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PSYCHIATRIC NEWS

Articles with "see" references appear as follows:

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Government News

CMS Acknowledges Need for Inclusive Part D Formulary

Protections in Medicare Part D to ensure access to a wide range of psychiatric drugs may be a good start, but additional regulations are needed to prevent drug formularies from posing barriers to care.

BY JIM ROSACK

APA has commended the Centers for Medicare and Medicaid Services (CMS) for "recognizing the medication needs of the particularly vulnerable population our members serve." The Association continues to be concerned, however, over some drug utilization management techniques and the potentially discriminatory restrictions those techniques may impose on patients' access to medications in the Medicare Part D prescription drug benefit.

The praise and concern were part of written comments submitted to CMS on March 6 in response to a draft guidance outlining how the agency plans to review drug formularies submitted by prescription drug plans (PDPs) that intend to participate in the program in 2007.

In that draft guidance, issued February 23, CMS proposed to continue the 2006 requirement that all PDPs include in their Part D formularies "all or substantially all" medications in six specific classes, including antidepressants, antipsychotics, and anticonvulsants.

In response, APA "strongly endorsed" the continued protection for the six classes of medications, which also include the immunosuppressants, antiretrovirals, and antineoplastics.

"Denial of the medications in these classes would not only harm enrollees," APA told CMS, "but in the long run would be detrimental to the entire Medicare program because of [potential] expenses incurred in increased hospitalizations and other acute care services."

Moreover, APA strongly recommended that the agency add several protective steps to its review process for formularies, in addition to the core requirements outlined in the United States Pharmacopeia (USP) Model Guidelines.

The USP's Model Guidelines were developed in 2004 as an outline of the drug categories, classes, and key drug types that should be included in formularies of all PDPs participating in Part D *(Psychiatric News*, October 1, 2004). Under the Medicare Modernization Act, which created the Part D benefit, all PDPs participating in Part D must cover at least two medications "within each therapeutic category and class of covered Part D drugs, although not necessarily all drugs within such classes."

In the comments that APA submitted to CMS, APA stated that the final guidance should refer to treatment guidelines that outline best practices to guide PDPs in developing their 2007 formularies. PDPs could, for example, review the practice guidelines developed by APA, the Texas Medication Algorithm Project, and the Schizophrenia Patient Outcomes Research Team. These expert guidelines, APA noted, could be valuable in alleviating problems experienced with some PDPs' denial of certain medications or particular dosing regimens for specific illnesses.

In addition, APA continued, "it is our view that many widely used pharmacy management practices are wholly inappropri-

please see ***Formulary*** *on page 8*

Jack Douthitt

Alma Herndon

Pedro Ruiz, M.D., becomes APA president in May, when Carolyn Robinowitz, M.D., becomes president-elect.

Association News

Robinowitz Chosen Next President-Elect

This year three APA Areas elected a trustee to represent them on the Board, and a record number of members took advantage of the option to cast their vote online.

BY KEN HAUSMAN

APA Secretary-Treasurer Carolyn Robinowitz, M.D., chalked up a decisive victory in the race to become APA's next president-elect, winning 76.1 percent of the vote. Her opponent was Jack Drescher, M.D., of New York City.

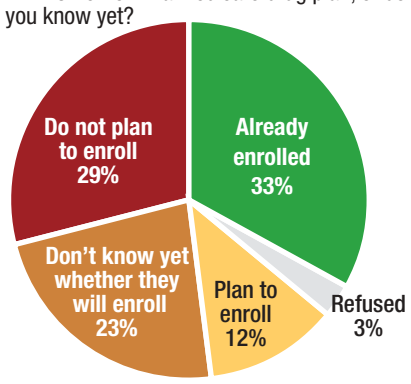
"My first task," Robinowitz told *Psychiatric News*, "will be to assist incoming president Pedro Ruiz achieve his goals for universal access, comprehensive parity, and humane care—goals that mesh with my focus on effective advocacy for our profession and our patients—and on increasing the value of APA membership.

"I will also concentrate on communication and collaboration by improving interactions with members and providing more just-in-time information and materials, while enhancing members' participation in policy development and implementation. I also want to enhance collaborations with

please see ***Election Results*** *on page 44*

Off to a Slow Start

A nationally representative sample of 262 seniors was asked these questions: Have you already enrolled in a Medicare drug plan? If not, do you think you will enroll in a Medicare drug plan, you will NOT enroll in a Medicare drug plan, or don't you know yet?



Source: Kaiser Family Foundation Health Poll Report Survey (conducted February 2-7, 2006)

See story page 4.

Association News

What's Your Part D Experience?

APA's Office of Healthcare Systems and Financing (OHSF) is monitoring how Medicare's new prescription drug benefit, known as Medicare Part D, is working for you and your patients. OHSF wants to pinpoint problems as soon as possible so they can be brought quickly to the attention of the Centers for Medicare and Medicaid Services and remedies sought. Your experiences are vital to letting OHSF know how Part D is really working. Share your comments by calling APA's PartD Line at (866) 882-6227 or sending them by e-mail to partd@psych.org.

Court Upholds Psychiatrist's Award In Suit Against State Hospital

Physician supporters hail a recent federal appeals court decision in favor of a Delaware psychiatrist as critical to efforts to maintain standards of patient care.

BY RICH DALY

The 3rd Circuit Court of Appeals in Philadelphia upheld a lower court's award of nearly $1 million, including $25,000 in punitive damages, to David Springer, M.D., on February 15, for the Delaware Psychiatric Center's violation of his First Amendment rights (*Psychiatric News*, May 21, 2004).

Springer's claim was against Renata Henry, director of the state's Division of Alcoholism, Drug Abuse, and Mental Health, who declined to reinstate his contract after he wrote memos that cited numerous problems at the facility, including serious staffing shortages and demeaning treatment of patients.

"Having a physician lose his employment and potentially lose his ability to obtain employment anywhere as a punishment for speaking out will have a chilling effect on doctors' willingness to do so, to the detriment to patients' health," said Jane Orient, M.D., executive director of the Association of American Physicians and Surgeons (AAPS), which follows national physician whistleblower issues.

Springer, head of the medical staff and director of residency training at the state's only public psychiatric hospital, filed suit in October 2000, after Henry told him his independent contractor agreement would not be renewed because he did not apply for it. His contract had been renewed automatically for each of the nine previous years.

The order from Henry to reapply followed revelations by Springer that serious problems at the hospital were compromising patient safety. Prominent among his concerns were inadequate supervision of patients on suicide watches that led to preventable suicide attempts, extreme overcrowding, and escapes of civilly committed patients.

After he and others protested to state officials, Springer said, the staff was intimidated by threats from Henry's department.

"The evidence supports the jury finding that Henry acted at least recklessly or callously, if not intentionally or maliciously, with respect to Dr. Springer's constitutionally protected rights," Judge Dolores Sloviter, wrote for the three-judge panel in *David T. Springer, M.D., v. Renata J. Henry.*

Springer's suit against Henry in her capacity as director of the mental health division contended he was terminated because he spoke out about his patient-safety concerns.

"The First Amendment's protection of an employee's right to speak on matters of public concern extends to independent contractors," wrote Sloviter. "Henry has not seriously disputed that the contents of Dr. Springer's speech (i.e., a physician's critique of patient safety and unsafe working conditions) constitute matters of public concern."

The $998,895 jury award includes $285,464 for lost earnings, $588,431 for lost future earnings, and $100,000 for injury to his reputation.

Springer, now in private practice, has urged the state legislature to hold hearings on the treatment of patients at the hospital.

Orient said physician whistleblowers are in a precarious position because hospitals may place an adverse action against them in the National Practitioner Data Bank, which allows few appeals for physicians and can make them unemployable and unable to obtain privileges at hospitals. The law under which the data bank operates contains a bad-faith clause, but bad faith is extraordinarily difficult to prove, Orient said.

"That is what makes Dr. Springer's win so fantastic, because so many others have tried and failed to withstand hospital pressure," Orient said.

Andrew Schlafly, an AAPS attorney who filed an amicus brief in the case, said such punitive moves by hospitals against physicians who raise patient safety concerns are increasingly common.

"Part of the reason is that hospitals are getting more adversarial in their approach to physicians," he said. "It's an 'us versus them' mentality."

He said the increasingly litigious approach of hospitals stems in part from legal advice they receive from their attorneys.

Recently courts have come to view retaliation against physicians through its adverse impact on patient care, which has led to judges increasingly ruling against hospitals and administrators that take action against whistleblowers, Schlafly said.

In one recent case, *Poliner v. Texas Health Systems*, a federal jury in Dallas awarded $366 million to a cardiologist who claimed that his practice was ruined when three fellow doctors and a hospital worked together to suspend his privileges to perform heart procedures. The August 2004 jury award was against the three doctors, who were held individually liable for breach of contract, defamation, interference with contractual relations, and intentional infliction of emotional distress.

[David T. Springer, M.D., v. Renata J. Henry, United States Court of Appeals for the Third Circuit, No. 04-4124]

The ruling is posted at <www.aapsonline.org/judicial/044124p.pdf>. ■

Prevalence, Treatment Data Raise Troubling Questions

BY STEVEN SHARFSTEIN, M.D.

How many Americans suffer from symptoms of psychiatric disorders in a year? How many people have psychiatric disorders whose symptoms are serious and disabling? What proportion of these people receive adequate treatment? These and other critical questions for the practice of psychiatry have been addressed in an elaborate and far-reaching study in the "National Comorbidity Survey Replication" conducted by Ron Kessler and colleagues and published in a series of three papers last June in the *Archives of General Psychiatry*.

This study involved detailed interviews with nearly 9,300 randomly chosen American adults, representative of persons in the general U.S. population, between February 2001 and April 2003. The results indicated that 26 percent of respondents reported having symptoms sufficient for diagnosing a mental disorder in the previous 12 months. Not surprisingly, prevalence estimates were highest for anxiety disorders at 18 percent, and then mood disorders at nearly 10 percent (*Psychiatric News*, July 15, 2005).

These rates of disorder are consistent with the rates found in the previous survey a decade ago. In the recent study period, as there have been no "cures" developed for psychiatric disorders, the lack of change in basic prevalence is not surprising. However, it is important and desirable to be able to document a decrease in disability and the burden of disease as our psychiatric treatment continues to improve. I believe many patients are "better, but not well" as Gerald Klerman, M.D., put it.

In terms of the severity of psychiatric symptoms, most of the respondents identified as having a psychiatric disorder had symptoms that were considered to be in the mild (41 percent of disorders) or moderate (37 percent of disorders) range, while fewer persons had symptoms that were considered to be in the serious range (22 percent of disorders and 6 percent of the total population sample).

The findings about treatment are most illuminating. Of the people identified as having a psychiatric disorder in the past 12 months, close to 60 percent had not received any treatment for their disorder. Among those who sought treatment (approximately 40 percent), close to one-third did so with unproven therapies, such as dietary supplements or acupuncture. Of those who sought traditional care for their psychiatric problems, the largest number was treated by general medical providers, not psychiatric or mental health specialists. In fact, psychiatrists treated only 12 percent of cases identified as having a psychiatric disorder.

The proportion of the population treated for mental illness over a 12-month period, some of whom did not meet the threshold for a psychiatric diagnosis, has grown to 17 percent from 13 percent a decade ago. This expansion was mainly in the general medical sector, with more primary care physicians providing psychiatric services and psychiatric medications than in the past.

Most distressing to me was the general inadequate level of care that persons received for their psychiatric disorders. Only 13 percent seen for mental health problems by general medical providers received minimally adequate care (defined as receiving either at least two months of an appropriate medication for a focal disorder plus four visits to the physician or with a health care or human services professional for psychotherapy lasting an average of 30 minutes a session). The care was better when provided by psychiatrists; but only 48 percent of those who went to psychiatrists received care that met minimal standards.

These minimally adequate treatment standards set at levels consistent with general levels of treatment guidelines do not answer the question, What are the results of these treatments? More attention is needed to assess treatment outcome in terms of both symptoms as well as functional abilities in the everyday lives of our patients as we make the case for more resources to provide these treatments.

Another important issue this study investigated is the age of onset of psychiatric disorders and the delay in seeking help or treatment. Half of those identified as having a psychiatric disorder reported showing signs of illness by age 14; three-quarters reported showing signs by age 24. Delays for treatment ranged from an average of nine to 23 years for anxiety disorders and six to eight years for mood disorders.

The study raises many questions and issues about the nature of psychiatric disorders and the role of psychiatrists. Does our *DSM* nosology have too low a threshold in selecting symptoms of mental disorders? Many of these disorders may be self-limiting and mild in response to life stresses. As noted by Dr. Kessler in a recent NPR interview, how much credibility does our diagnostic system lose by attaching a psychiatric diagnosis to these relatively mild and self-limiting problems? Should all people

please see ***From the President*** *on page 43*

Annual Meeting

College MH Concerns

APA's Task Force on Mental Health on College Campuses will hold an open discussion about college mental health concerns at APA's 2006 annual meeting in Toronto on Tuesday, May 23. The session will meet from 10 a.m. to 11 a.m. in the Montebello Room on the Hospitality Floor of the Royal York Hotel. Psychiatrists who have a special interest in college mental health issues will have an opportunity to raise concerns and discuss them with their colleagues. Psychiatrists who want to learn more about this topic are also invited to stop by. ■

Most Americans Don't See Part D in Their Future

A Kaiser Family Foundation tracking poll finds that 45 percent of seniors say they have enrolled or plan to enroll in a Medicare Part D drug plan, 29 percent say they do not intend to enroll in a drug plan, and 23 percent say they are uncertain.

BY MARK MORAN

Problems continue to plague the new Medicare Part D prescription drug program, with some states extending emergency coverage of "dual eligibles" transitioning from Medicaid into the program.

And a recent poll shows that fewer than half of American seniors had enrolled in the program or a plan by the last week of February or were planning to do so.

Irvin (Sam) Muszynski, J.D., director of APA's Office of Healthcare Systems and Financing, said that his office is continuing to receive reports through the Part D monitoring system it established regarding serious problems with enrollment of patients in the program and lack of access to necessary psychotropic drugs for patients who did get properly enrolled.

"There's a large gap between the Centers for Medicare and Medicaid's [CMS] policy on continuity of care for medically vulnerable patients and the drug plans' compliance with them," he said.

"The amount of time we are spending with prior authorizations is bringing the rest of our work to a standstill."

Muszynski added that CMS has continued to assure APA that psychotropic drugs are supposed to be made available through every participating drug plan. "The draft 2007 formulary guidelines were sent to us on February 23 by CMS, and these continue the 'all or substantially all' protections that are supposed to be in place for antidepressants, antipsychotics, and anticonvulsants" (see page 1).

(In the run-up to January 1, CMS had said that "all or substantially all" of six classes of drug would be included on drug formularies. Those included antidepressants, antipsychotics, anticonvulsants, antineoplastics, immunosuppressants, and HIV drugs.)

APA members can contact the Association's Part D monitoring system by e-mail at partd@psych.org or by phone at (866) 882-6227. APA is continuing to post information with its partners about the program at <www.mentalhealthpartd.org>. APA is particularly interested now in information about how the prior authorization and appeals process is working.

Psychiatrist Andrea Stone, M.D., medical director of the Carson Center for Human Services in Westfield, Mass., has reported to *Psychiatric News* a host of problems with the new program since its beginning on January 1. Those include unexpected copayment requirements, failure to ensure continuity of care for dual-eligible beneficiaries transitioning from drug coverage under their Medicaid plan, and utilization review requirements that detract from clinical duties and sometimes result in lengthy delays in receiving medication.

More than six weeks into the start of Part D, and after Massachusetts instituted emergency coverage for dual eligibles and other beneficiaries unable to access their medication, Stone told *Psychiatric News* that she and her staff are still busy coping with enormous problems associated with the program.

She acknowledged that while many beneficiaries may be smoothly receiving their medications, it is the problem cases that command attention, and those problems are not insignificant, she said.

Requirements for prior authorization that are burdensome and sometimes clinically illogical appear to be the most persistent complaint.

"The amount of time we are spending with prior authorizations is bringing the rest of our work to a standstill," she said. "This is affecting every level. The secretaries are spending enormous amounts of time on hold with the prescription drug companies, nurses are trying to get people medications by whatever means possible in the short term, and the doctors have to fill out forms providing clinical information on patients in order to justify prior authorizations. Meanwhile, we are not getting responses very quickly.

"The kind of information they want includes previous treatments and reasons for failure, and for some patients who have been stable for 10 years, that kind of information can be very difficult to track down," she said. "We understood that if people were stable on meds by January 1, they would have no problem receiving their medication. That may be happening in some cases, and we only hear about the problems, but it's not happening for everyone."

Meanwhile, a Kaiser Family Foundation tracking poll found that 45 percent of seniors said they enrolled or plan to enroll in a drug plan, 29 percent said they do not intend to enroll in a drug plan, and 23 percent said they are uncertain. The majority of those who do not plan to enroll said they have another program or plan that helps pay for their prescriptions.

Though more seniors are enrolling in a drug plan each month, the tracking poll also showed that seniors have become less enthusiastic about the new Medicare drug benefit over the past six months. Seniors are now almost twice as likely to say they view the benefit unfavorably (45 percent) as favorably (23 percent). That finding reflects a shift since August, when seniors' positive views peaked, and they were as likely to view the benefit favorably (32 percent) as unfavorably (32 percent).

The nationally representative tracking poll was conducted among 262 seniors from February 2 to February 7, more than a month after the January 1 start date for the Medicare drug plan.

"A substantial number of beneficiaries are already enrolled, but a lot turns on what those who are on the fence decide to do between now and May 15," said Drew Altman, president and CEO of Kaiser Family Foundation.

Mollyann Brodie, a Kaiser Family Foundation vice president and director of public opinion and media research, said, "The plan finder at <Medicare.gov> is the best way to compare Medicare drug plans, but relatively few beneficiaries and their helpers are using it to date."

In other news, some states are seeking to extend emergency coverage of dual eligibles experiencing problems with access to drugs under the new program.

