POLICY & PRACTICE

New ADHD Society

The American Professional Society of ADHD and Related Disorders (APSARD) made its debut in June. The Mt. Royal, N.J.–based society says it is the first devoted to ADHD and aims to improve quality of care, boost research, and disseminate best practices. The organization is also launching the quarterly peer-reviewed Journal of ADHD and Related Disorders. The board of directors includes Dr. Ronald Kessler of Harvard Medical School and Dr. Joseph Biederman, chief of the adult ADHD program at Massachusetts General Hospital. Dr. Biederman has been under fire from Sen. Chuck Grassley (R-Iowa) for alleged failures to disclose conflicts of interest. According to APSARD Executive Director Gene Terry, the society expects to fund the majority of its activities from journal subscriptions, advertising, and membership dues, and it will accept industry support for independent continuing medical education.

Parity Law Won't Have Bad Impact

The new law requiring employers to offer comparable medical and mental health coverage won't lead to a drop in benefits, according to a survey conducted for an arm of the American Psychiatric Foundation. The Partnership for Workplace Mental Health surveyed 1,000 employers on what changes they might make when the law goes into effect next January. About 40% of the 143 respondents were businesses with more than 5,000 workers; 40% had fewer than 1,000 employees. Almost 90% of respondents offered both mental health and medical coverage currently, the survey found. Only eight of the respondents said they were considering dropping mental health and substance abuse coverage, and five of those were so small that they would be exempt from the parity law, anyway.

$460 Billion for Addiction, Abuse

In what it is calling the first report of its kind, the National Center on Addiction and Substance Abuse (CASA) at Columbia University said substance abuse and addiction directly cost local, state, and federal governments close to $470 billion annually. And that was based on the 4-year-old data. The feds spent the most, $238 billion, but state governments were tapped for a hefty $135 billion. Only about 2% of overall spending went to prevention and treatment and 0.4% to research, said CASA. The largest amount of federal and state spending was for health care, $207 billion or 58% of the dollars; 13% ($47 billion) was devoted to incarceration, probation, parole, and the court systems.

Obama: Give MedPAC More Clout

The Obama administration wants to give the Medicare Payment Advisory Commission (MedPAC) greater influence. In a June 2 letter to Sen. Ted Kennedy (D-Mass.) and Sen. Max Baucus (D-Mont.), President Obama said he supported giving each MedPAC recommendation the force of law unless it's opposed by a joint resolution of Congress. This appeared to embrace the approach in the MedPAC Reform Act of 2009, which Sen. Jay Rockefeller (D-W.Va.) introduced in May. Currently, MedPAC advises Congress, which then decides whether to act on the recommendations. At a Brookings Institution conference in mid-June, White House Office of Management and Budget Director Peter Orszag said the administration wants MedPAC recommendations to "become much more relevant."

Vermont Bans Most Pharma Gifts

Vermont Gov. Jim Douglas (R) has signed into law a bill that prohibits manufacturers of drugs, medical devices, and biologics from providing free gifts, including meals and travel, to physicians and other health care providers. The toughest of its kind in the nation, the legislation also requires disclosure of any allowed gifts or payments, regardless of their value. In 2002, a Vermont law required disclosure of gifts or payments of $25 or more. Under the stronger law, manufacturers can give physicians only gifts such as samples intended for patients, "reasonable quantities" of medical device evaluation or demonstration units, and copies of peer-reviewed articles. Companies still can provide scholarships or other support for medical students, residents, and fellows to attend educational events held by professional associations, as long as the association selects the scholarship recipient.

ED Overcrowding Continues

The emergency department wait time to see a physician for emergent patients—those who should be seen in 1-14 minutes—averaged 37 minutes in 2006. Half of such patients waited longer than recommended, the GAO said in a report. In addition, patients who should have been seen immediately waited an average of 28 minutes, and about three-fourths had to wait to be seen. Hospitals performed better with urgent cases: Those patients, who should be seen in 15-60 minutes, waited an average of 50 minutes, and only about 20% waited longer than recommended, the report said. Lack of inpatient beds continues to be the main driver of ED overcrowding, the GAO noted. The American College of Emergency Physicians warned that overcrowding and wait times will only get worse as the population ages. "People age 65 and older represent the fastest growing segment of the population and the group whose visits to the emergency department are increasing the fastest," said Dr. Nicholas Jouriles, ACEP president,in a statement.

—Alicia Ault

Early Detection of Ideation Is Key

Suicidality *from page 1*

psychiatric services (Am. J. Emerg. Med. 2008;26:701-5).

Separate data from South Carolina show that 10% of people who committed suicide had been in an ED within 2 months of their death.

