SAMHSA Helps the Refugee Psyche Recover from Tumult and Loss

The thousands of Cuban, Amerasian, Vietnamese, and Soviet Jewish refugees who have come to the United States in recent years form a special constituency of the Public Health Service's Substance Abuse and Mental Health Services Administration (SAMHSA).

Cuban Refugees

Refugee mental health efforts did not really coalesce into a single program within SAMHSA's predecessor agency, the Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA), until 1980, in response to the boatlift from the Cuban port of Mariel.

The unexpected migration included several thousand prison inmates and mental hospital patients sent by Fidel Castro to the United States, along with the many Cubans who chose to leave voluntarily. By the time the United States stopped accepting the refugees, a total of 129,000 Cubans had arrived.

The U.S. Immigration and Naturalization Service turned to ADAMHA's National Institute of Mental Health to process and respond to the needs of this special subpopulation of refugees appropriately. These early efforts ultimately resulted in the formation of the Refugee Mental Health Program (RMHP), now known as the Refugee Mental Health Branch (RMHB).

The RMHP established a program to assess, treat, and rehabilitate psychiatric patients from Cuba. The program, which continues to serve this population, includes mental health evaluations, treatment in a hospital setting for those who need it, and a community halfway house program.

"The Mariel Cuban mental patients represent a unique group. They experienced migratory stresses such as a loss of their familiar culture, but many also had serious pre-existing mental disorders," says Dr. Thomas H. Bornemann, EdD, former Chief of the Refugee Mental Health Branch, now Chief of Refugee Programs for the Office of Refugee Health within SAMHSA's parent Department of Health and Human Services.

"Even as the program developed, we had to adapt it constantly to their unique psychosocial problems and treatment needs," Dr. Bornemann adds.

Many of the Mariel Cuban refugees had lived in mental institutions for 20 to 30 years where a socialist state system provided all of their care, Dr. Bornemann explains. In addition to expecting the same type of care here, they had unrealistically high expectations of affluence in the United States, which they viewed as a "country of gold."

Instead, they were confronted with a competitive, industrially complex society that emphasizes individuality and personal responsibility. A major part of their rehabilitation has involved acculturation to American society.

In addition, Dr. Bornemann says, Cuban society emphasizes the family and has a collective orientation. Cubans define themselves by how they fit into their families, communities, and societies. In their departure from Cuba, many of them lost this important psychosocial anchor.

The primary mode of mental health treatment in Cuba at the time of the Mariel migration was called "ergotherapy." In this model, work and employment are the primary vehicles of treatment, in contrast to psychotherapy in the United States, which focuses on the resolution of intrapsychic conflict or behavior modification. In Cuba, patients progress by moving through five increasingly complex levels of work.

Also in contrast to American psychodynamic psychotherapy, the role of the Cuban therapist is much more authoritarian. The therapist is seen as directing the activity of the patient, as opposed to facilitating self-insight.

To adjust to the needs of this special population, the RMHP had to make several adaptations in treatment and rehabilitation services, according to G. Bryan Jones, Jr., PhD, RMHB Operations Officer at the hospital for Mariel Cuban psychiatric patients.

Overall, the therapeutic milieu emphasizes a bicultural approach, in which both American and Cuban cultural practices are observed, he says.

Treatment providers speak both English and Spanish, and serve as directive role models once they gain the trust and respect of the patients.

To make up for the loss of family, the program substitutes the environment of the community halfway houses, and to a lesser extent, the hospital.

The therapeutic method includes sensitivity to an alternative spiritual and religious system known as "Santeria," common among many Cubans. This Afro-Cuban belief system integrates African spirit religion with Catholicism.

After discharge, patients frequently maintain contact with the staff and, at the halfway houses, go back periodically to visit and share a cup of coffee—an important custom in Cuban culture.

"The Cuban refugees are encouraged not only to become as financially self-sufficient and socially acclimated as possible, but also to achieve their highest potential within both Cuban and American cultural norms," says Dr. Jones. "This pragmatic approach has been particularly successful with this unique patient population."

Amerasian Youth

The United States did not officially acknowledge responsibility for the children of U.S. soldiers and Vietnamese women until Congress passed the 1982 Amerasian Immigration Act. The Act, the 1983 Orderly Departure Program, and the 1987 Amerasian Homecoming Act have brought 51,000 Amerasians and their families to the United States. There are still 33,000 waiting in Vietnam to be processed and 7,000 at the Philippine Refugee Processing Center awaiting resettlement.

In 1991, the RMHP co-sponsored with the Department of Health and Human Services Office of Refugee Resettlement (ORR) a series of conferences to examine the mental health needs of these Amerasian refugees. Conference planners and presenters included service providers working at minority mental health service and research centers.

Amerasian youth have faced special problems both in Vietnam and the United States.

"There is a lack of empirical data about this group," says Dr. Bornemann, "so currently our knowledge is limited to generalizations whose validity have not been firmly established."

