Posthurricane Mental Services Funds Unused

BY ALICIA AULT
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New Orleans — An American Red Cross program that offers subsidies for mental health care to people affected by hurricanes on the Gulf Coast has been so undersubscribed that the organization is extending the deadline to apply and the period in which benefits will be offered by 6 months.

The Red Cross also has doubled the amount of money available to each applicant—from $1,000 to $2,000.

Anyone—even if he or she did not live in one of the affected Zip codes—who lost a family member may be eligible to receive benefits.

The organization is reluctant to give out figures on how many people have used benefits under the Access to Care program and how many it hopes to accommodate. Jeanne Ellinport, director of communications for hurricane recovery at the Red Cross, said in an interview that there is a cap on the amount of money that will be distributed, but that the program has not come close to reaching that limit.

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One psychiatrist who's been trying to get the word out about the program—Dr. Grayson S. Norquist, professor and chairman of the department of psychiatry and human behavior at the University of Mississippi Medical Center in Jackson—said he had been told that as many as 40,000 people could receive benefits and that only about half that many have done so.

Access to Care was launched in late September 2006, about a year after hurricanes Katrina, Rita, and Wilma ravaged the Gulf Coast of Louisiana and Mississippi, as well as New Orleans and parts of Alabama, Florida, and Texas. It was modeled after a program instituted in New York after the attacks of Sept. 11, 2001, according to Jacqueline Yannacci, program manager, emotional support for recovery, at the Red Cross.

Both the Sept. 11 program and the hurricane-related program are administered by the Mental Health Association of New York City.

Past experience has shown that depression, anxiety, and posttraumatic stress disorder tend to hit the hardest about a year after a disaster, hence the September 2006 launch, Ms. Yannacci said.

Those eligible for Access to Care are people who lived, before the hurricanes hit, in a Zip code affected by one of the three storms—about 133 counties in Texas, Louisiana, Mississippi, Alabama, and south Florida, Ms. Yannacci said. The residents have to provide proof of residence in those areas before the storm. While that might be close to impossible for storm victims whose homes were flooded or wiped out by winds or a storm surge, Ms. Yannacci said the Red Cross does everything possible to help people get proof. Those who received assistance from the Red Cross are in an organization database; in some instances, case managers call utilities or do other detective work to get residency proof, she said.

Applicants have to show that the storms had a significant impact on their lives—for instance, that they had been displaced from their homes for longer than 2 weeks, had lost their home or job, or their children had been uprooted and placed in a new school. If the "significant impact" criteria are met, even people who no longer live in those areas are eligible.

Initially, applications had to be received by Oct. 1, 2007; that has now been extended to March 30, 2008. Services will be covered from Aug. 30, 2005, to Sept. 30, 2008—instead of April 1, 2008. Claims can be filed as late as Dec. 30, 2008.

The Red Cross also removed a big potential hurdle for applicants. Initially, they had to use insurance benefits—if they had them—before they could receive Access to Care funds. Now, if they are accepted into the program, applicants can make use of up to $2,000 without using their insurance first. The payments can be made directly to providers—psychiatrists, social workers, psychologists, even acupuncturists. The money can be used for counseling, acupuncture, testing and evaluation of children up to age 21, and psychotropic medications.

Dr. Norquist said few of those who might use Access to Care—and few of his psychiatric colleagues on the Gulf Coast—know about the program, he said in an interview.

A major issue for Gulf Coast residents who might want to seek psychiatric care is the continuing shortage of health providers. Mississippi Gulf Coast clinics have about 75% of the staff they had before the hurricane, and they are seeing as many or more patients, Dr. Norquist said.

Meanwhile, the Metropolitan Human Services District (MHSD), a semiregional agency in charge of providing and managing publicly provided mental health and substance abuse services, is collaborating with the Red Cross to increase awareness of Access to Care. But a change in strategy might be needed, said Dr. Jerome Gibbs, executive director of the MHSD. "We need to think about how we market and label the services we provide," he said, noting that for many people, there is still a stigma attached to seeking care for a mental health issue. ■

For more information about the Access to Care program, go to www.a2care.com or call 866-794-4673.

