Daniel Borenstein Is Chosen APA President-Elect; Allan Tasman to Succeed Rodrigo Muñoz as APA President

Daniel B. Borenstein, M.D., of Los Angeles was chosen as president-elect of the American Psychiatric Association in mail balloting by the membership this winter and will assume the APA presidency in May 2000.

The current president-elect, Allan Tasman, M.D., of Louisville, Kentucky, will become APA president next month at the conclusion of the APA annual meeting in Washington, D.C. He will succeed Rodrigo Muñoz, M.D., of San Diego.

Dr. Borenstein received 59 percent of the vote in a race against Lawrence A. Stone, M.D., of San Antonio. A member of the APA board of trustees since 1989 and an APA vice-president since 1997, Dr. Borenstein is in full-time private practice in Los Angeles.

In the race for APA vice-president, Paul S. Appelbaum, M.D., of Worcester, Massachusetts, defeated Jeremy A. Lazarus, M.D., of Englewood, Colorado, to win a two-year term. Dr. Appelbaum, who received 59 percent of the votes cast, has served as APA secretary since 1997. He is professor and chair of the department of psychiatry at the University of Massachusetts Medical School. Dr. Appelbaum will fill one of two vice-presidential posts; the other is held by Richard K. Harding, M.D., of Columbia, South Carolina.

Michelle B. Riba, M.D., of Ann Arbor, Michigan, was elected to a two-year term as APA secretary with 62 percent of the vote. Her opponent was Chester W. Schmidt, Jr., M.D., of Baltimore. Dr. Riba, a member of the APA board of trustees since 1996, is associate chair for education and academic affairs and clinical associate professor in the department of psychiatry at the University of Michigan.

Ann S. Maloney, M.D., of New York City was elected trustee-at-large in a three-way race with Richard Balon, M.D., of Detroit and Ezra E. H. Griffith, M.D., of New Haven, Connecticut. Dr. Maloney is in full-time private practice.

Herbert S. Peyser, M.D., who is in private practice in New York City, won a three-way race for area 2 trustee. His opponents were Edward M. Stephens, M.D., of New York City, and Anthony F. Villamena, M.D., of Bronxville, New York.

Jack W. Bonner III, M.D., of Greenville, South Carolina, defeated Dudley M. Stewart, Jr., M.D., for the post of area 5 trustee. Dr. Bonner is medical director and administrator of behavioral health services in the Greenville Hospital System.

Sandra M. DeJong, M.D., a resident in the department of psychiatry at the University of Massachusetts in Worcester, won a four-way race for the post of member-in-training trustee-elect. Her opponents were Emine Nalan Iscan, M.D., of Boston, Elizabeth Ortiz Schwartz, M.D., of Valhalla, New York, and John C. Webber, M.D., of Little Rock, Arkansas.

APA members approved amending the bylaws so that changes in membership procedures can be made through the association's operations manual rather than requiring a change in the bylaws. They also approved a constitutional amendment that would allow APA to explore the possibilities of electronic voting in the future and eliminate the requirement that proposed amendments to the constitution and bylaws be read at the association's annual meeting, reducing the time needed to enact changes. A constitutional amendment that would have restructured fellowships into separate categories of fellows and distinguished fellows failed to pass by a narrow margin.

Two Best-Practice Guidelines Focus on Assessment and Treatment of Adolescents at Risk for Substance Abuse

In early March the Center for Substance Abuse Treatment (CSAT) issued two publications aimed at improving identification and treatment of young people at risk for substance abuse. The best-practice guidelines were developed by a panel of treatment experts in a process that combines the findings of empirical research with clinical knowledge and experience.

Recent national studies have raised alarms about the efficacy of treatment for adolescents and the increased use of substances in this group. Results of a nationwide five-year outcomes study released in late 1998 showed that although treatment is effective for adults, it does not lead to successful outcomes for adolescents– reducing neither substance abuse nor the criminal activity associated with it. In addition, data from the 1997 National Household Survey on Drug Abuse, released at about the same time, indicated that illicit drug use rose to 11.4 percent among 12- to 17-year-olds, up from 9 percent in 1996. Recent significant increases among eighth graders also show a trend toward earlier onset of drug use.

Both of the CSAT guidelines– *Screening and Assessing Adolescents for Substance Use* and *Treatment of Adolescents With Substance Use Disorders*– warn that the annual focus on rising and falling statistics among teens can distract attention from the seriousness of the problem. Sustained drug and alcohol use causes great damage to young persons by disrupting their ability to complete developmental tasks. Chronic substance use allows them to mask emotions, which undermines their learning to cope with feelings. A great deal is at stake intellectually as well, the guidelines point out. Substance abuse blunts the development of critical intellectual abilities that form during adolescence– abstract thinking, propositional logic (the ability to form hypotheses and consider possible solutions), and metacognition (the ability to think about the thought process itself).

