RIPSNEWS

RHODE ISLAND PSYCHIATRIC SOCIETY • *A District Branch of the American Psychiatric Association*

President's Message

Barry W. Wall, MD

There are a lot of changes going on nationally within APA and locally within RIPS. Although some of the following information has been reported on locally and nationally, I thought I'd take a moment to condense some of the biggest topics into this column.

On a national level, it looks like the restructuring efforts voted on by the membership are beginning to pay off. The APA Headquarters has moved from Washington, D.C. to Rosslyn, Virginia to cut costs. Jay Scully is the new Medical Director; he replaces Steve Mirin, who was in that position for six years. Although the APA's national elections will continue to be an annual affair, a vice president position will be eliminated from the copious list of elected positions, and the positions of secretary and treasurer will be combined into one position. Nationally, there is a projected surplus for this year, which should help prevent dues increases (we haven't had a dues increase in over six years, and local dues were actually lowered a couple of years ago).

Locally, RIPS's new web site is nearing completion. We ask that you update your directory information as soon as possible, and a mailing has already been sent out to you. The new site will include an event calendar that should make it easier to get to meetings. Another big development is that Kazi Salahuddin is reorganizing the International Medical Graduate Committee; the first re-organizational meeting was held a couple of months ago. The thrust of the new committee is to get IMG's involved more in the professional work of APA, as a number of IMG's have voiced feeling isolated to some degree from American Medical Graduate colleagues. If you are an IMG and are interested in participating in this, contact Sarah Stevens at the Society's office. Last but not least, the RIPS office has now moved to the Foundry Building, just a few hundred yards west of its old location. The new office is less venerable, but much more functional.

In my next column, I will talk about recent changes in the fellowship structure of the APA, which is another important development for those who are currently fellows and for the rest of us who want to become one. ❖

We've moved!

The Rhode Island Psychiatric Society office has a new address.

RIPS is now located at 235 Promenade Street, Suite 500, Providence RI 02908. The phone and fax numbers are still the same: 331-1450 phone, 751-8050 fax. Miss Sarah Stevens continues as the Administrative Assistant for the Society.

February 2003

Volume 34, Number 1

Editorial

Anthony Jay Thornton, MD
Editor

Psychiatry: A View from the Fringe

We all new it was coming. It was bound to happen…just not this way. The inevitable malpractice allegations in the aftermath of the Andrea Yates tragedy began almost immediately with legal action soon to follow. In the weeks and months following the drowning of her children, much speculation was abuzz in the media about what went wrong in the mental health care of this woman with reported severe psychosis and postpartum depression. Her husband, Russell, made the talk show circuit alluding to possible legal action due to perceived inadequate medical care.

The first legal volley fired, however, came from a group called the Citizens Commission on Human Rights (CCHR). This organization is self-described as "a non-profit, public benefit organization dedicated to exposing and eradicating criminal acts and human rights abuses within psychiatry" and was founded by the Church of Scientology in 1969. This group apparently contacted Ms. Yates' brother and filed a complaint on his behalf with the Texas Board of Medical Examiners with a grievance to the U.S. Department of Health and Human Services to follow. The complaint alleges Ms. Yates was "in a psychotic state caused by premature release from care, use of inappropriate drugs and overmedication."

A visit to the websites for Scientology (www.scientology.org) and the CCHR (www.cchr.org) are very illuminating in regards to these organizations' views of psychiatry and mental health care in general. I always knew these organizations "had it in" for psychiatry for some reason, and discounted anything I heard about them as fringe element ramblings. It is worth a trip to the websites if for nothing more than to get a feel for the depths of hatred and contempt toward our profession and us. The level of scathing vitriol is quite beyond belief. It is clear their plan is the eradication of our profession, as we know it. With Scientology trying to be seen as a bit more mainstream, replete with Hollywood icons lining up as members, this is all the more concerning.

Some months back, it was interesting to see a representative, Mr. Boswell, from CCHR interviewed by Katie Couric on the *Today* show in regards to *continued page 10*

Lt. Governor Fogarty Addresses General Membership

The December 9, 2002 General Membership Meeting took place in the Rotunda Room at the Rhode Island Convention Center. RIPS was honored to have Lt. Governor Charles Fogarty speak about Rhode Island government and mental health issues. As you may be aware, Lt. Governor Fogarty is quite active in improving access to health care and was instrumental in revamping the 1994 mental health parity law. Because of this, Rhode Island leads the nation with expanded mental health care benefits.