To improve detection and intervention, new strategies include teams of mental health workers who hover in EDs to catch suicidal adolescents; family-focused, on-the-spot counseling; pocket guides for ED clinicians; and 1-hour cognitive-behavioral therapy sessions.

A panel of experts described their ongoing studies of leading-edge practices in a session at the annual conference of the American Association of Suicidology.

Most of the studies include these common components, in various forms:

- ► Hear what patients have to say; listen to their stories.
- ► Challenge their entrenched thoughts.
- ► Help patients know what they can do differently next time they feel suicidal.
- ► Link them to follow-up care.

Cheryl King, Ph.D., described a pilot study of the Teen Options for Change program, which screened 298 adolescents (aged 13-17 years) in a Michigan ED for suicide risk. Of the 49 teens (16%) who screened positive, 13 (27%) had come to the ED for nonsuicide reasons. At-risk teens underwent individual or family-based adapted motivational interviews and on-the-spot counseling.

"It's highly feasible to screen teens in the ED and to do brief interventions," said Dr. King, chief psychologist in the department of psychiatry and psychology at the University of Michigan, Ann Arbor.

Although two-thirds of suicidal teens seen in mental health practices are girls, "the boys who are suicidal do not come into the mental health setting. Going to the emergency department was our attempt to find the boys," Dr. King said. A refined version of the program will be tested in a randomized, controlled pilot study of 1,100 adolescents in the ED.

A pocket card listing a quick guide for clinicians is being used in a suicide prevention program in the Veterans Affairs medical system, said Gregory K. Brown, Ph.D., of the department of psychiatry at the University of Pennsylvania, Philadelphia.

Similar to the SBIRT (Screening, Brief Intervention, and Referral to Treatment) model that is used to train ED staff to quickly assess for the presence and extent of hazardous substance use and to deliver brief interventions, the guide reminds clinicians to help potentially suicidal patients develop their own safety plans.

The steps include recognizing warning signs of suicidality, using internal coping strategies, turning to family members or others if internal strategies don't resolve the crisis, contacting professionals and agencies if needed, and reducing access to lethal means.

Two pilot studies hope to increase the likelihood that suicidal patients in the ED will engage in treatment after leaving the ED, adhere to treatment in the 3 months after the ED visit, and decrease their risk of suicidal ideation and behavior in that time period. The studies employ separate interventions: a problem-solving interview, and a brief motivational interview, said Barbara Stanley, Ph.D., professor of clinical psychology at Columbia University, New York.

"The ability to maintain suicidal individuals in treatment has eluded practitioners," she said. Previous data suggest that 38% of suicide attempters who are hospitalized for 3 months do not engage in outpatient treatment after discharge, and that 73% of attempters are not in treatment at 1 year after their suicide attempt, she noted.

A family-focused intervention for suicide prevention is the basis of the SAFE-TY (Safe Alternatives for Teens and Youth) program being tested by Joan Asarnow, Ph.D., and her associates. One important element seems to be the development of an "expert leader" team in the ED, including security guards and others who help identify suicidal visitors, said Dr. Asarnow, professor of psychiatry and biobehavioral sciences at the University of California, Los Angeles.

The intervention includes assessing imminent danger in ED visitors aged 10-18 years, helping them identify feelings and high-risk emotional states, developing a plan for coping with trigger situations, and facilitating positive family interactions and support. Having the young patients write down three steps in a safety plan helps. "You have to practice with the kids" in the session, with the parents there, for best effect, she noted.

Dr. David Knesper and associates have taken a 1-hour cognitive-behavioral therapy intervention that was developed on medical-surgical units after suicide attempts by patients, and have transplanted the program to the ED.

"I tell patients, 'We have 1 hour.' It's comforting to them to know there's a beginning and an end," said Dr. Knesper, director of hospital and community psychiatry at the University of Michigan, Ann Arbor. "Hopefully, in 1 hour we develop a rapport, and I say, 'Now, can we spend a little more time in a follow-up appointment?' "

Mental health workers need to take the lead in improving suicide detection and interventions in EDs, Dr. Knesper said. "In mental health, we get shortchanged" in the emergency department, he said. "If you have a heart attack, they make all kinds of room" for cardiac specialists. "We have to fight for that mental health."

The Suicide Prevention Resource Center offers a "Best Practices Registry" for ED clinicians, Dr. Litts said, and produces a poster, printed guide, and handouts in English and Spanish that are available on the group's Web site (www.sprc.org) or through the U.S. Substance Abuse and Mental Health Services Administration or the Emergency Nurses Association. ■