The guideline on screening and assessment targets a wide audience of professionals, including medical per-

sonnel such as pediatricians and school nurses, educators, coaches, workers in the juvenile justice system, and substance abuse treatment providers, in an effort to ensure early identification of at-risk youth. It describes differences between screening, which is a brief process to uncover red flags, and assessment, which is a comprehensive evaluation leading to diagnosis and a treatment plan.

Two hallmarks of a screening program are noted– its ability to be administered in ten to 15 minutes and its broad applicability across diverse populations. A screen should focus on the severity of the adolescent's substance use and a core group of associated factors such as legal problems, mental health status, educational functioning, and living situation.

The consensus panel reviewed all available screening instruments for adolescent substance use. Seven such instruments are described in an appendix to the guideline. The summaries list the areas assessed by each instrument, completion time, and reading level and provide information about how to obtain the instrument.

The CSAT guideline recommends routine screening of several subgroups: adolescents who are arrested or detained, teens receiving mental health care, adolescents entering the welfare system, school dropouts, special education students, and students who show increased oppositional behavior, significant changes in grade-point average, and a great number of unexcused absences. Screening is also indicated for adolescents whose behavior changes substantially or who suddenly begin experiencing medical problems such as accidents, injury, or gastrointestinal disturbance.

The guideline recommends that all positive screens be followed up with a comprehensive assessment conducted by a well-trained professional. The panel chose nine assessment instruments focusing on adolescent substance abuse, including self-report questionnaires and structured and unstructured interviews. The instruments, which all meet stringent reliability and validity criteria, are described in an appendix, along with several other instruments assessing related domains such as school functioning and the family.

The other new CSAT guideline, *Treatment of Adolescents With Substance Use Disorders*, emphasizes the importance of tailoring treatment to adolescents. Efforts that approach young people as "little adults" are bound to fail, the guideline notes. Program staff should be carefully trained to understand how adolescents perceive and react to treatment. Entering unfamiliar treatment settings can intensify adolescents' feelings of fear and self-consciousness, and acting out may be a sign of intense anxiety rather than resistance.

Particularly important among adolescents are explicit and impartially administered standards for behavior, the guideline notes, but for those who break the rules, confrontation should be avoided in favor of a steady emphasis on personal responsibility and choice. Staff should make every effort to protect adolescent clients from peer harassment, such as teasing and hazing.

The guideline focuses on three modalities– 12-step-based programs, therapeutic communities, and family therapy– and describes how they can be tailored to the adolescent treatment population. For example, the juvenile justice system increasingly mandates treatment in therapeutic communities. Modifications for adolescents include shorter stays, attention to developmental delays and neurological impairments, a strong focus on completing education, and involvement of families. The guideline points out that many adolescents adopt false identities and negative self-images from street culture and gangs. A critical task for staff in therapeutic communities is to help youthful clients understand how a healthy identity is developed and maintained. Staff must also be prepared to help clients manage strong sexual impulses and overwhelming feelings of guilt over their past actions.

Legal and ethical issues are especially complex for any program that treats adolescents for substance abuse because a mix of federal and state laws govern these areas. Both documents provide an overview of critical issues, such as consent to treatment and confidentiality, and highlight important considerations for providers.

For example, in states where adolescents under age 18 must obtain parental consent for treatment, a program may be faced with a legal dilemma if an adolescent applies for treatment but refuses to permit the program to communicate with a parent or guardian. One set of confidentiality regulations governs such treatment applicants. However, if, without parental consent, the program decides to accept the adolescent as a client, a more stringent set of confidentiality regulations applies. The guideline suggests that programs in such states should establish policies that will protect them from liability while permitting them to provide needed treatment.

Screening and Assessing Adolescents for Substance Use is number 31 and *Treatment of Adolescents With Substance Use Disorders* is number 32 in CSAT's Treatment Improvement Protocol (TIP) series. All TIPs are available on the CSAT Web page at www.samhsa.gov. They can be ordered free of charge from the National Clearinghouse for Alcohol and Drug Information at 800-729-6686.

