



Community Psychiatrist

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President's Column



A Holiday Wish: Real Change in Behavioral Health

As the holiday season approaches, we need good cheer. For me as a clinician, the best cheer I can think of is real healthcare reform. But the wish gets a little more specific: I want healthcare reform that really affects the lives of the people I serve and –as a result –gives me greater satisfaction in the work that I do. It's not-self serving but it's a plea that these reforms improve a few important things as they affect the behavioral slice in the healthcare pie. Among these things, maybe the most important is *time*.

Time permits clinicians and the people we serve to engage and focus on recovery goals. It makes it possible for us to listen more effectively, permits us to do the work beyond face-to-face time, enables us to talk with other clinicians about what's important to coordinate care, including returning phone calls promptly, reaching out to family --and with actual confidence that we are together assisting people we serve instead of patching holes.

Though the outcome is far from certain, some form of a healthcare bill will likely pass Congress. Broad outlines are encouraging so far and, as of this writing toward the end of October, both the House and Senate offerings have proposals that could help improve the efficiency and utilization of time. In the Finance Committee bill that moved to the Senate floor on October 13th there is recognition that primary care and

behavioral healthcare must be closely coordinated and that preventive care is important, even as far back as early childhood. These elements could improve the efficiency with which providers use their time. Access would improve, permitting phased-in Medicaid eligibility for people whose income is up to 133% of federal poverty limits. Some have estimated that this might increase Medicaid enrollment by up to 50%, presenting formally improved access but also real challenges on the ground because of unavailability of services providers –and greater demands on, yes, quality time shared by providers and consumers. Both House and Senate bills increase funding for training. In community behavioral healthcare, we already suffer human resource problems and these could mushroom with universal coverage. Will funding keep pace with demand?

The bills accentuate health outcomes and recognize the value of evidence-based practices. More specifically compelling, though, the present Senate bill calls for the creation of a "Patient Centered Outcomes Research Institute" that would disseminate services research findings based on this tenet. Person-centeredness is key to advancing recovery-oriented practice, which necessitates quality collaborative time spent between a professional and the person engaged in services.

But not yet in the calculus are behavioral healthcare financing mechanisms that will really permit this kind of quality. The fee for service system honors time-as-premium, minimally rewarding building a provider-consumer relationship, except in so far as encouraging a person to show up to reduce costs.

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The current senate bill provides for up to 13 state-administered demonstration projects focusing on capitation modeling and one of its modifications, case-rate systems. Can we encourage our state-level behavioral health program directors to opt into these methodologies like these, *and* to do so with adequate funding to embrace increased demand and to focus on person-centered outcomes? These outcomes have ingredients that are not neatly billable in the traditional increments of 15, 30, or 45 minutes. Also, many services, especially for people with serious mental illness are administered outside of health insurance (my favorite example: the US Department of Agriculture funds food stamps!). Can we advocate for coalescing more of the widely scattered funding into more focused resources within “behavioral health”? Finally, we cannot forget parity. The Wellstone-Domenici Act that signed last year has yet to be interpreted into administrative regulations, despite a kickoff date of January 1, 2010. How do we preserve the intent of this law as its details are spelled out while healthcare reform is also crafted? Given the ethos of federalism, one possibility is that many details could have state-by-state texture, requiring us to focus on our localities.

We could be on the verge of real reform. Advocacy will concern a rational system of financing that permits recovery-orientation –including the *time* we need to assist people in their goals. The action is in Washington right now but will come to our own communities. Let’s hope that the Federal phase of this yields satisfying holidays, offering motivation to move ahead on behalf of our patients in the New Year.

Hunter McQuiston MD



Ruined Russian school dormitory - fifty yards from the current dormitory at Vohkma Orphanage.

Editor’s Brief A Russian Mission:

Last time in Editor’s Brief, Ramotse Saunders and Sarah Altschuler discussed the monumental changes that have occurred in psychiatry over the last year. Feedback from AACP members have focused on how these changes bring opportunity – the opportunity to renew our commitment to be of service to our local community or throughout the world.