Medications for Addictions Are Safer and More Effective

BY JANE SALODOF MacNEIL
Southwest Bureau

Tucson, Ariz. — Antiaddiction medications are becoming safer, more effective, and less prone to cause relapse, Dr. Michael E. Scott told clinicians at a psychopharmacology conference sponsored by the University of Arizona.

Not all patients remain abstinent on the new medications targeting neurotransmitters, but relapses tend to be shorter and less frequent, said Dr. Scott, medical director of the Sierra Tucson treatment center and a professor at the University of Arizona, Tucson.

"Success can be harm reduction, improvement in quality of life, and decrease in relapse severity," he said, urging greater use of pharmacotherapy.

Patient selection and education are important with these agents, according to Dr. Scott. Compliance can be a problem, and objections from addiction professionals committed to abstinence programs as well as from some family members need to be addressed.

"A medication is not the same as a drug. …A medication is a therapeutic thing, and education is important. The patient needs to know the difference," he said, adding, "Those early in recovery are less likely to understand medication. Those later in recovery are at greater risk of relapse. You need to know where they are."

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DR. SCOTT

Alcohol Withdrawal

Dr. Scott favored benzodiazepines as the cheapest, safest, most effective therapies for alcohol withdrawal. Four drugs have been approved for treatment: disulfiram (Antabuse), naltrexone (ReVia), acamprosate (Campral), and naltrexone IM (Vivitrol).

Disulfiram works best in patients who are motivated, intelligent, and not impulsive, according to Dr. Scott. He said evidence does not support its use as a single agent to promote abstinence but suggests it can reduce drinking days and works well with cognitive behavioral therapy. He gives it to people in recovery programs.

Studies have shown oral naltrexone (approved for alcohol and opiate dependence) can delay relapses and reduce heavy drinking. "This drug, while it does not protract abstinence, it does help if someone slips to get them back into recovery," Dr. Scott said.

Compliance is a major problem, however. He called it abysmal and suggested the best candidates for naltrexone therapy are patients mandated to treatment—for example, airline pilots and physicians in recovery.

Intramuscular naltrexone received U.S. Food and Drug Administration approval for alcohol dependence in 2006. Dr. Scott said physicians are still learning how to use it, but the once-a-month injections make compliance less of an issue. Patient selection is complicated, he noted, in that naltrexone IV has an extensive list of serious side effects, including suicidality and depression.

Compliance also is an issue with acamprosate, he continued, calling its three-times-a-day dosing requirement a fantasy. "It is too difficult a challenge for patients who are compliance-poor to begin with," he said.

Acamprosate seems to promote abstinence, however, and has been shown to work well with naltrexone. "I think we are going to find the combination is better," Dr. Scott said. "I think it's the trend where polypharmacy of addiction is going to be the norm rather than the exception."

Opiate Detox

There is no clear choice of opiate detoxification regimen, according to Dr. Scott. Buprenorphine is a new option that only physicians can prescribe and only if they are licensed after taking a one-day training program. "Even if you are not interested in addiction medicine, you do get addicts and opiate dependents in your practice," he said, encouraging physicians to become licensed.

He discouraged another new approach, however: rapid/ultrarapid detoxification in which naloxone and naltrexone are administered under general anesthesia. "This is not a life-threatening illness. You don't want to kill your patients," he said.

The treatment options include naltrexone, nalmefene (Revex), methadone, levo-alpha-acetylmethadol (LAAM), and buprenorphine.

Dr. Scott said that to make sure a patient is opiate-free before starting naltrexone or nalmefene, and he warned again that compliance is a major obstacle. Methadone is effective, he said, but LAAM has received a black-box warning and is not recommended.

Buprenorphine is available by itself as Subutex or in combination with naloxone as Suboxone. Dr. Scott said both are effective but Suboxone can precipitate withdrawal and should not be used in pregnant women. Buprenorphine should not be used with benzodiazepine; the combination can be fatal.

Helping Smokers

Nicotine replacement, bupropion (Zyban), nortriptyline, and clonidine can help 1 more person out of 14 to quit smoking—an absolute benefit of 7%, according to Dr. Scott. Clonidine has serious side effects, however, and he suggested nicotine replacement products might be underdosed.

Dr. Scott said a newly approved medication called varenicline (Chantix) might be more effective. "We are using it a lot more," he said. "Patients seem to like it. It is fairly easy to take." ■