Because family is of primary importance and identity and self-definition are

derived through patriarchal lineage in Vietnamese culture, it is assumed that Amerasians experienced some degree of discrimination in Vietnam. Without fathers they are already identified as misfits, and being physically conspicuous in an ethnically homogeneous country compounds the situation. The African Amerasians may experience an even greater degree of ostracism.

Although the conditions of Amerasians in Vietnam vary widely in family background, socioeconomic status, years of formal education, and level of discrimination experienced, studies have shown that Amerasians have more clinical symptomatology compared to their Vietnamese counterparts in Vietnam and the United States.

"We noticed a large number of mostly unsuccessful suicide attempts among Amerasian females, especially among those who were pregnant. This is what prompted us to work with ORR," says Dr. Bornemann.

"With the downsizing of the U.S. military involvement in other countries, such as closing of Subic Bay and Clark Airforce military bases in the Philippines, the U.S. may experience another influx of children fathered by U.S. servicemen," he says.

"The road to recognizing our responsibilities to these children must include the search to understand the particular psychosocial issues they face, and to assist them in dealing with these issues."

Vietnamese Political Prisoners

The departure of Americans from Vietnam after the war also had profound repercussions for another group: more than 125,000 Vietnamese soldiers and officials who had served as U.S. allies during the war. They were considered to be traitors in need of re-education under the subsequent communist regime. In 1988 an agreement was reached allowing the former political prisoners (FPPs) and their families to come to the United States. To date, some 80,000 have been resettled in the United States.

Recognizing that the FPPs would require special services beyond those provided by resettlement agencies, ORR allocated funds in Fiscal Year 1990 to support a national initiative that would provide supplemental services at the community level for these men and their families.

In 1991, ORR asked the RMHP to assess the Vietnamese Former Re-Education Camp Detainee Program, as the initiative was officially known, according to Angela Gonzalez Willis, PhD, the RMHP researcher who conducted the assessment and prepared a report.

"Because of having been imprisoned and psychologically tortured, sometimes for as long as 15 years, the FPPs have experienced nightmares, anxiety, depression, and other psychological trauma in addition to their severe physical debilitation," says Dr. Gonzalez Willis.

During their imprisonment, the FPPs were deprived of food and other basic necessities. They were confined in cramped cells, often in solitary confinement and sometimes in total darkness. They were forced, repeatedly, to write "memoirs" in which they admitted their guilt. The threat of execution was constant.

The goal of the communist re-education camps was to break the spirit of the individual, Dr. Gonzalez Willis says. After release, the political prisoners returned to a society in which they were stigmatized, forced to account for all their daily activities, and prevented from working except in minimally paying jobs.

Many of the men, well-educated in such fields as medicine, aviation, and diplomacy, experienced a terrible loss of self-esteem both within their own families and in society at large. In a culture where women were expected to serve in a secondary position to their husbands, the men were humiliated by the reversal in family roles in which they were economically dependent on their wives.

Upon arrival in the United States, the FFPs continued to experience great frustration. They had no marketable skills in their new country and they were hampered by a lack of knowledge of the technological advances that had occurred while they were in prison.

Their unhappiness was often compounded by a shattered expectation that their lives would improve as soon as they arrived in the United States, says Dr. Gonzalez Willis. They often believed that because they had fought alongside U.S. soldiers, they would receive back pay for their years in the camps, and perhaps even a house and a car.

Loss of respect from their children, as these youths acculturated more rapidly to American society, also created stress within the family.

As with the Mariel Cubans, services to address mental and emotional issues had to evolve through trial and error.

"Traditional American talk psychotherapy does not work for these men," says Dr. Gonzalez Willis. "We do not even use the term 'mental health' when we speak with them, due to the stigmatization they associate with it. Also, for the most part, these men are simply experiencing normal reactions to the abnormal life circumstances they were forced to endure."

What works best, Dr. Gonzalez Willis says, is for the FPPs to meet in a relaxed setting where they can discuss old times with their fellow FPPs—a kind of informal support group.

They also benefit from intensive vocational services, classes in English as a second language, and driver education. These activities give them a sense of control of their lives and improve their self esteem in a way that benefits their emotional state, Dr. Gonzalez Willis says.

Soviet Refugees

For the past several years Jews fleeing the former Soviet Union have been the single largest group of legal-status refugees entering the U.S., says Dina Birman, PhD, an Assistant Research Scientist Officer within the RMHB. More than 300,000 Soviet Jews have come to the United States since 1972.

The resettlement of Soviet Jews has been unexpectedly difficult, according to Dr. Birman, who immigrated to this country at the age of 12 as a Soviet Jew.

Many of the refugees have been assisted in their resettlement by Jewish social service agencies, and evidence suggests that the interaction between refugees and agency personnel is seen as difficult on both sides.

"I believe that miscommunication and misinterpretation due to cultural differences between Soviet and U.S. Jews account for many of these problems," Dr Birman says. "For Soviet Jewish refugees, the process of acculturation is very complicated because Russian, Soviet, Jewish, and American cultures must be resolved into a single identity."

American Jews generally define themselves by religion, whereas Soviet Jewish refugees view their Jewish identity in ethnic terms.