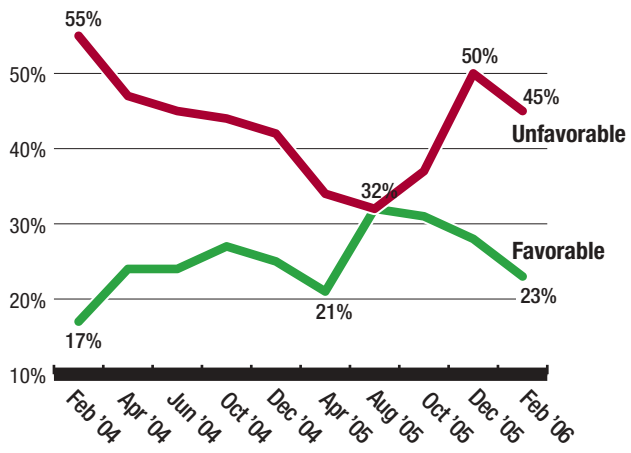
"We see no evidence that sufficient improvements have been made to the Medicare prescription drug program that would give the state any confidence that the most vulnerable clients in our state will be adequately served should we turn their drug coverage over to Medicare and its contractors," wrote Ann Clemency Kohler, director of New Jersey's Division of Medical Assistance and Health Services, in a letter to CMS.

Kohler said that some 4,000 dual-eligible beneficiaries in the state were not yet enrolled in a prescription drug plan, and another 4,000 beneficiaries had been "auto-enrolled" in plans that did not even operate in New Jersey. And about 600 dead people were enrolled in Part D.

"To date we have paid $113 million in claims for our dual eligibles and. . .continue to pay $2.6 million per day," Kohler wrote. "In light of the significant data issues, it is unlikely that the problems with Part D will be resolved" quickly. ■

Devil Was in Details?

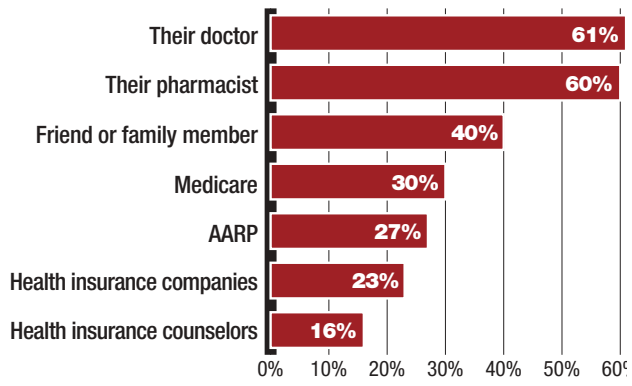
Over a two-year period, seniors were asked whether they had a favorable or unfavorable impression of the new Medicare Part D drug benefit. Release of program details did not improve perception.



Source: Kaiser Family Foundation Health Poll Report Survey (conducted February 2-7, 2006)

Whom Do You Trust?

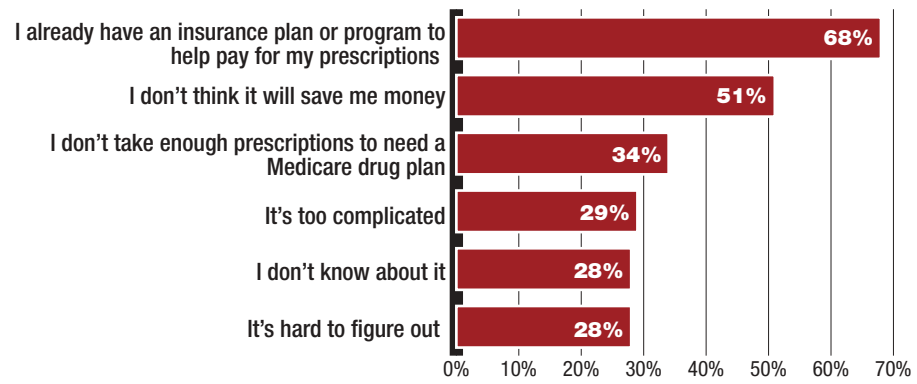
Seniors were asked which of the following they trusted "a lot" to help them understand and choose among Medicare drugs plans.



Source: Kaiser Family Foundation Health Poll Report Survey (conducted February 2-7, 2006

Why Aren't Seniors Enrolling in Part D?

These are the leading reasons reported by the 29% of a nationally representative sample of 262 seniors who said they were not enrolling in a Medicare prescription drug plan.



Source: Kaiser Family Foundation Health Poll Report Survey (conducted February 2-7, 2006)

Professional News

Call for Nominations

Psychiatry residency training directors are invited to nominate residents for the APA/Bristol-Myers Squibb Fellowship in Public Psychiatry. The goals of the APA/BMS Fellowship Program are to provide experiences that will contribute to the professional development of residents who may be leaders in the public sector in the future and heighten the awareness of psychiatry residents of the many activities and career opportunities in the public sector.

Based on their interests, fellows are assigned to an APA component and take part in all deliberations, projects, and initiatives. They attend APA's fall component meetings in September in Washington, D.C., and other meetings as appropriate at the fellowship's expense. Fellows also participate in APA's Institute on Psychiatric Services.

Psychiatry residents entering PGY-3 during the fellowship term are eligible to participate in the program. Residents who will be in PGY-4 will be considered if they are in a five-year training program. The deadline for applications is April 1; selection notifications will be made in May.

Additional information and an application is available by visiting <www.psych.org/edu/med_students/bmsfellow/index.cfm> or calling (703) 907-8663. ■

WYETH AYERST SYMPOSIUM
P4C

President Wants Budget Savings To Come From Health Programs

President Bush's proposed Fiscal 2007 budget would cut a variety of mental health programs, but election-year politics may help preserve many of those programs.

BY RICH DALY

Mental health programs would face a variety of cuts in President Bush's proposed $2.77 trillion Fiscal 2007 budget, released last month. The proposed budget would cut nondefense discretionary spending for the second straight year and save about $15 billion by eliminating or significantly reducing 141 programs.

Large savings of $65.2 billion over five years would stem from cuts in the growth of entitlement spending, including $35.9 billion in Medicare cuts over five years and $12 billion from Medicaid over 10 years.

The cuts may prove difficult to sustain in an election year, especially since Congress only recently cleared last year's hotly contested $39 billion savings package, which was the first since 1997 to slice Medicare, Medicaid, and several other entitlement programs *(Psychiatric News*, March 3). Republican leaders of Congress said the $11 billion in savings from Medicare and Medicaid in last year's package was not easy, and it may be too soon to seek more cuts.

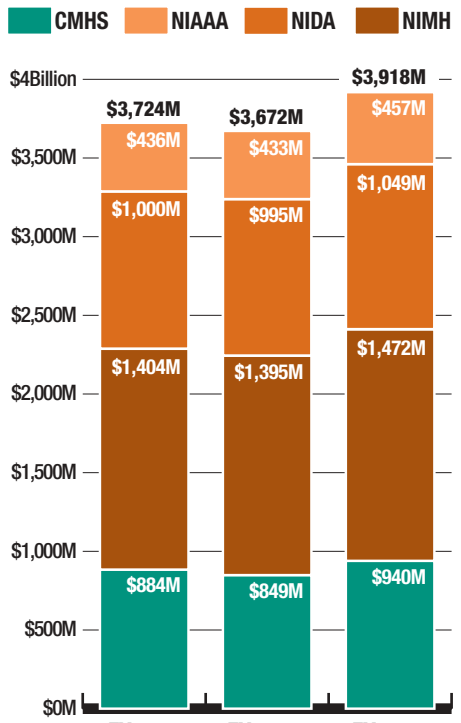
"We remain hopeful in the fact that this midcycle election year will offer some protection to some health care programs because no one in an election year wants to be accused of recommending federal funding cuts that would hurt people who are poor or with disabilities," said Lizbet Boroughs, deputy director of APA's Department of Government Relations (DGR).

The proposed budget seeks $698 billion for the Department of Health and Human Services (HHS), up from $677 billion in Fiscal 2006. Net Medicare costs are expected to reach $387 billion in Fiscal 2007, but discretionary spending would drop 4 percent, to $72.6 billion.

The Bush budget aims to slow the growth of Medicare through increased cost sharing for high-income seniors and reduced payments for some providers, including home health care agencies and hospitals. Much of that savings would be eaten up by the president's $29 billion proposal to expand the use of tax-free health savings accounts.

Cuts Proposed for MH

The Bush administration is asking for a $52 million (or 1.4%) cut to the combined budgets of CMHS, NIAAA, NIDA, and NIMH for 2007.



* MHLG = Mental Health Liaison Group
Source: National Mental Health Association, February 6, 2006

Medicaid Savings Sought

Medicaid funding would also be cut through changes to the formulas for drug reimbursement and by increasing rebates from drug manufacturers.

Funding for the National Institutes of Health (NIH) for Fiscal 2007 would be held to the Fiscal 2006 level, or $28.6 billion. Mental health advocates consider this a reduction, when an expected 3.5 percent rise in biomedical costs this year is considered.

"It gives us pause that we are backing away from what was for many years a national will to increase our investment in biomedical and severe illness research," said Andrew Sperling, director of legislative advocacy at the National Alliance on Mental Illness (NAMI). "It is unfortunate that we have to back away from that now."

The Substance Abuse and Mental Health Services Administration (SAMHSA) would be cut by $70 million, largely by changes to the State Mental Health Block Grant and State Substance Abuse Treatment Block Grant. The change would mandate that states receiving the grants establish a voucher system to reimburse the cost of health services provided by faith-based programs, a favored Bush administration initiative. The net effect is a cut in the block grants because this change would fund the vouchers through funds that were previously available for a range of projects under the block grant, said Boroughs.

Minority Training Would Be Cut

Other HHS proposed cuts include a

please see ***Budget*** *on page 43*

FOREST SYMPOSIUM
(ROOSE)
P4C

New Mexico Declines to Board Outpatient Commitment Bandwagon

Mental health advocates plan to develop a comprehensive approach to preventing violence by patients with mental illness following rejection of a bill to mandate outpatient psychiatric treatment.

BY RICH DALY

The New Mexico legislature adjourned February 17 without passing a version of New York's so-called Kendra's Law that would have permitted involuntary outpatient treatment for those with psychiatric illness convicted of violent crimes.

The measure would have allowed judges to order assisted outpatient treatment if they determined that a criminal defendant with mental illness had been incarcerated or violent too frequently within too short of a prescribed period of time.

State officials describe the procedure proposed in the New Mexico bill as similar to that for a civil inpatient commitment, in which a physician proposes a treatment plan and a hearing is required with counsel to represent the person with mental illness. The plan for the outpatient commitment was to require an expiration date, but if warranted, the treatment could be extended.

The Psychiatric Medical Association of New Mexico (PMANM) was neutral on the legislation, although it does support some form of mandatory assisted outpatient treatment, said George Greer, M.D., the district branch's legislative representative.

The PMANM has joined a group of legislators and patient activists to develop legislation for next year to plan and fund a comprehensive system to help in the treatment, housing, and care of mentally ill people.

Kendra's Law is named after Kendra Webdale, a woman who died in January 1999 after being pushed in front of a city subway train by an individual who had failed to take the medication prescribed for his mental illness.

The New York State Psychiatric Association (NYSPA) supports this type of program, with caveats, said Barry Perlman, M.D., president of the NYSPA. If such a program is well funded and its implementation is carefully monitored, research has found that such programs can reduce hospital recidivism and improve community integration for some with mental illness. "It's important to pay for psychiatrists' treatment of patients and for court appearances they have to make," Perlman said.

Psychiatrists differ on some aspects of the program, he noted, such as whether the program should allow mandatory medication in the community instead of in a hospital, where the New York program requires such medication to be administered.

Forty-two states and the District of Columbia have outpatient commitment statutes, though there are many variations in the implementation of such laws.

Patient advocates opposed the New Mexico program over concerns that it did not protect the civil rights of patients with mental illness.

"New Mexicans have turned the tide on forced treatment and rejected the simplistic approach represented by Kendra's Law," said Michael Allen, a senior staff attorney at the Bazelon Center for Mental Health Law. "This victory for a sane mental health policy will resound across the country, refocusing public attention where it should be—on adequate funding for the services and supports needed by people with mental illnesses."

Harvey Rosenthal, executive director of the New York Association of Psychiatric Rehabilitation Services and a member of the Bazelon Center's board of trustees, also lobbied against the bill in New Mexico and plans to work with state officials and legislators on "real solutions and real reforms of the public mental health system."

Improvements should begin with adequate funding for evidence-based practices, such as supportive housing and peer support.

The text of HB 174 are posted at <http://legis.state.nm.us/lcs/_session.asp?chamber=H&type=++&number=174&Submit=Search&year=06>. ■

Nominations Invited

Association News

APA invites nominations for an appointment to the Residency Review Committee (RRC) in psychiatry. The three-year term begins January 1, 2007, and is renewable once.

These are among the criteria for appointment: the candidate should have experience with residency training and administration; must be a present or past psychiatry residency training director or otherwise familiar with the Essentials and the Special Requirements for Psychiatry, as well as having had hands-on experience with the administration of a psychiatry residency training program; must be a nationally known educator in psychiatry; must be an APA member in good standing; and must commit to attending all RRC meetings, including the fall meeting prior to the appointment date and a workshop for specialist site visitors.

Nominations should consist of a letter or letters of nomination and the nominee's curriculum vitae. The deadline for nominations is May 1.

Nominations should be sent to RRC Nomination, APA's Office of Graduate and Undergraduate Education, c/o Nancy Delanoche, 1000 Wilson Boulevard, Suite 1825, Arlington, Va. 22209, or faxed to (703) 907-7849. More information is available by phone at (703) 907-8635 or by e-mail at ndelanoche@psych.org. ■

Formulary

continued from page 1

ate if applied to medically vulnerable populations. . . . Best practices for the Part D patient population served by APA members have been developed and should be CMS's reference point."

Safety Edits Present Problem

APA is particularly concerned with the current guidelines' use of "so-called safety edits by PDPs to establish quantity limits." The Association commends the use of such edits when they serve as Drug Utilization Review alerts, that is, requiring verification from the physician of, for example, a dose of medication prescribed that is outside usual parameters. APA is concerned, however, that "[u]nder Part D thus far in 2006, safety edits are being used to restrict access to necessary doses of medications, even when the physician assures the PDP that the patient has been stabilized on the dose prescribed."

APA also expressed concern over language in the draft guidance that would, for example, appear to allow step therapy or "fail-first" utilization management techniques, as well as language that appears to allow formularies to exclude extended-release formulations when immediate-release versions of the same medication are covered.

Finally, APA told CMS, it is working "with other expert groups" to develop a detailed analysis of issues "inherent in the use of conventional utilization techniques for patients with mental illness." APA welcomes "the opportunity to dialog with CMS about this activity and hope[s] that [APA and CMS] can develop specific guidelines that will aid CMS in its review of PDP utilization management practices."

APA Objects to USP Proposal

APA's latest round of comments came two months after the Association had submitted written comments to the USP regarding a proposed revision of its Model Guidelines for 2007 for drug categories and classes covered in Part D formularies. In those comments, signed by APA President Steven Sharfstein, M.D., APA said that without the addition of specific protections, the proposed revision would likely lead to decreased access to psychiatric medications for Medicare beneficiaries with mental illness and result in substandard clinical care.

"The proposed guidelines," Sharfstein wrote, "do not provide an appropriate drug classification system for beneficiaries with mental illnesses and substance use disorders. The specific therapeutic categories involved are antidementia agents, antidepressants, antipsychotics, and bipolar agents. Moreover, the complete absence of a therapeutic category for addiction treatment agents is inexplicable" (see story below).

Not only are the proposed model guidelines inconsistent with current standards of care, the proposed categories and classes (see table at right) compress the available medications in a manner that is "inconsistent with appropriate organizing principles for these drugs and inconsistent with accepted practice in the field."

Sharfstein told USP that the "potential chilling effect of the current guidelines on beneficiary access and physician treatment options" had been partially ameliorated [during 2006] by CMS's adoption of the "all or substantially all" formulary guidance. However, he cautioned, "subregulatory guidance should not and cannot be a substitute for an appropriate classification system."

Sharfstein noted that APA's review of the original model guidelines "found them insufficient to support necessary access to medications…."

"APA believes that the proposed revisions to the USP Model Guidelines. . . have deficiencies that could harm beneficiaries' access to needed drugs," he wrote.

Last year CMS issued a subregulatory guidance aimed at clarifying how the agency would determine whether formularies submitted by PDPs included all the drugs required by the USP Model Guidelines. (A guidance is an interpretative document that can be changed by a federal agency without going through the formal regulatory process.)

The USP Model Guidelines for 2006 listed 146 drug categories, classes, and key drug types; however, psychotropic medications were distilled into categories and classes that APA believed would promote PDPs' coverage of only two of the least-expensive antidepressants or antipsychotics. In addition, coverage of medications for substance abuse appeared to be absent.

Partly in response to input from APA and allied organizations, CMS adopted the "all or substantially all" requirement to ensure access to specific medications. The February 23 CMS draft guidance proposes to continue the 2006 policy and updates how the agency will use the revised USP Model Guidelines to ensure adequate drug coverage in formularies in 2007.

More information on USP's revision of the Part D Model Guidelines is posted at <www.usp.org/healthcareInfo/mmg/phase2/index.html>.The CMS draft guidance on formulary review is posted at <http://new.cms.hhs.gov/PrescriptionDrugCovContra/03_RxContracting_FormularyGuidance.asp>. ■

Revised Psychotropic Categories and Classes for Medicare Formularies in 2007

The U.S. Pharmacopeia (USP) has revised its Model Guidelines for drug formulary development to be used by prescription drug plans (PDPs) participating in the Medicare Part D drug benefit. The revised categories and classes would be used by PDPs to design formularies in effect for Fiscal 2007. PDPs are required by law to include in their formularies at least two medications from each category and/or each class. Below are the revised categories and classes pertaining to psychotropic medications.

Therapeutic Category	Pharmacologic Classes
Anticonvulsants	Calcium channel modifying agents
	GABA augmenting agents
	Glutamate reducing agents
	Sodium channel inhibitors
	Anticonvulsants, other
Antidementia agents	Cholinesterase inhibitors
	Glutamate pathway inhibitors
	Antidementia agents, other
Antidepressants	MAO (Type A) inhibitors
	Serotonin/norepinephrine reuptake inhibitors
	Tricyclics
	Antidepressants, other
Antipsychotics	Atypical
	Conventional
Anxiolytics	Antidepressants
	Anxiolytics, other
Bipolar agents	No pharmacologic classes
Central nervous system agents	Amphetamine
	Non-amphetamine
Sedative/hypnotics	No pharmacologic classes

Source: Medicare Prescription Drug Benefit; Model Guidelines Version 2.0: Drug Categories and Classes in Part D. USP, 2006

Addiction Experts Troubled by List Of Drugs Covered in Part D

The leaders of four organizations concerned with addiction treatment ask USP to rethink its model guidelines categories and classes.

