Allan Tasman Chosen APA President-Elect in Mail Balloting by Members; Will Succeed Rodrigo Munoz

Allan Tasman, M.D., of Louisville, Kentucky, was chosen president-elect of the American Psychiatric Association in mail balloting by APA members in January and early February. He received 62 percent of the vote in a race against Robert Michels, M.D., of New York City. Dr. Tasman, who is currently an APA vice-president, is professor and chair of the department of psychiatry and behavioral sciences at the University of Louisville School of Medicine, where he also directs the Laboratory for Cognitive Neurosciences.

Dr. Tasman will become APA president at the APA annual meeting in Washington, D.C., in May 1999, succeeding the current president-elect, Rodrigo A. Munoz, M.D., of San Diego. Dr. Munoz will assume the presidency at this year's annual meeting in Toronto, when the current president, Herbert S. Sacks, M.D., of Westport, Connecticut, completes his one-year term.

Richard K. Harding, M.D., of Columbia, South Carolina, was elected to a two-year term as one of APA's two vice-presidents, with 67 percent of the vote. Dr. Harding, a former speaker of the APA assembly, is in private practice and is clinical professor in the department of psychiatry and pediatrics at the University of South Carolina School of Medicine in Columbia. His opponent was Samuel B. Guze, M.D., of St. Louis. APA's other vice-president is Daniel B. Borenstein, M.D., of Los Angeles.

Maria T. Lymberis, M.D., of Santa Monica, California, was elected to a two-year term as APA treasurer in a three-way race with Carol A. Bernstein, M.D., of New York City and Ronnie S. Stangler, M.D., of Seattle. Dr. Lymberis, a former APA trustee-at-large, is in full-time private practice and director of the psychotherapy program of the Los Angeles Psychoanalytic Society and Institute.

Richard S. Epstein, M.D., of Bethesda, Maryland, was elected to a three-year term as trustee-at-large. Dr. Epstein, who is in full-time private practice, received 58 percent of the vote in a race against John M. Oldham, M.D., of New York City.

Julie K. Schulman, M.D., of New York City was elected member-in-training trustee-elect in a three-way race with Satyanarayana Chandragiri, M.D., of Philadelphia and Peter M. Steiner, M.D., of Louisville, Kentucky. Dr. Schulman is a psychiatric resident at New York University Medical Center–Bellevue.

Edward C. Leonard, Jr., M.D., who is in private practice in Philadelphia, was reelected to a three-year term as area 3 trustee with 75 percent of the vote. His opponent was Jorge Pereira-Ogan, M.D., of Wilmington, Delaware. Maurice Rappaport, M.D., Ph.D., of San Jose, California, was elected area 6 trustee in a race with Thomas K. Ciesla, M.D., of Santa Monica, California. Dr. Rappaport received 56 percent of the vote. He is in private practice.

By an overwhelming majority, APA members approved a constitutional amendment establishing the new membership categories of international member and international fellow to replace the categories of corresponding member and corresponding fellow. Amendments related to implementing the new membership categories were also approved.

New Publication Highlights Intimate Relationship Between Substance Abuse and Domestic Violence

A new publication developed by a panel of experts brought together by the Center for Substance Abuse Treatment (CSAT) draws attention to the intertwined problems of domestic violence and substance abuse. In the United States a woman is beaten every 15 seconds. An estimated three million children witness acts of violence against their mothers every year. Medical costs associated with injuries to women by their partners total more than $44 million annually. One-fourth to one-half of men who commit acts of domestic violence also have substance abuse problems. In addition, many victims of such violence use substances as a way of coping with abuse and chronic threats of violence, and children from these families have an increased risk of both substance abuse and violent behavior as adults.

The primary focus of the 152-page document, *Substance Abuse Treatment and Domestic Violence,* which was released in late January, is on helping substance abuse treatment providers recognize both survivors of domestic violence and batterers as they enter the treatment system so that the system can respond appropriately to their needs. Failure to address domestic violence interferes with treatment effectiveness and contributes to relapse, the consensus panel concluded. The panel strongly recommended that all clients entering substance abuse treatment be questioned about current domestic violence as well as childhood physical and sexual abuse.