In addition, specific interactional styles may also lead to misunderstandings. From the refugees' perspective, trust between people is earned in the context of a relationship that is tested through conflict and disagreement. Such an argumentative and confrontational style may startle American service providers because they perceive it as impolite or hostile.

Soviet refugees are confused by many American customs, such as the perfunctory greeting, 'how are you?' It makes no sense to Russians, says Dr. Birman, for

someone to ask this without actually wanting an answer. Such interactions may cause them to view their American service providers as insincere and untrustworthy.

American mental health service providers must be mindful of these issues in their attempts to help resettle Soviet Jews, says Dr. Birman.

"The mental health of refugees is one of the most compelling issues of this decade," says RMHB incoming Chief Neal Brown, MPA. "The increase in refugees both here and abroad presents (us) with an important leadership opportunity. We can serve as the conduit of information to treatment providers. We can also continue to offer technical assistance, help coordinate refugee programs throughout the United States, and work to improve the quality of refugee mental health services provided throughout the world."

—DEBORAH GOODMAN, Writer-Editor, Substance Abuse and Mental Health Services Administration

New Computer Program Presents Public Health Data in Map Form

Epi Info (*1*), the popular series of microcomputer programs that combines word processing, data base, and statistical functions for public health and other disciplines, now has a companion program called Epi Map.

Epi Map produces maps that present public health and epidemiologic data from geographic boundary files, data values entered from the keyboard, and data supplied either from Epi Info or dBASE files. Both programs are in the public domain, may be freely copied, and are available in a growing number of foreign languages.

Data entered in Epi Map may be counts, rates, or other numeric values. The values are rendered in color or patterned maps of the specified geographic area, such as a country, a State, a county, or another specified subarea. In dot density maps, randomly placed dots are proportional in number to the values for each entity. Epi Map also produces cartograms, with the value for the geographic entity controlling the size of the entity. Outline maps, or boundary files, are part of the program. Boundary files consisting of a series of numbers representing map coordinates may be created and edited. Maps can be enhanced by selection of the type of map, patterns or shading or color, number of cases per dot, color and thickness of boundaries, and three-dimensional shading, titles, legends, text, boxes, symbols, or lines.

Epi Map functions with Epi Info, or independently. Numeric data can be entered in Epi Info, manipulated and analyzed, and sent to Epi Map for display and printing in map form. Or, data can be entered directly into Epi Map, the simplest method for small data sets. Epi Map supports a range of printers, including dot-matrix, laser, inkjet, PostScript, and HP-compatible plotters.

Epi Info handles epidemiologic data in questionnaire format and can be used for organizing study designs and results into text that can be incorporated into reports. The program also can be the basis for the data base for a powerful disease surveillance system, with many files and record types. Epi Info includes features similar to those most used by epidemiologists in such statistical programs as SAS or SPSS and in data base programs like dBASE. Epi Info programs and manuals are available in English, Spanish, Arabic, French, Portugese, Italian, and Czech. Chinese and Russian versions are being tested.

Epi Info and Epi Map were produced by the Centers for Disease Control and Prevention's (CDC) Epidemiology Program Office and the World Health Organization's (WHO) Global Programme on AIDS. Version 6 of Epi Info, a major upgrade, is scheduled to be released late in 1993. Work has begun on a future Epi Info program combined with Epi Map, using object-oriented programming techniques. It will be designed to run on such computers and in such environments as DOS, Windows, Macintosh, OS/2, and NT.

A 34-minute instructional video, "Introduction to Epi Info," has been produced by CDC. The video enables a viewer to identify appropriate uses for the program, make a questionnaire, enter data, and produce line listings, frequencies, cross tabulations, and appropriate epidemiologic statistics.

Technical information on Epi Info and Epi Map is available from a hotline, tel. (404) 728–0545, fax. (404) 315–6440. Epi Info and Epi Map are distributed by USD, Inc., 2075–A West Park Pl., Stone Mountain, GA 30087; tel. (404) 469–4098, fax. (404) 469–0681. Diskettes and documentation for either program are $38, and combination orders are available. Comments on the programs may be directed to Andrew G. Dean, MD, MPH; CDC, EPO, MS C08, Atlanta, GA 30333; tel. (404) 639–1326; fax. (404) 639–1546.

Reference

1. Dean, A. G., Dean, J. A., Burton, A. H., and Dicker, R. C.: Epi Info: a general-purpose microcomputer program for public health information systems. Am J Prev Med 7: 171–882 (1991).

PHS to Spotlight Research Misconduct

The Public Health Service's Office of Research Integrity (ORI) has published information about closed cases of confirmed misconduct in the Federal Register, the Government's legal publication.

Information on such cases previously has been available only by request. But ORI Acting Director Lyle W. Bivens said, "Affirmative steps should be taken to make these cases known, both for public health purposes and to serve an educational and deterrent purpose."

Since its formation in May 1992, ORI has debarred from Federal research grants or otherwise restricted 14 researchers in cases involving three incidents of plagiarism and 11 incidents of falsified research. These cases will be described in an initial Federal Register notice. Future notices will be published individually as cases are closed.

