

Ideas

o f r e f e r e n c e



Combat Stress Control:

Two Minnesota reservists' firsthand experience in wartime mental health

By Eric Brown, MD

We know there are many aspects of the current war in Iraq that make it different from those the U.S. has previously fought. Among these is the armed forces' approach to maintaining the mental health of its soldiers. In the current war the military is making more extensive use of Combat Stress Control units (sometimes described as "Brain Rangers") than ever before. One such unit, the Army Reserve 785th Medical Company (CSC), is stationed at Fort Snelling in St. Paul. Kevin Roberts and Russ Bacon are both psychiatric nurses at the Minneapolis VA Medical Center, and both are also members of the 785th. Roberts, who describes himself as a "minor Major" in the Reserves, says the unit has been in existence in some form since about 1985, when it began as a Medical Detachment. Over time it grew to Company size within the Army's medical services. The company has played a number of roles serving the mental health needs of the Army over the years, including providing education and counseling to soldiers pre- and post-deployment during the Gulf War and during the first wave of the Iraq War. The company was itself deployed overseas for the first time in its history in February of 2004, and returned from Iraq in February of 2005. During its yearlong tour, it functioned using the combat/operational stress control model for serving the mental health needs of soldiers in the field.

Of course, there have always been mental health services available to soldiers in a war zone. The major innovation in the Combat Stress Control unit is the fact that it is a mobile unit, which has some distinct advantages. Bacon, who is a captain, explains, "Division Mental Health (the main Army mental health service) ... operated from a hospital and an office. The Combat Stress Control unit is a field unit. So while Division Mental Health is waiting for soldiers to come to them, Combat Stress Control moves forward to where the soldiers are at... We might go on patrol with the infantry or MPs, we might ride



Minneapolis VA Medical Center psychiatric nurses Kevin Roberts and Russ Bacon serve soldiers in Iraq as members of the 785th.

with the transportation companies as they did their convoys... Once we took a little risk with them, then they'd open up."

Both say that the primary goal of the unit is to keep soldiers doing their job. This means helping soldiers deal with anything that will make them less effective as soldiers, ranging from traumatic experi-

ences to day-to-day stress of being in a combat zone to "homefront issues." One contrast, Bacon notes, of working in Combat Stress Control as opposed to in a civilian mental health setting, is that "in combat stress we deal more with an average person in an unusual situation." Roberts agrees. "I did a lot of normalization of responses," he says. "These are young kids asking, 'am I normal?' and I'd say 'hell yes, you've seen you're friends blown up... your responses are normal to these situations.'" While very few of the soldiers they counseled had histories of mental illness, there was significant variation in the soldiers' responses to the difficulties of being in a war zone. "You could have somebody who was on LSA Anaconda [the major support base north of Baghdad], which in my mind was one of the safest places in Iraq, and they'd be frightened to death," says Bacon. "And then you could be out in one of the smaller forward operating bases with an infantry soldier, and he'd be [fine]." "Their premorbid functioning level had a lot to do

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Summer 2005

Volume XXXVIII

Ideas of Reference

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Ideas of Reference

The newsletter of the Minnesota Psychiatric Society is published quarterly: January, April, July and October for members of MPS and others on request. Signed articles express the opinion of the author and do not necessarily reflect policies of MPS. Articles submitted are subject to review by the editor.

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1/4 page	200	150	125
1/8 page	100	85	75

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"Once A Town Doctor, Now A Psychiatrist"

Tom Cruise certainly got my attention. After an initial jaw dropping response of disbelief, I flashed back to the biplane flying over Lake Michigan at a Chicago APA convention years ago. It was dragging a sign with the message, "Psychiatry Kills". I was reminded of how long the bizarre and outrageous Scientology PR campaign had been seeking attention. I've been impressed with the current overall response to Mr. Cruise's poorly informed comments as compared to the apparent lack of response to the planes and protesters of about twenty years ago in Chicago. I think we, along with many others, have made a difference in our efforts to promote public education about mental illnesses.

Not that stigma isn't clearly a current significant negative influence on many people and many initiatives. My jaw dropped almost as far as it did during the Matt Lauer interview a few weeks later when I heard the commentator set the scene for a professional's comments about some problem in Hanover, New Hampshire, by stating, "once a town doctor, now a psychiatrist". You could have taken this many ways, but it sure seemed to me that the poor fellow had been demoted, maybe disabled by some mysterious condition, or had, perhaps, semi-retired. It was inferred that, in some way, he just wasn't up to being a credible doctor and was now going to render some questionable opinions as the "psychiatrist". It seems stigma still trickles down from the patient, to their family, to their relatives, to their neighbors, to their doctors, and to all that are involved in trying to be helpful. Much is left to do.

