

Building Namibia's HIV and mental health services

University of Toronto faculty and students are breaking through the stigma of mental health and HIV by enhancing services for HIV-positive people in Namibia.

Members of 11 faculties at the University of Toronto together with colleagues at the University of Namibia (UNAM), have developed HIV-focused courses on HIV and gender, care and management and HIV and mental health. It is not known when they will be offered.

A recent workshop in Namibia was led by UNAM's HIV/AIDS task force and the Centre for International Health's HIV/AIDS Initiative-Africa at the University of Toronto. This program, initiated in 2003 and led by the Faculty of Medicine, partners with African universities to meet the challenges of HIV/AIDS through developing curricula, scaling up cutting-edge antiretroviral therapy and establishing a knowledge network.

Members of the UNAM task force visiting Casey House Hospice in Toronto were struck by the "multidisciplinary approach and the integration of mental health care as a key component of comprehensive HIV care," says Dr. Mark Halman, Casey House's consulting psychiatrist and an assistant professor at the University of Toronto.

"In Namibia, mental health and physical health are very separate in the health care structure," he says. But people with HIV contend with "lots of mental health issues." Nurses recognize this but have very little resources or time to address mental health concerns.

"There's a tremendous stigma around mental health and HIV in most places," says Halman, who is also the director of the HIV Psychiatry Program and a scientist in the Inner City Health Research Unit at St. Michael's Hospital.

In Namibia, 21.3% of adults are HIV-positive — the sixth highest rate in the world — but there is no medical school, few physicians (only 3 psychiatrists in the whole country), so nurses "take on a huge responsibility," says Halman. "Addressing mental health issues is seen as almost a luxury, but if they don't get addressed it takes a terrible toll."



M. Halman

In Namibia, Dr. Mark Halman of the University of Toronto works with Dr. Mary Ngoma on HIV curriculum development.

"We struggled with what it means when 21% of your population has HIV," says Halman. "It touches every aspect of people's lives." As a result the demands placed on government are "huge."

Halman and HIV-specialist nurses are developing courses in mental health and HIV for nurses, and curricula for diploma students in psychology, social work and nursing. Some of the courses are train-the-trainers, others are aimed at care providers.

The HIV/AIDS Initiative-Africa is also active in Kenya, and at the University of Zambia, where Toronto physical education faculty are developing activities and traditional games as teaching tools to prevent HIV/AIDS. — Barbara Sibbald, *CMAJ*

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Alberta pharmacists may get prescribing powers

Confusion and accusations of conflict-of-interest surround new regulations that would give Alberta's roughly 3500 pharmacists the broadest scope of practice in Canada and one of the broadest in the developed world.

The regulations will allow pharmacists to prescribe many Schedule 1 drugs and blood products, as well as administer some injections. But they will be pro-

hibited from prescribing narcotics and controlled drugs such as barbiturates and anabolic steroids. The change is expected to take effect in 2007.

Dale Cooney, deputy registrar of the Alberta College of Pharmacists (ACP), says the move has been in the works since the Health Professions Act was passed 7 years ago. "We believe allowing pharmacists to prescribe will give patients increased access to the medications they need. It will allow them to benefit more fully from the pharmacists' expertise regarding medications."

Although many of the details (like accepted standards of practice) have yet to be ironed out, the regulatory change will allow pharmacists to alter the dose, formulation and regimen of a drug; renew prescriptions; substitute another drug for a prescribed Schedule 1 drug; administer flu and travel vaccines; and assess patients and prescribe without necessarily obtaining physician authorization.

Essentially, pharmacists will be allowed to initiate new prescriptions under 3 circumstances: if they deem it appropriate after conducting a "patient assessment," if they've received a recommendation from an authorized health professional that drug therapy is warranted, or if, in consultation with a health professional, it is determined that a Schedule 1 drug or blood product is appropriate.

A pharmacist's capacity to prescribe will be conditional on compliance with standards and a code of ethics established by the ACP, completion of an orientation course and proof of \$2-million in personal professional malpractice insurance.

Cooney knows of no other jurisdiction where pharmacists have taken on a primary prescribing role although British pharmacists "sponsored" by a physician can prescribe certain drugs.

