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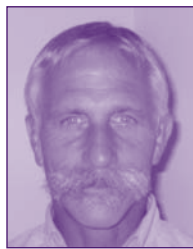
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President's Column

The Real Transformation: A Day in the Life



Wes Sowers, MD

Each Wednesday I begin my day at a women's shelter in downtown Pittsburgh. We have a behavioral health clinic there that was established in part through a HUD grant to provide an easily accessible source of free care for persons who are homeless and without healthcare resources. It is an integrated clinic with co-located medical and dental capacity. Many of the clients I see there are transient and are only engaged until other more permanent and comprehensive services can be arranged (or until they are somehow lost), but there are several who I have been seeing there for years and who have likely managed consistency in engagement and significant

gains in the quality of their lives only because this care is provided in a non-traditional setting. There was once a fund available to obtain medications for clients without any insurance coverage, but the grant is no longer allowing significant expenditures for treatment. We have had to transform our practices for obtaining medications for uninsured individuals, now needing to rely more on samples. Part of my morning is often spent talking with pharmaceutical representatives to obtain samples, a practice I do not relish, and one that prevents me from spending that time with my clients. The rest of the team is likewise prevented from spending as much time interacting with clients as they normally would, since they are charged with managing the samples pharmacy and maintaining the documentation requirements imposed on clinics that choose to use this resource.

My next stop is in the Hill District of Pittsburgh at a program called the Neighborhood Living Project, the winner of two national awards. The "NLP" is a modified ACT program, providing housing and support to persons who have been chronically homeless and who have been unable to engage in traditional service settings. Until recently, grant funding for NLP covered \$380,000 annually in supportive and clinical services. With the loss of this funding and the resultant deficit in operating expenses, NLP has necessarily undergone a major transformation of case management and nursing resources so that services provided can be billed to cover costs. But since many of the services provided by our case managers and nurses in the past are not "billable", they have been discontinued. Nursing positions have been eliminated. Our once tightly knit team has been fractured by the departure of several staff members who have feared for the security of their jobs. For many of the clients we serve, this has meant the dissolution of relationships that were not easily constructed. While many of these relationships remained tenuous over time, they have frequently been one of the few stable aspects of their lives. We have already seen an increase in missed appointments or "appearances" and other signs of disengagement, such as absences during scheduled home visits, in the face of these disruptions. Until now, we have been able to provide a collaborative context for care, emphasizing autonomy and choice in homey, informal settings. The

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(President's Column Continued)

billing process brings with it new regulations and requirements that do not lend themselves well to the populations with which we work or the settings in which we have provided service.

Later in the afternoon, I visit a clinic in a drop-in center. Prior to clinic consultations, a multi-agency service meeting takes place, reviewing the progress of the clients served there. The behavioral and physical health issues of these people, as well as housing and other supportive services, can be addressed in the same visit in this clinic for homeless persons. The new requirements for billing have transformed the scope of what we can accomplish though, the presence and capacity of staffing being much diminished by workforce reductions and restrictions on outreach and engagement activities. Many of the "behind the scenes" arrangements and negotiations can no longer occur because they do not count toward "productivity" for professional staff. And who will pay for the intangible value of a psychiatrist "being there" even when billable contacts are not tightly scheduled? How many of these men and women will miss their opportunity to begin to change their circumstances as a result?

I work in several other settings during the course of my work week. One such setting is a small independent clinic for Gay, Lesbian, Bisexual and Transgender persons that provides care on a sliding scale related to ability to pay. Whether these clients have Medicaid or Medicare, their medication plans have been transformed and are increasingly restrictive. Many have instituted a step plan, where a history of failure to respond to cheaper medications must be established before more expensive formulations will be approved. Consequently, I receive many calls from pharmacists telling me that my prescriptions have been denied. As a result, I can either spend a significant amount of my time gathering the required information from the records (the notification often comes after I have left the clinic for the day, so it is not conveniently available until the following week), or I can attempt to contact the recipient of the prescription to discuss other options or reschedule the follow-up visit at an earlier date. Whatever decision I make, I will lose time that could otherwise be spent more productively and profitably for the people I am working with. In the other settings in which I work, a methadone clinic, a half way house for women in early recovery from substance use, a shelter for battered women, a residential treatment program for men coming out of jail with mental illness and substance use disorders, the stories are much the same, just variations on these themes.

These stories are sadly familiar to most of you who are reading this column. There has been much talk about system "transformation" in recent times, and this has gained momentum since the issuance of the President's New Freedom Commission Report in 2003. The reality is that the system is being transformed but not in the ways described or aspired to in the report. Instead, reductions in resources and the pressures for corporate profit have driven these changes. Many observers have seen the only real commitment to recovery principles in service delivery as being those aspects that will reduce costs by using unpaid human resources in the community. Meanwhile, a huge percentage of our national budget is being consumed by destructive activities abroad, creating tremendous obstacles to the type of change needed to bring about systems of care that would actually end discrimination and marginalization for persons with behavioral health issues.

Attempts to truly transform our systems of care to ones in which services will be easily accessible to all, medications which are indicated can be obtained, choice is not severely restricted by economic constraints, and human needs can be met in humane settings and circumstances, will only be successful when our national priorities change and we come to understand that the best interests of our whole society will only be served by assuring the welfare of each individual in it. How long will we watch and wait?

Wesley Sowers, MD
President, AACP



Editor's Brief

Updates, Fact Sheets. . . Lots of Information

Hello everyone. This issue of the newsletter contains many sheets of information—fact sheets, spread sheets, updates, etc. Hopefully, you will find this information useful and not put this at the bottom of your cat's litter box.



Warachal Faison, MD

In the issue, we bring news regarding the dual membership with the American Orthopsychiatric Association and interview the organization's president, Dr. Diane Willis. This dual membership with Ortho would result in a **20% discount** from the full combined price of a membership in both organizations. If you join now, you would pay only **\$204** for a dual membership in both Ortho and the AACFP. There are multiple benefits in joining both organizations, including obtaining subscriptions to the *American Journal of Orthopsychiatry* and the *Community Mental Health Journal*.

Our own Ben Crocker, MD shares information on navigating Medicare Part D, the donut hole, and generic psychiatric medication spreadsheets. He believes that most of his colleagues will deem him a boring person as a result of this compilation of material. . . those of us that KNOW him realize that of all the various ways to describe him, he surely can not be described as boring. He has exhausted himself by developing and compiling information so that many of us do not have to "reinvent the wheel". To tell someone to just do something versus creating a step by step guide (as he has done!) requires drastically different degrees of energy. I feel privileged that AACFP is able to be apart of the dissemination of Dr. Crocker's material.