Another news item, or commentary, also caught my attention recently. It was said that if we diligently applied all of the DSM IV-TR diagnostic criteria to the American public, over 50% would be considered to be currently suffering from a mental illness or disorder. This would, at face value, appear to fly in the face of common sense. It struck me that this needs to be attended to as we promote our credibility, and that of our patients, and that of their families. We may be sliding the wrong way in this matter as we try to advocate for understanding mental illnesses and for acceptance, understanding, and equal treatment for those that suffer with them.

Ronald Groat, MD

Primary Care Educational Series
Primary Care Approach to
Integrated Care of Depression

Tuesday, September 13, 12:00 PM

Mankato Clinic, Mankato, MN

Call MPS at 651-407-1873.

MPS and MMA: Power in Numbers



by Eric Larson, MD
MPS President

Psychiatrists practice in radically differing settings. The daily challenges of an academic clinician researcher, solo outpatient psychiatrist, and state hospital psychiatrist (insert your setting here) are worlds apart in some ways. We all play important roles in psychiatric care, but some activities are rarely addressed except through organized medicine. These include any efforts to create laws or public policy that benefit psychiatric patients, formal efforts with insurance companies to end discriminatory coverage and reimbursement, and communication with other mental health clinicians such as psychotherapists' and nurses' organizations.

In recent years MPS led efforts which brought psychiatric reimbursement up to parity with primary care practitioners. We successfully changed Medicare policy in Minnesota to improve reimbursement to practitioners. MPS members are your voice in meetings with key advocacy groups, and in speaking for patients treated in public settings including correctional facilities. The Integrated Care Initiative led by Roger Kathol, MD., is attracting national attention, and will bring psychiatric practice and economics more fully into the fold of medicine.

The Minnesota Medical Association has been our best ally in almost all of our successful efforts in recent years. Their advice and political muscle have brought us to the table with the insurance companies and legislators, and have made a difference. The MMA Health Care Task Force Reform Report clearly states that behavioral health care should be treated the same as other medical care. We have received countless hours of support from MMA Chief Executive Officer Bob Meiches, MD., and Lead Counsel Christina Rich, among many others. MMA plays a key role in the MPS Integrated Care Initiative, our most ambitious project. All this advocacy has cost MPS nothing, despite the fact that psychiatrists have the lowest rate of MMA membership of any medical specialty.

Belong to MPS and MMA so you can help these organizations represent you and your patients in

ways that cannot happen except through organized medicine. MPS and MMA cannot fully align with each of our opinions and needs- one look at our differing practice settings can tell us that. The organizations are as powerful or weak as the number of people who pay dues and who choose to get involved. Your dues alone help psychiatry to have a larger voice in Minnesota Medicine. Your involvement will do even more.

Thank you again for your support of MPS. If you are not a MMA member, please join this powerful advocate for psychiatry and psychiatric patients. Tell your colleagues to join and participate, too. Burning issue you want to address? Unhappy with MPS or MMA policy? Get involved and change things- that's how it happens. Want to get involved and not sure how? Email me at <larsol128@umn.edu>. I'll be glad to help. ■

INTEGRATING General Medical and Behavioral Health Care in the Medical Setting

Embassy Suites Hotel Minneapolis-Airport
Bloomington, Minnesota

October 10th & 11th, 2005

This seminar assists clinical staff, health care administrators, and health care purchasers interested in improving access for and effective treatment of patients with behavioral health disorders in the general medical setting understand how to create integrated clinical programs that measurably improve health and decrease cost.

Register: www.mnpsychsoc.org or call 651-407-1873.

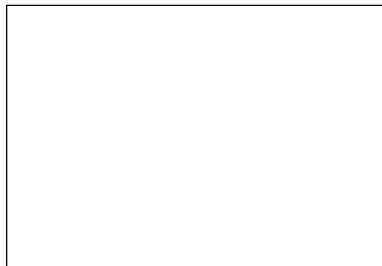


Scientific Meeting and Annual Recognition Dinner

By Linda Vukelich

The 2005 Spring Scientific Meeting provided a wealth of information for those who attended. The program featured Lorna Smith Benjamin, PhD who presented a workshop on Interpersonal Reconstructive Therapy for Treating Anger. This approach can be effective for the treatment resistant or non-responder population that fails to benefit from repeated trials of medications or psychotherapy. The workshop focused on clinical management of treatment resistant anger. Dr. Benjamin included lecture, video case presentations and small group discussions during the workshop. Attendees reported valuable gains.