I wanted to take some time and discuss a service need I believe can help us as clinicians as well as world citizens: overseas mental health missions. Whether you hook up with Doctors Without Borders, a US government sponsored organization or a foreign charitable non-profit, the possibilities are endless.

In 2004, I became a volunteer at rural orphanages for special needs children in two regions of Russia. Children’s Hope Chest, a Colorado Springs non-profit and its Russian sister organization, Nadehzda (translated Hope) provide the logistics and staff to make these missions possible.

My initial four trips were to Luktanova Orphanage in Vladimir region. I traveled with a local Methodist church and learned the Hope Chest model. I found I could be helpful by volunteering joyfully for necessary non-medical duties and providing medical support to our team members.

Over those four trips, I saw the range of care available to orphans who were mentally challenged, learning disabled or mentally ill. In Russian psychiatric practice, all these conditions are lumped together as “oligophrenia”. The meaning in Greek is “small brain”.

I saw the “baby homes” for pre-school age infants, the orphanages for school-aged children providing nine levels of classwork that may take a special needs child eleven years to complete, the

technical schools in cities where they often learn skills of marginal value and the ministry centers started by US churches to help the orphans after they term out of care. Funding for these orphanages are often skeletal – only teachers’ salaries and food money are budgeted for 80 to 150 orphans. The director is responsible for maintaining a building complex that includes a dormitory, a school and various ancillary buildings such as carpentry shops, boiler buildings or barns.

If the furnace breaks, there is no money provided to fix it; there is no budget for cleaning supplies or toilet paper. Funds for required security cameras or electricity are non-existent so the money comes from staff salaries or food. An older building is abandoned and a new one is built beside it. The school administrator may wait decades to have the demolition approval to tear down the old building while it deteriorates into a safety hazard. If a toilet piece breaks off, the rules dictate that funds must be found to replace the whole toilet – not just the broken part.

Only 10-20% of the orphans are true orphans. The remainder are removed from the home or abandoned by their parents. They are called “social orphans”. While an embryonic foster care system is slowly developing, re-unification with families is not common.

Without intervention, almost 10 - 25% of special needs orphans will die within a few years of graduation from accidents, murder, exposure or suicide. Prostitution or drug-related life styles are common, because the orphans have no jobs or support.

Involvement in mission programs and attendance at ministry center services has been shown to change these grim statistics. Graduates obtain jobs and stay away from chemicals. Many orphan grads become mission workers as staff or volunteers.

Small monetary contributions provide more bang for the buck in Russia compared to the US due to a lower cost

of living. A psychologist’s salary may be as little as \$250 a month. \$150 may provide cleaning and hygiene products for an orphanage for three months.

When teams travel to the orphanages, each mission member can bring 100 pounds of humanitarian aid such as a CD player for relaxation training or wood working tools for shop class. The orphanage nurse may desperately need blood pressure cuffs, triple antibiotic ointment or bandages. She may place on her “wish list” a nebulizer for her asthmatic students or a glucometer for her diabetic children. Works projects may include building a playground or creating a group therapy office.

After four trips with the Methodist congregation, a change in the trip times meant that I could no longer go to Luktanovo with that group. The Roman Catholic Church designated 2008 as the year of Saint Paul, the emissary to other lands. The priest in my parish felt this was a good sign to start a mission from SS Peter and Paul Church in Beaver.

Taking what I learned at Luktanovo, I started a new mission to a very remote special needs orphanage in the northeast region of Kostroma. The orphanage is located at a 1500 person village named Vohkma. We are currently prepping for our third trip there in 2010. I speak Russian with all the skill of a dysarticulate three year old but the experience has been life changing for me.

Consider whether there is a public service mission that needs your help. It does not need to be in Russia, and it may be more social service than psychiatric service. Most of my contribution to the mission is non-psychiatric. When I do contribute using my medical degree, I practice more basic medicine than psychiatry. What my psychiatry background provides is the knowledge about what Vohkma Orphanage may need and the way to be a more effective trip leader.

Children’s mental health improve when their environment improves. Sometimes that is a greater gift to offer than giving

a more specific diagnosis for chart than “oligophrenia”.