"As rare as misconduct may be, it must be vigorously pursued and effectively dealt with where it is proven," Bivens said. "The notices will help correct the scientific literature as well as serve to deter scientific misconduct."

The initial 14 cases involved research in such areas as AIDS, brain tumors, and cocaine use. Some were published in major scientific journals and were subsequently retracted.

The ORI has prohibited the researchers from receiving Federal grants or contracts or imposed restrictions and conditions on future Public Health Service-supported research conducted by them. In many cases, the researchers were prohibited from serving on advisory committees of the Public Health Service (PHS).

ORI was created in 1992 to replace a similar activity at the National Insti-

tutes of Health. The Office is responsible for investigating charges of scientific misconduct in all of the PHS health research agencies, including the National Institutes of Health (NIH), the Centers for Disease Control and Prevention (CDC), and the Agency for Health Care Policy and Research. The responsibility also covers laboratories directly operated by the agencies as well as recipients of PHS grants or contracts at universities and hospitals in the United States and abroad.

In the first Federal Register notice, ORI identifies researchers who worked at NIH, the University of California at San Francisco, St. Luc Hospital in Montreal, Harvard Medical School, the University of Houston, and elsewhere. In most cases, the allegation of misconduct was initially reviewed by the school or institute involved.

ORI announced nine debarments from Federal grants and contracts. The researchers are

— James B. Freisheim, former Chairman of the Department of Biochemistry and Molecular Biology at the Medical College of Ohio, who was found by the university to have submitted a research grant application to NIH that he had plagiarized from another scientist's grant application—one that he himself reviewed for NIH. ORI debarred him for 3 years and placed other restrictions on him for 10 years.

— Paul F. Langlois, former postdoctoral fellow at the National Institute of Allergy and Infectious Diseases, found to have presented computer printouts and graphs for which primary data did not exist. Langlois appealed a PHS-recommended disbarment, but it was upheld by the Appeals Board of the Department of Health and Human Services. The debarment is for 3 years.

— Tinn-Shing Las, former postdoctoral fellow at Joslin Diabetes Center, Harvard Medical School, found by Harvard to have presented data for cell counts that were never performed. ORI concurred and debarred him from grants or contracts for 5 years.

— Anthony A. Paparo, former Professor at Southern Illinois University, found to have falsified micrographs and radioisotope data in work supported by NIH. He was debarred for 3 years.

— Roger Poisson, MD, at St. Luc Hospital, Montreal, found by ORI to have fabricated and falsified tests and dates of procedures in 115 instances from 1977 to 1990. He was debarred for 8 years.

— Sheela Ramasubban, former master's degree student at the University of Houston, found by the university to have fabricated data on the biochemical basis of rhythmic behaviors in work supported by the National Institute of Mental Health. She admitted altering data and was debarred from receiving grants and contracts for 3 years.

— Mitchell O. Rosner, a former Howard Hughes Medical Institute-NIH research scholar in residence at the National Cancer Institute, found to have diluted control samples to affect a result in studies of embryonic development in mice. The researcher admitted the misconduct and signed an agreement not to seek grants or contracts for 5 years.

— Craig T. Shelley, former resident in neurosurgery at the University of Tennessee at Memphis and a former fellow at the National Institute of Neurological Disorders and Stroke, Bethesda, MD, admitted to altering an autoradiographic slide. He was debarred for 3 years.

— Raphael B. Strickar, former Assistant Professor at the University of California at San Francisco, found by the university to have reported AIDS research findings of an antibody in 29 of 30 homosexuals but not in nonhomosexuals, suppressing data showing the antibody in 33 of 65 nonhomosexuals. Stricker retracted a study in the New England Journal of Medicine and agreed not to apply for Federal grant or contract funds for 3 years.

ORI placed restrictions short of debarment in these cases:

—Judy Guffee, a former technician at the University of Miami, who was found to have falsified the labeling of solutions to cover up a failure to produce large quantities of polyclonal antiserum. ORI required that her work be certified for a 5-year period.

— Raymond J. Ivatt, formerly of Cetus Corporation of Emeryville, CA, found by the corporation to have falsified progress in a research project grant supported by NIH. ORI required that any future application, proposal, or report be certified for accuracy by the organization sponsoring it.

— Mark M. Kowalski, former Postdoctoral Fellow at the Dana Farber Cancer Institute and Harvard University, found by the institute to have plagiarized a complete grant application and submitted it to NIH. ORI said any further applications must be certified by his organization. He has been prohibited for a 3-year period from serving on PHS advisory committees, boards, and review groups.

— Leo A. Paquette, Professor at Ohio State University, found by the university to have submitted a grant application plagiarized from another scientist's grant application that Paquette had received in confidence as a peer reviewer for NIH. Paquette accepted full responsibility but said the inclusion of the other scientist's text was inadvertent. Future work must be certified, and he is barred from PHS committees, boards and review groups for 10 years.