This new legislation significantly expands the scope of the law by redefining mental illness to include those mental disorders (including substance abuse) listed in the current edition of the Diagnostic and Statistical Manual (DSM) or the International Classification of Disease Manual (ICD). In addition, the following changes were made:

- **Provides for New Types of Coverage**

Provides for a new definition of "mental illness coverage" to include inpatient hospitalization; partial hospitalization provided in a licensed hospital or any other licensed facility; intensive outpatient services; outpatient services; and community residential care services for the treatment of substance abuse. Under the 1994 mental health parity law, coverage is limited to inpatient hospitalization and outpatient medication visits.

- **Removes Cap on Inpatient Days**

Eliminates the cap on inpatient coverage for substance abuse and mental illness. Inpatient services are capped under the 1994 law at 90 consecutive days for mental illness and 30 days per year with a lifetime cap of 90 days for substance abuse. Partial hospitalization will now be considered an inpatient service.

- **Mandates Outpatient Benefits for Mental Health**

Provides for a new mandate for outpatient benefits for mental health services of up to 30 visits in any 12-month period (excluding medication visits). The 1994 law does not require outpatient services for mental illness, however many health plans include 20 annual outpatient visits. The substance abuse coverage for 30 hours per year of outpatient benefits for individuals under treatment is retained in the new law.

Dr. Dawn Picotte, Dr. Luisa Skoble, Dr. Wilma Rosen

Dr. Russell Pet, Dr. Robert Johnston, Dr. Barry Wall, Dr. Lou Marino, and Dr. Mickey Silver

Lt. Governor Fogarty and Dr. Lou Marino

- **Expands Detoxification Benefits**

Expands detoxification benefits to up to five occurrences or 30 days in any calendar year whichever comes first. The old law provides for up to three detoxification occurrences or 21 days per year whichever comes first.

- **Eliminates Out-Of-State Restriction**

Eliminates the restriction on out-of-state mental health service providers. Using a pre-authorization process, out-of-state providers will be allowed if an in-state provider were not available.

It was pointed out that as good as the new law is, there is no parity mandated in compensating providers.

This year the focus will be more affordable health care for all Rhode Islanders. This will include working on a state solution for obtaining affordable prescription drugs, especially for seniors on Medicare. Expanded satisfaction surveys for all Rhode Island health care facilities and finding solutions for the nursing shortage will be additional areas of focus.

The take home message is that we all can have considerable influence with our state government. Rhode Island is a small state with easily approachable legislators. The Lt. Governor made the point that even a few voices echoing the same concerns can seem like a groundswell of support and can spur change. ❖

October 2002 General Membership Meeting: Handling HIPAA Hype

The October 28, 2002 General Membership Meeting was held at the Florentine Grill in North Providence. Over 50 members attended the meeting, one of our most well attended. This was likely fueled by the frightening volume of confusing HIPAA information with which we all have been inundated.

Jacqueline Melonas, RN, MS, JD, who is Vice President of Risk Management at Professional Risk Management Services, Inc. (managers of the APA-endorsed Psychiatrists' Professional Liability Insurance Program) gave the talk. For those that have been on extended leave outside the country, HIPAA stands for the Health Insurance Portability and Accountability Act of 1996. Among the many things it attempts to do, enhancing the privacy and security of protected health information (PHI) in all its forms (oral, paper, and electronic) is paramount. An additional significant goal is "administrative simplification" of electronic claims processing.

Learning about HIPAA for most people is as exciting and illuminating as reading the U.S. Tax Code (learning about it over a filet and a glass of wine at the Florentine Grill makes it slightly more palatable). This behemoth of a legislative package is now expanded many times over by numerous "clarifications" which for some parts of the rule are shifting and changing as you hold this newsletter.

As Ms. Melonas' talk began, it became clear that it is difficult for some to even determine if the rule applies to them ("covered entity" in HIPAA speak). For those that have determined for themselves that HIPAA does not apply to them, don't let your eyes glaze over and mind wonder just yet. Ms. Melonas believes the rule will eventually be applied everywhere as a standard. It would behoove us all to learn as much as we can now.

Jacqueline Melonas, Dr. Barry Wall, and Dr. Lou Marino

When does all this take place? Compliance with the privacy rule is required as of April 14, 2003. Transaction code sets to be used in electronic billing were due by October 16, 2002 unless you applied for the automatic one year extension to 2003. The security rule section is not even finalized as yet.