BY JIM ROSACK

APA has expressed "extreme concern" over the lack of a therapeutic category for medications used to treat substance use disorders in the proposed revision of the United States Pharmacopeia's (USP) Model Guidelines for prescription drug plan (PDP) formularies participating in the Medicare Part D drug benefit.

Following provisions of the Medicare Modernization Act (MMA) that created the Part D drug benefit, USP was charged by the Centers for Medicare and Medicaid Services (CMS) to develop a uniform set of guidelines that CMS could use to evaluate individual PDPs' proposed formularies.

The MMA also specified that USP is to periodically update those model guidelines to ensure that they include a complete and accurate listing of the drug categories, classes, and key drug types that all Part D formularies must cover (see page 1). USP recently released its proposed revisions for the Model Guidelines to be used in 2007 and invited public comment, as required by the MMA.

In a letter signed by APA President Steven Sharfstein, M.D.; Michael Gendel, M.D., president of the American Academy of Addiction Psychiatry; Elizabeth Howell, M.D., president of the American Society of Addiction Medicine; and Michael Brooks, D.O., president of the American Osteopathic Academy of Addiction Medicine, the four organizations told USP that a specific category should be added to the model guidelines to encompass the FDA-approved medications currently used to treat addictions.

While these medications produce their clinical effects through different mechanisms of action, they can generally be divided into two main classes: medications used to treat withdrawal symptoms and medications used to deter future use of a substance of abuse. Based on that guiding principle, APA and the other organizations strongly recommended that a new therapeutic category of "Addictions Treatment Agents" be added to the revised guidelines (see table at left).

Within the new category, drugs would be subdivided into a pharmacologic class of "Deterrents," which would include key drug types for medications used to deter alcohol or opioid use.

The second drug class, labeled "Withdrawal Agents," would contain three key drug types—medications used as alcohol detoxification, nicotine detoxification, and opioid detoxification.

Some addiction treatment medications are listed in the USP revision for 2007. However, they are lumped into the broad category of "Antidotes, Deterrents, and Toxicologic Agents" along with "Ion Exchange Resins" and antivenins. This listing "seems an inappropriate categorization," the presidents of the four organizations wrote. Substance use disorders, they continued, are highly prevalent medical conditions with significant morbidity and mortality. "Given the proven effectiveness and evidence base of these pharmacologic treatments, our organizations strongly believe that these medications should be included in the revised guidelines." ■

Proposed Category for Addictions Treatment Agents

APA, the American Academy of Addiction Psychiatry, the American Society for Addiction Medicine, and the American Osteopathic Academy of Addiction Medicine joined together in asking the USP to add a distinct category and classes encompassing the medications used to treat substance abuse to the Model Guidelines Version 2.0: Drug Categories and Classes in Part D. If adopted by USP, drug formularies participating in Part D would have to include at least two medications from each category/class listed.

Therapeutic Category	Pharmacologic Classes	Formulary Key Drug Types
Addictions treatment agents	Deterrents	*Alcohol deterrents*
		Opioid deterrents
	Withdrawal agents	*Alcohol detoxification agents*
		Nicotine detoxification agents
		Opioid detoxification agents

Source: APA, AAAP, ASAM and AOAAM letter to USP; January 5, 2006

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Physicians May Overlook Black-Box Warnings

To avoid "black-box violations," drug-label warnings must be clarified and simplified, making them more readily understandable.

BY JIM ROSACK

Buried amid the seemingly never-ending advance of the U.S. Food and Drug Administration's (FDA) black-box warnings on the labels of most psychiatric drugs available today, there is increasing debate on the power of those warnings to change physicians' prescribing behavior.

Over the last 16 months, the FDA has imposed new black-box warnings on all antidepressants marketed in the United States and all newer-generation antipsychotics as well as many older antipsychotic drugs. Last month an FDA advisory committee, after little discussion or debate, recommended that the agency add a new black-box warning to the labels of all stimulants used to treat attention-deficit/hyperactivity disorder *(Psychiatric News*, March 3).

However, one issue that was addressed by that committee—the Drug Safety and Risk Management Advisory Committee—involved speculation regarding the impact of the black-box warning. Some members hoped the impact would be significant, akin to the large drop in the number of antidepressant prescriptions dispensed to children and adolescents that followed warnings about the potential risk of suicidality. Other committee members were more skeptical, saying that most physicians today do not read or follow the advice given in the warning sections of drug labels.

Now, a new study looking at black-box warnings and the extent to which physicians follow them indicates that 1 in 10 patients whose records were reviewed was written a prescription for a medication that carried a black-box warning. More importantly, however, 7 in 1,000 patients received a prescription for a drug that was contraindicated because of a potential adverse interaction between the new medication and another drug the patient was already taking, or because the new drug should not have been prescribed to a patient with that particular diagnosis.

The study was funded by grants from the Harvard Risk Management Foundation and Partners HealthCare Information Systems and appeared in the February 13 *Annals of Internal Medicine*.

Researchers led by Karen Lasser, M.D., M.P.H., an instructor in the Department of Medicine at Harvard Medical School, reviewed the electronic health records of patients receiving care from Partners Health Care in the Boston area to determine how frequently physicians prescribed a drug contraindicated by a black-box warning and how frequently that prescribing resulted in harm. Partners Health Care is a group of ambulatory practices including 40 hospital-based clinics, four community health centers, and seven community-based practices. All prescribing for these outpatient practices was done electronically.

At the time of the study, however, the electronic prescribing system provided physicians with only drug-allergy cross-checking and default dosing suggestions. The system did not inform prescribers about black-box (or any other) warnings, check for interactions between the drug prescribed and other medications the patient was on, check for interactions between the drug prescribed and laboratory monitoring necessitated, or check for contraindications for the drug prescribed due to incompatibility with a patient's diagnosis.

The researchers first identified all prescriptions written in 2002 for any medication carrying a black-box warning. They then looked at the records of individual patients who received prescriptions for drugs with black-box warnings to determine whether the warning should have precluded writing the prescription for that particular patient. The team designated prescriptions that should have been precluded as "black-box violations."

Lasser and her colleagues identified 33,778 prescriptions written for drugs with black-box warnings, representing 10.4 percent of the total of 324,548 outpatient prescriptions written during 2002. However, of those 33,778 prescriptions, only 2,354 prescriptions (0.7 percent of all prescriptions) were written for outpatients who should not have received the particular medication prescribed.

The overwhelming majority of those prescriptions —1,744 (74 percent)—were written for medications with black-box warnings requiring some type of laboratory monitoring that was not adequately completed as recommended in the warning. A total of 401 prescriptions (17 percent) were written for patients who had a contraindicated disease, and 209 prescriptions were written for patients who were already taking a contraindicated drug that may have resulted in a serious drug-to-drug interaction.

The data compilation for the study was completed in early 2004, prior to the imposition of the black-box warnings on antidepressants (October 2004) and antipsychotics (April 2005). In addition, the researchers looked at all drug classes with black-box warnings in 2002, not just psychotropic medications. Overall, the researchers found that black-box warnings were most commonly not followed regarding prescriptions for several antineoplastic drugs and several antifungal medications.

However, prescriptions for several psychotropic medications were identified to which black-box warnings were frequently disregarded, mostly involving anticonvulsant/mood stabilizing medications. Nearly 25 percent of patients (129 of 526) identified by the study as taking carbamazepine had no documented evidence of monitoring of CBC and platelet counts at baseline and at least once each year during therapy. Nearly 70 percent of patients (266 of 385) taking lithium did not have serum lithium levels drawn every two months as advised in the drug's black-box warning.

Lastly the researchers determined what, if any, impact violating the black-box warnings had on patients. The researchers found four adverse drug events (ADEs) resulting from a violation of a black-box warning, three of which were rated as serious (requiring urgent medical intervention) and one less significant. There were 92 possible ADEs identified, 18 of which were rated as having a potential for a fatal or life-threatening ADE, 71 for a serious ADE, and the remainder for less significant ADEs. In addition, 154 medication errors were identified.

Overall, Lasser and her team found that patients who were female, were aged 75 or older, and took multiple medications (four or more) were at highest risk of a black-box violation compared with younger male, nonwhite patients, who took fewer medications.

Lasser and her colleagues said one solution for reducing black-box violations would be for the FDA to "make these warnings more specific so they are more readily understandable by providers."

"Adherence to Black-Box Warnings for Prescription Medications in Outpatients" is posted at <http://archinte.ama-assn.org/cgi/content/short/166/3/338>. ■

Do Physicians Heed Black-Box Warnings?

Researchers found varying levels of adherence among physicians to black-box warnings and recomendations on various drug labels.

Drug Name	Drug Type	Black-box content	Nonadherent to warning
Carbamazepine	Anticonvulsant	Monitor CBC-platelet count at baseline and during therapy (once per year)	24.5%
Clozapine	Antipsychotic, antimanic	Check weekly WBC count for first 6 months of continuous treatment	88.0%
Lithium carbonate or citrate	Antimanic	Check serum levels at least every 2 months	69.1%
Nefazodone	Antidepressant	Contraindicated in patients with "active liver disease"; withdraw therapy if AST or ALT level >3 times the upper limit of normal	0
Thioridazine	Antipsychotic	Contraindicated in patients with a history of cardiac arrythmia or congenital long QT syndrome	23.1%
Valproate sodium	Anticonvulsant	Check baseline LFTs and periodic monitoring (once per year)	30.1%

Source: Medicare Prescription Drug Benefit; Draft Model Guidelines: Drug Categories and Classes in Part D. United States Pharmacopeia Convention, 2004

Govt. Hopes Partnership Can Find Genes Underlying Several Illnesses

***Carpe diem* (Latin for "seize the day") is the philosophy behind a new NIH–private company initiative to speed identification of the genetic roots of some major illnesses.**

BY JOAN AREHART-TREICHEL

The U.S. Department of Health and Human Services (HHS) announced last month the creation of a new public-private partnership. The purpose: to accelerate the identification of genetic causes of illnesses with substantial public impact, such as Alzheimer's disease, autism, obesity, and schizophrenia.

The partnership is called the Genetic Association Information Network (GAIN). It will include the National Institutes of Health (NIH); the Foundation for the National Institutes of Health, which is a nonprofit foundation established by Congress to support NIH's mission; Pfizer Global Research and Development of New London, Conn; Affymetrix Inc. of Santa Clara, Calif.; and some other major pharmaceutical and biotechnology companies.

"These are the kinds of innovative efforts that we should support," HHS Secretary Mike Leavitt asserted in an NIH press release. "We must seize the historic opportunity provided by the Human Genome Project and the International HapMap Project to speed up the discovery of the genetic causes of common diseases. . . ."

"We've translated early information from genetic research into valuable medicines for HIV/AIDS, heart disease, and the prevention of organ rejection," Martin Mackay, Ph.D., a senior vice president with Pfizer Global Research and Development, said in the same NIH press release. "But these advances have only scratched the surface of possible revolutionary approaches to treat and cure disease. . . .Our hope is that this public/private initiative will encourage a deeper collective understanding of the genetic factors of disease for major new therapeutic advances."

GAIN will focus on single nucleotide polymorphisms (SNPs)—that is, genetic variants—that can occur in people's genomes. Although most are of no biological importance, a small fraction alter the functions of genes and may increase risk of various illnesses.

Some 10 million SNPs are estimated to exist in the human population. Scanning the genomes of a large number of subjects for such a gargantuan number of SNPs would be prohibitively time consuming and expensive. But fortunately, a major shortcut has been found that reduces the task about 30-fold. The International HapMap Project, led by NIH and completed in 2005, demonstrated that the 10 million SNPs cluster in local neighborhoods, called "haplotypes," and that they can be accurately sampled by as few as 300,000 carefully chosen SNPs.

More information about the Genetic Association Information Network is posted at <www.genome.gov/17516707. ■

ELI LILLY SYMPOSIUM
(ARNOLD)
P4C

Psychiatrists Find Home In Primary Care Clinics

Integrated or collaborative care models help both patients and primary care physicians by bringing psychiatry closer to primary care.

BY AARON LEVIN

Two years ago, one-fourth of Houston's Harris County Hospital District's patient visits included a psychiatric diagnosis, a daunting figure that left the system's primary care physicians frustrated.

"We'd have patients with diabetes or high blood pressure who wouldn't take their medications or couldn't get them filled or were too depressed or anxious about side effects," said Thomas Gavagan M.D., M.P.H., the system's vice chair for community health and assistant chief of staff at the community health program in the Department of Family and Community Medicine at the Baylor College of Medicine. "All this led to primary care not being very effective."

The psychosocial burden on patients was not trivial. The Harris County system is one of the largest health care providers in the country for persons on public assistance, recording 1.2 million patient visits a year. Despite the 25 percent prevalence of psychiatric diagnoses in its patients, those who needed to see a psychiatrist had to wait six to eight months for an appointment at the system's main facility, Ben Taub Hospital.

"The district couldn't afford to hire another 20 or 30 psychiatrists, so we had to reorganize," said Britta Ostermeyer, M.D., director of the psychiatric outpatient clinic at Ben Taub and an assistant professor of psychiatry at Baylor College of Medicine.

Their solution, part of a wider trend in patient care, meant putting their psychiatrists and mental health professionals into primary care clinics.

The Community Behavioral Health Program began as a test at three sites in 2004, the latest example of integrated or collaborative care, a practice model that has slowly gained acceptance over the last decade. Collaborative care involves systematic care management—usually by a nurse, social worker, or other non-M.D.—linked to consultation with the primary care provider and a psychiatrist or other specialist.

"Under the new system, a psychiatrist may see scheduled patients but is also available to consult with the primary care doctors, either in or out of the examining room, while the patient is still there," said Ostermeyer.

The hospital district and the Hogg Foundation of Austin gave $1 million in July 2005, to expand the program to the three hospitals, 11 primary care clinics, seven school-based clinics, and several other partner sites that compose the system.

Today, the system's nine psychiatrists work at the primary care sites, backed up by social workers who conduct individual or group therapy three to five days a week at each site. Substance-abuse counselors also spend three to five days each week at the primary care locations.

Once patients are stabilized, the primary physicians can supervise their mental health care. More severe cases are treated in the hospital or directly by the psychiatrists.

"The program mirrors the way that cardiologists and other specialists work," said Ostermeyer. "They assess and stabilize patients then return them to the care of their primary doctors, who can write cardiac prescriptions as needed."

The waiting period has dropped from six to eight months down to four weeks, said Ostermeyer.

Patients in crisis can be seen the same day by psychiatrists or by a social worker in their absence. The program helps reduce stigma and overcomes barriers to psychiatric care because patients visit the same site for both psychiatric and primary care.

please see ***Primary Care*** *on page 44*

Courtesy of Britta Ostermeyer, M.D.

Following a request from Brett Perkison, M.D. (left), a primary care physician and medical director of the Strawberry Community Health Center, psychiatrist Britta Ostermeyer, M.D. (right), discusses the patient's problems and psychiatric treatment plan.

Company Tries to Clear Up Confusion About Bupropion

Bupropion by any other name is still bupropion. But is it sustained-release or extended-release you are looking for?

BY JIM ROSACK

GlaxoSmithKline (GSK) is continuing its efforts to educate prescribers and pharmacists about reports of medication errors involving patients taking the company's Wellbutrin brand of bupropion. Confusion between the Wellbutrin XL formulation (bupropion extended release), Wellbutrin SR (bupropion sustained release), and some generic forms of Wellbutrin SR have led to patients' receiving higher than intended doses of bupropion and experiencing serious adverse events.

In March 2005 GSK, in consultation with the Food and Drug Administration (FDA), sent a "Dear Healthcare Provider" letter primarily devoted to required new labeling on all antidepressants related to the possibility of increased risk of suicidality. In that same letter, GSK noted the multiple formulations of bupropion and their differing dosage schedules. "Awareness of these various formulations," the company said, "is important to help avoid confusion and potential medication errors involving these products."

Then, this past January, GSK sent out a "Dear Pharmacist" letter, again advising of the various formulations and the occurrence of medication errors due to confusion between them. Now the company is reaching out again in an effort to avoid further medication errors.

The problem stems from confusion between the XL formulation of the product, which as an extended-release product is dosed only once a day using 150 mg or 300 mg tablets for a total daily dose of 300 mg to 450 mg of bupropion. No generic versions of the XL formulation are available in the United States.

The SR formulation of bupropion, in contrast, is a sustained-release product that is taken twice a day using 100 mg, 150 mg, or 200 mg tablets to achieve a total daily dose of between 300 mg and 400 mg bupropion. Generic versions of the Wellbutrin SR formulation are available in the United States.

It seems that both prescribing and dispensing errors have occurred. Prescribing errors have occurred "whereby the prescription was written as Wellbutrin XL *twice daily*, instead of *once daily*, which resulted in a higher exposure to bupropion," than recommended, company documents show. Because bupropion is associated with a dose-related risk of seizure, patients receiving in excess of the maximum recommended daily dose of 450 mg are at increased risk for seizure.

According to the FDA-approved labeling, "At doses of up to 300mg/day of the sustained-release formulation (Wellbutrin SR), the incidence of seizure is approximately 0.1 percent, or a seizure possibly occurring in 1 out of every 1,000 patients. At doses of 300 mg/day to 450 mg/day of the immediate-release formulation (Wellbutrin [bupropion HCl]), the incidence of seizure is approximately 0.4 percent, or possibly 4 patients with a seizure out of every 1,000 patients."

In addition to prescribing errors, dispensing errors may occur because of the United States Pharmacopeia's (USP) nomenclature for generic equivalents to Wellbutrin SR. USP officially designates the SR formulation as "bupropion hydrochloride; tablet, extended release." The generic name for the XL formulation is "bupropion hydrochloride; tablet, extended release." Although the generic drug names are the same, the two products are not therapeutically equivalent or interchangeable.

In an effort to help reduce bupropion-dispensing errors, some drug references (for example, Wolters Kluwer Health's *Facts and Comparisons–2006*) now list the SR product as "bupropion HCl; tablets–sustained release (12 hour)" and the XL formulation as "bupropion HCl; tablets–extended release (24 hour)." However, confusion may continue, as pharmaceutical manufacturers are required to use USP official nomenclature on drug labels for distribution in the United States.