Well, in a few weeks, I will see many of you at the APA meeting in San Diego. Although we are a separate entity from APA, we do collaborate and attempt to infiltrate APA in every way. APA President, Pedro Ruiz, MD, incoming President Carolyn Robinowitz, MD, and 2008 President-Elect Nada Stotland, MD have strong community psychiatry ties. Diversity issues as well as community collaboration are critical issues to all three of these leaders. Just look at the APA meeting foci to get a glimpse of their passion. The 2007 APA Annual Meeting focus under the leadership of Dr. Ruiz is *Addressing Patient Needs: Access, Parity, and Humane Care*. The 2007 IPS under Dr. Robinowitz will focus on *Recovery: Patients, Families, Communities* in New Orleans. As we look forward to APA's leadership, I recall many encounters with Dr. Stotland who charges many of us to be proactive to evoke change. I hope that many of you took the time to impact APA this year and will continue. I still feel that community psychiatrists have a special pulse on the field of psychiatry and the community at large. If we are not fighting for change, then who will?



See you soon,
Warachal

Calendar

May 11-12, 2007

Pharmacology and Late-Life Mental Illness, Sponsored by the American Association for Geriatric Psychiatry
Marriott Hilton Head Beach and Golf Resort
Hilton Head, South Carolina
For more information, visit website http://www.aagponline.org/programs/mc_conference.asp

June 7-9, 2007

7th International Conference on Bipolar Disorder
David Lawrence Convention Center, Pittsburgh, PA
For more information visit the website at <http://www.wpic.pitt.edu/stanley/7thbipconf/>

June 25-29, 2007

American Orthopsychiatric Association Annual Symposium at the Cape Cod Institute
Trauma and Violence: Prevention, Intervention and Treatment
For more information, visit <http://www.cape.org/>

October 23-28, 2007

American Academy of Child & Adolescent Psychiatry Annual Meeting
Sheraton Boston Hotel, Boston MA
For more information, visit <http://www.aacap.org/>
Future APA Meetings

APA Annual Meeting
May 19-24, 2007
San Diego, CA

Institute on Psychiatric Services
October 11-14, 2007
New Orleans, LA

APA Annual Meeting
May 3-8, 2008
Washington, DC

Institute on Psychiatric Services
October 2-5, 2008
Chicago, IL

AACP WELCOMES NEW MEMBERS

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Jasbir Virk

Area 5
Nat Sandler
Amy O'Neill
Latonia Sweet
John Keddy Wilson

Area 7
Michael Snyder
Pradeep Arora



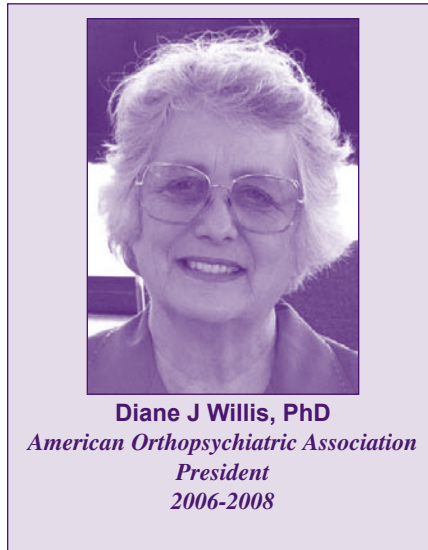
Welcome AMERICAN ORTHOPSYCHIATRIC ASSOCIATION!

Over the past several months our board meetings have included discussions about various organizations that wish to partner with us and organizations that we wish to approach about partnership. It makes sense. . . our mission overlaps with numerous organizations. The problem is that so many have approached us. Given that many AACCP members are associated with the American Orthopsychiatric Association and vice versa, it should not be surprising that we have come together to offer an excellent opportunity for our members and future members. **If you don't know, there is now a dual membership opportunity for both of these organizations—You will receive 20% discount for joining both organizations. . . membership dues are \$204.00 to join both.**

In the Winter Issue of the American Orthopsychiatric Association newsletter, *Ortho Bulletin* (February 2007), the editor, Jessica Tartaro, MA, interviewed our own Wes Sowers. Now, AACCP interviews **Ortho's President, Dr. Diane J. Willis.**

Diane J. Willis, PhD

- Professor Emeritus, Department of Pediatrics
University of Oklahoma Health Sciences Center (OUHSC)
- Consultant, Indian Health Service
- Former Director, Psychological Services and Training at the Child Study Center, OUHSC
- Former journal editor of the *Journal of Clinical Child Psychology*
- Founding editor of the *Journal of Pediatric Psychology*
- Former President, Oklahoma Association of Infant Mental Health
- Past consultant, Zero to Three
- Former member, American Indian Advisory Group in the Center on Alcohol Research, OUHSC
- Former president of several divisions within the American Psychological Association
 1. Society of Clinical Psychology
 2. Psychotherapy
 3. Society of Pediatric Psychology
 4. Society of Clinical Child Psychology
 5. Children, Youth and Families



AACP: *Could you describe the mission of Ortho to our members?*

DJW: I am pleased to respond to questions about the American Orthopsychiatric Association. Ortho and its journal was the brainchild of Karl Menninger, M.D. in the 1930's. Thus, we have almost an 80 year history of advocating one simple but revolutionary idea—that the mental health of people depends, to a great degree, on the environment in which they live and how they are treated in that environment. Ortho's purpose, as spelled out in our by-laws, states that "The Association is a multi-disciplinary organization designed to facilitate the generation and exchange of knowledge

relevant to the development and implementation of policies and practices consistent with the promotion of mental health and social justice, including the protection of human rights." If you look at the wonderful and distinguished history of Ortho, this organization did much in the 1960's and 1970's to advocate for community mental health centers as opposed to large mental hospitals, promoted models for returning psychiatric patients to the community, and advocated for cooperative apartments patients with mental illness.

Similar to community psychiatrists, members of Ortho focus on community at home and abroad. With the World Health Organization's (WHO) estimate that 450 million people around the world suffer from mental or behavioral problems, all of us have a vested interest in protecting human rights to help prevent mental disorders. On an international level Ortho's past-president, Gary B. Melton, Ph.D, is truly an international human rights advocate. Dr. Melton has helped to develop, internationally, regional centers on children's rights and children's policy issues, and he is the driving force within Ortho now for us to take an international focus. At the community level, Ortho also focuses on health promotion and preventive intervention programs in the schools. Early intervention and prevention is paramount in preventing serious disorders later in a child's life.