The good news is that we in the mental health field have always had a high degree of protection of the confidentiality of our patients' healthcare information. Rhode Island also has had stricter laws than many other states. In the case of conflict between federal and state requirements the stricter law prevails to assure the maximum protection. Nevertheless, HIPAA will greatly impact the way we do business in the handling of healthcare information.

Hundreds of thousands of pages have been written and numerous weeklong seminars set up to explain HIPAA to us. Thus, further detailed information here is beyond the scope of this newsletter. One source of information sited by Ms. Melonas was the American Health Management Information Association website at www.ahima.org. There are practice briefs on many aspects of HIPAA at this site. The AMA has model forms for use in authorization and giving notice of privacy practices at www.ama-assn.org.

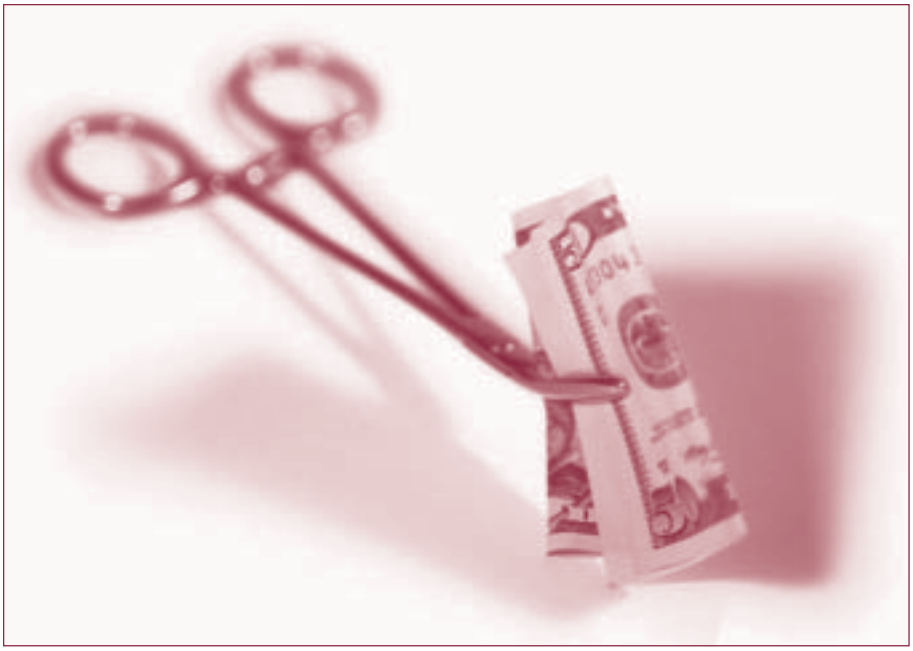
Stay tuned as the HIPAA saga unfolds. With the many delays and changes, we have only begun our journey down this road. In the mean time, come join us at a General Membership meeting. We would like to see you there. Learn something, eat something, and have an enjoyable time talking about something with your peers. ❖

From A- to E in Forty Days

Anthony Jay Thornton, MD

We are all by now painfully aware of the current malpractice insurance mess in this country. Daily we are bombarded with accounts of doctors closing up shop and doctor walkouts at hospitals. With malpractice premiums as high as $200,000.00 per year for some specialties in some states, this is understandable. Fingers are pointing and everyone has a different solution (depending on your interest group).

This has all hit close to home for those of us with the APA sponsored malpractice insurance program. The APA has sponsored a malpractice insurance program for many years. Legion Insurance Company was chosen and had an A.M. Best rating of "A" (Excellent) initially. The rating went to "A-" (still Excellent) over time. On February 19, 2002 A.M. Best downgraded Legion's rating to "B" (Fair). On April 1, 2002 the Pennsylvania Insurance Department, which has jurisdiction over Legion because it is a Pennsylvania-based company, placed the company under state-supervised rehabilitation. At this time, A.M. Best downgraded Legion to "E" (Under State Supervision). Thus, over a period of about 40 days, Legion fell from 'Excellent' to 'Under State Supervision'– a complete meltdown no matter how you look at it. Does the fact that "most states have some reserves for failed companies" reassure you in the event of a malpractice claim occurring during the period of Legion's coverage?