The program also include a post-workshop presentation about the Minnesota Medical Association's Health Care Reform Report. MPS

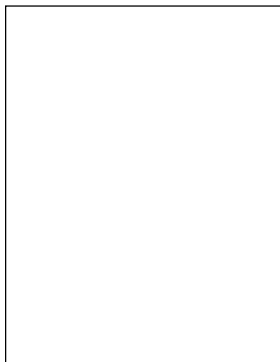


(l to r) Distinguished Fellows Judith Kashtnan, MD and Suzanne Albrecht, MD are in good company with new Distinguished Fellow Suzanne Witterholt,

member and MMA Task Force member Roger Kathol, MD, presented the report. It offered insights into the current system's shortcomings and suggested alternatives including integrated care.

Dr. Kathol is also the chair of the MPS Integrated Care Task Force. MPS Past President and MPS Trustee Karen Dickson, MD offered a short update about the MMA and invited participants to support psychiatry by joining organized medicine as MMA members.

The Annual Recognition Dinner featured a keynote address by Minnesota Attorney General Mike Hatch. He spoke to the packed room about ways to work together and noted that improvements in access will improve quality. Awards were presented to the founding members of the Minnesota Legislature's Mental Health Caucus and we heard from Representatives Mindy Greiling, and Bruce Anderson as well



MPS President Will Dikel reviewed the year's accomplishments.

as Senator Steve Dille. Due to other commitments, Senator Linda Berglin could not be there. The other members of the Caucus received frame-able certificates in the mail.



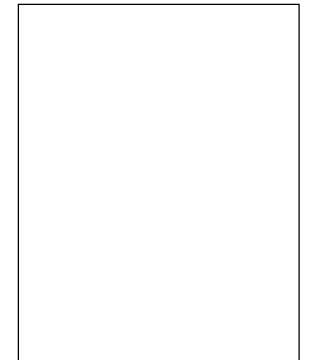
Minnesota Attorney General Mike Hatch

Our Gloria Segal Award Winners were featured in the spring issue of this newsletter. Both were outstanding; if you have not read about their achievements, please go to the MPS webpage and view that issue.

Unfortunately, Benjamin Peake could not join us, but we were glad that

Kerry Ellen Wangen could attend to receive her award in person. In addition, we were pleased to host Dr. Martin Segal, spouse of the late Gloria Segal for whom the award is named.

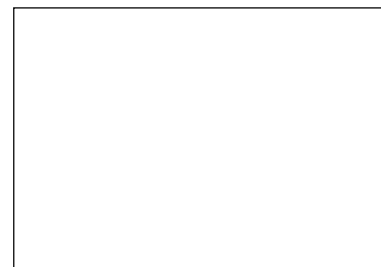
MPS members who had achieved Distinguished Fellowship, Fellowship and Life Distinguished Fellowship were recognized for their contributions to the profession and MPS Past President Karen Dickson received her award for Presidential Service as a small token of our appreciation for her three years of service as President Elect, President and Past President. Her enthusiasm and dedication were praised and her accomplishments were noted



Past President Karen Dickson, MD received her award for presidential service.

with gratitude.

The Annual Recognition Dinner is always an uplifting evening and please plan to make it next year on March 9! ■



MPS Councilor Jon Van Loon, MD congratulates 50-year Distinguished Fellow Renato Alarcon, MD.

Psychiatrist to Lead Ramsey Medical Society



Jim Jordan, MD

MPS member Jim Jordan, MD, is preparing for his term as president of the Ramsey Medical Society (RMS) which begins on January 1, 2006. Dr. Jordan has served on the RMS Board for 8 years. RMS is unique among county medical societies for its board construction; the board is comprised of seats representing specialty groups.

Christina Templeton, MD of Lakeville recently accepted the nomination to serve on the RMS Board of Trustees in the psychiatry seat vacated by Dr. Jordan.

RMS Executive Director Roger Johnson looks forward to Dr. Jordan's term as president, noting that RMS records indicate only one other psychiatrist, Dr. Ernest Hammes (1978), has served as president during

its 137-year history. It is interesting to note that the Minnesota Medical Association has only had one psychiatrist as president in its history. Dr. John Reagan served in the early seventies. RMS has a long history of working with MPS members on joint initiatives and MMA resolutions and RMS is currently a partner on the Primary Care Psychiatry Education Project.