Community psychiatrists are urged to review the Table of Contents and articles published in Ortho's journal, *The American Journal of Orthopsychiatry*, to get an idea of Ortho's focus. Journal articles are submitted by psychiatrists, psychologists, social workers, public health workers, lawyers, and nurses. These professions also reflect Ortho's membership, which also includes pediatricians and sociologists—a truly multidisciplinary organization.

A number of psychiatrists have served as President or members of the board of Ortho. These distinguished individuals include Dick Gross, Joel Feiner, Judith Landau, Ira S. Lourie, Joe Yamamoto, Eli Newberger, Chester Pierce, Bertram Brown, Ezra Griffith, and Harold M. Visotsky to name a few.

AACP: I'm curious how you approach advocacy in Ortho?

DJW: Currently we provide a liaison to a consortium on mental health issues in Washington, D.C., work with the Academy of Pediatrics on issues relating to health coverage for disadvantaged and uninsured children, focus on mental health issues involving immigrants and the homeless, and occasionally testify before Congress on mental health issues. We are also in the process, perhaps this next year, of enlisting the services of a Washington-based Fellow who might work with international organizations to monitor mental health issues. Several of our Board and Ortho members work through other organizations such as APA's Public Policy Office, to advocate for Early Head Start, Head Start, mental health parity, poverty related issues, etc.

AACP: Can you describe the kinds of annual events that Ortho hosts?

DJW: Ortho hosts a summer institute during one week of the Cape Cod Institute (CCI) in Eastham, Mass, and one day of workshops/symposia and awards presentations at APA's Institute of Psychiatric Services. As an example of Ortho's awards, at APA in San Diego last year we presented the Hayman Award to Ferid Agani, M.D., a psychiatrist who is a member of parliament of Kosovo. Dr. Agani received the award for his development of a system of mental health services to facilitate the recovery of people traumatized in the civil war in Kosovo. He is an Assistant Professor of Neuropsychiatry at the University of Prishtina. Ortho and its board are also in the process of planning a conference focusing on American Indian Mental Health issues in 2008 and another on Mental Health and Human Rights.

The Ortho Summer Institute focus in 2006 was on "Caring for Children in Schools, Health Clinics, Places of Worship, and Other Community Settings." The 2007 focus is on "Trauma and Violence: Prevention, Intervention, and Treatment". Speakers this year include national and internationally known psychiatrists, psychologists, social workers, a sociologist and a lawyer. The dates are June 25-29, 2007 and participants receive 15 hours of CEU (see www.cape.org, click on Ortho and view the program.)

AACP: What would you say are the most important elements of creating a transdisciplinary spirit in mental health services?

DJW: Ortho has a long history of fostering collaborative research as viewed in our journal publications. The conference programs sponsored by Ortho always bring together

interdisciplinary groups and provide a forum for an exchange of ideas. Ortho's focus is on the common values and common advocacy interests that cut across all disciplines. This is what drew me to Ortho. For example, as a pediatric/clinical child psychologist in both a Dept. of Pediatrics and Dept. of Psychiatry and Behavioral Sciences, I have enjoyed my work and collaboration with physicians, social workers, physical therapists, teachers, speech pathologists, and others over the years. I have learned from all the professions, published with some, read articles from various journals, and find commonality with them. For example, in the area of child abuse I began the first Child Protection Committee at Children's Hospital of Oklahoma in the 1970's, right after the child abuse law was first passed. It was my recommendation to the Chair of the Dept. of Pediatrics that he appoint a pediatrician as Chair of the committee and I became the Vice Chair. We had on the committee multiple disciplines all devoted to protecting children, trying to strengthen families, providing them with resources they lacked, going to court when necessary and working with attorneys, judges, and the police. The supraordinate goal of the various disciplines was not a 'punitive' goal but one of protecting children and strengthening families. One discipline could not do this alone—we broke down barriers and everyone learned to respect and appreciate, or at least understand, what the other disciplines had to offer. Professionals who work in communities where there are large pockets of poverty and disadvantage reach out to each other and do not play the turf game, or at least I hope they do not. We all need each other, and the people in the community whom we serve certainly need us. Having consulted on Indian reservations, I experienced that it is not unusual to work with physicians, nurses, teachers, elders, employment specialists, law enforcement, mental health tech's, substance abuse counselors, dietitians, and others to try to remedy problems of suicide, depression, domestic violence, child abuse (mainly neglect), and mental health problems accompanying poverty and health related disorders such as diabetes and CVD's. One can really see various disciplines working with each other.

AACP: Are you a member of AACP?

DJW: Yes, I am a member of AACP as of 2006 when Ortho and AACP developed a joint membership fee. I attended the New York meeting and found it to be very good. I enjoyed the programs and the poster sessions and found them to be intellectually stimulating. I have been involved with Ortho for many years, and when Ortho had national conventions I attended and even presented at a couple of them. I value very much the interdisciplinary nature of Ortho and the wealth of information we can glean from social, cultural, biological, psychological, and legal perspectives as we continue to foster practice, research, and social policy agendas and publications.

As President of Ortho I hope that community psychiatrists will take advantage of the joint Ortho/ACCP membership and become involved in Ortho's leadership. See www.amerortho.org for joint AACP/Ortho membership information!!



Intensive Psychotherapy More Effective Than Brief Therapy for Treating Bipolar Depression

Patients taking medications to treat bipolar disorder (<http://www.nimh.nih.gov/healthinformation/bipolarmenu.cfm>) are more likely to get well faster and stay well if they receive intensive psychotherapy, according to results from the Systematic Treatment Enhancement Program for Bipolar Disorder (STEP-BD), funded by the National Institutes of Health's (NIH) National Institute of Mental Health (NIMH). The results are published in the April 2007 issue of the Archives of General Psychiatry.

Bipolar disorder is a debilitating illness marked by severe mood swings between depression and mania that affects 2.6 percent of Americans in any given year. "We know that medication is an important component in the treatment of bipolar illness. These new results suggest that adding specific, targeted psychotherapy to medication may help give patients a better shot at lasting recovery," said NIH Director Dr. Elias A. Zerhouni.