My question is this: "What is the value of an A.M. Best rating?" This rating system is held up to us at every turn as proof of a solid financial company. A visit to the A.M. Best website proudly displays in graphs, numerical data and prose the extreme unlikelihood of an "A" company failing. What good is this if the rating is lowered mere days prior to a failure? This is somewhat akin to scribbling the word "wreck" on a sign, hanging it on a Thurbers Avenue curve accident, and calling this a motor vehicle accident prediction program.

After Enron and Worldcom, it is all too easy to see how this situation can occur. Even legal accounting practices seem to lead to grossly misleading balance sheets and inaccurate estimates of corporate health. This may be all the rating companies have to go on, so bad information leads to rather useless ratings.

For those of you still with the APA sponsored program, you have already received replacement coverage with a concomitant 30% increase in malpractice insurance premiums. The flier describing the new company proudly claims an "A++" A.M. Best rating. Now we can all rest easy! ❖

The Importance of Child-Specific Mental Health Reimbursement Codes

Gregory K. Fritz, MD
Editor, *The Brown University Child and Adolescent Behavior Letter*
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When it comes to children's mental health, there is no bigger problem than lack of access to treatment. In every state and for every discipline, waiting lists are long, child mental health positions go unfilled, and both parents and referring professionals are frustrated as they endeavor to get services for children they care for. The genesis of the problem is clearly complicated and poorly understood, but here is one simple solution that would have a big impact: institute child-specific reimbursement codes that reflect the inherent differences between treating a child and an adult.

Why is this seemingly mundane issue so important? In essence, whatever the task—from a comprehensive evaluation to a "brief" medication check—it takes longer when the patient is a child. Although it is obvious to those who work with children, it appears that most of the rest of the world does not realize that a) children don't talk as directly or as readily about their problems as adults do; b) children come with parents, whose views and involvement are as essential as the child's; and c) schools, agencies and other adults are involved in children's lives to a much greater degree than is the case with adults, and their input must be obtained as part of appropriate psychiatric care. The result is that child and adolescent mental health evaluation and treatment take 30 percent to 50 percent longer than the comparable work with adults. But with only a few exceptions scattered about the country, the same codes are used for reimbursing both child and adult mental health professionals, whatever their discipline. The same reimbursement for a task that takes much longer means that, functionally, child mental health professionals are paid significantly less per hour than those who treat adults. A number of bad consequences follow from this sad fact.

First, there is a disincentive to work with children, significantly worsening the access-to-care problem. Since most child mental health professionals are also fully trained to treat adults, we have the option of choosing our patients. It's no secret that many child and adolescent psychiatrists, psychologists and social workers also see a number of adults, motivated by both professional interests and financial incentives. If insurance companies removed what amounts to a reimbursement penalty for treating children by implementing fair, child-specific codes, they would see increased accessibility of child mental health professionals. Fewer would refuse to participate in insurance company provider panels.

Second, child-specific codes would make child mental health a more attractive specialty to trainees considering it. To use child and adolescent psychiatry as a specific example, currently, extra years of training and a second board certification lead to *lower* income (unless the psychiatrist focuses on the out-of-pocket, "carriage trade.") A recent survey of all physicians completing training and entering practice in New York City revealed that the starting salary for adult psychiatrists averaged three percent *more* than for child and adolescent psychiatrists (Center for Health Workforce Studies; http://chws.albany.edu). When professionals get paid less and *still* have a daily struggle between taking enough time to do quality work and seeing enough patients to earn their salary; it is easy to see trainees avoid the child mental health arena.

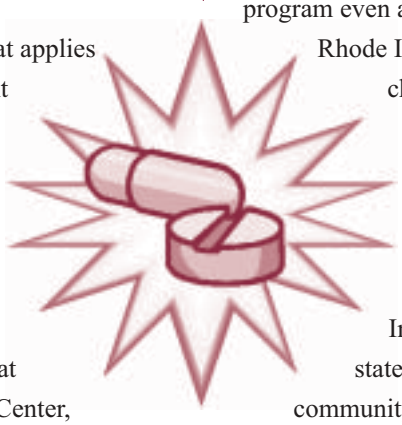
Third, there are a number of good ideas for enhancing the training experience to increase recruitment of young child mental health professionals These include more intensive mentoring by faculty who work with children, increased exposure to child mental health work early in training involvement of trainees in exciting child psychobiological research, child mental health interest groups, etc. Such innovations all entail more time contributed by faculty in the child mental health disciplines. Since faculty-generated clinical revenue increasingly is required to support faculty teaching time, child-specific reimbursement codes will effectively fund the expanded academic investment.