During his term as president, Dr. Jordan plans to focus on mental health practice by defining and implementing a model in basic care standard for mental health evaluation and treatment services.

Dr. Jordan is the co-chair of the MPS Ethics Committee and an APA Life Distinguished Fellow. He has been the Director of Hamm Memorial Psychiatric Clinic, Inc., in St. Paul, since 1985. Dr. Jordan was trained in Psychiatry at the Mayo Clinic and did a fellowship in Community Mental Health at the Tavistock Clinic in London, England after his Psychiatry Residency at Mayo. Dr. Jordan also treats patients in his private practice in St. Paul.

MPS Members in Atlanta

On Monday, May 23, the Minnesota Psychiatric Society hosted a dinner during the APA Annual Meeting in Atlanta. The dinner was co-hosted with the University of Minnesota and sponsored by Pfizer. Attendees included MPS members and U of M faculty and their guests as well as former members and others with ties to Minnesota. The event was held at Fogo De Chao, a Brazilian steak house in Atlanta and it offered a unique experience since offerings were presented on swords hot off the grill. A good time was had by all and it was a nice opportunity to take a break from the hectic routine of the annual meeting.

Members on the go!

New MIT: Allison Holt, MD; Juliette Petersen, MD

Reinstatements: Allison Holt, MD; Steven Kubas, MD; Thomas Mackenzie, MD; William Orr, MD; Christopher Wall, MD

Transfer In: Yasser El-Hammany, MD; John Kluznik, MD; Michael Cesta, MD

Upgraded to GM: Olukayode O Awosika, MD; Eric Brown, MD; Victor Karpyak, MD

Hennepin-Regions Psychiatry Residency Program Joins APA 100% Club



Congratulations to the Hennepin-Regions Psychiatry Residency Training Program for making 100% membership. Watch for them in APA publications and posters!

2006 Spring Events Planned

Mark your calendars for March 9-10, 2006! Join us for the Annual Recognition Dinner on Thursday, March 9 and our Spring Scientific Meeting on Friday, March 10 next year. APA President Steve Sharfstein, MD will join us, so please plan to attend. Watch the website and this newsletter for more information.



Council highlights

Highlights and Actions from the May and July 2005 Council Meetings

Saturday, May 14, 2005 Lake Nokomis Community Center, Minneapolis, MN

President's Report—Will Dikel, MD reviewed the mission and workplan, noting that Minnesota is a leader nationally. He announced the formation of the Native American Psychiatric Issues Task Force to be chaired by Read Sulik, MD. Dr. Sulik has met with national leaders for input and will work with MPS members who expressed interest. Dr. Dikel noted that APA attorney Sam Musinski will work with MPS on contracting and workforce issues. Dr. Dikel thanked Dr. Anderson and the Private Practice Committee for their work on medical necessity criteria. A plan to distribute the information will follow.

Executive Director's Report—Linda Vukelich offered updates on the primary care depression training project, the lawsuit and efforts to obtain APA funding for the integrative care initiative. MPS will join with the University of Minnesota September 19, 20 in lieu of a separate educational conference this fall.

Private Practice Committee Report—Floyd Anderson, MD noted that, with work concluding around medical necessity, the committee is looking at more social get-togethers as opportunities for networking and collegial interface. They meet quarterly and are open to more assignments around contracts.

Integrated Care Task Force Report—Roger Kathol, MD reported that there would be a meeting with the MMA and Council on Health Plans. He will also work on getting the employer community and ICSI involved.

Membership Committee Report—Nancy Raymond MD reviewed the report, noting that we need 28 members to make our goal of 450 active members.

Action: Dr. Raymond will write a letter to recruit nonmembers and Linda Vukelich will email a list of nonmembers to our current members asking them to contact their nonmembers colleagues to encourage them to join MPS. She will ask them to let her know who they will contact.

Saturday, July 9, 2005 Administrative Board Room, Fairview Riverside East, Minneapolis, Minnesota

President's Report—Eric Larson, MD noted that he will focus on supporting MPS volunteers and lauded the groundbreaking work of the Integrated Care Task Force and Network. He will also focus on contracting

and workforce issues. He encouraged email communications. The Memorandum of Understanding with the Minnesota Nurses Association has been renewed. Dr. Larson and Ms. Vukelich are meeting with MNA executive director. Dr. Larson reported that Drs. Negar Beheshti and Karen Dickson will co-chair the Public Affairs Committee.