Regards, Suzanne Vogel-Scibilia MD
Fall Editor, Community Psychiatrist



The National Health Care Debate: One member’s argument for Improved Medicare For All

The cost of medical care in the United States is a problem. We spend thirty-one cents of every health care dollar on administration, twice as much as other developed countries. Using private for-profit insurance companies increases administrative costs.

Medicare is a popular, uniquely American program which covers everybody over 65 and has low cost administration. Single payer national health insurance (Improved Medicare for All - SB 703) is the most fiscally conservative reform and the only one which many believe will not cost America more.

In 1948 the UN said, "Healthcare is a right". Improved Medicare for All can cover everyone. We spend twice as much on health care as other countries and our health outcomes are worse. We have excellent doctors, hospitals and

other resources but lots of unnecessary care which does not make us healthier.

Single payer is simple, 200 pages, not 1000 pages like the House bill. Our economy is suffering and we are not competitive globally because of our high cost of health care. Our President said health reform would be the single one thing we could do right now to speed our economic recovery.

But we need real reform, not phony reform. "Reform" which leaves the private, for-profit insurance "system" in place will not save money. Individual mandates (like Massachusetts) have been tried eight times and have failed. Insurers have demonstrated their ability to evade regulation and cherry pick healthy, low-cost people to cover. Our private for-profit "system" breeds fraud as high as \$1.7 billion. The "public option" will cover only two million people and will get the sick, expensive people, subsidized by us taxpayers. With one risk pool we have plenty of money to cover everybody for all necessary medical care.

The House bill will cut psychiatry disproportionately. The safety net in Massachusetts has already been cut. In Canada, patients with serious and persistent mental illness get more care while here the worried well get more care. With managed care the detection of depression in primary care has gotten worse and functional outcomes for depressed patients after psychiatric treatment have declined. Most of the conclusions from President's New Freedom Commission and the American Psychiatric Association's New Vision Statement of 2003 would be addressed by single payer. AACP already supports Improved Medicare for All but we have a lot of work to do to educate our friends, relatives, neighbors, colleagues and congress.

When the House passed the current bill, insurers stocks went up. They wrote it; they will make more money. It's a bailout for them. We can do better. President Obama said if we were starting from scratch we should do

single payer. We need to start from scratch.

Medicare was enacted in less than one year and was not "disruptive". Our government already pays for 62% of our medical care. This is more than any other country which pays for all of its medical care. Taiwan is a rich, developed country which successfully enacted single payer in the 1990s.

Think about it. Read about it. Educate yourself. Become an advocate. Give a talk. Write an op-ed. Lobby your congressional representatives. We may not have \$1-2 million a day to spend on lobbying but we have votes. It took 80 years for women to get the vote, soon we had civil rights. We can have real health reform. Check out pnhp.org and let me know what you think.

Leslie Hartley Gise MD
AACP Member

A Cautionary Tale for Off-Label Prescribing

Authors:

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A 2004 court settlement involving Warner-Lambert, now owned by Pfizer, Inc., serves as a cautionary tale to all psychiatrists who prescribe drugs for off-label uses. All patients have unique needs and sometimes the off-label use of a drug is the best option based on good clinical judgment. But when decisions about off-label use are influenced by explicit and deceptive marketing tactics, it is a lot harder for physicians and other prescribing professionals to determine what the best treatment is for any individual patient.

This case highlights the extent to which overzealous marketers can distort or ignore scientific evidence in pushing off-label prescribing. In the settlement, it was revealed that Warner-Lambert illegally marketed gabapentin, sold under the name Neurontin[®] for the treatment of bipolar disorder despite the fact that the drug had only been approved by the FDA for epilepsy and certain pain disorders. To make matters worse, there was—and still is—no substantial evidence showing that gabapentin helps people with bipolar disorder manage their condition.

The facts of the settlement raise obvious questions about how and why Warner-Lambert was able to market a drug for off-label uses when this practice is illegal. It also raises questions about how the company was able to successfully market a drug for a condition that it could not treat. The answers lie in court documents and in 29 articles published in peer-reviewed research literature between 1997 and 2007.