Congressman Patrick Kennedy (Dem., R.I.) is sponsoring a bill aimed at increasing the number of child mental health professionals through training incentives such as grants, loan repayment, etc. Establishing child-specific mental health reimbursement codes will complement this effort and help retain professionals in the field once their training is complete. Children are fundamentally different from adults and so are their medical care needs. Society must recognize this and pay for it even if children don't vote or control the economy. Now is the time for intense advocacy to correct the reimbursement problem if we are to make a serious impact on the shortage in the mental health workforce. ❖

Child Psychiatry: A Sub-specialty in Great Transition

In part from an Interview with Greg Steiner, MD

Anthony Jay Thornton, MD



Constant and rapid change is a description that applies to the entire medical field, especially in recent years. Clinical change seems turbocharged in Child Psychiatry. However, the system of service delivery is broken, or in some cases nonexistent, and change cannot come soon enough. Greg Steiner, MD, agreed to an interview to give us a snapshot of his field. He is Director of Child and Adolescent Services at Newport County Community Mental Health Center, President of the Rhode Island Council of Child and Adolescent Psychiatrists (RICCAP), Psychiatry Consultant to the Cranston school system, and is engaged in private practice.

Clinically, there has been an explosion in the use of medications to treat childhood mental illness. This has been exciting in the improvements seen in troubled children's lives. It has also been frustrating, as medications are mostly used off label due to the dearth of good studies. Clinical practice has definitely outstripped research.

The number of children receiving mental health care has risen dramatically in recent years, putting a severe strain on the system, and often highlighting areas where no system exists. Rhode Island has one of the most comprehensive programs for treating chronically mentally ill adults (the Community Support Programs found at the Community Mental Health Centers). There is no such comprehensive program even available for chronically mentally ill children.

Rhode Island does have a number of programs for children scattered around the state, each with a different focus and usually with limited time available for treatment (that is if the child can snag a treatment slot; waiting lists can go for weeks and months). Comprehensive Emergency Services (CES) and Children's Intensive Services (CIS) are two of the major statewide programs. CES provides 60 days of community-based crisis intervention to help reduce or prevent child abuse and neglect, and family stress. Case managers staff this program and there is some involvement of Master's level clinicians. The program works closely with schools and coordinates services with appropriate human service agencies. CIS consists of crisis intervention lasting 6 months to one year and seeks to prevent hospitalization and/or out-of-home residential placement. Master's level clinicians, usually with social work and marriage and family therapy backgrounds, staff this program. CASSP (Child and Adolescent Service Support Program), a program separate from the community mental health centers but with some relationship to them, attempts to integrate services. A more recent effort to beef up the coordination of children's programs in the state has led to the creation of CEDARR (Comprehensive Evaluation Diagnosis Assessment Referral Re-Evaluation) centers. It is designed for the more severe and complicated patient and provides clinical evaluations for individuals and families, referrals, coordination of services, and crisis intervention by phone.

Confronting this dizzying array of disparate programs and navigating through this confusing landscape is not the only challenge facing the child psychiatrist. There is a severe shortage of Child and Adolescent psychiatrists in the United States, including Rhode Island. The work is complicated. You must interface not only with the child and family (sometimes more than one due to separations and divorces), but also the school systems and various governmental agencies such as DCYF (the Department of Children, Youth's and Families). Diagnosis can be difficult

as children are often not forthcoming with the needed information and it takes a lot of time to sift through information from the numerous sources. After all this, reimbursement codes are usually the same as for adult psychiatrists, leading to less pay for amount of time spent. Many institutions have eliminated outpatient service altogether as it is no longer financially feasible. DCYF, itself in disarray, has been talking of changing the funding stream patterns of certain programs which may decimate the already inadequate services currently available to children and adolescents.

Dr. Steiner has attended a RIPS council meeting to discuss how our society can work with RICCAP to assist in some of these problems. RICCAP has approximately 30 members not including resident membership (by comparison, RIPS has about 250 members). It was agreed that the President of RICCAP would periodically meet with the RIPS council to sustain this joint effort. Dr. Steiner believes it makes sense to invest in the treatment of children and adolescents and not wait until they become adults. He believes this will result in better outcomes – better citizens and employees. ❖

Committee on Women

Alison Heru, MD

CEDAW

On the 30th of July 2002, the Senate Foreign Relations Committee passed the treaty known as the Convention on the Elimination of All Forms of Discrimination Against Women. Of the nine Republicans, Lincoln Chaffee and Gordon Smith of Oregon joined the 10 Democrats to pass the treaty. The committee action clears the way for a possible vote by the full Senate in the fall. This treaty, which was adopted by the United Nations in 1978, signed by President Carter in 1980 and submitted to the Senate later that year, has been languishing in Washington since then. The Senate Foreign Relations Committee approved it in 1994 by a vote of 13–5, but it did not come to a vote in the Senate due to objections.