"STEP-BD is helping us identify the best tools — both medications and psychosocial treatments — that patients and their clinicians can use to battle the symptoms of this illness," said NIMH Director Thomas R. Insel, M.D.

Psychotherapy is routinely employed as a means to treat bipolar illness in conjunction with medication, but the extent to which psychotherapy is effective has been unclear. In addition, most psychotherapeutic studies have been limited to a single site and compared only one type of treatment to routine care. Thus, in addition to examining the role of medication, STEP-BD set out to compare several types of psychotherapy and pinpoint the most effective treatments and treatment combinations.

With 293 participants, David Miklowitz, Ph.D., of the University of Colorado and colleagues set out to test the effectiveness of three types of standardized, intensive, nine-month-long psychotherapy compared to a control group that received a three-session, psychoeducational program called collaborative care. The intensive therapies were

- family-focused therapy, which required the participation and input of patients' family members and focused on enhancing family coping, communication and problem-solving;
- cognitive behavioral therapy, which focused on helping the patient understand distortions in thinking and activity, and learn new ways of coping with the illness; and

- interpersonal and social rhythm therapy, which focused on helping the patient stabilize his or her daily routines and sleep/wake cycles, and solve key relationship problems.

All participants were already taking medication for their bipolar disorder, and most were also enrolled in a STEP-BD medication study reported in the *New England Journal of Medicine* on March 28, 2007 (<http://www.nih.gov/news/pr/mar2007/nimh-28.htm>). The researchers compared patients' time to recovery and their stability over one year.

Over the course of the year, 64 percent of those in the intensive psychotherapy groups had become well, compared with 52 percent of those in collaborative care therapy. Patients in intensive psychotherapy also became well an average of 110 days faster than those in collaborative care. In addition, patients who received intensive psychotherapy were one and a half times more likely to be clinically well during any month out of the study year than those who received collaborative care. Discontinuation rates among the groups were similar — 36 percent of those in the intensive programs discontinued and 31 percent of those in collaborative care discontinued. None of the three intensive psychotherapies appeared to be significantly more effective than the others, although rates of recovery were higher among those in family-focused therapy compared to the other groups.

"Intensive psychotherapy, when used as an adjunctive treatment to medication, can significantly enhance a person's chances for recovering from depression and staying healthy over the long term," said Dr. Miklowitz. "It should be considered a vital part of the effort to treat bipolar illness."

The National Institute of Mental Health (NIMH) mission is to reduce the burden of mental and behavioral disorders through research on mind, brain, and behavior. More information is available at the NIMH website, <http://www.nimh.nih.gov>.

The National Institutes of Health (NIH) — The Nation's Medical Research Agency — includes 27 Institutes and Centers and is a component of the U.S. Department of Health and Human Services. It is the primary federal agency for conducting and supporting basic, clinical and translational medical research, and it investigates the causes, treatments, and cures for both common and rare diseases. For more information about NIH and its programs, visit www.nih.gov.



NAVIGATING A CONFUSING GENERIC MEDICATION MARKET

Benjamin Crocker, MD

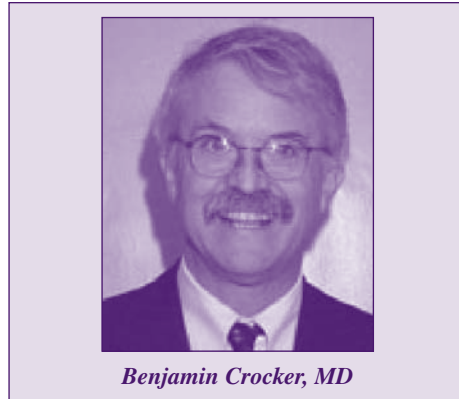
Taking Matters into my Own Hands

Last year, with the help of some of my colleagues in the Maine DB, I constructed spreadsheets to show the differences in planned utilization management for psychiatric and other common medications in the various Medicare D plans with premiums low enough for them to be assigned patients with Medicaid. Eventually I got these posted on the websites of some smaller national psychiatric organizations, and a downscaled version of these spreadsheets for 2007 is posted on our DB website. I made t-shirts with the spreadsheets on them, projected them at meetings, and did posters. But there was not much interest from other clinicians; one or two people in Maine used them, and I frequently showed them to my patients to illustrate that they have choices regarding plans. The patients were generally quite interested, and this has continued to motivate me to help them understand their choices under Medicare D.

Most of the patients I see as a consultant get their prescriptions, psychiatric and otherwise, from primary care providers. By and large the people I see who have Medicare and Medicaid do not know that they could change plans or appeal formulary or utilization management denials. Giving them a copy of a spreadsheet demonstrating their choices is fast and does not require internet surfing, though I try to encourage them to confirm what the spreadsheets say, since the data can change, and thus far posted UM data on the Medicare D website has been unreliable.

Patients (or Patience??): Medicare without Medicaid AND the Donut Hole

But a lot of the people I see have Medicare without Medicaid, and many of these people are poor, but do not know if they could qualify for one of a variety of Medicare subsidies. They cannot change plans except for the brief period from mid November till the end of the year, so showing them plan comparisons



Benjamin Crocker, MD

is not helpful; they have to learn to live with the plan they have. I refer them to state-affiliated agencies in Maine that help people apply for Special Help, as federal subsidies to Medicare D beneficiaries is called. But in the meantime, they sometimes pay fairly substantial amounts for their medications, especially when they are in the donut hole, as many of them were last fall and will be again next year if they do not qualify for the extra subsidies.

Patients: The Uninsured and the Competitive Shopper

And then there are the uninsured, which have to subsist on generics and samples or drug company Pharmaceutical Assistance Plans (known as PAPs).



Until recently, I heard stories of people paying over \$100 for a one-month supply of brand SRI, or almost that much for a generic. They rarely went back for another month's worth.

Then I started hearing about \$4 generics at Wal-Mart and Target, and the social workers at clinics I worked at told me about mail-away programs, costing 20 or 30 dollars for a three-month supply that called themselves PAPs and have income limits, RxOutreach and Xubex. I had already checked out the US internet market for generics, and generally found the best prices at Costco, which was offering several generics for \$10/hundred pills, and venerable K-Mart offers a smaller list for \$15 for three months without quantity limits. I have heard that some

chain pharmacies will meet the other big box prices if asked.