The move worries the Alberta Medical Association. President Dr. Tzu-Kuang Lee says concerns include patient safety, proper diagnosis, liability and conflict-of-interest. Doctors, he notes, are forbidden to both dispense and prescribe drugs. "Who would be responsible if there were side effects from any prescription, especially if that resulted in admission to hospital? And

who has access to the patients' medical records to document the changes?"

A prescribing pharmacist would have to perform physical exams, as a diagnosis cannot be made from a patient's history alone, Lee adds. "You can't prescribe in isolation — prescribing is part of a total package of caring for a patient."

The Alberta chapter of the Consumers' Association of Canada has also weighed in with concerns that the change will inevitably result in accrued costs to consumers; increased fragmentation of care and decreased confidentiality.

"We seriously question a number of assumptions about the benefits of enhanced prescribing powers and anticipated uses," said spokesperson Wendy Armstrong. — Alicia Priest, Victoria

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Crisis in US emergency departments

US emergency departments (EDs) are dangerously overburdened, underfunded and unprepared to cope with mass casualties from hurricanes, pandemics or terrorist attacks, according to 3 landmark reports issued in June.

A nearly 3-year investigation by the Institute of Medicine, an independent scientific group, found a crisis in US EDs, which provide the only treatment

guarantee for 47 million Americans without health insurance.

The reports, collectively entitled *The Future of Emergency Care*, are the first extensive studies of US emergency care in the past 40 years. They present a bleak picture: a half million times a year — about once a minute — ambulances carrying critically ill patients are diverted from full EDs to more distant sites. Once stabilized, patients can wait several hours, even days, on gurneys in ED hallways for inpatient beds. On-call specialists are in short supply because of the cost of malpractice insurance and the difficulty of collecting payment from uninsured patients.

Demand is surging in EDs as capacity is dropping. The number of patients treated at EDs rose 26% between 1993 and 2003. During the same period, US hospitals closed 425 EDs, partly to control spiraling costs.

A 1986 law requires US EDs to stabilize anyone who shows up, regardless of their ability to pay. Only half of ED patients require life-saving intervention, according to the reports.

Inadequate resources put children, who account for 27% of all visits to EDs, at risk. Only 6% of US EDs have all the equipment needed to treat pediatric emergencies, the reports found. Half had 85% of essential supplies.

Many of the reports' key recommendations were aimed at the US Congress including:

- Allocate \$50 million to reimburse hospitals for unpaid emergency care to uninsured patients, \$88 million over 5 years for projects to test ways to promote greater coordination among emergency care providers and \$37.5 million to improve pediatric emergency services.
- Increase funding for disaster preparedness in hospitals.
- Create a lead agency in the Department of Health and Human Services to consolidate government programs dealing with emergency care.

The reports also called on hospitals to stop diverting ambulances and "boarding" patients on gurneys. It also urged EDs and responders to adopt modern information and communication technologies to improve patient flow and improve coordination between 911 dispatchers, ambulance workers and EDs.

Senate Majority Leader Bill Frist (R-Tenn.), a surgeon, wrote in the *Philadelphia Inquirer* that the problems in EDs are symptoms of larger problems and deficiencies in the US health care system. "Fixing them stands as one of the great public policy challenges of this decade," Frist wrote. — J.R. Brooks, Salt Lake City, Utah

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News @ a glance

Cervical vaccine approved: The first-ever vaccine against cervical cancer, was approved by Health Canada in July. Gardasil (quadrivalent human papillomavirus types 6, 11, 16, 18, recombinant vaccine) was approved for use on females age 9 to 26 (*CMAJ* 2006;175 [2]:234). Health Canada's National Advisory Committee on Immunization, which provides recommendations on vaccines, is expected to provide a recommendation on Gardasil by the end of 2006. However it is up to the provincial and territorial governments to decide whether to offer the vaccine free of charge. Gardasil is expected to cost \$135 for a full 3-shot course over 6 months.

Hep C compensation: Eight years after its initial settlement, the federal government



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The US Institute of Medicine concludes American EDs are dangerously overburdened.