CEDAW is often described as an international bill of rights for women. By accepting the Convention, States commit themselves to undertake a series of measures to end discrimination against women in all forms, including: incorporating the principle of equality of men and women in their legal system, abolishing all discriminatory laws and adopting appropriate ones prohibiting discrimination against women; establishing tribunals and other public institutions to ensure the effective protection of women against discrimination; and ensuring elimination of all acts of discrimination against women by persons, organizations or enterprises. The Convention is the only human rights treaty which affirms the reproductive rights of women and targets culture and tradition as influential forces shaping gender roles and family relations. It affirms women's rights to acquire, change or retain their nationality and the nationality of their children. States parties also agree to take appropriate measures against all forms of traffic in women and exploitation of women.

Countries that have ratified or acceded to the Convention are legally bound to put its provisions into practice. They are also committed to submit national reports, at least every four years, on measures they have taken to comply with

their treaty obligations. To date, 170 countries are party to the treaty for women's rights. The United States has so far resisted ratifying the treaty. What has been the problem? The following brief excerpt from the fact sheet from the Republican website for the Senate Committee on Foreign Relations may give you a clue.

"Elimination of discrimination against women is a critically important goal. But unacceptable consequences will result if the Senate approves CEDAW. For starters, it will:

1. Open the last remaining sanctuaries in the American home and workplace to multilateral governmental and non-governmental scrutiny;

2. Weaken efforts to protect women and girls from prostitution and sexual exploitation;

3. Strengthen groups seeking unrestricted access to abortion, since post-CEDAW, abortion activists will argue that such access has assumed the character of an internationally-protected human right;

4. Flood our courts with claimants seeking remedies based on the treaty rather than on settled U.S. law;

5. Further undermine the concept of federalism by "internationalizing" what traditionally have been state and local responsibilities under our constitutional form of government.

6. Generate calls for U.S. submission to the UN "gender police" envisioned in a CEDAW protocol.

7. And for your further reading pleasure, look at these comments in a letter dated July 29th 2002, by Jesse Helms, the minority leader on the Senate Foreign Relations Committee:

"Unfortunately some are confusing the very clear moral imperatives to secure basic freedoms and liberties for women with pretense that a need exists to ratify the United Nations Convention on Elimination of All Forms of Discrimination Against Women (CEDAW).

The documented radical agenda of the Committee established by CEDAW is un-disputed. (Among other things, the committee has directed China to legalize prostitution and has criticized Belarus for establishing Mother's Day.) These findings are simply out of step with generally held values of democratic nations. Moreover, there can be no doubt that CEDAW supporters are attempting to use this treaty to advance a radical abortion agenda. This is evident in committee reports directing Ireland to legalize abortion, and criticizing Ireland for the Church's influence in public policy.

I understand that some members on our Committee, who are advocating for CEDAW, are attempting to brush aside abortion concerns by citing the so-called "Helms Amendment" that was offered as a resolution of ratification in 1994 when the Foreign Relations Committee last reported CEDAW. The suggestion has been made by these CEDAW supporters that this language adequately addresses the abortion issue…However, the negotiated provision of my proposal was so watered down, that the amendment would not result in that CEDAW's radical abortion agenda being eliminated…which is why I voted against CEDAW in 1994 and would do so again, if I had been able to attend the Committee's deliberation on CEDAW this week."

I have spent considerable time reviewing reports from CEDAW on the Internet and have found no evidence on which to base any of the above concerns. Do some of our elected senators have some kind of paranoid stance that allows them to interpret the opposite of what is actually reported? (Yes, I hear you say.)

If you spend time reading the work of the CEDAW, you will be filled with dismay at the tragedies that are occurring throughout the world. Some of the issues that CEDAW is working on include the trafficking of women, the use of children for prostitution, the lack of access for women to basic education and health care and gender based violence.