Executive Director's Report—The Council approved submitting a resolution supporting integrated Care for the MMA Annual Meeting. The Council approved the production of a directory / member resource as a revenue-generating project to be outsourced and expanded to include web ads.

Private Practice Committee Report—Floyd Anderson, MD reported that the private practice committee is looking at contracting and liability issues. APA support is available, and MPS may request a presentation by Sam Musinski.

Integrated Care Task Force Update—Roger Kathol, MD reported that Julia Bell, MD had agreed to co-chair. He noted that there is potential for a meeting with health plans in September. An Educational Program for network providers is set for October 10-11. Noting that interest is coming from outside the network. Dr. Kathol requested permission to open the meeting to outside participants. Council members agreed. As defined in the grant, Network participants will attend at no fee and others (primary care, nurses, psychologists, health plan administrators, other psychiatrists) may attend for a registration fee.

Secretary-Treasurer's Report—Bill Clapp, MD reviewed the reports generated using new accounting software and added that the software conversion allows MPS to get outside review on a monthly basis.

Legislative Committee Report—Mike Koch, MD and Dominic Sposeto offered a Session overview. A full summary is available on page 10.

Scope of Practice Task Force—Jonathan Uecker, MD The Council opted to authorize Dominic to review and report back to the Council and the Task Force. ■

Walk for Mental Health Research Launches Partnership

Linda Vukelich



On May 14, MPS joined with the University of Minnesota and the other members of the Minnesota Education Network for Mental Health and Mental Illness to raise research funds in Minnesota through the Minnesota Medical Foundation. The annual walk



Judge Richard Hopper

had raised funds for NARSAD (National Alliance for Research on Schizophrenia and Depression) in previous years, but organizers opted to focus on Minnesota research and keep funds in the state. The award fund reflects the collaborative efforts and many disciplines of the volunteers and organizations included in the Education Network. The

one thing they all share is a passion to serve the mentally ill community with support for research to improve lives. This Walk is a lot of work to organize and it could not have been done without the generous volunteers from the Education Network. We understand that the walk resulted in over \$8,000 this year.

The state focus brought increased participation from University of Minnesota researchers who wore tee shirts with the message, "Ask me about my research." on them. Other participants received "Walk for Mental Health Research" tee shirts at registration. Braving the uncomfortably



Charles Schulz, MD.



Walkers listen to the program before their wet and windy walk.

windy and wet weather, walkers made their way around Lake Nokomis after a rousing send off from Judge Richard Hopper, Advocate and family member Susan Segal and psychiatrist and U of M Department of Psychiatry Head Charles Schulz, MD.

In addition, the walk featured an expanded Mental Health Fair thanks to a generous grant from GlaxoSmithKline and in-kind donations from Coke. Mental Health Fair-goers and wet walkers were serenaded by a



Susan Segal

local high school band as everyone shared lunch and met with colleagues and fellow advocates touring the information booths in the Lake Nokomis Community Center.

Watch for the Walk next May and plan to support the research being conducted right here in Minnesota as we all work to improve the lives of those with mental illness in our state. ■





Crash Course- MEDICARE PRESCRIPTION DRUG BENEFIT

By Susan Meland, MD, MPS Medicare Carrier Representative

The full report is available at <www.mnpsychsoc.org>. Implementation of MMA-D is an ongoing concern; help us inform your colleagues by sending questions and concerns to <l.vukelich@comcast.net> for a follow-up report.

What is it?

- A new voluntary prescription Medicare benefit for drugs and preventive screens and tests.
- Result of the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003
- Currently- MMA provides temporary help available through drug discount cards and transitional assistance for low-income beneficiaries.
- These Medicare-approved drug discount cards can be used until 5/15/06 or until the beneficiary signs up for Part D, whichever comes first.
- Starting 1/2006 MMA gives elderly and disabled people on Medicare access to drug coverage (Part D).
- Part D plans include either a Prescription Drug Plan (PDP) that is added to traditional Medicare or a Medicare Health Plan (Medicare Advantage which replaces Medicare Plus Choice) which offers Medicare Prescription Drug Benefit (MA-PD).
- The US is divided into regions. Each region must have 2 Prescription Drug Plans (PDP) available to beneficiaries.
- Insurance companies and other private companies will work with Medicare to offer these PDP's. They will be selected by a competitive bidding process.
- The PDP's will negotiate discounts on drug prices.
- All PDP's will provide a minimal standard level of coverage, with Medicare will set. Some plans may also offer additional coverage at a higher premium.