More information is posted at <www.wellbutrin-xl.com>. Health care providers with questions regarding bupropion formulations also may call GSK's Medical Information Department at (888) 825-5249. ■

Children's Institute

The Fifth Children's Institute National Conference will be held May 4 at the Biltmore Hotel in Los Angeles. This year's theme is "In Harm's Way 2006: Preventing and Healing Childhood Trauma."

The conference brings together professionals from the broad spectrum of child and family services to address child welfare, early childhood development, domestic violence, mental health, substance abuse, and other issues.

The conference is sponsored by the Children's Institute Inc., which this year is celebrating its 100th anniversary of serving at-risk children and families throughout Los Angeles County.

More information is available by visiting <www.childrensinstitute.org> or calling (213) 385-5100, ext. 1672. ■

TAKEDA SYMPOSIUM
(NEUBAUER)
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More Psychiatrists Attracted To Sleep-Medicine Career

A recently recognized multidisciplinary field offers diverse career options.

BY LYNNE LAMBERG

A woman hospitalized for treatment of her mood disorder snored so loudly that other patients complained. A sleep study showed she had severe obstructive sleep apnea.

After using a continuous positive airway pressure (CPAP) device that delivers air via a mask worn in sleep, she felt more focused and alert. "Her mood improved, and we were able to make greater inroads into her psychiatric problems," related William Clemons, M.D., then a resident in psychiatry at West Virginia University in Morgantown.

The contribution of a previously unrecognized sleep disorder to the woman's psychiatric illness proved a signal event for Clemons. He pursued a sleep-medicine fellowship at the University of Michigan, completing the one-year program in 2004. He now practices sleep medicine at the Baptist Sleep Institute in Knoxville, Tenn.

While in medical school, Paul Teman, M.D., took a two-week elective in sleep medicine that included undergoing an overnight sleep study. Found to have mild obstructive sleep apnea, he was started on CPAP treatment. Then overweight, he shed excess pounds and no longer needs the CPAP device.

"I already had planned a career in psychiatry," he recalled. "My experience helped me understand apnea patients' resistance to wearing a CPAP mask, a big issue in compliance."

The elective also heightened his interest in behavioral consequences of sleep disorders. Teman now is taking a sleep medicine fellowship at the Mayo Clinic, where he also completed his psychiatry residency.

"We are seeing an explosion of interest in sleep medicine as a career option for psychiatrists," said Michael Sateia, M.D., a professor of psychiatry and chief of sleep medicine at Dartmouth Medical School. This interest is reflected in the American Board of Medical Specialties' (ABMS) approval last year of sleep medicine as a subspecialty for physicians practicing psychiatry, neurology, internal medicine, and pediatrics, he noted. ABMS recently added otolaryngology to the list.

Starting in 2007, the American Board of Internal Medicine will administer the sleep-medicine board exam, with certification conferred by boards overseeing the specialties listed above. The exam formerly was given by the American Board of Sleep Medicine.

"The new exam acknowledges that sleep medicine involves a sufficient body of knowledge and skill sets to qualify as an independent medical subspecialty," said Lawrence Epstein, M.D., president of the American Academy of Sleep Medicine (AASM) and regional medical director for Sleep HealthCenters in Boston.

The Accreditation Council for Graduate Medical Education (ACGME) has approved 24 sleep-medicine fellowships nationwide. ACGME recognition means that funding for fellowships is available from the Centers for Medicare and Medicaid Services. Fellowships typically provide an annual stipend of about $60,000.

Stephen Grant, M.D., now in PGY-4 of an internal medicine/psychiatry residency at Dartmouth, plans to apply for a sleep-medicine fellowship. "I like to bill myself as doing mind/body medicine," he said. "Sleep is the perfect example of that.

"About two-thirds of the patients I see in the psychiatry clinic and one-third of my internal medicine patients report sleep problems. I always ask about sleep patterns and habits."

Grant sees veterans with posttraumatic stress disorder who served in Iraq or Afghanistan at an internal medicine/psychiatry clinic at the Veterans Affairs Medical Center in White River Junction, Vt. "One of our immediate challenges is to re-

please see ***Sleep Medicine*** *on facing page*

Psychiatrist Practices Sleep Medicine In Iran

Psychiatrist Mir Farhad Ghaleh Bandi, M.D., returned to his native Iran after completing an eight-month sleep-medicine fellowship in the United States in 2004. He trained at the University of Utah-affiliated Intermountain Sleep Disorder Center based at LDS Hospital in Salt Lake City.

Ghaleh Bandi now directs the psychiatric residency program at the Iran University of Medical Sciences in Tehran, where he soon will open the country's first full-service, university-based sleep lab.

Insomnia and sleep-related breathing disorders prompt the majority of referrals to the semiprivate sleep lab where he consults. "Psychiatric symptoms are very common in these patients," he reported by e-mail. "We use psychoeducation, sleep hygiene, and pharmacotherapy to treat such problems."

Ghaleh Bandi teaches sleep medicine to medical students, psychiatry residents, psychiatrists, and other specialists and to the general public. He and his colleagues plan to study sleep in bus drivers and the elderly, and in people with multiple sclerosis, epilepsy, blindness, and other medical disorders.

He and his colleagues recently founded the Iranian Sleep Medicine Society, which was scheduled to elect officers this month. Members include specialists in psychiatry, neurology, pulmonology, otolaryngology, pediatrics, occupational medicine, endocrinology, cardiology, and dentistry.

Programs Fail to Teach Coordination of Services

The New Freedom Commission on Mental Health has recommended the coordination of a broad array of services and attention to the interaction of mental health, employment, housing, and protection from unjust incarceration.

BY MARK MORAN

The public-sector psychiatrist must be an expert not only in individual patient care, but in the creation, management, and evaluation of whole systems of care.

So say thought leaders in psychiatric education and public psychiatry queried for a report on public-sector training that appeared in the February *Psychiatric Services*.

Yet the same report shows that directors at training programs around the country—including those that are invested in public-sector training—consistently downplay the importance of tasks that involve integration of services across institutions with different missions.

"We really owe it to our patients to try to make sure the educational system provides our trainees the opportunity to evaluate whole systems of care, so they will be in a better position to make decisions for our patients," said Carol Bernstein, M.D., a lead author of the *Psychiatric Services* report and the residency training director at New York University School of Medicine.

But Bernstein said the current emphasis on training in "competencies" has naturally tended to emphasize competency in individual care of patients. "When it comes to leading the charge around health care system development, that requires another set of competencies," she said.

So adequate training in systems management will require leadership and initiative from directors who care about public-sector psychiatry. "The job we have as training directors is so complicated and so determined by multiple requirements," she said. "Unless you are a well-resourced program with strong leadership, your program ends up being driven by regulatory agencies."

Bernstein and colleagues conducted in-depth interviews with 10 leaders in psychiatric education and practice who were knowledgeable and concerned about public-sector care. Those thought leaders identified 16 tasks (see box).

Most of the tasks could be grouped into one of two categories: coordination across social-service systems (for example, incorporating psychiatric intervention into psychosocial rehabilitation and interacting with staff of supportive housing programs to care for patients) and integration across institutions with different missions (for example, determining whether the behavioral problems of a prisoner stem from an underlying psychiatric disorder and providing continuing treatment in nonpsychiatric settings, such as prisons or shelters).

Directors of all general psychiatry residency programs in the United States were then surveyed to determine how they rate the importance of these tasks for delivery of care and how their training program prepares residents to perform each task. Possible scores ranged from 1 to 10, with higher scores indicating higher priority. A total of 114 of 150 residency directors (76 percent) responded to the survey.

Slightly more than half of the program directors said their programs placed above-average emphasis on public-sector care.

"Unless you are a well-resourced program with strong leadership, your program ends up being driven by regulatory agencies."

Yet tasks entailing integration of services across institutions with different missions were consistently rated least important, preparation to perform them was least likely to be required, and, when required, the tasks were addressed through less-intensive modalities.

But Bernstein and colleagues emphasized the importance of such training to effective public-sector leadership, citing the fact that there are three times as many people with mental illness in jails and prisons as in psychiatric institutions and that 40 percent of people with mental illness have had some involvement with the criminal justice systems.

"Acknowledging these dynamics, the recent report of the New Freedom Commission on Mental Health recommended the coordination of a broad array of services and attention to the interaction of mental health, employment, housing, and protection from unjust incarceration," Bernstein and colleagues wrote.

So, how well are training programs preparing psychiatrists for leadership in the public sector?

"It depends on the structure of the program," Bernstein told *Psychiatric News*. "If it has public-sector patients in the program, the residents will learn something more or less, depending on the scope of the program. Most programs do have Medicare and Medicaid patients, so most residents get some exposure.

"But how much they get to look at the entire system and consider ways to create other systems is a different story," she said.

"A Survey of Psychiatric Residency Directors on Current Priorities and Preparation for Public Sector Care" is posted at <http://psychservices.psychiatryonline.org/cgi/content/full/57/2/238>. ■

How to Make Public-Sector Care Work

One hundred and fourteen of 150 psychiatry residency directors surveyed throughout the United States were asked to rate the importance of a list of tasks for delivery of care in the public sector. Below are 16 tasks the directors identified.

- Establish an appropriate role on a multidisciplinary team.
- Treat both substance abuse and mental illness for patients with dual diagnoses.
- Recognize the symptoms of interaction between psychiatric medication and illicit drugs.
- Adapt treatment strategies to accommodate patients' cultural beliefs.
- Integrate psychiatric intervention with psychosocial rehabilitation.
- Assume leadership of a multidisciplinary team.
- Interact with staff of supportive housing programs in caring for your patients.
- Assess the appropriateness of referring a particular patient to a clubhouse or sheltered workshop.
- Work with Assertive Community Treatment teams.
- Determine whether behavioral problems of a prisoner stem from an underlying psychiatric disorder.
- Counsel a patient with private insurance who has exceeded insurance limits on available public-sector options.
- Maintain a rapport with patients who rely heavily on alternative therapies.
- Help homeless patients move toward permanent housing.
- Provide ongoing treatment in unconventional settings.
- Determine whether a patient charged with a low-level offense should be considered for a jail-diversion program.
- Develop a comprehensive treatment plan for a felony offender with a chronic psychotic disorder as an alternative to incarceration.

Sleep Medicine

continued from facing page

store their sleep," he noted.

Hunter Hearn, M.D., now a PGY-3 resident in psychiatry at Dartmouth, is exploring sleep medicine via an elective. "It's a nice hybrid of medicine, psychiatry, and neurology," he said.

In contrast to much of psychiatry, he observed, sleep medicine utilizes objective tests such as polysomnographic studies. Some of his fellow residents wonder whether sleep medicine involves long hours looking at a computer screen.

"I find that's a small part of it," he said. "Most of what I'm doing involves direct patient contact. Even if I don't go into sleep medicine per se, I feel comfortable evaluating patients with a sleep complaint, knowing what I can treat and when to refer."

Allen Richert, M.D., the psychiatry residency training director at the University of Mississippi Medical Center, thinks sleep medicine education belongs in the psychiatry residency.

"Sleep disorders and sleep deprivation contribute to depressed mood, irritability, attention deficits, and sleepiness," he said. "Psychiatrists need experience with hypnotic medications and cognitive behavioral therapy for insomnia."

Patients with sleep disorders benefit from a psychiatric perspective, he added. "Psychiatrists understand how patients' emotions drive behavior."

After completing a sleep-medicine fellowship at Beth Israel Deaconess Medical Center in Boston in 2004, Martha Praught, M.D., entered private practice in Brookline, Mass.

She has diagnosed sleep disorders in patients with psychiatric problems including mood disorders, attention-deficit/hyperactivity disorder, schizophrenia, and menopausal issues.

"It's a challenge to stay active in sleep medicine in a private-practice situation," she said. "Not all insurers reimburse psychiatrists for diagnosing and treating sleep disorders. That has to change."

Psychiatrists interested in sleep medicine should contact their local sleep disorders centers, suggested Daniel Buysse, M.D., a professor of psychiatry at the University of Pittsburgh School of Medicine. "Many centers are looking for more input from psychiatrists to help them manage patients with sleep disorders and psychiatric comorbidity."

AASM offers continuing medical education courses on sleep and sleep disorders for psychiatrists and other physicians throughout the year. Details are posted at <www.aasmnet.org>. Information and application forms for ACGME-approved sleep medicine fellowships are posted at <www.aasmnet.org/FellowshipTraining.aspx>. ■

Professional News

Analytic Group To Meet in Toronto

At its meeting in Toronto May 18 to 21, the American Academy of Psychoanalysis and Dynamic Psychiatry will commemorate its 50th anniversary with special sessions and events. The meeting will take place just before the opening of APA's 2006 annual meeting.

"The academy welcomes the participation of clinicians, medical students, and psychiatry residents who wish to expand their knowledge of the 'talking cure' in a collegial and intellectually stimulating atmosphere," said academy trustee and meeting co-chair Gerald Perman, M.D.

Among the highlights will be presentations by two of the academy's founders, Marianne Eckardt, M.D., and Milt Zaphiropoulos, M.D., who will reflect on the group's five-decade history.

In addition, Richard Friedman, M.D., will discuss the past, present, and future of psychodynamic psychotherapy, while Stuart Yudofsky, M.D., chair of the Department of Psychiatry at Baylor University, will talk about "connections between psychodynamics and neurobiology" and where these connections will lead. Jack Drescher, M.D., will deliver a special lecture titled "Homosexuality and Psychoanalysis: The Past 50 Years."

On Saturday, May 20, is a gala dinner with musical accompaniment by several of the academy's talented members.

Information about the meeting is posted at <www.aapsa.org> or available by e-mail at gpperman@gmail.com. ■

community news

Psychiatrist Challenges Choice of Department Chair

Concerns about patient care and resident education issues drive a psychiatrist to try to convince his hospital to reverse its decision to appoint a psychologist as head of its psychiatry department.

BY KEN HAUSMAN

A Pittsburgh psychiatrist has challenged the appointment of a psychologist to chair the psychiatry department at a hospital where he has privileges, claiming that the appointment of a nonphysician violates state regulations and the standards of accrediting bodies.

Jordan Garber, M.D., has raised concerns about the April 2000 appointment of psychologist Anthony Mannarino, Ph.D., to head the psychiatry department at Pittsburgh's Allegheny General Hospital (AGH), where he volunteers his time as a teacher and, until hospital officials recently terminated his appointment as a member of the Institutional Review Board.

Garber has filed complaints with the Pennsylvania Department of Health and the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and has asked the Accreditation Council for Graduate Medical Education (ACGME) and the Residency Review Committee for Psychiatry (RRC) to review the issue. All of these organizations have indicated in responses to Garber that the appointment puts the hospital in violation of their requirements.

Garber had had privileges at AGH since 1990 and at Suburban General Hospital since 2001. In January 2005, AGH began operating Suburban, and he became "acutely concerned," he told *Psychiatric News,* that the hospital administration's appointment of a nonphysician psychiatry department chair violated medical staff bylaws and other regulations.

His first action was to inform the compliance liaison of AGH's parent organization, West Penn Allegheny Health System, Garber told *Psychiatric News.* The response he received indicated that West Penn saw no violation in appointing a psychologist as psychiatry chair.

Garber next filed a formal complaint with the Pennsylvania Department of Health, which indicated that by naming a nonphysician, AGH violated state regulations regarding qualifications for a department chair position.

In a May 19, 2005, communication to the AGH's chief executive, the state health department told AGH that it needed to remove the psychologist from the chairmanship to be in compliance with its rules. The health department subsequently denied a request from AGH for a reconsideration of the decision.

In a letter to Sandra Knoble, director of the state health department's Division of Acute and Ambulatory Care, AGH President and CEO Connie Cibrone defended the hospital's appointment of Mannarino. She said that in his "five-year tenure as chair, the Department of Psychiatry has transitioned from an unstable department to a stable, well-respected department." She added that the Pennsylvania Department of Health "has conducted annual site visits of our inpatient psychiatric services, and the Department of Public Health has conducted annual site visits of our outpatient psychiatric services. In each instance we have received outstanding reviews."

The executive director of the RRC for Psychiatry, Larry Sulton, Ph.D., also indicated that the hospital is in violation of its rules, telling Garber that the RRC, which mandates that psychiatry departments must be headed by a physician trained in psychiatry, planned to investigate the matter and would request an explanation of the appointment from AGH officials. Garber told *Psychiatric News* that the RRC has "proposed probation" for the AGH residency program because of the chairmanship issue and will make a further determination at its April meeting.

John Herringer, associate director of the JCAHO's Standards Interpretation Group, responded to Garber by stating, "A psychologist who does not have medical training cannot oversee the clinical care provided by a physician and other members of the department. . . . It would be acceptable for the psychologist to be the administrative director of the department, but there would need to be a board-certified physician as the clinical person responsible for oversight of the clinical work of the department."

Garber also took his concerns to the Pennsylvania Psychiatric Society and the Pennsylvania Medical Society. In a joint response to the Pennsylvania Department of Health, the organizations' presidents, M. Ruiza Yee, M.D., and William Lander, M.D., stated their contention that even if the psychologist chair were to delegate some clinical responsibility to a physician, the solution would not be workable. The primary role of a psychiatry department chair, they wrote, "is to move the department toward excellence. This requires not only administrative skill but intimate knowledge of medical care and psychiatric professional standards."

They also described how the situation came about, noting that at the time Mannarino was appointed chair, "the hospital system of which [AGH] was a part had declared bankruptcy. We understand that it was difficult to find suitable psychiatrists willing to take on the chairmanship at that time, when the department had been decimated and uncertainty about the hospital's future abounded."

This controversy is not yet over, as several of the organizations Garber contacted continue to assess the situation or plan follow-up actions. ■

Association News

Become an APA Fellow!

Fellow status is an honor that reflects your dedication to the work of APA and signifies your allegiance to the psychiatric profession. Information and application materials are posted on APA's Web site at <www.psych.org/members/memcorner/applyfellow.cfm>.

Lawmakers Reject Civil Commitment for Sex Offenders

Psychiatrists successfully oppose what they describe as a misuse of civil-commitment programs to incarcerate those convicted of sex crimes after their prison sentences are over.