For as long as I can remember, I knew that certain entities like hospitals and Federally Qualified Health Centers (FQHC) could sell generics for way below the retail price through some kind of government sanctioned plan. But these prices were not available to people who were treated in the freestanding clinics I saw them in. And it seemed to me that in recent years, generic prices had started to go up a lot. Now they were coming down.

Don't Believe Me! Do Your Own Research. . . . It's Easy

I had heard that last year some medications were cheaper outside some of the Medicare D plans, and since my UM project had not generated much interest, it occurred to me that comparing Medicare D drug prices (now looking at the unsubsidized people who had to pay variable 25% copay and the whole plan price in the donut hole) to these new low prices for generics would be interesting.

It is pretty easy to type in a list of 25 medications you are interested in (including as many dosage forms as you like) on the Medicare D site, and save the list with a date you pick that serves as a kind of password and a file number the website assigns to your list. Then at your leisure you can look at how the various PDPs in your region price the medications you are interested in. For instance, I made a list of generic psychiatric medications in PDP Region 1 (Maine and New Hampshire) with the file #811219533 and password September 11, 1995, that the reader could find with a few clicks and brief entries on the Medicare D website. (See box for detailed step-by-step instructions.) For anyone who has not constructed such a list or otherwise plumbed the mysteries of this website, I recommend trying to do this, if only to experience what our patients are expected to do if they wish to be informed consumers and make the elaborate market that has been constructed for them actually function. It takes about 5 minutes, working through 10 or 12 successive choices, starting with the top choice on the Medicare D opening page "compare plans". My impression is that most of my colleagues find this too tedious to do. But it is not much harder

(Continued next page)



than buying an airline ticket on the internet. Once you get to the individual plan versions of the list you are looking at, you can save the URL of each PDP version of the list you look at in your web browser's favorite places, and pull it back up later in a couple of clicks. A list of the URLs for all the PDPs in a region could easily be sent around for those who are not willing to make or look up the lists in the first place.

While in many plans a number of generic medications are more expensive when purchased at pharmacies in the donut hole at the Medicare D price compared to one of the bargain alternatives, this becomes less frequent when the Medicare D comparator price is for mail-away programs, which for most plans offers substantial savings. Still, some generic medications, like sertraline and paroxetine, are often so much more expensive at the Medicare D plan price than the alternative sources that even the 25 % copay is more than the total alternative source price, and the mail price remains several times the alternative source price. For these and a few other medications, patients can clearly save by buying at a different price, regardless of the source.

For many other medications where the Medicare D price is only 20% or 30% more than the alternative price, other issues need to be taken into account. If a patient has few medication costs and is not likely to reach the donut hole, buying in the plan is usually cheaper except for a few exceptional cases like the SRIs mentioned above. For the patient just entering the hole in October,

the other side of the hole is not likely to be seen, so true out of pocket expenses (TrOOP) is a moot point, and by buying outside of Medicare D before they get to the hole they can stretch the initial coverage, saving it for medications that are not available at bargain prices. If a patient enters the donut hole early in the year, the issue of TrOOP can make a difference if the prices are close, a few dollars different. For a patient with high drug costs who is likely to make it to the other side of the hole long enough to benefit from the 95% catastrophic coverage, TrOOP helps speed transit through the hole. To cut to the chase, as I understand it, you get TrOOP if you buy in person at one of the big box pharmacies (which generally charge Medicare D a price lower than the PDP price and this a lower copay for the patient), and you don't get TrOOP from one of the "PAPs" that charge "administrative fees" like RxOutreach and Xubex. (You can get TrOOP credit for "copays" you may make to other PAPs and for certain charitable contributions to your medication needs.)

Boring—who cares? This is Crucial Information and We Need to be Proactive for our Patients!

By now many readers have probably glazed over, and I expect to get feedback again that I am boring people with arcane details. My point in insisting on going on about this is that this is what all Medicare beneficiaries are expected to understand, if in fact market forces are supposed to be making Medicare D work. Market forces are playing a role in the current state of selected cheap generics, and many effective psychiatric medications are now available for much lower prices than just a few years ago. For my patients, saving a few hundred dollars a year is a big deal, saving 50 or 60 dollars on one prescription, as the above information may allow them to do for commonly used medications like sertraline or paroxetine, is quite a big deal. For some of my uninsured patients, the availability of a one-month supply of an SRI for less than the cost of a pack of cigarettes is also a big deal, especially as samples for the few remaining brand-only antidepressants are more rapidly depleted.

CMS has discouraged physicians and clinicians generally from advising patients about the details of Medicare D, and my impression is that they generally don't do it. While State Insurance Health Plans and other volunteer and semi-governmental agencies work hard trying to get the word out about available subsidies and choices, for a lot of patients, clinicians are still the main point of contact with the healthcare "system". My patients often appreciate advice about their choices regarding Medicare D and the price of medications, and a high percentage of them are not well informed about this. Most of the primary care clinics I work with do not have systematic ways of educating patients about how to obtain medicine.

(Continued next page)

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Board Member News

Neal Adams, MD, MPH, one of our Representatives at Large, currently serves as Director of Special Projects for the California Institute of Mental Health. Dr. Adams will be leaving the board to focus on other activities. AACCP wishes to thank Dr. Adams for his contributions and dedication to AACCP. . . . now, past, and future.



Dr. Neal Adams



Understanding the details of Medicare D is tedious, but it is not rocket science or brain surgery. You don't have to have a MD to do it, but MDs are capable of doing it, just like we can draw blood, remove fecal impactions, sew up lacerations and take careful social and substance abuse histories. Nowadays we increasingly supervise or delegate to the people who actually do these things, but we cannot effectively lead people to do things we cannot do or understand ourselves.

There are many other aspects of the medication market that have to be taken into account as we move into this new phase of competitive generics. Some patients have different responses to different generic or brand name forms of the same medication, and even among brand medications there have at times been quality issues leading to recalls, as in the case of paroxetine

CR in 2005. Benzodiazepines are available via mail across state lines from some programs at low prices, possibly hampering state efforts to track prescribing patterns. The huge informal market that recycles prescription medications whose initial purchase has in the past usually been financed by third parties is more price sensitive to the degree that initial purchases switch to cash to avoid third-party scrutiny, so we might expect issues to arise regarding diversion of inexpensive mail order medications. The 90 day mail prescription that is least expensive per pill may be clinically risky, or even wasteful if the medication is changed. As prescribers we must demonstrate both to our patients, and to the state and federal authorities who sanction our shrinking monopoly on prescribing that we are aware of and ready to deal with these issues.

