents went along with the child's fantasy that she was a boy, there would be no overt distress, but it would hardly solve the underlying problem and would merely reinforce it.

When GID in children persists into adolescence, often the only way the adolescent can feel comfortable about himself or herself is to go through the difficult process of contra-sex hormonal treatment and physical sex-change procedures. Hill's characterization of GID as a "phantom disorder" seems remarkably naive.

KENNETH J. ZUCKER, PH.D.
Toronto, Ontario

Recovery: Nothing New

Those of us who trained 50 years ago in large state hospitals were well aware that many schizophrenia patients recovered to a great extent ("Skepticism Greets Report of Schizophrenia Recovery," August 1). We depended on these patients to run our severely underfunded hospitals.

At Norristown, Pa., where I started my training, schizophrenia patients worked the farm that fed the hospital and ran the bakery, kitchen, and commissary. They assisted nurses on the wards and cleaned the floors. The man at the information desk was a recovered schizophrenia patient, and those of us who lived on the grounds entrusted our children to kindly old ladies with schizophrenia as babysitters. These people only remained in the hospital because the communities they came from had "closed ranks," and they had no place to go.

In a later chapter of my life, I practiced

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from 1963 as a community psychiatrist in a small city where I still occasionally encounter patients whom I treated as many as 40 years ago. While some continue to hallucinate, especially at times of stress, many are at worst slightly eccentric and take very little medication.

C. BROOKS HENDERSON, M.D.
Dunnellon, Fla.

Another Kind of Pause

The increasing clinical and research attention directed toward the psychophysiological effects of low testosterone in men (and women) and the beneficial outcomes of replacement therapies has been stimulating and exciting in the past two to three years. Of course, research literature on the topic has been compiling for decades, but it can now be elaborated on in a more sophisticated way in the context of the evolution of psychiatric nosology and the immense advances in psychoneuroendocrinology.

I have been noticing that among respected academicians publishing in monthly journals, using the terms "andropause" and "male menopause" has seemingly been accepted by editorial staff and allowed to continue.

Our profession has had to live with the outcomes of naming syndromes badly with terms we've then been stuck with ("borderline" is probably the best example). So why are we allowing the propagation of "andropause?" I am unclear about the origins of the term, but this neologism is predictably troublesome. My *Dorland's Medical Dictionary* defines menopause as, "cessation of menstruation in the human female, . . .premature failure of ovulation, possibly due to primary germ cell deficiency. . . ."

When authors of studies published by psychiatric journals (approved by editorial staff) include the term "male menopause," one with a common-sense appreciation of language might be logically correct in assuming they were talking about cessation of menstruation in men. And "andropause"? This sounds more like a brand-name for a new women's product that can be used to tone down her frisky male partner's unrelenting advances. Or a new device for men to use when they want to get in touch with their feminine side.

Before our professional linguistics are overtaken by, like, you know, the pop media, whatever, we might want to develop a useful and accurate term for what has typically been called hypogonadism or androgen deficiency, or at least stay consistent, for now, with the *DSM* terminology that was previously labored over meticulously to avoid future nosological embarrassments.

I'd continue, but my castration anxiety is flaring up again. . . . I need a dose of andropause!

MICHAEL L. JAMES, M.D.
Salt Lake City, Utah

Holistic Psychiatric Care

I was glad to read the Viewpoints article "Exercise, Nutrition Advice Crucial to Psychiatric Care" by Dr. Ashley B. Benjamin in the September 5 issue. I, too, discuss health issues with my patients.

Many patients lack interest in taking care of themselves because of their psychiatric condition. They gain weight for many reasons: the consumption of excess fatty foods and lack of exercise. Many live in group or family-care homes that provide high-calorie foods that cost less than nutritious foods. Also, most psychotropic medications are associated with weight gain.

I ask my patients what kind of health problems they have or think they will have by being overweight. Now many of them are able to repeat at least, "Diabetes, high blood pressure, heart problems. . . ." I encourage them to exercise—such as walking, jogging, and practicing yoga, depending on the status of their health and access to programs. If needed, I give them a calorie chart and ask them to keep a daily list of the food they eat.

Another common problem is that many patients smoke or smoke to excess to try to decrease their feelings of depression and anxiety. I ask my patients whether they know the consequences of smoking, and I encourage them to quit. If they don't know the consequences of smoking or have only partial knowledge, I give them a list.

Let us not forget that we became physicians before we became psychiatrists. We should take the time to pass on general health and fitness advice to our patients—especially since some busy doctors may do only short medical checkups when they see a "mental" patient. Let us enjoy the satisfaction of work well done.

SATISH VARMA, M.D.
New Hyde Park, N.Y.

Ethics and Addiction

I read with considerable interest Dr. Brealyn Sellers' Resident's Forum titled "Conflicting Social Forces Impede Addiction Treatment" in the August 2 issue. The elaboration of the ethical dilemma surrounding such efforts as methadone maintenance and needle-exchange programs was most eloquent: "[I]t can be a stretch to feel on solid ethical grounds 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."

I happen to believe that such programs do indeed support the perpetuation of self-destructive behavior in the form of addictive disease, and in no way can these programs be considered "treatment" of addictive disease. Harm reduction is public-health preventive medicine that, one could hope, would be a prelude to abstinence-based treatment.