BY RICH DALY

The Vermont legislature rejected a measure last month to establish a civil-commitment program for people convicted of sex crimes, legislation that was overwhelmingly opposed by Vermont psychiatrists.

By a vote of 77-59, the Vermont House rejected an attempt to add the program as an amendment to legislation aimed at toughening penalties and expanding prosecution of sexual offenders. The bill (H 856) would have increased minimum sentences for people convicted of sexual assault and included the possibility of a life sentence for these crimes.

The legislation also would have also made treatment programs available to virtually all sexual offenders.

The heavily debated amendment would have allowed the state to keep already incarcerated people in custody after their sentence is over through civil commitment, if they are deemed a significant risk to the public's safety.

Treatment Not Main Goal

"The purpose of this was to find a way to keep people locked up who had completed their jail terms," said Jonathan Weker, M.D., who is the Vermont Psychiatric Association (VPA) representative to the APA Assembly and helped lead opposition to the measure. "This is a misuse of a process long used to treat people with mental illness."

The measure was opposed by 95 Vermont psychiatrists who signed a petition against the proposal that was presented to legislators the morning of the vote.

The program lumped multiple patient populations together, including those with antisocial personality disorder, who may not benefit from such treatment. It also blurred the distinction between mental illness and criminal behavior, Weker said.

The measure's sponsor, Rep. Tom DePoy (R), said the program was needed to address violent sexual offenders scheduled to be released in a few years, he told local media.

The measure stemmed, in part, from the highly publicized Vermont case of a man convicted of molesting a girl for four years beginning when she was age 6, who a judge sentenced to only a 60-day minimum sentence. Following nationwide outrage and calls by the governor for his resignation, the judge amended the sentence to three to 10 years.

The sexual offender legislation was discussed by legislators last year but picked up momentum when Gov. Jim Douglas (R) threw his support behind creation of a civil-commitment program for sexual offenders.

"Vermont must take another important and necessary step by ensuring that the most dangerous and violent sexual offenders are not released into our communities until, and unless, there has been a determination that the offender does not pose a danger to the public," Douglas said in a statement. "That is exactly what a civil-commitment statute would do."

The program created by the amendment would have been much more limited than one proposed by Douglas, which would have made sexual offenders as well as other violent offenders eligible for civil commitment.

Psychiatrists were joined in their opposition to the program by a coalition led by the American Civil Liberties Union (ACLU) of Vermont.

> **"The VPA petition was a big part of the reason we were able to stop this legislation."**

VPA Efforts Applauded

"The VPA petition was a big part of the reason we were able to stop this legislation," Allen Gilbert, executive director of the ACLU of Vermont, told *Psychiatric News*.

If enacted, the program could face a constitutional challenge, according to the ACLU branch, because the U.S. Supreme Court ruling in *Kansas v. Hendricks* allowed involuntary civil commitment for sexual offenders if the main goal is treatment of an offender's proven mental illness. If a program's goal is simply an extended jail sentence, it fails the constitutional test.

The Vermont proposal would have put the facility for holding involuntary committed sexual offenders at an existing prison, which implies the purpose of the program was incarceration rather than treatment.

Courtesy of Jonathan Weker, M.D.

Jonathan Weker, M.D.: "This is a misuse of a process long used to treat people with mental illness."

In 1999 APA's Task Force on Sexually Dangerous Offenders reported that the treatment approach most likely to have an effect on recidivism is multimodal and combines pharmacological, cognitive, and behavioral treatments and relapse prevention (*Psychiatric News*, November 18, 2005). The task force issued a report that opposed the sexual predator laws that established postincarceration civil commitment because the laws misused psychiatry to detain a class of people for whom confinement rather than treatment was the real goal.

At least 16 states and the District of Columbia have laws allowing authorities to confine violent sexual offenders to psychiatric hospitals after their prison terms are over.

Other States Consider Changes

Several other state legislatures are considering measures to enact civil-commitment programs for sex ual offenders.

A California bill would expand the term of civil commitment from two years to five years. New York legislation would fund a new secure facility and treatment programs for sexual predators upon their prison release. A Virginia bill would expand the list of crimes qualifying as sexually violent offenses and make perpetrators of such crimes eligible for civil commitment.

Nebraska legislation would increase the number of people eligible to go through the state's civil-commitment process. A South Dakota bill would establish a civil-commitment procedure for people judged to be violent sexual predators, allowing them to be confined for treatment until they are deemed safe.

Kansas, which in 1991 became the first state to allow indefinite confinement of violent sexual predators for treatment after they have served their prison sentences, is considering measures to increase prison sentences for such prisoners. Those measures may lead to a major reduction in the use of civil commitment, according to local media.

The text of H 856 is posted at <www.leg.state.vt.us/docs/legdoc.cfm?URL=/docs/2006/bills/house/H-856.HTM>. ■

Exhibit Reveals What's Behind Faces Of People With Mental Illness

A traveling photo exhibit explores the fine line between mental health and mental illness in its frank portrayal of people who are living with psychiatric disorders.

BY EVE BENDER

How well can you get to know more than 50 people in the space of, say, an afternoon?

Pretty well, if you are a visitor to Michael Nye's photography exhibit, "Fine Line: Mental Health/Mental Illness," which features the images and voices of 55 people with mental illness.

The exhibit opened at the Witte Museum in San Antonio in October 2003 and has traversed the country since that time, educating spectators at museums and medical schools about what it is like to live with mental illness.

Each black-and-white photo tries to capture the essence of Nye's subjects, who happen to be professors, parents, writers, artists, and war veterans.

But it is their audiotaped stories, which touch upon universal themes of fear, alienation, redemption, hope, and survival, that ultimately reveal Nye's subjects to those who stand in front of them, gazing and listening.

According to Nye, people often find something in common with the men and women in his photographs.

"We might find ourselves saying, 'that is not unlike my story or my sister's story,' " Nye said to a crowd of consumers, mental health professionals, and government officials who came to the headquarters of the Substance Abuse and Mental Health Services Administration in Rockville, Md., to catch the exhibit in January.

"When you get underneath the surface of what mental illness looks like, you really see that someone's life is more than the illness," Nye observed. "You see them as human beings first."

The exhibit features Jamie, who was presented to her community as a debutante at the age of 16 and has skied the Swiss Alps. Though she considers herself to be well-educated, she was homeless and pregnant at the time Nye met and interviewed her.

She is also an Operation Desert Storm veteran and lives with posttraumatic stress disorder and debilitating panic attacks and depression. "I try every day to make a difference in somebody else's life, so that my life will count for something," she said in her audio segment.

A photograph of Jerry, a tattooed and scarred man, conveys the defiance and vulnerability of a man who recalls that he was first hospitalized for psychiatric problems at age 6, has spent time in jail, and believes that the public should be better educated about bipolar disorder.

Since he met and interviewed him a few years ago, Jerry has died, Nye said.

Beth, another of Nye's subjects, said she endured physical and sexual abuse as a child

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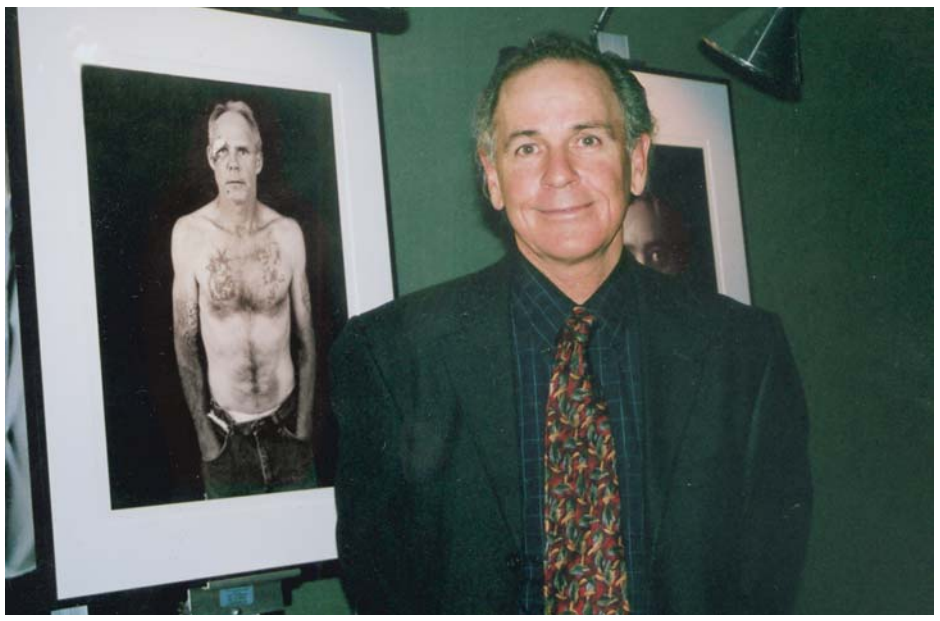

Eve Bender

Jerry (in photo at left behind photographer Michael Nye) died not long after this photo was taken. Jerry had spent time in jail due to his mental illness and felt strongly that the public needed to be better educated about mental illness.

When Dating a Psychiatrist, Rules of the Couch Don't Apply

BY SUDEEPTA VARMA, M.D.

It was their first date and 30 minutes into it, "Michelle" realized that "Mark," the handsome French transplant sitting before her at Del Posto, Mario Batali's swanky New York eatery, had not asked her what she did for a living. For that matter, he hadn't really asked her much about herself. Was he just being polite by not asking what kind of work she did? Was this a French thing? Or was she just used to doing more of the listening, she wondered?

Michelle, a psychiatry resident, recounted the evening to me with mixed reviews on her cab ride home. The next morning while on her way to the hospital, she received a text message from Mark. "Bon jour! Thanks for the evening—I gotta say—I never met someone so grounded and so present before. Would you be up for a second date?" She was surprised, since she felt that the date was a bit monotonous. Was it possible for anyone to talk more about himself?

Sudeepta Varma, M.D., is a PGY-3 psychiatry resident at New York University School of Medicine.

When Michelle told me her story, I laughed, realizing that I, too, had fallen victim to the same routine. Used to asking a lot of questions and not revealing much about myself, I was known as the "mystery woman" in some nonpsychiatric circles. I often ask myself, whether I was being "mysterious" or withholding. Is a psychiatrist's observant nature the reason he or she entered this profession or a result of it?

I often think to myself about the voyeuristic nature of psychiatry. In no other situation would it even be mildly appropriate to ask another individual intimate personal details including early life experiences or sexual fantasies. The work of other medical professionals does indeed parallel the invasive nature of psychiatry in some respects. Their patients often strip down to the bare for a medical exam, and depending on the nature of the exam, the patient can often find himself or herself in a compromising position, so to speak. There is something fragile, raw, and almost pious about the psychiatrist-patient relationship.

I have heard from a few psychiatrists that, had they not gone into psychiatry, they would have considered becoming surgeons. I have also, but less frequently so, heard the converse. I can think of a few surgeons who after completing surgery training, decided to go into psychiatry. I wonder whether having both professions under one's belt somehow allows the doctor to come full circle.

Psychiatrists possess a desire to delve deep into the depths of a forbidden zone, the same way a surgeon cuts open someone's sternum. Neither is a routine activity of daily living, and both can be a painful yet necessary "evil."

Not too long ago, I was at a joint holiday soiree thrown by a dermatology resident friend and her attending. It was well attended by an eclectic bunch of doctors, lawyers, singers, songwriters, belly dancers, and henna artists. Some of the invitees were the attending dermatologist's patients. I inadvertently got into a conversation of "boundary crossings" with one of the guests. I soon realized that I needed help getting my foot out of my mouth.

I do, however, at times envy my colleagues in other medical specialties who seem to have a much more personal relationship with their patients. Ralph, a college friend and now in an internal medicine group practice, often gets homemade rugulah from his patient Rosie, an 82-year-old diabetic Holocaust survivor. It's not so much about the rugulah, but the warmth and the connection implied by this relationship that I miss from my medical rotations.

Learning to balance the subtle differences between the social intercourse of the psychiatrist "on the clock" and "off the clock" is a unique challenge. We go from being active observers to loquacious participants depending on which side of the clock we find ourselves.

As for Michelle and Mark, I have yet to hear if there will be a second date. ■

CYBERONICS SYMPOSIUM

(DUNNER)

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ProfessionalNews

HAPA to Meet

The Hellenic American Psychiatric Association (HAPA) will holds its seventh annual meeting on Tuesday, May 23, in conjunction with APA's 2006 annual meeting in Toronto. The meeting will be held at the Westin Harbor Castle from 6: 30 p.m. to 10 p.m. It includes a scientific program, business meeting, and dinner.

This year's scientific program includes two presentations: "Advances in the Treatment of Alcohol Dependence" by Ismene L. Petrakis, M.D., and "Ethics in Psychiatry: From Hippocrates to the WPA Declaration on Ethics" by George N. Christodoulou, M.D.

More information is posted at <www.hellenic-psych.org/news.html>. Membership information is available from Vassilios Latoussakis at vasilat@yahoo.com. ■

PFIZER GEODON IM
P4C

Distinguished Career Takes Psychiatrist Back Home

An innovative community psychiatrist visits her native land to use the skills and knowledge she acquired in the United States to benefit underserved populations with mental illness.

BY EVE BENDER

When Geetha Jayaram, M.D., M.B.A., sat down to interview for the Johns Hopkins psychiatry residency program after graduating from medical school in India in the 1970s, she fielded an important question: if gifted physicians continually come to the United States to pursue training and a career, how does this affect patients living their native countries?

"This question has always stayed with me through the years of raising my family and making a life for myself" in the United States, Jayaram told *Psychiatric News*.

Though she tried unsuccessfully to obtain a job as a psychiatrist in India after completing her training at Johns Hopkins in 1981, she has made up for lost time by returning to her native country 20 years later to ensure that people living with mental illness in remote villages receive the care they need.

"I can now give much more than what I could have if I had lived there," she said, referring to the considerable experience she has acquired in the United States as a community psychiatrist and academician.

She is an associate professor of psychiatry at Johns Hopkins and physician advisor in the Department of Psychiatry and also maintains a private practice.

Courtesy of Geetha Jayaram, M.D., M.B.A.

Psychiatrist Geetha Jayaram, M.D., M.B.A., said her humanitarian work in India brings a great deal of meaning to her life.

Improving Public-Sector Psychiatry

It is perhaps her work as a community psychiatrist that best prepared her for the work she would undertake in India.

As director of mental health in Prince George's County, Md., in the 1980s, Jayaram ensured that public-sector patients with serious mental illness would receive continuous care by organizing a network of physicians who would travel between community mental health centers in the county and continue seeing patients during periodic hospitalizations. "This seemed like a small thing to do, but it had never been done before," she noted.

In addition, she organized an outreach effort in which county vans that had previously been sitting idle circulated around the community to pick up patients and bring them to a clinic where they could receive depot prolixin injections.

"After receiving their treatment, the patients would frequent the local businesses. They began to look forward to these outings. It was like a social day for them," Jayaram said.

> **"Women are twice as likely as men to suffer from depression and anxiety, and their needs are often ignored."**

In subsequent years, Jayaram would go on to direct a 1,000-patient community psychiatry clinic and the AIDS Psychiatric Evaluation Unit, both of which are affiliated with the Department of Psychiatry at Johns Hopkins. It was under Jayaram's leadership that the clinic won APA's Psychiatric Services Gold Award in 1989.

Getting Down to Business

Throughout her career, Jayaram has been interested in ensuring that psychiatric services are run efficiently. In the 1990s, she fine-tuned her administrative skills by earning an M.B.A. from Johns Hopkins after taking a position as physician advisor in the hospital's psychiatry program.

As physician advisor, she oversees the quality of psychiatric services offered at Johns Hopkins. She is responsible for issues related to credentialing, risk management, and adverse medical events and supervises a staff of more than 200 psychiatrists.

"The physician advisor's work has become increasingly important with the emphasis on quality of care and safety in the medical arena," she noted.

She also teaches psychiatry residents about these issues during rounds on morbidity and mortality. She chaired APA's Scientific Program Committee in 2003 and 2004 and currently serves on the *Psychiatric*

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News and *Focus* editorial boards.

As her career unfolded, the question posed to Jayaram as an international medical graduate on the brink of a career in the United States would one day take center stage in her professional life. That is, how could she help underserved populations living in her native country?

Humanitarian work runs in Jayaram's family. Her father was a philanthropist and "trained us to help the poor and underprivileged" by providing them with education and employment opportunities, she said. He was also a lifelong member of the Rotary Club, an international service organization of professionals who provide humanitarian services around the world.

Jayaram has two brothers living in India who perform humanitarian services as Rotarians. A third brother, who has since died of leukemia, raised hundreds of dollars as a Rotarian to establish a blood bank in Bangalore, India.

Jayaram joined the Rotary's Rotaract youth service club and met her husband, Jay, as a young Rotaractor in India when she was 19 and he was 23.

Rotaractors are members of the Rotary's youth service club who perform community and international service projects.

So when Jayaram decided to organize a mental health outreach project in India, it seemed only natural that she would raise the funds through the Rotary Club.

Through the Rotary Club of Columbia, Md., Jayaram raised $25,000 by organizing workshops for women throughout India and received a matching grant through the Rotary Club in 2002.

The money enabled her to hire a team of health care workers to conduct a door-to-door survey of approximately 17,000 households in 30 villages outside of Bangalore and to screen people for mental health problems.

Those who screened positive for psychiatric symptoms were brought to a mental health clinic established by clinicians from a local medical school to be evaluated. A local psychiatrist visited the villages on a weekly basis to treat those with psychiatric symptoms.

Jayaram and her team studied 300 of the villagers who received treatment for depression.

Using the Structured Clinical Interview for *DSM-IV-TR*, they confirmed diagnoses of depression in more than 200 patients, the vast majority of them women.

"Women are twice as likely as men to suffer from depression and anxiety, and their needs are often ignored" in Indian culture, she noted.

Using the Hamilton Depression Rating Scale, they found that 129 of this group had significant depression six months after their initial treatment. Depression had remitted in 72 of the patients.

They also found that comorbid anxiety was a significant factor in those with persistent depression.

Jayaram plans to raise more funds through the Rotary to ensure that those with depression continue with treatment. "Many of the villagers live hand to mouth" she said, and cannot necessarily afford to take time off from working in the fields to receive treatment at the clinic."

The additional funds would permit caseworkers to go to patients' homes with medicines, she added.