A chapter on screening and referral outlines a step-by-step method for conducting a screening interview for domestic violence and provides a list of specific questions and a description of indicators of abuse. Other than visible injuries, clues that a client may be a survivor of domestic violence include a history of relapse or noncompliance with treatment plans; inconsistent and evasive answers about injuries; complications in pregnancy, including miscarriage, premature birth, and infant illness or birth defects; stress-related illnesses and conditions, such as headache, backache, chronic pain, gastrointestinal distress, sleep and eating disorders, and fatigue; anxiety-related conditions, such as heart palpitations, hyperventilation, and panic attacks; and a sad and depressed affect and talk of suicide. Another clue is documented child abuse perpetrated by the client's partner. The chapter

also provides tips on screening for and reporting child abuse and neglect.

Separate chapters on survivors and batterers identify issues unique to these groups, particularly those that may interfere with substance abuse treatment. For example, the batterer may be the survivor's drug supplier, which may discourage her from reporting his abusive behavior. Dissociation by means of substance use may be a survivor's way of coping with chronic abuse, and abstinence may bring a flood of repressed emotions and physical sensations.

Another chapter on legal aspects discusses federal, state, and local regulations related to domestic violence, in particular the 1994 Violence Against Women Act. Also addressed are restraining orders, duty to warn, the legal obligation to report threats and past crimes, and confidentiality. Appendixes include instruments to screen for domestic violence and to assess a batterer's dangerousness, a sample safety plan for a survivor, and a list of national programs and hotlines for domestic violence.

An overall goal of the document is to open a line of communication between the fields of substance abuse treatment and domestic violence treatment. Professionals in these fields have worked largely in isolation from each other, despite considerable overlap in their client populations. In creating the report, the 18-member panel, made up of experts from both fields, confronted the differences in priorities, terminology, and philosophy that have hampered their collaboration, which are described in an introductory chapter.

For substance abuse treatment providers, abstinence is a key goal, while for domestic violence programs, ensuring survivors' safety is of paramount concern. Domestic violence programs focus on empowerment to encourage battered women to build a new life. Counselors in these programs tend to distance themselves from medical models that imply that survivors are "sick," such as those used to conceptualize substance abuse and dependence. The panel concluded that when each field gains knowledge of the other and when community programs in both fields are closely linked, treatment providers can forgo an "either-or" approach in treatment planning and can adjust priorities on a case-by-case basis.

To that end, the final chapter, "Linkages: A Coordinated Community Response," outlines a model for systemic reform and provides suggestions for community-based systems of care. The panel recommended that a new mechanism be developed at the state level to coordinate planning among agencies, devise strategies to blend funds from different state and federal programs, ensure equitable allocation of resources among agencies, and establish a vehicle for resolving problems that emerge in linking the two treatment systems.

Substance Abuse Treatment and Domestic Violence is the 25th publication in CSAT's Treatment Improvement Protocol (TIP) series. All TIPs are available on the CSAT Web page at www.samhsa.gov, or they can be ordered free of charge by contacting the National Clearinghouse for Alcohol and Drug Information at 800-729-6686.

Rapidly Growing Employee Assistance Programs Face Major Changes, More Intense Competition

The field of employee assistance has a bright future, but it is evolving so rapidly that programs of the past 20 years will have little in common with future programs, Monica E. Oss and John Clary concluded in an industry analysis of employee assistance programs (EAPs) in the January issue of the newsletter *Open Minds.*

They reported that the total national enrollment in EAPs grew from 27 million persons in 1994 to 39 million in 1997, a 45 percent increase. As enrollment has grown, EAP firms have become increasingly consolidated, so that as of November 1997 the 20 largest EAPs accounted for almost 86 percent of enrollment. Magellan Health Services, Inc., with 34 percent of the enrollment, dominated the field. Value Behavioral Health, Inc., was a distant second with 12 percent.

Currently about 33 percent of all private, nonagricultural work sites with 50 or more full-time employees offer EAP services to their employees. However, about 82 percent of employees in the largest firms have access to EAP services. EAP enrollment is currently estimated to represent 42 percent of the potential market, but it could reach 65 percent by the year 2000, with 20 million new enrollees.

Employee assistance programs originally focused on getting employees who abused substances into treatment and later incorporated a broad range of clinical services and organizational tools for promoting productivity. But after the emergence of managed behavioral health care in the mid-1980s, they began to develop expertise in management of health benefits.