— Michael A. Sherer, former resident and research fellow at the National Institute on Drug Abuse, found to have falsified data and required to retract a published study on cocaine. ORI required certification of any future work from him and prohibited him from serving on PHS agency committees, boards, and review groups. These actions are effective for a 3-year period.

"The universities, agencies, and institutes have been alert and cooperative," Bivens said. "I think that's because we know—whether we're scientists, consumers, physicians, scholars, or patients—that we are all losers when the integrity of health research is called into question.

"This Public Health Service office will continue to investigate scientific misconduct and will work with other scientific groups to prevent it by making sure all researchers working with Federal dollars conduct and report their research in a responsible manner."

WHO Launches Research into Quality of Life

About 6,000 patients in at least 11 countries are to be involved in a unique research project launched by the World Health Organization (WHO) to find out how to assess the effects of illness and its treatment on people's quality of life.

"We want to know more about how patients feel about their illness and about the way their lives are affected by it and by the health care they receive. This is very much patient-

centered research, and answers should lead to better care and improved quality of life for them," according to Dr. John Orley, senior medical officer in the WHO Division of Mental Health and one of the coordinators of the project.

Countries taking part in the study include Australia, Croatia, France, India, the Netherlands, Panama, the Russian Federation, the United Kingdom, the United States, Thailand, and Zimbabwe. Medical research centers in these countries will each ask 500 patients to answer questions about their physical health, psychological well-being, level of independence, and social relationships. The study will explore how satisfied they are about these aspects of their lives and what problems they experience.

The questions that will be explored are contained in an instrument developed by WHO to measure quality of life related to health and health care. The study is a pilot exercise involving the instrument, called WHOQOL, and the completion of the project is expected to lead to the method being introduced widely in health services.

"By focusing on the person's own view of their life situation and their functioning and adding this assessment to the objective evaluation of patients' health, the WHOQOL will provide a new perspective on disease. We believe this instrument will have numerous uses," Dr. Orley said. "In clinical practice, it will assist clinicians in making judgements and treatment decisions about the areas in which a patient feels most affected by disease, in addition to tne areas physicians judge to be most important.

"By increasing the physicians' understanding of how disease affects the way patients see their own position, the interaction between patient and physician will change and improve. This will give more meaning and fulfilment to the work of the physician and should lead to the patient being provided with more satisfactory and effective health care."

Dr. Orley said the WHOQOL will also be of considerable use in clinical trials, looking at changes in quality of life over the course of treatment, particularly where disease prognosis is likely to involve only partial recovery or remission.

"Chemotherapy for cancer, for example, may prolong a person's life, but may only do so at considerable cost to the quality of that life. By using the WHOQOL to look at changes in the person's well-being over the course of treatment, a much fuller picture can be gained".

The data collection phase of the project will run until the end of 1993. The data that emerges from the study will then be analyzed, and the WHOQOL will be refined and subjected next year to further testing with large numbers of patients in each of the participating countries. Special versions of the instrument will be developed for use in the assessment of quality of life in people living in possibly high-risk situations—such as the elderly in institutions and refugees in camps—and for different types of chronic illness and disability.

Further information can be obtained from Dr. Norman Sartorius, Director of the Division of Mental Health, WHO, Geneva; tel. 41 22 791-3617.

The Silver Platter Award: Reform in Restaurants

To some, regulation is a dirty word, but in Camden County, NJ, restaurant regulation is taking on a whole new look that has restaurateurs "polishing their silver." The Silver Platter Award is a pilot program administered by the Camden County Division of Health. It replaces the adversarial relationship between business and government with an incentive-based cooperative program that increases compliance with health codes while reducing costs. The program applies a theory known as "interactive corporate compliance," a model that government regulators are turning to as budgetary pressures grow and calls for stronger enforcement persist.

Silver Platter is a voluntary program open to all full-service restaurants in Camden County. Under the program, restaurateurs who perform quarterly self-inspections and attend food handling classes are eligible to win a Silver Platter Award from the Board of Freeholders (the governing body of the county government) and the Division of Health, if they meet all the mandatory requirements under New Jersey's Sanitary Code. By voluntarily exceeding the basic requirements, award winners obtain a market advantage. Winners are encouraged to display their awards and utilize them in advertisements. The awards are strictly related to sanitary conditions and do not reflect on other amenities.

The likelihood of food-borne illness is reduced when the Division of Health trains restaurant workers in food handling methods and they perform self-inspections between the Division's annual examination. The prospect of failing the annual inspection is reduced, decreasing the number of re-inspections. There is also another benefit. The voluntary self-inspections and training classes emphasize the Analysis Critical Control Point (HACCP) standards. HACCP is an inspection process that emphasizes food protection and attention to critical areas linked to food-borne illness.

The key element in the structure of the program is the elimination of the adversarial relationship. By structuring a win-win scenario under which the restaurants can be rewarded for voluntarily exceeding the minimum health code requirements, the government is using the marketplace as a means to enhance compliance and reduce costs.