Jayaram has also provided volunteer services for the Maryland Psychiatric Society and the Disabled Persons Review Boards for two decades. "My humanitarian work is gratifying and brings much meaning to my life, and hopefully to the lives of others as well," she said. ■

APA Institute

Institute Invites Residents' Submissions

BY YVETTE DRAKE MCLIN, M.D.

Psychiatry residents will have a valuable opportunity this October to present at poster sessions and participate in activities offered for them at APA's Institute on Psychiatric Services.

The institute will be held at the Marriott Marquis Hotel in New York City from October 5 to 8.

The institute will feature five poster sessions that will make it easy for residents working on research projects to present their findings to a national audience. In the past, approximately 90 percent of all poster submissions were accepted for presentation.

The theme of the 2006 institute is "Trauma and Violence in Our Communities"; however, poster submissions on all areas of psychiatric research are welcome. Training departments often pay for registration and/or travel if the resident is also presenting a poster.

The institute provides an excellent opportunity for residents to learn about innovative work from around the country while meeting resident colleagues and interacting with experts and leaders in the field. In addition to the poster sessions, the institute includes many other experiences directed toward residents including a residents-only welcoming session, leadership and career development seminars, a "Meet the Experts" luncheon that allows for informal consultation with leaders in psychiatric specialties, a full-day session on working with homeless mentally ill individuals, mentoring opportunities, and clinical discussion groups in general and public psychiatry.

This year there will also be several workshops and presentations that will focus on disaster psychiatry with specific focus on mental health treatment during and after the recent hurricanes and 9/11.

The institute also features general receptions, daily prize drawings in the Exhibit Hall, and industry-supported lunch and dinner symposia.

The poster-submission deadline is June 5. Residents interested in submitting posters may obtain a submission form by calling APA's Answer Center at (888) 357-7924 or by downloading a form from <www.psych.org/IPS2006>. The completed form should be faxed to (703) 907-1090.

More information is available from Jill Gruber, associate director of the institute, by phone at (703) 907-7815 or by e-mail at jgruber@psych.org. ■

Yvette Drake McLin, M.D., is a 2005-2007 APA/Bristol-Myers Squibb fellow.

annual meeting

Course Shines Spotlight On Therapeutic Alliance

Through the use of "standardized patients," a CME course will help psychiatrists sharpen their skills at effectively utilizing countertransference and meta communication.

BY MARK MORAN

How do you repair and sustain a therapeutic relationship with an angry patient? Therapeutic alliance has come to be recognized as crucial in every doctor-patient encounter and a critical factor in the outcome of psychotherapy. And this year, APA members attending the annual meeting in Toronto, will have an opportunity to sharpen their alliance-building skills in a course that has won awards at the Mt. Sinai Institute of Psychotherapy at the University of Toronto.

"Achieving and Sustaining Psychotherapy Effectiveness" is a full-day course that will seek to offer psychiatrists practical skills to improve psychotherapy outcomes through enhancing the therapeutic alliance.

Course codirector Paula Ravitz, M.D., told *Psychiatric News* that the course, which can be taken for six hours of continuing medical education credit, is designed to provide experienced psychotherapists with an expanded clinical repertoire to manage commonly encountered clinical challenges in contemporary psychotherapy.

Her co-director is Molyn Leszcz, M.D., of the University of Toronto, who is a coauthor with Irving Yalom of the newest edition of *Interpersonal Psychotherapy*.

Particular attention will be paid to the therapeutic alliance, effective use of countertransference, and therapeutic metacommunication, Ravitz said.

A distinguishing feature of the course will be the use of "standardized patients"—typically, professional actors enacting patient roles in scripted scenarios.

At the opening of the course, a scenario will be enacted with faculty playing the role of the treating psychiatrist. The presentation is designed to be interactive—lending a "living theater" quality to the teaching—so that faculty may stop to make more transparent some crucial aspect that is being illustrated in the scenario or to allow course participants to ask questions.

Later, course participants will break into small groups in which patient-actors will enact separate scenarios for each group with participants playing the role of clinician.

Throughout, the emphasis will be on providing experience, not theory.

"We want to go beyond theory and give participants very practical approaches and strategies for commonly encountered clinical challenges related to the therapeutic alliance," Ravitz told *Psychiatric News*.

She is director of the Mt. Sinai Psychotherapy Institute, head of the Interpersonal Psychotherapy Clinic at the Center for Addiction and Mental Health, and an assistant professor of psychiatry at the University of Toronto.

"The dynamic approach of this course is going to have an impact," added Nancy McNaughton, M.Ed., director of the standardized patient program at the University of Toronto School of Medicine. "People will have a very clear memory of this class because it's practical and engaging."

The course will enable participants to

- Acquire an understanding of the evolution of contemporary psychotherapy and the central role of the therapeutic relationship.
- Acquire an understanding of critical factors related to the effective establishment and maintenance of the therapeutic alliance.
- Learn approaches that reduce the risk of therapeutic impasses and negative outcomes in psychotherapy.
- Gain an appreciation for the effective utilization of countertransference and metacommunication.

Ravitz emphasized that the therapeutic alliance has come to be recognized as critical in all forms of therapy. "Our curriculum focuses on skills enhancement related to the therapeutic relationship across models," she said. "Rather than focusing on the question of what works for whom, we focus on how to make whatever therapy is being employed work as effectively as possible. It's meant to be skill building rather than indoctrinating."

And participants will be able to continue the learning experience after they leave the annual meeting. Through the University of Toronto Faculty of Medicine and Mt. Sinai Hospital Department of Psychiatry, Mt. Sinai Psychotherapy Institute, course participants can receive one-on-one distance supervision, allowing them to communicate problems, questions, and clinical vignettes through a confidential, password-protected Web site.

The course will be held Tuesday, May 23, from 9 a.m. to 4 p.m. in the Dominion Ballroom South on the second floor of the Sheraton Centre. Advance registration for APA members is $160.

Deborah Hales, M.D., director of APA's Division of Education and Career Development, urged clinicians to sign up.

"Our intention is to offer this as a CME exercise for experienced physicians to get a meaningful review of their interviewing technique with standardized patients under observation," she said. "We want to begin to help practicing physicians realize that communication skills need practice, just as clinical skills do." ■

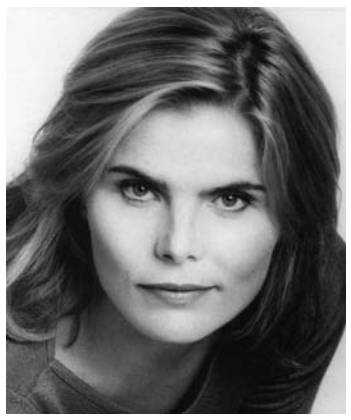
Toronto Tourism

Actress to Describe Journey From Mental Illness to Recovery

A member of a famous American family touched by both creativity and mental illness will share her experiences and insights at APA's 2006 annual meeting.

BY MICHELE WERNER

The actress, model, author, and mother Mariel Hemingway will be the featured guest and speaker at the fifth annual "Conversations" event hosted by the American Psychiatric Foundation on Tuesday, May 23, from 5:30 p.m. to 6:30 p.m., in Hall A of the Toronto Convention Center at APA's 2006 annual meeting. Modeled after the "Inside the Actors Studio" program on Bravo, the "Conversations" format creates the opportunity for a relaxed and often intensely personal interview.



Richard Harding, M.D., professor and chair of the Department of Neuropsychiatry and Behavioral Science at the University of South Carolina School of Medicine, will interview Hemingway. Dr. Harding is an APA past president and current member of the American Psychiatric Foundation Board of Directors.

At age 13, Hemingway began her film career in "Lipstick" followed by an award-winning turn in Woody Allen's film "Manhattan." Featured in more than 30 films and television projects, Hemingway is a yoga enthusiast who released a memoir of personal growth called *Finding My Balance* in 2003. Her book details her quest for life balance in a family well known for its legacy of mental illness.

Most recently, Hemingway has become a mental health spokesperson and advocate. She is a frequent guest on "Larry King Live," discussing depression and suicide. Her poignant personal story combined with her commitment to her personal mental health, the mental health of her family, and her belief in treatment and recovery promises a memorable interview.

The foundation launched its "Conversations" event four years ago so that psychiatrists could hear from well-known people whose daily lives have been affected by mental illness. The event is supported by an unrestricted educational grant from AstraZeneca. ■

Michele Werner is the development officer at the American Psychiatric Foundation.

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U.S. Psychiatrists Help Heal Earthquake's MH Wounds

Nongovernmental organizations are training primary care health workers to assess and treat individuals for mental health problems in the wake of a devastating earthquake in Pakistan.

BY AARON LEVIN

The South Asia earthquake last October 8 killed 73,000 people and left more than 3 million homeless. Many lived in isolated mountain areas, inaccessible after roads were destroyed. The remoteness of the disaster, and perhaps because it followed previous catastrophes like the Indian Ocean tsunami and Hurricane Katrina, meant that it faded from television screens and newspaper front pages all too quickly.

Relief efforts continue, though, first to care for survivors' need for food and shelter during the mountain winter, but also to attend to longer-term needs.

The Pakistan Ministry of Health, with the assistance of the World Health Organization (WHO), coordinates reconstruction of basic health services in the earthquake area.

Additionally, several nongovernmental organizations (NGOs) have been active in mental health work in the earthquake area. Some provide direct patient care, while others are pursuing longer-term goals.

"The main role of outsiders is in capacity building," said Lynne Jones, M.D., mental health specialist for International Medical Corps (IMC), a California-based NGO, in an e-mail interview from Sri Lanka. "We avoid short-term, stand-alone counseling programs that disappear with the funding." But building capacity has to be done in a culturally appropriate manner, she added. "One size does not fit all, and different health systems have quite different needs."

Needs Change With Culture

Even the nature of the victims may change with geography and culture, said Jones. For example, women and children were the most vulnerable in Pakistan, while in Aceh, Indonesia, men who had lost their entire families were at greater risk after the tsunami.

In Pakistan, IMC now provides mental health training to primary health care workers, preparing them to handle mental health cases themselves rather than relying on specialists, said Jones. IMC has arranged weekly training sessions for primary care staff in the towns of Balakot and Mansehra. (WHO also provides mental health care and training there, too.)

They also run mental health clinics one day a week at Kashtri and Bassian refugee camps. A camp doctor with additional mental health training sees the patients, backed up by an IMC supervisor and supported by a Pakistani psychologist. The psychologist counsels patients needing more intensive help and conducts home visits. Every mental health care patient is assigned a general practitioner, and follow-up appointments are conducted during the doctor's normal clinic time.

Women receive particular attention. Grief support, anxiety management, literacy, and activity groups have been set up for women and teenage girls. IMC has also trained women health workers and other camp volunteer staff in community-support skills such as effective listening, problem solving, and grief work.

"In disasters much of our initial work is paying attention to grief and loss for the wider community and to the seriously mentally ill who are often neglected in these situations," she said.

Photo courtesy of Syed Arshad Husain, M.D.

S. Arshad Husain, M.D. (right), of the University of Missouri addresses mothers in training to become teachers in the "Mothers as Teachers" program in Karachi, Pakistan. The 10 mothers enrolled in the program learn to teach a first-grade course to five children aged 5 to 7.

Psychiatrist Returns Several Times

One United States psychiatrist with long experience among traumatized populations has returned to Pakistan several times since the quake to address the needs of one especially vulnerable group of quake victims.

"The earthquake had a devastating effect on the region's children," said S. Arshad Husain, M.D., a professor of child psychiatry and child health at the University of Missouri in Columbia and a member of APA's Committee on Psychiatric Dimensions of Disasters.

"For one thing, the earthquake struck shortly after children had arrived at school. Many were killed or badly injured as school buildings collapsed, and over 17,000 children were orphaned."

Husain is a native of India who lived for 15 years in Pakistan and trained in England and Canada before joining the Department of Psychiatry at the University of Missouri in 1970. He and a team from the International Center of Psychosocial Trauma at the University of Missouri ran training programs for mental health personnel after manmade disasters in Albania, Kosovo, and Afghanistan, showing them how to train others. They spent two days in November in Islamabad, Pakistan's capital, training school principals, mayors, teachers, and physicians to recognize psychological reactions to trauma and teaching some basic counseling skills.

"People suffer silently," said Husain. "Adults may see symptoms in children but don't know what to do. Train them and they can see."

In January, Husain secured land from the local government about 20 miles outside Mansehra, arranged to purchase and ship 150 prefabricated shelters from the United States, and hired a local manager to oversee their installation. One hundred of the corrugated plastic shelters will form the core of the "village of hope," he said.

Each shelter will house four orphans (defined in Pakistan as a child whose father has died) and a mother or other houseparent.

please see ***Earthquake*** *on page 43*

Most Iranian Inmates Drug Addicted, But Few Get Treatment

Mental illness appears to be rampant among Iranian prisoners, just as it is among Western ones. But the mental illness profile of the former differs somewhat from that of the latter.

BY JOAN AREHART-TREICHEL

While Western countries have been trying to contain Iran's nuclear capabilities, some Iranian psychiatrists have been waging a different kind of battle—determining the prevalence of mental illness among Iranian prisoners.

Their study was conducted in one of the largest men's prisons in Iran. It included a random sample of 351 prisoners and was based on interviews using the clinical version of the Structured Clinical Interview for *DSM-IV* Axis I Disorders and the Psychopathy Checklist: Screening Version. A troubling finding emerged from the study: Some three-fourths of the prisoners interviewed were either currently dependent on opioids or had been at some time in their lives.

"This is one of the strongest associations between crime and drug addiction reported thus far," the principal investigator of the study told *Psychiatric News*. He is Seyed Mohammad Assadi, M.D., an assistant professor of psychiatry at Tehran University of Medical Sciences.

The study was funded by the Iran University of Medical Sciences. Results were published in the February *British Journal of Psychiatry*.

As Assadi and his colleagues pointed out in their report, only 25 percent to 50 percent of prisoners in Western countries have been found to have had a lifetime substance abuse diagnosis.

The reason why so many Iranian criminals appear to abuse opioids, Assadi speculated, might be because "Iran is the main route of opiate trafficking between Afghanistan and Europe. According to the United Nations Office on Drugs and Crime, Iran is among the countries with the highest prevalence of opioid abuse."

Another noteworthy finding to emerge from their study was that 29 percent of the inmates studied were currently suffering from a major depression. In contrast, only 10 percent of male prisoners in Western countries have been found to have a major depression, Assadi and his group stated in their study report.

Moreover, 4 percent of the prisoners were found to have a lifetime diagnosis of psychosis. This rate is comparable to that reported for male prisoners in Western countries. A lifetime diagnosis of psychopathy was found in 24 percent of the prisoners. This rate is comparable to that found in North American prisoners (25 percent to 30 percent), but higher than that reported in European prisoners.

Also of interest, when the Iranian prisoners in this study were grouped according to offense, their prevalence of mental illness was discovered to vary considerably.

For example, all of the subjects imprisoned because of drug-related offenses had a lifetime diagnosis of an Axis I disorder, compared with only 54 percent of those imprisoned because of financial crimes. The latter "are usually individuals whose financial forecasts have proved wrong during economic fluctuations," Assadi and his colleagues explained in their study report.

Further, whereas 31 percent of the drug-offense group had a lifetime diagnosis of psychopathy, only 16 percent of those incarcerated for murder, robbery, or other violent crimes did, and only 15 percent of those imprisoned for immoral acts did. Immoral acts in Iran, Assadi and his group explained, include "fornication, prostitution, and alcohol use or trading."

Finally, according to the data collected in the overview section of the clinical version of the Structured Clinical Interview for *DSM-IV* Axis I Disorders, only 11 percent of prisoners with current Axis I diagnoses were receiving psychiatric treatment. So when *Psychiatric News* asked Assadi whether their study results might lead to better treatment of Iranian prisoners' mental illnesses, he replied: "We hope. We think this report and a few other smaller studies have drawn attention to the substantial burden of psychiatric problems in Iranian prisoners."

An abstract of "Psychiatric Morbidity Among Sentenced Prisoners: Prevalence Study in Iran" is posted at <http:bjp.rcpsych.org/cgi/content/abstract/188/2/159>. ■

CEPHALON SPARLON

P4C

Antipsychotic Polypharmacy: Value for the Money?

In California's Medicaid program, antipsychotic polypharmacy costs three times more per patient than monotherapy, though superior efficacy for polypharmacy has not been proven.

BY MARK MORAN

Antipsychotic polypharmacy appears to be a common but costly practice whose effectiveness is not supported by evidence, according to two reports in the January issue of *Psychiatric Services*.

At the state-hospital level, however, the practice can be significantly curtailed if hospital leadership focuses its attention on reviewing prescribing patterns, according to one of those reports.

Researchers at the Neuroscience Education Institute in Carlsbad, Calif., analyzed California Medicaid fee-for-service pharmacy claims from May 1999 through August 2000 for patients who received risperidone, olanzapine, or quetiapine.

Of the 116,114 patients who received at least one of these agents, 4.1 percent received a combination regimen. Polypharmacy was the most expensive form of second-generation antipsychotic use, costing up to three times more per patient than monotherapy, according to Stephen Stahl, M.D., Ph.D., an adjunct professor of psychiatry at the University of California, San Diego, and Meghan Grady, senior medical writer at the Neuroscience Education Institute.

They found that the average amount paid per patient receiving just one antipsychotic medication in the Medi-Cal program (the state's Medicaid program) was $2,382, compared with $7,536 per patient receiving two or more antipsychotic medications for more than 60 days.

"Initially, we talked about polypharmacy, and psychiatrists were well aware of the incidence, but we couldn't make a change despite the education."

"If antipsychotic polypharmacy were more effective than monotherapy, this practice may actually reduce total costs despite the higher pharmacy costs," Stahl and Grady said. "However, there are currently no data available to support the effectiveness of antipsychotic polypharmacy. Thus, there is no reason to believe that antipsychotic polypharmacy would reduce total costs."

A second paper in *Psychiatric Services* reported the effectiveness of a medication review by hospital administrators who actively focused attention on antipsychotic polypharmacy in an effort at re-education.

Vijayalakshmy Patrick, M.D., a clinical associate professor of psychiatry at the University of Medicine and Dentistry of New Jersey, and colleagues reported on an initiative undertaken by psychiatrists and hospital administrators at an unnamed 570-bed state psychiatric hospital in the northeastern United States aimed at reducing antipsychotic polypharmacy.