It was disappointing to read that Dr. Sellers suggests that we physicians might be willing to alter our ethical stance to accommodate the harm-reduction approach. Ethics is defined as a system of moral principles, and she rightly suspects that harm-reduction efforts constitute a violation of the principle of "physician, do no harm." To abandon one's ethical principles is to engage in the moral relativism that grips Western culture today.

JAMES W. BELVINS, M.D.
Santa Clara, Calif.

Candidates

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training on people without those resources.

"I would support logical funding incentives to get more people into the workforce with jobs that pay enough to purchase private mental health care," said Dean in his statement.

Dean and Kerry would make improving access to community-based care a priority along with better coordination of services for people with mental illness. "Government agencies should coordinate programs for mental and physical health care, drug treatment, housing, and employment training," said Dean.

Dean also proposed earmarking federal support for programs that "employ people recovering from mental illness to provide peer support and counseling for people who need mental health care."

Dean also supports school-based screening and treatment for children. "Schools need enough resources to help all children who would benefit from counseling instead of struggling to barely address only the worst crises."

Kerry pledged to fund the Individuals With Disabilities Education Act (IDEA) when the Senate takes up the legislation's reauthorization bill (HR 1350). The bill passed the House with several amendments in April (*Psychiatric News*, July 20).

Kerry would also ensure that mental health care is included in the nation's response to terrorism and said he would support laws that protect people with mental illnesses, including the Americans With Disabilities Act and privacy protections, according to his statement.

Both Dean and Kerry pledged to promote greater public awareness of mental illness and reducing stigma.

Information about the Campaign for Mental Health Reform is posted on the Web at <www.mhreform.org>. Dean's speech and record as governor are posted on his Web site at <www.deanforamerica.com/#>; his positions on health and mental health issues are posted under "On the Issues." Kerry's mental health press release is posted on his Web site at <www.johnkerry.com/news/releases/pr_2003_0912b.html>. ■

community news

Violence

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Jaycox, or believe they could have stopped it from happening, she said that group facilitators help the children challenge such thoughts and work on overcoming avoidant behaviors they may develop in relation to the trauma—such as being too afraid to walk to school or avoiding the local playground.

Walking a Fine Line

Group leaders sometimes walk a fine line when trying to help students cope with all-consuming fears about the world around them, Jaycox said. "When something bad happens to us, we tend to believe the world is an extremely dangerous place."

Although CBITS is designed to challenge such fears, "the world is a dangerous place for many students who live in impoverished neighborhoods where there is a lot of violence," Jaycox explained, so group leaders teach students to distinguish between safe and dangerous situations and how to stay as safe as possible.

During the first year of the EIEP project, Wong said school counselors screened about 1,000 immigrant children in the third to eighth grades.

The children were asked if they had witnessed or been the victim of an attack with or without a weapon. The levels of exposure to violence differed from school to school, she recalled, but ranged from 75 percent to 90 percent in the 11 East L.A. schools.

Working With Limited Resources

Schools didn't have the staff or resources to conduct the intervention with that many children, so those with three or more incidents of exposure to violence were given priority.

She noticed that the students who wound up in the group intervention would never have been identified if it weren't for the screening. "They might not be doing as well as their teachers wanted them to, but they weren't acting out."

Wong said she calls these children "hidden in plain sight."

In addition, many of the children who participated in the group intervention were experiencing clinically significant levels of PTSD and depression.

Such was the case with one student from Central America. During a New Year's celebration, Wong said, the boy's family members were outside socializing when a group of soldiers burst on the scene and shot and killed the boy's uncle. A year after the child emigrated to the United States, Wong said, "he couldn't think straight—he had nightmares and intrusive thoughts about the violent scene."

The boy's mother did not understand why her son was performing poorly in school until the boy, in an individual session, began to describe the violence in detail and talk about how the memories haunted him, Wong said.

"She began to understand what her son was experiencing," she added, "and the empathy she was able to show him was additionally healing."

The CBITS intervention is now being implemented and studied in one school in South Central Los Angeles, Wong said, with funding from the Substance Abuse and Mental Health Services Administration.

More information about the CBITS program is posted on the Web at <www.rand.org/publications/RB/RB4557>. ■

Insurance

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through other means becomes exhausted, states might impose restrictions on enrollment that will further increase the number of uninsured.

Selby Jacobs, M.D., told *Psychiatric News*, "The rise in the number of uninsured in the United States, now biting into the working and middle classes of American society, could not come at a worse time. Not only does it aggravate the problem of access to care, the 'cushion' that Medicaid usually provides in these circumstances is compromised by the fiscal plight of the states. The convergence of the two problems creates a crisis in access to care that affects not only the poor but a broad sweep of Americans."

Jacobs is chair of APA's Committee on Public Funding of Psychiatric Services, director of the Connecticut Mental Health Center, and a professor of psychiatry at Yale University School of Medicine in New Haven.

"Health Insurance Coverage in the United States: 2002" is posted on the Web at <www.census.gov/prod/2003pubs/p60-223/pdf>. "2003 Employer Health Benefits Survey" is posted at <www.kff.org/content/2003/3369>. ■