Camden County is home to a myriad of restaurants. Participants in the Silver Platter Awards Program have ranged from national chains (Red Lobster) to family-owned diners (Ponzio's of Cherry Hill). Prior to startup of the program, county officials met with representatives from the industry. The reception was positive, and to date the program has been well received. Recipients have displayed their Silver Platter Awards and at least one has used it in advertisements.

Silver Platter began in 1990 and five awards were presented that year. In 1991 the program was put on hold during a change in administration at the county. The program was reinstated in 1992, and eight awards were presented in April 1993.

The Strawbridge and Clothier restaurant in the Cherry Hill Mall was a Silver Platter winner in 1993. Manager Barbara Kiesel said, "I have received at least ten new customers as a result of the award." Furthermore, she noted that Silver Platter has helped her save on food costs because she is wasting less. Donna Leonetti, manager of the Red Lobster restaurant, said "the award was written up in our company's newsletter and it has had a positive impact on my staff." Chris Fifis, owner of Ponzio's in Cherry Hill said "the best thing is the feeling of security for customers (provided by the extra reas-

surance) that Silver Platter provides."

Like all new programs, Silver Platter takes some getting used to on the part of health inspectors and food handlers. However, both see the value of working more cooperatively and learning from each other. Like any experiment, the benefits will accrue over time, and if the initial responses are any indication, the program has the potential for being very successful.

Like all governments, Camden County is under pressure from taxpayers to cut taxes. However, taxpayers don't want to see any reduction in enforcement, particularly when it comes to health and their restaurants. The Silver Platter program is well on its way to meet the goals of industry while maintaining high level sanitary control codes. Regulators in all fields would be well served to monitor the program, for it represents a new means of regulatory reform that will set a precedent for the future.

—LOUIS S. BEZICH, Chief Operating Officer, Camden County, NJ.

FDA Bans Over-the-Counter Smoking Deterrents

The Food and Drug Administration (FDA) has concluded that no over-the-counter smoking deterrent product on the market today has been shown to be effective in helping people quit or reduce smoking. New shipments of these nonprescription products will be prohibited after Dec. 1, 1993.

Products that will be affected include pills, tablets, lozenges, and chewing gum-type products sold under various names such as Cigarrest, Bantron, Tabmint, Nikoban and others. They may continue to be sold until supplies are exhausted.

Several manufacturers of the nonprescription products have discussed with FDA the possibility of conducting clinical trials on lobeline sulfate and silver acetate—two ingredients in products now on the market. Past studies with these and other ingredients have not proven their effectiveness in helping people stop or reduce their smoking, FDA reported.

Several prescription products are approved as smoking cessation aids. Marion Merrell Dow, Inc., which manufactures Nicorette, a prescription chewing gum drug for this purpose, has expressed interest in gaining FDA approval for switching the product to nonprescription status to allow its use without the supervision of a physician. Before allowing a switch, the agency would need to consider carefully Nicorette's own potential for addiction, since it contains nicotine.

WHO Conducts Study on Chemical Pollution and the Elderly

The environment contains more than 750,000 different chemicals, natural and artificial. Each year, between 1,000 and 2,000 new substances are produced. Although much attention is devoted to the effect of the environment on such risk groups as infants, children, and pregnant women, the elderly have been somewhat neglected by specialists until now.

To remedy this situation, the International Program on Chemical Safety of the World Health Organization (WHO) has conducted a study, "Principles for Evaluating Chemical Effects on the Aged Population." Its results have just been published in English in the Environmental Health Criteria series, which runs to almost 150 technical reports on the properties and dangers to health of chemicals or other constituents of the environment.

The specific problems of the elderly must be faced, because the elderly population is growing throughout the world, especially in developing countries. In 1988, there were 488 million people older than age 60 in the world; the figure is expected to rise to 612 million by the year 2000, of whom 61 percent will be living in developing countries.

There are various reasons why old people are particularly sensitive to certain substances. There is the aging process itself and the effect of chronic exposure to toxic substances in the environment. There are diseases of the elderly, which increase their vulnerability. Obviously, several of these factors can have joint effects.

Alzheimer's Disease and Aluminum

There is a suspected link, for example, between Alzheimer's disease and the toxicity of aluminum, since some autopsies have found high concentrations of the metal in the brain of people who had suffered from the disease. Manganese, also, would seem to be responsible for an age-related neuropathy, and the symptoms it causes in monkeys are similar to those of Parkinson's disease.

In general terms, the increased toxicity of certain substances in old people is due mainly to the fact that elimination of chemicals by the kidneys and liver becomes less effective with age. Nevertheless, time does not deal with people evenhandedly, so that physiological and psychological functions do not necessarily deteriorate in the same way or at the same rate. The habits and circumstances of a lifetime also affect the health of the elderly and their sensitivity to the depredations of the environment.

The working group that prepared the WHO study also considered another class of chemicals that are thought to affect the aging process. They are called "gerontogens" or "gerontoprotecters," depending on whether they accelerate or slow it down. The high incidence of disorders such as Parkinsonism and senile dementia observed among inhabitants of the Marianna Islands in the Pacific were thus linked with a vegetable substance in their diet that stimulates the aging of the nervous system.