Baseline prescribing practices were gathered for 14 psychiatrists at the hospital in May 2001. An initial educational program—including case discussions, consultations with psychiatrists, and psychopharmacology seminars—did not produce a decline in polypharmacy at follow-up in November of that year.

At that point, a new chief of psychiatry met individually with each psychiatrist to compare his or her antipsychotic prescribing data with that of anonymous peers and urged each to reduce polypharmacy prescribing by 10 percent. Psychiatrists were assured that results would not influence performance evaluations, according to the report.

A follow-up review in August 2002 found that 127 patients treated by the 14 psychiatrists were receiving antipsychotic polypharmacy compared with 197 patients in November 2001.

The largest subgroup had been receiving "mixed polypharmacy," the use of a first-generation agent plus a second-generation agent. That group also decreased significantly, from 165 patients in November 2001 to 106 in August 2002.

Of the 14 psychiatrists, 13 reduced their use of polypharmacy, and eight met the goal of decreasing polypharmacy by at least 10 percent.

"The performance improvement strategy was noteworthy because it did not include sanctions or compromise anonymity, but relied solely on the chief of psychiatry's personal expression of expectations along with provision of individual data for comparison," the report pointed out.

In an interview with *Psychiatric News*, Patrick said that monthly medication reviews typically do not address whether polypharmacy is necessary. But she emphasized that the use of multiple medications is not supported by evidence and may take the place of useful nonpharmacologic interventions.

Though outcome data on patients who switched from polypharmacy to monotherapy were not reported, Patrick said there were no adverse effects observed.

She said that because of the chronicity of severe psychiatric illness and frequent medical comorbidity, there are times when polypharmacy is necessary. But she added that in her experience, she had never known a patient to get worse after switching from polypharmacy to monotherapy, especially when other treatment modalities are combined.

Patrick said that the critical factors in the follow-up intervention were the focused attention of leadership and the availability of anonymous comparison data with peers. "Initially, we talked about polypharmacy, and psychiatrists were well aware of the incidence, but we couldn't make a change despite the education," she said.

"An Initiative to Curtail the Use of Antipsychotic Polypharmacy in a State Psychiatric Hospital" is posted online at <http://ps.psychiatryonline.org/cgi/content/full/57/1/21>. "High-Cost Use of Second-Generation Antipsychotics Under California's Medicaid Program" is posted at <http://ps.psychiatryonline.org/cgi/content/full/57/1/127>. ■

Antipsychotics May Be Overprescribed To Treat Bipolar Disorder

Many bipolar patients are maintained for long periods on two or more atypical antipsychotics, a practice for which there is no supporting evidence, researchers say.

BY MARK MORAN

Atypical antipsychotics should be used conservatively in the treatment of bipolar disorder, and careful monitoring—especially for weight gain and metabolic syndrome—is essential.

That's the message from the report "Emerging Treatments for Bipolar Disorder: Safety and Adverse Effect Profiles" in the February *Annals of Pharmacotherapy*.

The authors were Ronald Pies, M.D., a clinical professor of psychiatry at Tufts University School of Medicine, and Patricia Marken, Pharm. D., professor and chair of the division of pharmacy practice and a professor of psychiatry at the schools of pharmacy and medicine at the University of Missouri in Kansas City.

> **"The take-home message. . . is that conservative use and careful monitoring are very important when using the atypicals in bipolar disorder."**

The review, which was supported by an unrestricted educational grant from GlaxoSmith Kline (GSK), found that some newer antiepileptic drugs may cause less weight gain than older agents and require less therapeutic drug monitoring. GSK manufactures lamotrigine (Lamictal), an antiepileptic.

Pies and Marken conducted a MEDLINE search through July 2005 of randomized controlled trials, open-label studies, and reviews of treatments for bipolar disorder. They reviewed results for atypical antipsychotics—including olanzapine, risperidone, quetiapine, clozapine, ziprasidone, and aripiprazole—as well as antiepileptic drugs such as lamotrigine, topiramate, gabapentin, and oxcarbazepine.

"Our review highlights the many side effects possible with the newer, atypical antipsychotics," Pies told *Psychiatric News*. "Notwithstanding their antimanic effects and their probable but less established mood-stabilizing effects, I believe that the atypicals should still be used conservatively in bipolar disorder. I find that many bipolar patients are maintained for long periods on two or more atypicals, with or without classical mood stabilizers, and there is practically no controlled evidence to support this practice.

"Such 'irrational' polypharmacy definitely increases the risk of side effects and drug interactions," he said. "Weight gain and metabolic syndrome are of particular concern with the atypicals, especially but not exclusively olanzapine. Not every bipolar patient needs to be maintained indefinitely on an atypical antipsychotic, if a mood stabilizer alone—such as lithium, lamotrigine, or divalproex—can do the job. The take-home message, therefore, is that conservative use and careful monitoring are very important when using the atypicals in bipolar disorder."

The review found that new antiepileptic drugs appear to cause less weight gain than older agents, have fewer drug interactions, and require less therapeutic drug monitoring than older antiepileptic drugs.

"Lamotrigine seems to be a bona fide mood stabilizer and maintenance agent in bipolar disorder, though it is more effective for delaying recurrence of depressive episodes than of mania," Pies said. "There is growing, but still preliminary, evidence that lamotrigine is also useful in the acute treatment of bipolar depression, which makes it quite valuable as an alternative to potentially 'destabilizing' antidepressants."

But he added that the agent is not a panacea for bipolar disorder and is not risk-free.

"Whereas the fear of serious skin rash is almost certainly overblown when the drug is titrated slowly, it can be associated with headaches in some bipolar patients, and there are rare anecdotal reports of lamotrigine-induced hypomania or overactivation," he said. "Very high lamotrigine doses greater than 400 mg a day may be associated with cognitive side effects, but such high doses are rarely needed for most bipolar patients."

An abstract of "Emerging Treatments for Bipolar Disorder: Safety and Adverse Effect Profiles" is posted at <www.theannals.com/cgi/content/abstract/40/2/276>. ■

Call for Papers

Professional News

The National Resource and Training Center on Homelessness and Mental Illness has issued a Call for Papers on the topic of homelessness and mental illness for the *Journal of Primary Prevention*. More information is available by calling (800) 444-7415 or (301) 654-6740.

The center, which is part of the Center for Mental Health Services, is the only national center specifically focused on the effective organization and delivery of services for people who are homeless and have serious mental illnesses, according to the center's Web site. Center staff provide a link between emerging knowledge and everyday practice. ■

Major Study to Assess Lithium in Bipolar Youth

Off-patent drugs being studied include lorazepam for sedation of children in the ICU. On-patent drugs include morphine, buproprion, and zonisamide.

BY MARK MORAN

Nine academic medical centers around the country are studying the use of lithium to treat bipolar illness in children.

The multisite study is part of an effort by the National Institute of Child Health and Human Development (NICHD) to investigate the effects of more than 25 drugs in children. The project is being funded under the Best Pharmaceuticals for Children Act (BPCA), signed by President Bush in 2002.

"Lithium has been the recognized standard of treatment for adults with bipolar disorder since it was approved in 1970," said Jay Burke M.D., M.P.H., chair and chief of the Department of Psychiatry at Harvard Medical School, in a statement released by Harvard/Cambridge Alliance. "But it has never been fully studied for safety and efficacy in children. As a result, child psychiatrists have been reluctant to use it and may not have used it as effectively as we suspect it can be used."

Harvard/Cambridge Health Alliance is one of the sites being funded under the NICHD contract. A teaching affiliate of Harvard Medical School, Cambridge Health Alliance is a regional health care system with hospitals and primary care practices in the Boston area.

Perdita Taylor-Zapata, M.D., NICHD project officer for the contract, told *Psychiatric News* that the other sites involved in the lithium study are Case Western Reserve University, Children's Hospital and Regional Center in Seattle, Cincinnati Children's Hospital Medical Center, Medical College of Wisconsin, North Shore Long Island Jewish Research Institute in New York, University of Illinois at Chicago, University of North Carolina School of Medicine, and Stanford University School of Medicine.

Taylor-Zapata said the NICHD study will assess use of lithium in children aged 7 to 17 who have been diagnosed with mania.

Lithium is one of a number of "off-patent" drugs—meaning the patents have expired, and pharmaceutical companies are no longer conducting studies—that NICHD lists as study priorities.

Also on that list is lorazepam for sedation of children in the intensive care unit.

As of March 2004, four on-patent drugs had been listed for study. These are morphine, bupropion, sevelamer (used to reduce the level of phosphorus in the blood of patients with end-stage renal disease), and zonisamide (used to treat seizures). Taylor-Zapata said the list is updated every year by NICHD in collaboration with the Food and Drug Administration (FDA).

According to information about BPCA

please see ***Lithium*** *on page 42*

Depressed Patients Explain How They Define Remission

Depressed patients maintain that optimism, self-confidence, and a return to one's "normal" self and usual level of functioning are the best indicators that their illness has remitted.

BY MARK MORAN

How do you determine when a patient with depression is in remission? Not by symptom resolution alone, according to patients with the disorder.

A survey of 535 psychiatric outpatients who were being treated for *DSM-IV*-diagnosed major depressive episode found that they consider a wide range of factors when defining remission—and they do not consider symptom resolution alone to be sufficient. A report of the survey appears in the January *American Journal of Psychiatry.*

Among the factors considered of high importance in remission were "features of positive mental health" such as optimism and self-confidence; a return to one's usual, normal self; and a return to usual level of functioning.

But several other factors were also rated highly, such as not getting overwhelmed by stress, ability to fulfill usual responsibilities, satisfaction with life, feeling in emotional control, and enjoying relationships with friends and family.

Psychiatrist Mark Zimmerman, M.D., lead author of the report, said the findings show that the emphasis on resolution of symptoms alone—during clinical trials and by clinicians in practice—is too narrow.

"Patients consider multiple factors as very important in determining whether they are in remission," he said. "Certainly, these are not independent of themselves, but there is no consensus that there is one factor that should be clearly elevated above the others when determining if someone is in remission.

"And there is no indication that the concept should be narrowly defined in any case," Zimmerman told *Psychiatric News.*

In the study, unstructured interviews were conducted with outpatients at Rhode Island Hospital Department of Psychiatry in which they were asked how they knew that their depression was in remission, or if they were still depressed, how they would know when their depression was in remission.

From these interactions Zimmerman and colleagues derived a list of 16 potentially relevant factors.

Then the survey group of 535 patients was asked to rate each of the factors in terms of importance in determining remission, using a numeric scale of 0 (not very important), 1 (somewhat important), or 2 (very important).

Most patients judged at least one of the 16 factors as very important in determining remission from depression. On average, patients rated 10.7 factors as very important. Eighty-two patients rated all 16 factors as very important in determining remission from depression, and 15 of the 16 factors were considered very important by more than half of the patients.

"Patients consider multiple factors as very important in determining whether they are in remission."

The three factors that were the most frequently judged to be very important in determining remission were the presence of features of positive mental health such as optimism and self-confidence; a return to one's usual, normal self; and a return to usual level of functioning.

Four items were selected by more than 10 percent of the patients as the most important factor in determining remission from depression: presence of positive mental health, a return to one's usual self, a general sense of well-being, and the absence of symptoms of depression.

"The findings indicate for practicing clinicians that they should not limit their assessments to symptom severity alone," Zimmerman said. "For the field at large, it is time to start developing instruments that will more broadly capture an individual's functioning and ability to cope with stress."

"How Should Remission From Depression Be Defined? The Depressed Patient's Perspective" is posted at <http://ajp.psychiatryonline.org/cgi/content/full/163/1/148>. ■

Association News

Applications Invited

APA's Psychiatric Services Achievement Awards program is seeking applications for the 2006 competition. Innovative programs that deliver services to mentally ill or disabled individuals, that have overcome obstacles, and that can serve as models for other programs are invited to apply.

Two Gold Award winners will be selected, each to receive a $10,000 grant made possible by Pfizer Inc. In addition, winners will receive an invitation to participate in a special workshop at the 2006 Institute on Psychiatric Services in October in New York and coverage in two APA publications. The deadline for applications is Tuesday, April 11.

Applications can be downloaded from APA's Web site at <www.psych.org/psychpract/awards.cfm> or obtained by contacting Mary Ward by phone at (703) 907-8592 or by e-mail at mward@psych.org. ■

FOREST NAMENDA
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ELI LILLY SYMPOSIUM
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PFIZER GEODON
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Preventing Terrorism

I would like to encourage APA, possibly through *Psychiatric News*, to stimulate discussions about terrorism prevention. My understanding of this complex problem is that it has many facets, but inevitably we hear about damage to the developing self when we learn some of the histories associated with those who subsequently engaged in terrorist behaviors. And as we know, the damaged self tends to expand in terms of entitlement, grandiosity, and disinhibition of violence.

Individuals who suffer from developmental damage but have an otherwise healthy sense of self are not by any means restricted to those outside the borders of the United States. In considering ways to prevent terrorism, two things appear to be missing: First, there is a reluctance to look at the possibility of self-terrorism, in the sense of internally based or intranational origination. In fact, some terrible terroristic acts have already happened "at home."

Second, if terrorism relates to developmental injuries to the growing self, then we may be paying a price for overlooking some of the more obvious narcissistic injuries in our culture: educational problems, inaccessible medical health care, inadequate mental health care, and problems around imbalanced distribution of wealth.

What can happen at home is just as dangerous—maybe more so—than what can happen at the hands of a more distantly imagined "terrorist." I believe that psychiatry has much to offer in this area, but we need to focus more on prevention. It is unfortunate that people's interests and motivation, particularly as manifested by budgets, fail at prevention. It's as though we have to wait for a disaster that was predictable before prediction is given its just credibility. Psychiatry can help us get past various forms of epidemic denial. What psychiatry often finds is that the person who gets looked at last, namely oneself, is really the person who should have looked at oneself first.

DAVID FEDDERS, M.D.
Cincinnati, Ohio

Managed Care Has Progressed

In the article "Road to Today's Psychiatry Hard but Full of Promise" in the November 4, 2005, issue, the reporter references remarks made by APA President Steven Sharfstein, M.D., in a lecture given at APA's 2005 Institute on Psychiatric Services. Dr. Sharfstein is quoted as saying, "Despite the efforts of payers and their managed care hired guns to reduce and constrain care, there is a sense of rising expectations in society for effective psychiatric care."

I write to respond to this. If it is an actual quotation, it is an insulting and dismissive rebuke directed toward managed care medical directors. Implicit in such a remark is a lack of understanding of the role of psychiatrists within a managed care company. Many of these medical directors are members of APA, including me, and I do not appreciate the characterization. As an experienced psychiatric clinician and administrator, I believe psychiatrists play an essential role within MCOs. My own experiences with managed care reviewers 20 years ago led me to begin some work with managed care organizations to modify the process. Managed care review processes have evolved significantly over time.

The problem of health care inflation is well known and must be addressed since it is our reality. If psychiatrists do not participate in the evolution of the health care reimbursement system, underlying business

please see ***Letters to the Editor*** *on page 49*

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

clinical & research news

Lithium

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on the NICHD Web site, several practical problems have discouraged the testing of drugs in pediatric populations. These include ethical issues around parental permission and the child's assent; availability of technology to monitor patients and assay very small amounts of blood; lack of incentives for pharmaceutical companies to study drugs in neonates, infants, and children; and lack of suitable infrastructure for conducting pediatric pharmacology research.

In 1994 the FDA issued its Pediatric Rule, which allowed the labeling of drugs for pediatric use based on extrapolation of efficacy in adults, if the course of the disease and the response to the drug are similar in children as in adults.

Additional legislation passed in 1997 provided extra incentives to pharmaceutical companies for pediatric testing, including an additional six-month exclusivity period for marketing the drug.

The purpose of the BPCA is to establish a process for studying on-patent and off-patent drugs for use in pediatric populations and improve pediatric therapeutics through collaboration on scientific investigation, clinical study design, weight of evidence, and ethical and labeling issues.

"Our goal is primarily to get safety and dosing information on drugs that are routinely used in children but for which there are no guidelines on appropriate use," Taylor-Zapata said.

More information about the NICHD and the BPCA is posted at <www.nichd.nih.gov/bpca/action.cfm>. ■

Earthquake

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Some of the shelters will serve as schools for children aged 6 to 12. Others will serve as a community health center to provide physical and mental health care.

The U.S. team was scheduled to return to Pakistan at the end of February to train and carry out a needs assessment that will also serve as a baseline for future outcomes research.

"We hope to build local capacity and local support and then have local personnel take over," said Husain. The team's work is funded by Direct Relief International of Santa Barbara, Calif., the Association of Physicians of Pakistani Descent of North America, and local donors in Columbia, Mo.

"When I started, I didn't realize how complex it would turn out to be—organizing the land, the shelters, the food," he said. "But all the pieces are coming together now."

Lynne Jones also sees signs of progress in her corner of the quake zone.

"We are at the beginning, but I am impressed by Pakistani doctors' enthusiasm and interest in mental health and their engagement in the social issues," said Jones. "The whole point of the IMC program is to ensure sustainability by training staff who will continue to use the knowledge in their general practice." ■

Budget

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$155 million reduction in the Health Professions Training Program, which targets minority and underserved populations.

"This is one of the few programs in the federal government that looks to train people to serve populations that historically have a very hard time accessing services," Boroughs said. "It's a shame because that fellowship training program has been proven to work."

Payments to children's hospitals for graduate medical education would be cut by $198 million.

The budget includes $169 million to accelerate progress in health information technology. The funding aims to promote nationwide interoperability of health information technology systems through industry-wide standardization.

The Department of Housing and Urban Development would see its Section 811 housing for people with disabilities cut in half, from $237 million in Fiscal 2006.

Department of Veterans Affairs (VA) funding would swell by 6 percent to $35.7 billion, although the increase is linked to new health care fees that Congress previously rejected. Without the new fees the discretionary total would rise 3 percent above Fiscal 2006, and funding for medical care would increase 8 percent. That would reverse the trend over the past two years in which VA funding proposals did not keep up with inflation.

The demand for VA services among veterans has grown, and the cost of long-term care has risen, which contributed to two consecutive budget shortfalls that totaled nearly $3 billion.

"These are record increases because of the increased demand on the system," Sperling said about the veterans funding increases, which had been sought by NAMI.