How to Use the Generic Psychiatric Medication Spreadsheets

Benjamin Crocker, MD

The attached Spreadsheets are intended to get people interested in finding out more about the prices of medicines they buy. The prices they list were recorded in the winter of 2007, and probably will change—the lists are offered as examples, not gospel. You will do well to check current prices by either calling the pharmacies or looking their formularies up on the internet or getting them to mail you copies.

What I want people to see is that the prices for these medicines are different in different places. Sometimes there are big differences. Because people have a choice of where to buy their medicines, knowing how to find the best price is important.

If you were going to buy gasoline or bananas, you would expect to see prices posted. Most shoppers would not buy \$6 gas or \$2 bananas. The way medications are sold now, it would be like people buying gas without asking what the price was first, with one station selling it for \$2 a gallon, the next one \$4 a gallon and then one down the road for \$1. People are not used to shopping for medication prices like they are for other things.

Of course, if someone puts up a sign that they were selling gas for 29 cents a gallon or bananas for 10 cents a pound you might wonder what they were really selling. There are differences between different suppliers of generic medications. In general these are slight and the federal government requires that all generic medications sold in the US meet certain standards. Sometimes one might work better than another and sometimes an expensive brand-name medication works best. Usually a car or a boat will get you where you need to go, but sometimes you need an ambulance or an airplane.

I have made these spreadsheets to compare plans that are similar, for similar amounts of medication. Some of these plans are limited to just certain amounts and priced by the number of pills. Other plans cover a period of time with pretty much whatever number of pills you need. I have put these two kinds of plans on different sheets.

I have put some medications that are not covered by Medicare D on these sheets. The most common medicines that Medicare D will not cover are medicines like Xanax or Klonopin or Ativan. If you do not have other insurance, you will have to pay for these medications yourself. The Medicare D plans will sell them to you with no insurance benefit, but they are often cheaper elsewhere.

If you or your adviser would like to use the internet to find out more about medication prices, see the Medicare D Planfinder in this newsletter and websites below.

Kmart <http://userpages.chorus.net/harve/whs.htm>

RxOutreach <http://www.rxoutreach.com/>

Xubex http://www.xubex.com/contact_us.shtml

Costco <http://www.costco.com/Pharmacy/finddrugs.asp?log=&rxbox=&fromscript=1>

Target http://sites.target.com/images/pharmacy/pharmacy_4dollar_program_list.pdf

Wal-Mart <http://i.walmart.com/i/if/hmp/fusion/genericdruglist.pdf>

How to Make and Find a Medicare D Planfinder List of Medicines

1. Go to the Medicare Website www.medicare.gov
2. On the front page at the top of the main "Medicare Spotlight" click on the top choice "Compare Medicare Prescription Drug Plans"
3. On the next page on the left, click on "Find and Compare Plans"
4. On the next page on the right, click on "Begin general search"
5. The next page announces step 2. You put in your zip code and answer all 3 questions "no". (This assumes you are looking for the unsubsidized prices). Then click "continue."
6. The next page announces step 3, Review Current Coverage and Consider options. Just hit "continue." Trust me, this page has nothing worth looking at.
7. OK, now we are getting there. This next page invites you to "enter my drugs". If this is your first time, hit this button at the top; if you have already entered a list, put in its file number, which you should have saved, and its identifying date. Now hit "retrieve my drugs".
8. Assuming you hit "enter my drugs" you now are on a page titled, Find and Compare Plans, and below that Find and Enter Your Drug Information. Below that is a box titled "enter drug name". You can do this by typing it in or choosing from a drop-down list. I prefer the former as I am used to typing out drug names, and if you can do this it is faster than waiting for the alphabetized lists of meds to load. If you are not a good typist or would simply like to shop the lists, you can select from the drop-downs. In general you should use the generic name for drugs sold generically and the brand name for drugs that are brand only. If you enter the brand name for a medication that is available as

(Continued next page)



a generic, your list will usually find the generic for you. Sometimes it will list both the generic and brand version of a drug if you enter both the brand and generic names, but not always; this may have to do with the fact that not all brands and their generics cover the same dosage strengths, but I don't really know why this is. The planfinder tends to go with the generic listing, especially with older medications. So don't be surprised if an old brand name that you enter does not make it to the final plan-specific lists that you will soon see. There are some points of confusion when a drug is beginning to enter the now rather drawn out process of becoming generic, so always try both names (or more, in the case of meds that change their brand name like Razadyne or where there are 2 brands of the same molecule). The planfinder is still a bit slow on the draw in picking up new brands that the plans are covering, so if you are looking for a very new drug you may have to get the information about price and UM directly from the plan, or from the drug's detail staff..

9. When you have entered all the drugs you want to follow, up to 25 of them, hit "save my drug list". The next page will ask you to enter a date. You can pick any date from 1900 onward. Please note that this date will be a password when you return to see your list. Do this, then hit "continue".
10. Now comes a page you will want to print, or at least carefully copy the drug list ID number and date you have chosen, as you will need it to get back to your list. You can save this in your "My Medicare" account if you have one. (I think you have to be a Medicare beneficiary to have such an account.) When you have made one or more copies of this important number and date, hit continue.
11. The next page offers you the choice of selecting a particular pharmacy or not. The green-titled box at the left of the page advises to not choose a particular pharmacy, so as to see the lowest plan prices, since these vary from pharmacy to pharmacy. (This is not the whole story, as it does not seem to be taking into account the big-box prices that are offered within Medicare D that you get TrOOP credit for.) So click the "no" button here and hit continue.
12. Now you have arrived in the land of data. The left top of the page announces Your Personalized Plan List. Scroll down to see all of the PDPs in your region, or there are links at the top of the page to the Medicare HMOs—this year called Medicare Health Plans, and Special Needs Plans. Selecting favorites puts them at the top of the page and you call up three plan comparisons if you want; they are arrayed 5 at a time by default. I usually like to call up the whole list so I can scroll around looking for what I want. The order of appearance is by the total cost of all the drugs you have chosen, so this will vary with each list you enter.