What psychiatric providers can do to help

1. **Educate your patients.....**
 - to read all notices and letters re: Medicare Prescription Drug Benefits
 - that if they receive an application for extra help, they should fill it out and return. "Application for Help with Medicare Prescription Drug Plan Costs". Application can be done online at www.socialsecurity.gov or call SSA at 1-800-772-1213 or through Senior LinkAge at 1-800-333-2433.
 - to learn about the different plans to choose from starting October 2005. Check it out online <www.Medicare.gov>
 - to check out FAQs www.Medicare.gov

- that if they pay at least \$694/year on medication they will likely save money on the program
- to keep in mind that drug costs may increase as they grow older or become sick. Even if they don't need it now, they may need the Prescription Drug Program later. If they wait until after 5/15/06 they may no longer be eligible or they may have to pay a higher monthly premium.
- that if they are enrolled in a pharmaceutical sponsored patient drug assistance program, they should contact that company to see if they are still eligible once they begin Part D.
- that they may have to change their pharmacy (i.e. some plans will have limited pharmacy network). In urban areas, 90% of beneficiaries must have a pharmacy within 2 miles; in suburban areas-90% within 5 miles and in rural areas-70% within 15 miles.
- that they should check their plan options to see which covers the specific meds they are taking. These plan options will be available mid-October.
- that individual counseling is available through the State Health Insurance Assistance Program (SHIP). Minnesota residents can call 1-800-333-2433. They provide free counseling and assistance via telephone and face-to-face interactive sessions, public education presentations and programs and media activities.

2. Educate yourself:

- Medlearn has a web page dedicated to provider information on drug coverage at the toolbox at <www.cms.hhs.gov/medlearn/drugcoverage.asp>
3. **Once formularies are available**, consider downloading and keeping a copy available to consult when you are seeing patients and discussing the PDP options.
 4. **Print documents from the toolbox at Medlearn** <www.cms.hhs.gov/medlearn/drugcoverage.asp> and consider having copies available in your waiting or exam rooms. Documents that may be helpful for patients including, "Important Dates....." "Reproducible Artwork" "Quick Facts" and the two tri-fold pages. ■

The Bottom Line...

By George Dawson, MD



A recent Twin Cities article on the escalation of technology and real costs for cardiac care in Minnesota highlighted just how severe the resources have been skewed away from psychiatric care. [Olson J., Cardiac care focus worries insurers. Pioneer Press, August 8, 2005: p 1A, 4A.] If you have been following the Minnesota Psychiatric Society's initiatives in this area over the past few years it will probably come as no surprise - but even in that context I found the following numbers somewhat shocking:

Minnesota (a state with maximal managed care penetration) - has 40% fewer mental health beds per capita than the nation.

In the past 5 years - 5 new cardiac care facilities have opened at a cost of \$263 million.

An analysis of Medicare cost data for one hospital (United) shows why cardiac care is expanding and psychiatric care is shrinking. Here is a direct quote

from the article:

"A look at Medicare cost data for one local hospital shows why. It cost United Hospital \$8,091 to implant a pacemaker, but the hospital received \$11,538 for each procedure, according to 2003 data provided by the American Hospital Directory.

On the other hand, it cost United \$10,132 to treat a patient with psychosis, but the hospital received only \$4,282 per case. These are federal Medicare figures but the same disparities exist in payments by private health plans."

That's why you are seeing all of those shiny new Heart centers and no new psychiatric hospitals. Combined with the psychiatric outpatient penalty - it probably also goes a way toward explaining why the system is so fragmented and the seriously ill cannot find a psychiatrist.

An Entertaining and Eclectic Elucidation of Psychiatric Erudition

6th Annual Psychiatry Review

Radisson Metrodome Hotel, Minneapolis, MN

Monday September 19th

- 7:30 Registration and Continental Breakfast
- 8:30 Introduction; and Welcome; S. Charles Schulz, David E. Adson
- 8:40 Keynote address; The Texas Algorithm Project; Alexander L. Miller
- 10:00 Second Generation Antipsychotic Use in Depression and Anxiety; David E. Adson
- 10:45 The ADHD / Bipolar Conundrum; Gerald August
- 11:30 The Use of SSRIs in Minors; George M. Realmuto
- 12:00 Lunch
- 1:30 Gambling and other Behavioral Addictions; Jon E. Grant
- 2:15 Update on the Medicaid Mental Health Pharmacy Management; Mary Beth Reinke
- 3:00 Workshops
 - DBT and Borderline Personality Disorder; Richelle Moen Moore
 - Current Treatment of Impulse Control Disorder; Jon E. Grant
 - Treatment Algorithms; The Texas Project; Alexander L. Miller
- 5:00 Adjourn