Let us hope that the full Senate will ratify the treaty and let's hear it for the UN gender police! ❖

Mental Health Centers News

EAST BAY MENTAL HEALTH CENTER

CURTIS P. WILKINS, ASCW, LICSW, BCD, has been apointed Division Director of Acute Care Services at EBMHC. Curtis had served as the Adult Services Director at EBMHC, where he oversaw the agency's Adult and Addictions Services.

CEO, JOHN P. DIGITS, JR., recently announced that the East Bay Mental Health Center was awarded a $5000 grant from the Shriners of RI Charities Trust. The grant will be used to support EBMHC's Children's Psychiatric Services.

DR. IRWIN BENNET, a child and adult psychiatrist, recently joined the staff at EBMHC.

DR. PAUL J. FULTON, an adult psychiatrist, also joined the medical staff at EBMHC.

The American Psychiatric Association has moved!

The new address is:
1000 Wilson Blvd, Suite 1825
Arlington VA 22209-3901

You can reach the APA locally at 703-907-7300 or call the toll free number at 1-888-35-PSYCH.

Editorial (cont. from page 2)

the Yates case. He was claiming poor mental health care when the psychiatrist in the case discontinued her antipsychotic medication a few days prior. The discontinuation of psychiatric medi-cations is exactly what Mr. Boswell's group advocates. When Katie brought up the fact that his organization advocates for the eradication of psychiatry, this point was ignored and the double speak continued. It seemed to make no difference as to the consistency of his organization's stance. So much the better if another psychiatrist can be taken down.

At the Scientology site (which has links to the CCHR site) you will find histories of every atrocity committed in the name of psychiatry. Their viewpoint is that we sit around voting normal human behavior into pathological behavior, all for the sole purpose of extracting money, along with the drug companies, from the government and insurance companies. "Psychiatry is seeking to create a robotized or drugged, vegetable-like state so that we can be controlled".

No area of our field has been more targeted than Child Psychiatry, a focus area in this issue (i.e., the ADHD lawsuit, recently dismissed, against the APA, pharmaceutical companies, and others).

These are not, of course, the only such groups or individuals with similar views out there. At your local library is a book entitled *Toxic Psychiatry* by Peter Breggin, MD (supposedly a former Harvard psychiatrist). This tome could be easily replicated by publishing only the adverse reactions section of the PDR. All the many problems that can occur with medications are emphasized in bold relief, with absolutely no benefits or explanation as to why the medication was produced in the first place. Instructions are given to help even Schizophrenic patients on Clozaril discontinue their medications on their own. Not much help is given in replacement of the medication except for talk therapy, empathy, and love. I'm all for the latter, but I believe these existed in the pre-antipsychotic medication era and the result was life-long institutionalization for most.

Why do I even bother to give these groups press, especially in our newsletter? It is because these very active and well-funded groups are making huge efforts to get their messages out and our patients are bound to run across them. There is a local CCHR office nearby in Massachusetts and their goal is to fire off as many complaints to the Rhode Island Board of Medical Licensure and Discipline as possible. The Board must investigate all complaints, no matter how patently absurd or frivolous. This would be at least an irritation to have to take the time to respond. The more concerning issues involve vulnerable patients desperate for a "miracle cure" or easy fix. The more you know about these groups the more you can help your patients understand how dangerous they are.

The old adage of "know your enemy" would seem to apply here. ❖

Opportunities

Positions Available:
SE Massachusetts

Arbour-Fuller Hospital, a free-standing 82 bed psychiatric and substance abuse hospital, is currently recruiting for licensed psychiatrists to perform physician "on-call" duties (admissions, evaluations, unit response, etc.) on site weeknights and weekends.

This opportunity provides excellent clinical and networking experience for residents as well as staff psychiatrists.

For more information, please contact:
Gary Gilberti, CEO
Arbour-Fuller Hospital
200 May Street, S. Attleboro MA 02703
Gary.Gilberti@uhsinc.com
phone: 508-838-2212
fax: 508-838-2200

Save the Date!

The American Psychiatric Association will hold the 2003 Annual Meeting in San Francisco May 17–22, 2003.

More than 1,000 clinical papers, symposia, new research poster sessions and workshops will be presented at the 156th Annual Meeting of the American Psychiatric Association, "The Promise of Science and the Power of Healing". Please visit APA's homepage, www.psych.org, for updates and registration information.

The offices, exhibition, registration and major portion of the scientific sessions will be held at the Moscone Center, 747 Howard Street. The remainder of the scientific sessions will be held at the San Francisco.

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