It seems that the vast majority of Medicare D recipients are in a few large national plans. If you start looking at plans, chose the ones that your patients tend to be in, not the obscure marginal ones that have flocked to the market because of the initial subsidies. Before you start surfing around on your list, print the whole list off. This process will give you another chance to save your ID number and date, at the top left, and will tell you how many of the PDPs operating in your region are currently being listed by the Medicare site. For somewhat obscure reasons, Medicare may remove major players from the site for periods of time. Of note, this happened a good deal in 2006 and it is happening this year. If a big plan like Humana is not showing up on your list, do not think that it has gone out of business; if you want info about it you will have to go directly to the plan until it appears again. You can check what the full number of plans is in your region in other areas of the Medicare D site, and if the number of plans your list is pulling up is less than that, it means that some of the plans are doing some time in the woodshed.

View your list in the domain of a particular plan by clicking the plan name on the left. This will take you to a long "page" with the plan contact information at the top, a link to the plan website in case you want to check their formulary directly, and a comparison of the cost of the medications on your list in-store and through mail order, if the plan does mail order (most do). Then it lists the UM edits for the drugs on your list, followed by the prices, listing "full price" initial period copay, donut hole price and catastrophic coverage prices. The mail prices are easy to miss because for some reason you have to hit the + sign next to the mail price title that follows the in-store price list to get these prices to drop down. This is a very odd design flaw in this otherwise pretty amazing database, but so be it. Hit the + sign to see the mail prices. And if you want to print them out along with the rest of the information for the plan, here is a tip: at the top left of each plan list is a button, Print this Page. Hit the button and the page will transform into something like a PDF. The print box will drop automatically. CANCEL it. THEN on this new form of the list, scroll down until the mail prices appear, or hit the + sign to make them appear when you get to that title. THEN hit control P or otherwise call up the print box. I have found that if you print from the automatic print box, the mail prices usually will not print, even if you have quickly hit the plus sign and caused them to drop down on the displayed print friendly page You can save time and paper if instead of printing out the whole list, now 8-12 pages long, you only select about the first 2/3 of the pages (this will vary according to the length of your list, including dosage sizes and whether the plan has a mail system). So for instance, I usually select pages 1-8 out of 12 to be printed. The last few pages show the dosages and graphs of the costs that may be of interest to individual patients, but are not that useful if a provider is using this process mostly to monitor the prices. Saving a few pages with each printout makes a difference, if like me, you decide to print the prices for every plan in your region, usually over 50. I do this because I am doing research on this stuff and I never know when a plan will be banished from the Medicare website which may render the data inaccessible.

Before you leave the long page for the plan you have been looking at it, do the following: 1) Save it on your favorite places and make a folder for these URLs so you can find them easily; 2) Remember to title each one as you save it since the default names for these pages are all the same. You have to type in the name of the plan. This is worth it, at least for the common plans, because then you can find each plan page displaying one of your lists with a double click from your favorites list while you are connected to the internet, without having to go through the Medicare D site or all of the above pages again. (To get to the list of all the plans in your region you do have to go through the process. . .entering your ID number and date-password at step 7. This process does not take long at all.)

Once you have entered your list of 25 or fewer medications, you can easily modify it from any of the plan pages, adding meds if you have not used your full 25 slots, adding an unlimited number of dosage sizes, or removing meds and replacing them with others. I use 4 or 5 lists at the moment, for common generic, common brand, and other special groupings of psych meds. Curiously, the planfinder lists medications that are not Medicare D drugs, like benzos, with prices. As such, I have a benzo list, too. By and large, 2 or 3 lists should suffice for most prescribers. Lists of plans can be shared once entered by sharing the ID number and date and single plan specific medication lists can be shared by passing their URLs around. Please keep in mind, however, that these lists can be changed by anyone signed on to them. If you share your list, decide on a convention regarding changes. Once you get the hang of this, punching in 25 drugs does not take very long.

Ninety days of Medication

Administrative and mailing fee in dollars. Xubex and RxOutreach have Income Limits. Some medications in the 30-dollar tiers have limited quantities. Check plans for details K-mart plan is for in-store pickup, others are mail order, but in all cases your doctor would need to prescribe 90 days supply for you to use these plans. Prices winter 2007.

K-MART: <http://userpages.chorus.net/harve/whs.htm> 1-800-866-0086

RxOutreach: www.RxOutreach.com 1-800-769-3880

Xubex: www.xubex.com (866) 699-8239

Pharmacy		Xubex 90 days	K-Mart 90 days	RxOutreach 90 days
Medication	Brand Name	Benzo QL		
Alprazolam	Xanax	30	no	30
Amitriptyline	Elavil	20	15	20
Benzotropine	Cogentin	20	15	20
Buspirone	Buspar	20	15	20
Carbamazepine	Tegretol	20	15	20
Citalopram	Celexa	20	no	20
Clonazepam	Klonopin	30	no	30
Clonidine	Catapres	20	15	20
Diazepam	Valium	30	no	30
Doxepin	Sinequan	20	15	no
Fluoxetine	Prozac	20	15	20
Fluphenazine	Prolixin	20	no	no

<i>Ninety Days of Medication continued</i>				
Pharmacy		Xubex 90 days	K-Mart 90 days	RxOutreach 90 days
Medication	Brand Name	Benzo QL		
Gabapentin	Neurontin	20	no	20
Guanfacine	Tenex	no	no	no
Haloperidol	Haldol	no	no	20
Hydroxyzine	Atarax	20	15	no
Lithium Carbonate	Lithum Carb.	20	15	20
Lorazepam	Ativan	30	no	30
Mirtazepine	Remeron	30	no	20
Nortriptyline	Pamelor	20	15	20
Paroxetine	Paxil	no	no	30
Sertraline	Zoloft	no	no	30
Temazepam	Restoril	30	no	30
Thioridazine	Mellaril	no	no	no
Trazodone	Desyrel	20	15	20
Trihexyphenidyl	Artane	20	15	no
Thiothiense	Navane	no	no	no

QL means number of pills is limited for each 90 day period
Compiled by Benjamin Crocker, MD comments to Benjamin.Crocker4@att.net

"Full" Cost Prices for specific amounts of Generic Medications in Discount and 4 of the 53 Medicare D Plans.