Tuesday, September 20

- 8:00 Interface of Medical Illness and Psychiatric Disorders; Scott J. Crow
- 8:30 Clinical Utility of Neuroimaging; Jose V. Pardo
- 9:00 Overview of Treatment of Anxiety Disorders in Children; Anne Layne, Gail A. Bernstein
- 10:00 Second Generation Antipsychotics in Borderline Personality Disorder; S. Charles Schulz
- 10:45 The Use of Virtual Reality as an Adjunct to Psychotherapy, Christopher B. Donahue
- 11:30 Concluding Remarks; David E. Adson

Please note: MPS is teaming with the U of M on this program in lieu of a separate event.

Editorial



Legislative Update

By Dominic J. Sposeto, MPS Lobbyist

Legislative report

As I draft this article, the state legislature and governor continue to negotiate for a state budget solution that will end the special legislative session. Having failed to reach an agreement during the regular legislative session and during five weeks of a special legislative session, parts of state government have been shut-down. Now into the second week of the partial government shut-down, it appears that an agreement will be reached shortly. I am hopeful that by the time you read this article, our state budget for the next two years will be established and the state legislature will have gone home for the year.

A significant portion of MPS's legislative agenda is tied-up in the health and human services appropriation bill which is one of major budget bills in dispute. In this article, I will highlight the major legislative issues that were dealt with during the 2005 regular legislative session which ended May 23.

State Mental Health Services -

The legislature passed the Department of Human Services' 2005 mental health services bill. This bill follows up on the broad legislative authority granted to DHS last year to reform the state's regional treatment centers and community mental health services. This year's bill would allow the commissioner of human services to authorize additional days beyond the current 45 for people with mental illness who are admitted to state contracted acute care hospitals.

Rural counties would be given greater flexibility in providing mobile crisis intervention services. If a county demonstrates geographic or other barriers to current standards, it would be allowed to establish alternative provider standards. However these standards must result in increased access and comply with emergency mental health service requirements.

Other provisions in the bill make changes to court proceedings regarding child foster care

placements based upon access to treatment for severe emotional disturbances. Counties would be required to report to the court on the child's status in placement and include in that report the child's mental health treatment plan or interagency intervention plan. Also under this new law, advanced practice nurses certified in mental health can now be considered an "examiner" or "health officer of a health facility" for purposes of civil commitments. [Minnesota 2005 Session Laws, Chapter 165]

Mental Health Epidemiologist - MPS sponsored legislation to create a mental health position in DHS was not enacted. Our proposal to direct the commissioner of health to employ a mental health epidemiologist

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Addendum - Special Session Report

The state legislature and the governor finally reached an agreement on the state budget ending both the seven week special session and a ten day government shut-down. In this addendum, I will summarize the issues of interest to MPS that were part of the budget negotiations.

Most of our issues were part of the health and human services funding bill. This bill included:

- A new Health Impact Fee of 75 cents that will be levied upon every pack of cigarettes sold in the state. Using some of \$400 million raised from this fee, the legislature eliminated the limited benefit set for single adults under MinnesotaCare that was adopted in 20003, and also maintained current eligibility for families and single adults. The governor had recommended eliminating approximately 30,000 adults without children from the MinnesotaCare program.
- The \$5,000 cap on MinnesotaCare health care services for single adults was eliminated as was the \$3 co-pay for non-preventive office visits.
- The \$20 per month cap on co-pay for prescription drugs was reduced to \$12 a month.
- The state will pay for psychiatric consultations by video, email, phone or fax between a psychiatrist and a primary care physician or pediatrician beginning January 1, 2006. If the patient consents and subject to any federal limitations, the consultation may take place without the patient present.
- Effective January 1, 2006, any mental health services that are otherwise covered as a direct face-to-face service may be provided via two-way interactive video. Reimbursement will be at the same rates and under the same conditions that apply to that service. Interactive video equipment must comply with federal Medicare telemedicine standards.
- Pediatric Psychiatrists will be specifically added to the state's health professional student loan forgiveness program. Graduates or residents who agree to serve in "underserved" areas of the state will have portions of their medical school loans forgiven for each year served up to four years.
- Inpatient hospital fee for service reimbursement will be reduced by six