NEWS BRIEFS

Videos on dysthymia: The National Depressive and Manic-Depressive Association (NDMDA) has produced a new series of five half-hour videos about chronic depression, also known as dysthymia, featuring eight of the country's leading experts. Four of the videos are intended for health care professionals; the fifth is directed to patients and their families. The videos address the causes, control, and course of dysthymia, defined in *DSM-IV* as a chronically depressed mood that occurs for most of the day on most days for at least two years. Martin Keller, M.D., professor and chairman of the department of psychiatry and human behavior at Brown University in Providence, Rhode Island, served as chairman of the video project, which was funded by Pfizer, Inc. The videos are available free with a

$4.25 charge for fourth-class postage and handling or $6.25 for first-class mail. The consumer video may be viewed on NDMDA's Web site at www.ndmda.org. To order videos or obtain more information, contact NDMDA, 730 North Franklin Street, Suite 501, Chicago, Illinois 60610; phone, 800-826-3632; fax, 312-642-7243.

Advocacy tool kit: The National Mental Health Association (NMHA) has developed a tool kit to help mental health consumers, family members, providers, and advocates shape state mental health policy in times of reform. Called the *Advocacy Primer: A Tool Kit for Promoting Positive Health Care Reform Though Education and Advocacy*, it is based on NMHA's experience in conducting state health care reform training programs in 40 states since 1995. The tool kit describes the workings of managed care in the public and private mental health sectors, emphasizes the need to build coalitions to promote positive health care reform, and outlines strategies to influence decision makers and educate the public about mental illness issues. The *Advocacy Primer* is available for $7 from NMHA's information center; phone, 703-838-7534.

NMS hotline: Zeneca Pharmaceuticals announced in February that its sales representatives would begin distributing 100,000 Neuroleptic Malignant Syndrome (NMS) Hotline stickers to mental health and psychiatric clinicians across the U.S. The hotline, which can be reached toll free at 888-667-8367, is operated by the Neuroleptic Malignant Syndrome Service, founded in 1996 to help reduce morbidity and mortality from NMS, a drug-induced disorder characterized by disturbances in mental status, temperature regulation, and autonomic and extrapyramidal functions. Hotline consultants– board-certified psychiatrists and anesthesiologists who are experienced in dealing with NMS– are available by phone around the clock 365 days a year to help clinicians promptly recognize, diagnose, and treat NMS. Data collected through the hotline are entered into a scientific database to help determine the cause of NMS and develop a standard treatment protocol. More information is available by calling 888-776-6747 toll free or by visiting the service's Web site at www.nmsis.org.

Nominations sought: The Robert Wood Johnson Foundation seeks nominations for its Community Health Leadership Program (CHLP), which honors ten outstanding individuals each year for their work in creating or enhancing health care programs serving communities whose needs have been ignored or unmet. Each leader receives $100,000, which includes a $5,000 personal stipend and $95,000 for program enhancement over a three-year period. CHLP seeks out individuals who have the leadership skills to overcome complex obstacles and find creative ways to bring health care services to their communities. Winners generally are largely unrecognized and are likely to be in mid-career, most often having spent between five and 15 years in community health work. Nominations can be made by consumers, community health leaders, health professionals, and government officials who have been personally inspired by the nominee. For more information and a nomination form, contact CHLP, 30 Winter Street, Suite 920, Boston, Massachusetts 02108; phone, 617-426-9772; fax, 617-654-9922. The deadline for nominations is September 16.

Administrative psychiatry examination and award: The committee on psychiatric administration and management of the American Psychiatric Association annually conducts an examination for certification in psychiatric administration and management. The written portion is given each December, and successful candidates take the oral examination in May. The deadline for receipt of completed applications is August 1. More information and application forms are available from the Committee on Psychiatric Administration and Management, Office of Education, APA, 1400 K Street, N.W., Washington, D. C. 20005; phone, 202-682-6109. APA and the American Association of Psychiatric Administrators jointly sponsor an administrative psychiatry award, presented annually to a psychiatrist who has demonstrated extraordinary competence and achieved a national reputation in psychiatric administration. The deadline for nominations is August 1. For more information, contact the APA office of education at the address above.

Shelters for victims of domestic violence: The Department of Health and Human Resources (HHS) has announced the release of $62 million in grants to help develop and support shelters for women and children who are victims of domestic violence. Authorized by the Violence Against Women Act of 1994, the grants will also fund support services, including counseling, legal advocacy, emergency transportation, child care, and referrals for medical care and substance abuse. They will be awarded to all 50 states, the District of Columbia, and U.S. territories in amounts determined by population, but no state will receive less than $400,000. The fiscal year 1999 budget for HHS provides a total of $190 million for programs that address violence against women, including $45 million in grants to states for rape prevention programs and $15 million to reduce sexual abuse among runaway and homeless youth.

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