This sheet shows approximate prices these Medicare D plans charge in the Donut Hole. For your copays during the initial benefit allowance, see the Medicare Website Planfinder. THE MEDICARE D PRICES QUOTED ARE FOR MAINE AND NEW HAMPSHIRE: for other plans see the Medicare Website Planfinder Pricing Comparison is for selected generic psychiatric medications. With a few exceptions as noted, prices are for 30 pills. Costco prices are for 90 or 100 pills. Benzodiazepine medications such as alprazolam and clonazepam are NOT part of Medicare D formularies, but Medicare D plans will sell them at these prices, according to the Medicare Planfinder. Target and Walmart prices for drugs that are not part of the \$4 programs can be gotten by calling these pharmacies. MANY PHARMACIES WILL MEET A COMPETITOR'S DOCUMENTED IN-STORE PRICE, BUT ONLY IF YOU ASK FOR IT. Costco is a leading example of US internet pharmacies, some of whom also have in-store pharmacies. Prices are subject to change at any time, these prices were taken from the Medicare Planfinder in early 2007. Most in-store pharmacies participate in Medicare D and can credit your purchase to TrOOP. For Prices for 90-day prescriptions that mostly do not limit numbers of pills and offer more dose sizes, see the reverse of this page.

Pharmacy	Dose	Number of pills	Wal-Mart	Target	AARP	Cigna Value	Advantra Rx Value	Humana Std	Costco 100 pills/\$10 \$=see next column	Costco other prices 100 or 90pills
Medication			Brand Name		In store/mail	In store/mail	In store/mail	In store/mail		
Alprazolam	1 mg	90	Xanax	?	74.74/72.74	74.49/73.32	74.89/73.24	74.74/72.74	.5, 1mgs	
Amitriptyline	100	30	Elavil	4	6.28/4.28	3.78/2.03	4.15/2.04	3.97/1.97	25,50,100mgs	
Benzotropine	2	30	Cogentin	4	6.35/4.35	4.11/2.94	6.14/3.58	5.89/3.89	no	
Buspirone	10	60	Buspar	4	11.16/9.16	9.41/8.25	45.70/34.03	9.34/7.34	5,10mgs	
Buspirone	30	30	Buspar	?	59.78/57.78	34.82/33.66	30.46/22.30	23.35/21.35		
Carbamazepine	200	60	Tegretol	4	9.67/7.67	6.10/4.35	6.66/3.97	7.42/5.42	200 mgs	
Citalopram	40	30	Celexa	4	12.88/10.88	6.12/4.37	5.45/3.04	8.40/6.40	20,40mgs	
Clonazepam	1	30	Klonopin	?	19.96/17.96	19.71/18.54	20.11/18.46	19.96/17.96	\$	2mg \$22.34
Clonidine	0.2	30	Catapres	4	5.15/3.15	4.82/3.65	5.15/2.81	5.54/2.54	.1, .2mgs	
Diazepam	10	30	Valium	?	23.35/21.35	23.10/21.93	25.30/21.85	23.35/21.35	2.5 mgs	
Doxepin	100	30	Sinequan	4	6.49/4.49	5.38/3.63	6.44/3.80	6.05/4.05	25,50,100mgs	
Fluoxetine	20	30	Prozac	4	12.93/10.93	9.53/7.78	8.23/5.19	10.20/8.20	10,20mgs caps	
Fluphenazine	1	30	Prolixin	4	6.64/4.64	4.34/3.17	11.29/7.54	5.55/3.55	no	
Gabapentin	400	30	Neurontin	?	40.25/35.53	40.68/34.40	9.56/6.20	35.35/21.44	\$	
Gabapentin	300	90	Neurotin	?	78.22/76.22	99.08/86.01	22.89/16.47	85.39/53.61	\$	300mg\$14.28
Guanfacine	1	30	Tenex	4	13.51/11.51	5.73/4.56	8.56/5.44	11.18/9.18	1mg	
Haloperidol	5	30	Haldol	4	6.82/4.82	5.82/4.07	6.59/3.92	5.64/3.64	.5, 1mgs	
Lithium Carbonate	300	90	Lithum Carb.	4	7.45/5.06	13.91/12.16	7.41/4.55	15.16/13.16	300mgs	
Lorazepam	2	60	Ativan	?	27.06/25.06	26.81/25.64	27.21/25.56	27.06/25.06	\$	2 mgs \$19.82
Mirtazepine	30	30	Remeron	?	27.26/25.26	10.90/9.15	12.65/8.59	20.86/17.19	\$	30 mgs\$33.62
Nortriptyline	25	30	Pamelor	4	6.13/4.13	3.62/1.87	22.18/18.64	4.43/2.43	10,25mgs	
Nortriptyline	75	30	Pamelor	?	7.12/5.12	4.95/3.20	6.18/3.61	5.89/3.89		
Paroxetine	20	30	Paxil	4	23.94/21.94	20.88/19.13	21.59/15.47	30.20/28.20	\$	\$\$\$\$\$\$
Sertraline	50	30	Zoloft	?	61.50/59.50	58.77/57.60	57.65/43.24	59.02/36.66	\$	\$\$\$\$\$\$
Sertraline	100	30	Zoloft	?	61.50/59.50	58.77/57.60	57.65/43.24	59.02/36.66		
Temazepam	30	30	Restoril	?	24.08/22.08	23.83/22.66	24.23/22.58	24.08/22.08	\$	30 mgs 21.51
Thioridazine	25	30	Mellaril	4	10.68/8.68	6.81/5.64	7.02/4.25	8.10/6.10	no	
Trazodone	100	30	Desyrel	4	8.22/6.22	5.12/3.37	7.62/4.71	6.13/4.13	50,100mgs	
Trihexyphenidyl	2	30	Artane	4	5.69/3.69	4.68/3.52	4.70/2.47	4.51/2.51	2mgs	
Thiothiense	2	30	Navane	4	7.60/5.60	5.94/4.19	6.03/3.47	6.26/4.26	2mgs	

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The American Association of Community Psychiatrists (AACP) was formed in October 1984. The impetus came from a group of community psychiatrists who began sharing their interests and concerns at the May 1984 American Psychiatric Association Meeting and at many local psychiatric meetings. We found that community psychiatrists are a concerned, dedicated, energetic, and an underrepresented group. Our concerns had not been adequately addressed in other professional organizations, which often had other priorities.

The AACP has the following purposes:

- Promote and maintain excellence in the care of patients through the organization of psychiatrists practicing community mental health on state, regional and national levels.
- Help clarify and solve mutual problems commonly encountered by psychiatrists in community settings.
- Inform and educate the public about the role of the community health system in the care of the mentally ill.
- Establish liaisons with related professional organizations to advocate for relevant public policy issues.
- Promote cooperation between psychiatrists and other professional, paraprofessional, and consumer groups involved in mental health care.
- Encourage training and research in psychiatry which will increase the number of committed psychiatrist in community settings.