In the court settlement, the U.S. Department of Justice found that Warner-Lambert used several illegal tactics, which placed marketing goals over the safety and health of patients [1]. For instance, Warner-Lambert:

- Encouraged salespeople to provide one-on-one sales pitches to physicians about off-label uses of Neurontin without prior inquiry by doctors. These salespeople also made false or misleading statements about Neurontin's efficacy and its approval for off-label uses. Warner-Lambert also used "medical liaisons" who often misrepresented themselves as scientific experts to promote off-label uses for Neurontin.
- Paid doctors to attend expensive dinners or conferences that included presentations about off-label uses of Neurontin. This included trips to Florida, the 1996 Atlanta Olympics and Hawaii.

Continued from Page 4

- Held teleconferences in which physicians recruited by sales representatives would listen to a doctor or a Warner-Lambert employee speak about off-label use of Neurontin.
- Sponsored “independent medical education” events on off-label Neurontin uses with extensive input from Warner-Lambert regarding topics, speakers, content, and participants.
- Misled the medical community about the content and degree of company influence of these educational events. At least once, when a Warner-Lambert employee thought that unfavorable remarks were going to be made by a speaker, the company “planted” people in the audience to ask questions that highlighted the benefits of the drug.
- Paid physicians to allow sales representatives to accompany them while they saw patients, with representatives offering treatment advice that was biased towards the use of Neurontin [1-3].

At the same time that these illegal marketing activities were taking place, questionable articles appeared in the peer-review literature supporting gabapentin as a treatment for bipolar disorder. This questionable “research” dropped off precipitously after the settlement. A 2008 literature review published as part of a supplement to the *Journal of Psychiatric Practice*, showed that there were 29 articles published between 1997 and 2007 on the off-label use of Neurontin [4]. In most of these articles, the authors wrote optimistically about the drug's effectiveness in helping patients with bipolar disorder.

A closer examination revealed that this evidence base, like the drug's off-label efficacy for bipolar disorder, warranted more scrutiny. More than half (15) of the 29 articles were uncontrolled case series. More than a fifth (6) were reports

of a single case. Four of the published articles involved small randomized trials that demonstrated little, if any, efficacy. Further still, a majority of the original 29 studies did not disclose funding sources or were funded by industry (21), and many of the articles did not include published conflict of interest statements. An additional nine letters to the editor also reflected this same pattern. The findings presented in this collection of mainly case-series and case reports were not sufficient to suggest a systematic change in practice such as the treatment of bipolar disorder with Neurontin®.

The supplement article in the *Journal of Psychiatric Practice* provides more detail into the cascading impact that these 29 articles had on the greater body of research literature (ultimately being cited in more than 400 other articles). However, despite these 29 articles, the bottom line for prescribing professionals is that the data presented in this collection of mainly case-series and case reports were not sufficient to warrant a systematic change in practice, such as treating bipolar disorder with gabapentin.

This story should be a wake-up call for health care providers to alert them to the dangers of relying on pharmaceutical marketing to guide them in the proper use of prescription drugs. One should evaluate closely any clinical research literature that supports off-label uses for a drug. Health care providers should look for weaknesses and missing information within articles, as well as compare articles across journals to determine if these weaknesses and omissions have been addressed elsewhere. One way to do this is through systematic reviews, conducted by researchers without conflict of interest.

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ABOUT THE AACP

The American Association of Community Psychiatrists (AACP) was formed in October 1984. The impetus came from a group of community psychiatrists who began sharing interests and concerns at the May 1984 American Psychiatric Association Meeting and at many local psychiatric meetings. We found that community psychiatrists are a concerned, dedicated, energetic and underrepresented group. Our concerns had not been adequately addressed in other professional organizations, which often had other priorities.

The AACP has the following purposes:

- Promote and maintain excellence in the care of patients through the organization of psychiatrists practicing community mental health on state, regional, and national levels
- Help clarify and solve mutual problems commonly encountered by psychiatrists in community settings
- Inform and educate the public about the role of the community health system in the care of the mentally ill
- Establish liaisons with related professional organizations to advocate for relevant public policy issues
- Promote cooperation between psychiatrists and other professional, paraprofessional and consumer groups involved in mental health care
- Encourage training and research in psychiatry which will increase the number of committed psychiatrists in community settings



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