In their research Ms. Oss and Mr. Clary identified four types of EAPs:

- Integrated managed behavioral health–employee assistance programs, which focus on behavioral health benefit management and incorporate a gatekeeping function for access to employee assistance counseling and behavioral health benefits. This model is preferred by self-insured employers and union groups.
- EAPs based on human resource management consultation models, which usually offer both behavioral health counseling services and financial and legal counseling as well as assistance with elder care and child care issues. This is the traditional EAP model. However, an expanded model is emerging with additional services that include counseling for HIV-positive employees, stress management related to organizational change, disability management, dependent care services, and crisis management services.
- EAPs that function as wrap-around behavioral health outpatient benefits. Due to restrictions placed on the use of mental health services by health maintenance organizations, many smaller employers do not have

easy access to mental health services. Instead, they are contracting with EAPs to have ready access to outpatient behavioral health care.

♦ EAPs that ensure compliance with the Drug-Free Workplace Act. They provide alcohol and drug testing, counseling services, and medical review officer services. These programs are most often purchased by employers who must comply with regulations of the federal Department of Transportation.

The authors found that the newly consolidated EAP market is evolving into three tiers of service companies: national companies with enrollments of 800,000 or more; mid-sized regional companies with enrollments of 60,000 to 800,000; and local, proprietor-owned and -operated companies that are usually extensions of behavioral health professional practices, with enrollments of under 60,000. All face new competitive pressures in pricing, distribution, and information systems capabilities because of industry consolidation.

For a copy of the article, entitled "EAPs Are Evolving to Meet Changing Employer Needs," contact *Open Minds;* phone, 717-334-1329.

GAO Study Finds State Psychiatric Hospitals Get Biggest Share of Supplemental Medicaid Payments

A six-state study by the General Accounting Office (GAO) found that state mental hospitals receive a much bigger share of the federal payments available to hospitals that serve large numbers of Medicaid patients than do other public and private hospitals. In most cases states are using the funds to offset some of the costs of state hospital services that Medicaid cannot pay for directly, which is permitted under the rules of the Medicaid program.

The study was requested by Senator Kent Conrad (D.–N.D.), who asked GAO to examine whether states were using Medicaid's disproportionate share hospital (DSH) program, which provides the supplemental payments, to fund services that federal law prohibits Medicaid from covering. Medicaid has never covered services to adults age 21 to 65 who are in state psychiatric hospitals or other institutions for mental diseases. Their exclusion has been justified on the grounds that mental health services traditionally have been considered a state and local responsibility. State psychiatric hospitals can, however, receive DSH funding for uncompensated care and the difference between costs and payments for care of Medicaid patients. States have had broad discretion in determining the size of DSH payments to individual hospitals.

The six states studied—Kansas, Maryland, Michigan, New Hampshire, North Carolina, and Texas—were chosen by GAO because of their rapid growth in, high proportion of, or decline in mental health DSH expenditures between 1993 and 1995. GAO found that, overall, in fiscal year 1996 DSH payments to state psychiatric hospitals in the six states averaged about $29 million per hospital compared with an average of $1.75 million for private hospitals. The six states devoted from 20 to 89 percent of their total 1996 DSH expenditures to state psychiatric hospitals, even though they represented a much smaller proportion of the number of hospitals in the states.

In every state but Texas, the average DSH payment per bed day was much higher for state psychiatric hospitals than for other types of hospitals. In fiscal 1996 payments per bed day ranged from $756 in New Hampshire to $154 in Kansas. For private hospitals DSH payments per bed day ranged from $155 in New Hampshire to $4 in North Carolina.

In five of the six states studied, state psychiatric hospitals receiving DSH payments often served smaller proportions of Medicaid patients than other state-owned and local public and private hospitals. Only six of 34 state psychiatric hospitals in the six states had a Medicaid utilization rate higher than 25 percent. Average 1996 Medicaid utilization rates ranged from 3.1 percent in Texas to 22.1 percent in Kansas.

GAO said that a provision in the Balanced Budget Act of 1997 should reduce DSH payments to state psychiatric hospitals from 1996 levels because it limits the proportion of a state's DSH payments that may be made to psychiatric hospitals. For federal fiscal years 1998 to 2000, the limit is the ratio of 1995 mental health DSH payments to total DSH payments. For federal fiscal year 2001, the limit is the 1995 percentage or 50 percent, whichever is less. The payment limits decline to 40 percent in 2002 and 33 percent in succeeding years. GAO noted, however, that the amount of the reductions will depend in part on how states use the flexibility inherent in the Medicaid program.

Single copies of the report, entitled *Medicaid: Disproportionate Share Payments to State Psychiatric Hospitals* (GAO/HEHS-98-52) are available free from the U.S. General Accounting Office; phone, 202-512-6000; fax, 202-512-6061.