Food and nutrition play a considerable part. It is known that calcium deficiency causes osteoporosis in elderly women, making their bones brittle and prone to fracture. It is not so well known that deficiency of iron and zinc can affect the immune defense system.

Lifestyles of the Elderly

In diet, quantity counts as well as quality. "You dig your grave with your teeth," as the proverb has it. Common sense shows that any excess is damaging, and yet the role of dietary restrictions is only now being scrutinized in studies whose results are likely to be interesting. All the signs are that a reduction in calorie intake is likely both to delay the appearance of certain disorders related to age and to retard aging and lengthen life. At least, this is true of laboratory animals, although the mechanism governing this phenomenon is far from being fully explained.

The new publication also broaches the problems of alcohol and tobacco consumption among old people. Alcohol tolerance diminishes with age, and

alcohol in the body can slow down the metabolism of some substances while accelerating others, thereby increasing any toxic effect they have. A number of studies suggest that old people are more susceptible to the effects of smoking, while others suggest that duration of smoking is the critical factor.

Elderly people use a lot of medicaments—sometimes too many; in developed countries especially, it is estimated that the people older than 65 consume between 25 and 50 percent of all pharmaceuticals. The most commonly used are neuropsychiatric, cardiovascular, and anti-inflammatory drugs, analgesics, and diuretics. The WHO study recommends that account be taken of any interaction between such substances and environmental chemicals.

Delayed Effects

Of all the chronic effects of chemicals on health, cancer is certainly the most worrying. Cancer causes almost a quarter of all deaths of men and women between the ages of 65 and 74, with lung cancer alone accounting for 10 percent. In humans, cancer seldom manifests itself until 10–40 years after exposure to carcinogenic agents, so that cancers caused by chemicals are to be observed in the aged population. However, it is extremely difficult to track down the past exposure responsible for the disease.

The conclusion of the newly-published study is that a great deal of research is still needed, especially into long-term effects of chemical substances in the environment on the health of the elderly. Having lived for many years in an environment containing a great variety of toxic substances, old people can suffer accumulated consequences, even if the levels to which they have been exposed are relatively low. The pathological signs of such accumulation appear much later, and it is difficult to distinguish the causes of the various possible effects.

The International Program on Chemical Safety therefore advocates new research to gather experimental, epidemiological, and clinical data on the particular toxicity of environmental chemicals in the elderly. A better understanding of the physiology of aging is also important, to avoid its premature onset. For better or worse, the chemicals in the environment affect the way the population ages and the health of the elderly. It is now necessary to know how, so that the years of life can be increased and their quality improved.

"IPCS—Environmental Health Criteria 144—Principles for Evaluating Chemical Effects on the Aged Population" can be obtained from the Unit Distribution and Sales, WHO, Geneva, for 19 Swiss Francs, or in developing countries, 13.30 Swiss francs.

Mental Health Clinical Training Program Payback Labeled a Success

Some 80 percent of those who have completed their payback requirement are still working in public or private nonprofit agencies, according to a report to the Congress on the Mental Health Clinical Training Program.

The data reported substantiate the remarkable success of the clinical training program in supplying the public mental health system with competent professionals in the core mental health disciplines of psychiatry, psychology, psychiatric nursing, and social work.

Marriage and family therapists are not included because they have only recently become eligible for the program and have not yet incurred the payback obligation.

At an average cost of $11,000 per trainee, the program has supported more than 7,000 trainees. Of the 6,000 trainees who have completed training, 93 have either completed the payback obligation or are in the process of doing so. The other 7 percent have either elected to meet the obligation by monetary payback (2.0 percent), are totally and completely disabled, or dead (2.6 percent), or are currently being contacted to update their status (2.4 percent).

The clinical training program administered from 1948 until 1992 by the National Institute of Mental Health and now by the Center for Mental Health Services was modified in 1981 to include obligation to pay back 1 month of service by working in an approved setting with one or more of the priority populations for each month of Federal financial support as a clinical trainee.

The purpose of this requirement was to insure that clinical trainees who receive Federal financial support provide services to underserved mentally ill populations in public facilities. In response to specific questions from the U.S. Senate Appropriations Committee, this report presents the current contextual environment for clinical training and summarizes the major findings regarding payback service.

- For the disciplines of psychology, psychiatry, psychiatric nursing, and social work, 93 percent of the trainees who have finished training are either engaged in payback service or have completed the payback service obligation.
- Two-thirds of the payback service was done in inpatient hospital settings or in community-based outpatient settings.
- One-fourth of the trainees worked with children and adolescents, one-sixth with minorities with mental disorders, and another one-sixth with seriously mentally ill adults during the payback service period.
- Approximately one-third of clinical training funds were provided for programs that do not incur payback service obligations, such as the State Human Resource Development Program.
- Curriculum modifications have become progressively more specific in content and field experiences to train professionals to provide services to the priority populations.
- More than three-fourths of the trainees continue to work in public or private nonprofit mental health settings after completing the payback service obligation.