Nearly $800 million of the VA increase would be paid for from a proposed new $250 enrollment fee and boosting drug copayments from $8 to $15 per prescription for higher-income, less-disabled veterans.

APA officials told legislators in testimony for the Fiscal 2007 budget that it is concerned that some budget assumptions, such as the reliance on the collection of user fees and copays from veterans, might be overly ambitious if counted on to fund the entire budget increase. APA is concerned about the impact on the estimated 200,000 veterans it will affect including those who rely on the VA to pay for psychiatric medications.

Spending on VA medical care would see an 11 percent increase to $27.5 billion, if the fee proposals are rejected.

The president's budget proposals are posted at <www.whitehouse.gov/omb/budget/fy2007/>. ■

from the president

continued from page 3

who meet criteria for a disorder receive psychiatric treatment? How do we decide which ones should receive treatment and what kind? Who and how many should be seen by psychiatrists for treatment? Most important for psychiatry, if only a small minority of persons with a serious psychiatric disorder receives care that meets even basic treatment standards, what are the implications for our profession? What can we do to address this problem?

We need to have state-of-the-art performance measures for assessing individual clinical care in psychiatry. All the rhetoric around "evidence-based medicine" aside, without such, we do not know how well we are doing for our patients.

It is clear that there is an unmet need for treatment. There are far too few psychiatrists to meet that need. Barriers to care remain high. Continued improvements in psychiatric treatment need to translate to better outcomes. Better outcomes will enhance our case for nondiscriminatory insurance coverage. Let's hope that in another 10 years when this study is once again replicated, we will have made significant progress on all of these fronts. ■

Athens Congress

Professional News

The 19th Pan Hellenic Psychiatric Congress will be held in Athens, Greece, from May 4 to 8 at the Athens Hilton Hotel.

The 20th anniversary of the Hellenic Psychiatric Association will be celebrated at the congress. The association plans to hold joint meetings with the Hellenic American Psychiatric Association during the congress.

More information is available online at <www.hellenic-psych.org> or by phone at (310) 451-3152. ■

FOREST SYMPOSIUM
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Election Results

continued from page 1

psychiatric subspecialty organizations to multiply our effectiveness in public information and mental health policy, as well as developing partnerships between scientists and clinicians to promote professionalism and quality patient care."

Robinowitz, of Bethesda, Md., is in private practice of adult, child, and adolescent psychiatry and has held leadership posts in organizations representing a broad cross-section of the field. She was the founding director of APA's Office of Education, APA senior deputy medical director and chief operating officer, academic dean at Georgetown University School of Medicine, and a past president of the American College of Psychiatrists and the American Board of Psychiatry and Neurology. She is also a member of the AMA Council on Science and Public Health.

In the race to succeed Robinowitz as secretary-treasurer, Area 1 Trustee Donna Norris, M.D., of Wellesley, Mass., outpolled Prakash Desai, M.D., of River Forest, Ill., by 51.4 percent to 48.6 percent. Both Norris and Desai are former speakers of the APA Assembly.

Every three years, there is an election for the early career psychiatrist (ECP) trustee-at-large. (APA has three trustees-at-large who serve three-year terms, with one of these positions up for election each year. One position is designated for an ECP.) In this year's election, Amy Ursano, M.D., an assistant professor at the University of North Carolina, defeated Richard Granese, M.D., of Orange, Calif. Ursano received 67.4 percent of the vote to Granese's 32.6 percent.

The contest to be the next member-in-training (MIT) trustee-elect was the closest race this year. The winner, Abigail Donovan, M.D., a resident at Massachusetts General and McLean hospitals, bested Anjali Nirmalani, M.D., a resident at the University of South Florida. Of the 912 votes cast, Donovan garnered 50.3 percent, while Nirmalani received 49.7 percent. Only MITs vote in this race.

Three APA Areas had elections for their trustee position this year.

In Area 1 Jeffrey Geller, M.D., of Worcester, Mass., won 59.6 percent of the vote against opponent Patricia Recupero, J.D., M.D., of Providence, R.I.

In Area 4 two Chicagoans were competing. With 52 percent of the vote, incumbent Sidney Weissman, M.D., defeated Tanya Anderson, M.D.

In Area 7 William Womack, M.D., of Seattle outpolled Louis Moench, M.D., of Salt Lake City. Womack received 69.7 percent of the vote.

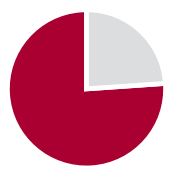
All of the new officers and trustees will take office in May at the end of APA's 2006 annual meeting in Toronto. Also at that time President-elect Pedro Ruiz, M.D., will become president, and Lysiane Ribeiro, M.D., now the MIT trustee-elect, will become the member-in-training trustee.

Of the 30,306 APA members eligible to vote in the the 2006 election, 9,819, or 32.4 percent, returned their ballots, generally in line with totals over the last five years. During the 1980s and 1990s, however, the percentage of members who voted was usually in the 40 percent range.

The option of voting online continues to gain in popularity. After last year's big jump, which saw about 23 percent of voters submitting online ballots, 28.3 percent chose to do so this year. In the 2004 election, only about 9 percent of members voted online.

The Tellers Committee presented these results to the Board of Trustees on March 5. ■

President-Elect



Carolyn B. Robinowitz, M.D.
7,401
76.1%

Jack Drescher, M.D.
2,326
23.9%

Total votes cast: 9,727

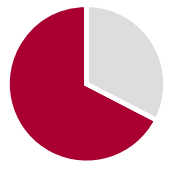
Secretary-Treasurer

Donna M. Norris, M.D.
4,901
51.4%

Prakash N. Desai, M.D.
4,634
48.6%

Total votes cast: 9,535

ECP Trustee-at-Large



Amy M. Ursano, M.D.
6,221
67.4%

Richard Granese, M.D., M.B.A.
3,006
32.6%

Total votes cast: 9,227

MIT Trustee-Elect

Abigail L. Donovan, M.D.
459
50.3%

Anjali Nirmilani, M.D.
453
49.7%

Total votes cast: 912

Area 1 Trustee

Jeffrey L. Geller, M.D., M.P.H.
791
59.6%

Patricia R. Recupero, J.D., M.D.
537
40.4%

Total votes cast: 1,328

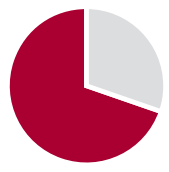
Area 4 Trustee

Sidney H. Weissman, M.D.
887
52.0%

Tanya R. Anderson, M.D.
819
48.0%

Total votes cast: 1,706

Area 7 Trustee



William Womack, M.D.
549
69.7%

Louis A. Moench, M.D.
239
30.3%

Total votes cast: 788

Frank Named

Association News

The Washington Psychiatric Society has named Julia Frank, M.D., the 2005 Psychiatrist of the Year. She was cited for her work at the D.C. Armory with Hurricane Katrina evacuees. Other honorees were Maryam Razavi, M.D., who was selected the 2005 Resident of the Year; Rep. Patrick Kennedy (D-R.I.) and Connie Garner, Ed.D., Wellstone Award; Maryland Sens. Brian Frosh and Paula Hollinger, Public Policy Makers of the Year; Mary Jones of Washington, D.C., Advocate of the Year Award; and Rod Drake, M.D., Immediate Past President Award. ■

professional news

Primary Care

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"The integration of psychiatry into the team makes a more powerful primary care unit that can take care of most problems in a cost-effective way," said Gavagan. "We used to spend a lot of time addressing the tip of the iceberg. We just treated the physical symptoms—headache, palpitations—or ordered a bunch of tests. But we have limited resources for the number of patients we see, so resources have to be directed more effectively."

Psychiatry Now 'Carved-In'

The psychiatrists also run an educational program for the system's primary care physicians. They lecture on major psychiatric issues like bipolar disorder, depression, psychosis, child psychiatry, and medications. Where psychiatry was once carved out of primary care, now it is "carved in," said Gavagan. "The physical and psychosocial sides are connected."

Psychiatrists also have set up a mental health curriculum for the primary physicians' office staffs, and for residents, as well.

"The psychiatry residents get exposure to the integrated model of care, while primary care residents have a chance to work with psychiatrists and get more practical exposure to psychiatry," said Ostermeyer. "It's a great experience for them."

Such models of care are becoming more common, said Nicholas Kates, M.D., a professor of psychiatry and family medicine at McMaster University in Hamilton, Ontario. They were a more prominent part of psychiatric care in Great Britain for a long time and have been part of major initiatives in Canada. In the United States, increasing academic research has led the way in studying the effectiveness of these models.

Clinical Trials Study Integrated Care

More than 20 clinical trials over the last two decades have examined the effects of integrating care, moving from "screen and refer" to "screen and treat."

The IMPACT study of 1,800 elderly patients reported in 2003 that nurses, supervised by psychiatrists, improved patient outcomes by about one-third, said study leader Wayne Katon, M.D. a professor and vice chair of psychiatry and behavioral science at the University of Washington Medical School in Seattle. The PATHWAYS trial of patients with depression and diabetes found that treating depression, which is twice as frequent among patients with diabetes, improved both depression scores and diabetes outcomes.

"And it may save medical costs, as well," said Katon.

Nationally, sources like the Hartford, the Robert Wood Johnson and MacArthur foundations, the National Institute of Mental Health, and Department of Veterans Affairs have funded studies and demonstration and dissemination projects in integrated care that are leading to wide-ranging changes in practice, said Katon.

If perhaps 25 percent of patients seen in primary care have a mental health diagnosis, an additional 20 percent have problems following their regimens because of behavioral problems, said Katon. "So half of what doctors do is mental health work. Without integration we won't be able to provide support to patients with mental illness."

"Many mental disorders must be understood as chronic illnesses, so perhaps care should be shared within primary care among physicians and other professionals," said Kates. Kates's clinical work includes a large practice involving 145 family physicians in Hamilton, such that 60 percent to 70 percent of the city's population now has access to mental health services in primary care offices.

Collaborative care involves more than putting a specialist in a primary care setting, cautioned Henry Chung, M.D., a clinical associate professor of psychiatry and assistant vice president for student health at New York University.

"It's not as easy as you think," said Chung, in an interview. "You can't just plop a psychiatrist into a primary care setting."

Access to specialty support in the same primary care setting is the key, he said, but the culture of psychiatric care may have to adjust as well.

For instance, in a similar program, Chung and colleagues scheduled appointments twice as frequently, every half hour, to mesh more closely with the pace of primary care doctors, who see patients every 15 minutes. Psychiatrists also wore white coats to match the primary care doctors, overcoming patient resistance to "seeing a psychiatrist" and lessening stigma.

"Integrated care is a very exciting idea," Katon said. "As psychiatrists we can do more in a primary care setting than when we hang up a shingle."

A discussion of collaborative psychiatric care, "Transforming Mental Health Care at the Interface With General Medicine," is posted at <http://ps.psychiatryonline.org/cgi/content/full/57/1/37>. ■

community news

Exhibit

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and was deprived of food. Today she is a poet and lives with agoraphobia, among other mental health problems. In her poems she speaks of "kindness, hush, and libraries," Nye said.

Nye told *Psychiatric News* that he was inspired to create the Fine Line exhibit after a close friend committed suicide. "He had everything. He was a leader, an athlete, and an artist who drew and painted," Nye said.

His friend was also an architect and at a young age built a house that was featured in an architectural magazine. He was diagnosed with schizophrenia in his 20s and committed suicide in his mother's garage in his 40s.

"He was gentle, kind, intelligent, and shy," Nye said of his friend. "He once told me, 'I can't go on delivering the mail everyday.' "

Nye found his subjects in and around San Antonio by speaking about his project to local mental health support groups such as those sponsored by the National Alliance on Mental Illness. It took him four years to recruit volunteers, interview and photograph each person, and mount the displays.

One of the things Nye learned while working on the exhibit was that "when you get underneath the surface of what mental illness looks like, you really see that their lives are about jobs, ethical foundations, and families—things we all want."

He decided to name his exhibit Fine Line because "we are all on that fine line between mental health and mental illness."

A number of his subjects told him they never believed that they would have mental health problems, Nye said. "They told me, 'I always thought it was that person over there, but never me.' "

More information about the Fine Line: Mental Health/Mental Illness exhibit is posted at <www.michaelnye.org/fineline>. ■

JANSSEN RISPERDAL
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PBW

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decisions might well bring more draconian measures to stop what many consider a serious problem for an employer or government-based health care system.

APA should represent all of its members, and APA officers should refrain from personal attacks. A collegial interchange is always more effective than name calling or expressing hostility toward people choosing to work in this setting.

MICHAEL A. HABERMAN, M.D.
Atlanta, Ga.

Dr. Haberman is assistant medical director at United Behavioral Health.

APA President Steven Sharfstein, M.D., responds:

My remarks in San Diego were not specifically focused on managed care medical directors as Dr. Haberman implies. I know quite a few of them and count them as friends and colleagues. But in the context of the early 1990s, when managed care companies, at the behest of the major third-party payers, cut the costs of care, there was an unprecedented morale crisis for our field. Clinical decision making was compromised in the effort to contain costs.

We can argue about whether that was necessary then, but the reaction from the profession and from patients and families led to significant changes in managed care practices. In the last five years, we have seen more interest in the field as practice once again is primarily determined by the treating, not the reviewing, physician. It is to the credit of the current generation of medical directors in managed care that the process of care and costs is much more collaborative than it once was, but from time to time there are conflict and sensitivity. I also believe health care inflation is real, and the administrative costs excessive in our overly managed system. I have devoted much of my research and work to finding ways of improving access to effective and efficient care for all Americans.

Personal attacks are not helpful as we need to understand each other and be part of the solution, not the problem. APA provides a forum for debate and discussion.

Developmental Stages Important in Recovery

There is much to commend in the suggested change in paradigm outlined by APA President Steven Sharfstein, M.D., in his column in the November 4, 2005, issue. It should be noted that recovery is a concept that has been widely accepted in substance abuse/addiction circles and is integral in the trauma literature, for example, Judith Herman's book *Trauma and Recovery* is some 20 years old. Perhaps the change in paradigm is overdue.

In my experience a major element in working with patients afflicted with a major mental illness is that for various reasons they have dropped off the developmental trail, most notably in the area of maturation of affects. Not identifying affect signals correctly and not developing language to be able to talk about these signals retard or distort the process of desomatizing affect signals. When children evolve into the preadolescent and adolescent stages and are threatened by affect signaling, their capacity to function in important roles, especially with peers, is curtailed and thus their maturations delayed or arrested. The concept of recovery should include recovering one's capacity to grow and develop in relationships—something that requires an increasing maturing of affects. I'm hopeful that our colleagues will join this debate to refine and integrate the concept of recovery into psychiatric practice.

JOHN L. BULETTE, M.D.
Nassawadox, Va.

Not Just Child's Play

After reading both Dr. Sudeepta Varma's article in the November 18, 2005, issue titled "Psychiatrist Children Often Find Parent's Profession a Mystery" and Dr. Emily Liffick's letter to the editor in the December 16, 2005, issue, I am prompted to share my experience at a "Psychiatrist Mommy-Baby Book Club" in Indianapolis. I have often wondered if psychiatrists as mothers face the same challenges as other working mothers, or do we have some more? Do we subconsciously analyze that the extra scoop of ice cream for disappointment that it might positively reinforce oral gratification and trigger an eating disorder? These unspoken worries and others bond a group of women psychiatrists with little ones at a book club in Indianapolis.

What I noticed is that the overt purpose is to read a toddler book and have a play group for the children, but we also end up talking about ourselves. We seem to share the most embarrassing and toughest moments we've had with the kids. At a recent meeting we discussed vomiting and diarrhea stories. A child had thrown up at the entrance of a fancy restaurant. This story was rivaled by that of another child whose diaper had dripped all over the supermarket. However, the show stopper was a 6-year-old who threw up in the backseat and into the face of his 2-year-old baby sister, leaving only her little eyes visible. Needless to say, we were all rolling over with laughter.

As with most physician mothers, we tend to become isolated because we are busy caring both for our patients and families. The book club provides valuable support for mothers ranging from residents, private practitioners, community providers, and faculty. We discuss call, boards, jobs, difficulties of starting a private practice, and much more. It provides a great opportunity to network and get practical solutions.

Finally, our children benefit from the social interaction offered by the play group. As time goes on, we hope they will realize that there are other mothers with careers in psychiatry and will benefit from the universality of this experience.

HARPRIYA (SONYA) A. BHAGAR, M.B.B.S.
Indianapolis, Ind.

Another Residency Program Joins APA's 100% Club

Education & Training

The child and adolescent psychiatry residency program at the University of Rochester is the latest residency program to have all of its psychiatry residents become members of APA.

It joins the ranks of an exclusive organization within APA: the 100% Club. This club was established to encourage residents in the United States and Canada to join APA and to do so with other trainees in their programs, according to Deborah Hales, M.D., director of APA's Division of Education and Career Development.

A photo of each program that joins the 100% Club will be turned into a poster and mailed to every medical school in the United States and Canada to encourage medical students to join APA. In addition, programs in the 100% Club receive a major textbook from American Psychiatric Publishing Inc. for each year that all of their residents are APA members and a free online subscription to *Focus: The Journal of Lifelong Learning*.

The training director at the University of Rochester is Michael Scharf, M.D. Scharf has had extensive involvement with APA. He was a Glaxo-SmithKline fellow in the 2000-2002 class and served as president of the Glaxo-SmithKline fellows on APA's Board of Trustees for the 2001-2002 term.

"Participation in APA helps us keep all of our oars in the water," said Scharf. "As someone who has been active in APA since medical school, I can appreciate the role that APA plays for members-in-training. Some of the most important benefits that I directly experienced as a member-in-training were having the opportunity to enhance my education through journals, educational sessions at meetings, and mentoring opportunities; being kept up to date on current events relevant to the field with periodicals and e-mail list serves; having access to an organizational structure for understanding and participating in advocacy opportunities for our patients and our field; and bringing psychiatrists in training from across North America together as one peer group are. I'm very pleased that all of my trainees will have these same opportunities."

More information about the 100% Club is available from Nancy Delanoche of APA's Division of Education and Career Development at (703) 907-8635. Programs that are interested in signing up all their residents should also contact Delanoche. ■

From left: Ajit Ninan, M.D., Shaili Patel, M.D., Michael Scharf, M.D. (program director), Gene Contreras, M.D., Sue Klein (program coordinator), Rakesh Shah, M.D., Jonathan Beard, M.D.