The average Federal investment per trainee has been $11,000, a modest investment to prepare mental health professionals to serve public mental health clients. Requiring trainees to work in public or private nonprofit settings has frequently resulted in their continuing employment in such agencies.

Experimental Device Designed to Reduce Costly Urinary Infections

An experimental device that can nearly wipe out microorganisms from urine—a leading cause of fatal infections in hospitals—is being developed at the University of Texas Medical Branch at Galveston (UTMB).

Each year, 500,000 to 1 million patients begin relying on urinary cathe-

ters to control their urine flow because of incontinence related to old age, Alzheimer's disease, head injury, bladder dysfunction, or spinal problems, according to the researchers.

Infections linked to these catheters lead to medical costs of more than $1 million a day, according to a 1987 review of medical literature. Such infections are also a major source of life-threatening and often fatal sepsis in hospitals and nursing homes.

A catheter to kill bacteria, fungi, and other microorganisms in the bladder is being developed at UTMB by Charles P. Davis, MD, Associate Professor of Microbiology and Surgery, Michael M. Warren, MD, Professor of Surgery and Urology, and their coworkers.

In laboratory experiments, the new device reduced the number of bacteria living in synthetic urine by more than 99.9 percent. In most experiments, no microorganisms survived. The researchers are preparing to test the device in human trials.

The new catheter relies on a variation on a medical technology called iontophoresis. In iontophoretic treatments for several diseases, a mild electric current is used to carry medications through tissues to the area that needs treatment.

The new device also uses a small electrical current, but not to deliver prepared medications. The current simply passes through the urine that enters the end of the catheter and changes its properties, making it lethal to microorganisms. The patient cannot feel the current.

The project is supported by the Advanced Technology Program of the State of Texas, the National Institutes of Health, and UTMB.

Factbook Profiles Health Professions in the U.S.

The Health Resources and Services Administration's Bureau of Health Professions (BHPr) has published the "Factbook: Health Personnel, United States," a volume of tables covering the most currently available data on education and employment among health care professionals. It serves as a compendium to the congressionally mandated "Health Personnel in the United States, Ninth Report to Congress, 1993."

The factbook includes data on physicians, physician assistants, podiatrists, dentists, registered nurses, licensed practical nurses, pharmacists, optometrists, veterinarians, chiropractors, clinical psychologists, and public and allied health personnel.

It details the occupational distribution of the health care workforce over time, including the specialty and geographic distributions of selected professions. It also shows the extent to which various racial-ethnic groups have increased their representation in health professions schools.

The volume is published in response to the needs of health policymakers and researchers for an array of data to analyze and assess trends in the health care sector and to develop strategies to improve the delivery of health care services.

The factbook can be accessed through the Bureau of Health Professions' Bulletin Board System (BBS) via personal computer. Use communications software to dial the BBS at 301–443–5913. Set parity to NONE, data bits to 8, and stop bits to 1, (N,8,1). Set the terminal emulation to ANSI or VT–100. For a printed copy of the factbook or additional information, contact Evelyn Christian or Dr. Herbert Traxler, Office of Health Professions Analysis and Research, Room 8-47 Parklawn Building, 5600 Fishers Lane, Rockville, MD 20857; tel. 301–443–6662.

Innovative Health Proposals Sought for 1994 Competition

The Department of Health and Human Services has opened its 12th annual competition for the Secretary's Award for Innovations in Health Promotion and Disease Prevention. The deadline for entries is Tuesday, April 19, 1994. Entries consist of a 2,500-word original proposal for an innovative health project.

The first place award is $5,000, second place is $4,000, and third place is $3,000. The 17 semifinalists each receive $300. Winning papers and abstracts of semi-finalist papers will be published in *Public Health Reports* early in 1995. The 1992 winning papers and abstracts were published in *Public Health Reports* in the March-April 1993 issue. Copies are available on request. The 1993 winners are to be published early in 1994.

The competition draws entries from schools of allied health professions, dentistry, health administration, health education, health sciences, medicine, nursing, optometry, osteopathic medicine, pharmacy, public health, and veterinary medicine. The competition is sponsored by the Department of Health and Human Services, Public Health Service, in collaboration with the Federation of Associations of Schools of the Health Professions (FASHP). The competition is open to students of the health professions whose institutions are members of FASHP associations.

"Award for Innovations in Health, 1994," a brochure that describes the competition and the procedures for entering, will be available in January 1994 from student affairs offices or the offices of appropriate officials of those schools of the health professions that are members of FASHP. Information on institutional affiliation is available from FASHP, 1400 16th St. NW, Washington, DC 20036; tel. (202) 265–9600. The coordinator for the 1994 competition is Lois Bergeisen, Association of American Medical Colleges, 2450 N St. NW, Washington, DC, 20037–1126; tel. (202) 828–0579.

Reprints of the 1992 winning papers and semifinalist abstracts, published in the March-April 1993 issue of Public Health Reports, *may be requested from* Public Health Reports, *Parklawn Bldg., Room 13C–26, Rockville, MD 20857; tel. (301) 443–0762.*