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Mobile Mental Health Crisis Services for Kids in the East Metro:

Responding to kids in crisis--when and where they need it



Children experiencing a mental health crisis need the appropriate level of care at the appropriate time ñ something that until now has been difficult to find. In an effort to improve outcomes for children having a mental health crisis Ramsey, Dakota and Washington counties have developed mobile mental health crisis services for children that offer:

- On-site response in 30 minutes to children in homes, schools or institutions
- 24/7 availability (except for Washington County)
- De-escalation and crisis intervention services ñ de-escalating the crisis, performing a thorough assessment to determine any mental health issues, and creating an initial crisis plan
- Crisis stabilization services - providing appropriate short term care (up to 2 weeks), transition to ongoing treatment, and crisis recurrence reduction strategies

The services are provided by licensed mental health professionals or mental health practitioners under the supervision of a mental health professional. Each county provides these services through existing mental health providers: Ramsey County/St. Paul Youth Services Children's Crisis Response, Dakota County Crisis Response Unit, and Human Service, Incorporated (HSI) Mobile Crisis Response.

Crisis response and crisis stabilization services are covered by M.A. and most local major health insurance companies. In Ramsey and Dakota County services are available to anyone regardless of ability to pay or insurance type. In Washington County services are dependent on insurance type.

Data shows that average wait times for children with a psychological or emotional crisis presenting at the Emergency Room can be 3-5 hours and only half of those children end up being admitted to in-patient units. The other half is released back into the community, often without adequate follow-up or ongoing services in place.

East Metro mobile teams are able to arrive at a home within 30 minutes and are able to de-escalate and stabilize over 90% of their initial crisis calls with the child staying at home. During the initial visit or later as a part of crisis stabilization services, the children and families are connected to additional community resources.

These services were developed in partnership with hospitals, health plans, providers, parents and the State of Minnesota. Providing the right level of care at



the right time leads to better outcomes for children and families, saves limited hospital beds for kids in need of more intensive care, and is a more cost effective service.

To access these services call:

Ramsey County - 651-774-7000

Dakota County - 952-891-7171

Washington County - 651-777-5222

For more information on these services, to set up an in-service training or to order free EMCCS brochures contact the EMCCS coordinator at 651-645-3688. ■

Psychiatrist

Part-time independent contract child/adolescent psychiatrist sought for large, comprehensive, nonprofit community mental health center in Washington County, MN-just east of the Twin Cities Metro area. Board certification in child/adolescent psychiatry preferred. Collaboration with nurse clinicians and many other mental health disciplines also enriches this job experience. We are a training site for the American Psychological Association. Visit our web page at www.hsicares.org. This is a part-time position. Salary negotiable. Send a vita and letter of interest to: Human Services, Inc. c/o Wendy Strom, 7066 Stillwater Blvd. No., Oakdale, MN 55128. Email to wstrom@hsicares.org. Fax to 651-251-5111.

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Scientific smorgasboard

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Theories of schizophrenia: a genetic-inflammatory-vascular synthesis

BMC Medical Genetics 2005, 6:7+doi:10.1186/1471-2350-6-7
Daniel R Hanson and Irving I Gottesman
Published February 2005

Schizophrenia, a relatively common psychiatric syndrome, affects virtually all brain functions yet has eluded explanation for more than 100 years. Whether by developmental and/or degenerative processes, abnormalities of neurons and their synaptic connections have been the recent focus of attention. However, our inability to fathom the pathophysiology of schizophrenia forces us to challenge our theoretical models and beliefs. A search for a more satisfying model to explain aspects of schizophrenia uncovers clues pointing to genetically mediated CNS microvascular inflammatory disease.

Discussion

A vascular component to a theory of schizophrenia posits that the physiologic abnormalities leading to illness involve disruption of the exquisitely precise regulation of the delivery of energy and oxygen required for normal brain function. The theory further proposes that abnormalities of CNS metabolism arise because genetically modulated inflammatory reactions damage the microvascular system of the brain in reaction to environmental agents, including infections, hypoxia, and physical trauma. Damage may accumulate with repeated exposure to triggering agents resulting in exacerbation and deterioration, or healing with their removal.

There are clear examples of genetic polymorphisms in inflammatory regulators leading to exaggerated inflammatory responses. There is also ample evidence that inflammatory vascular disease of the brain can lead to psychosis, often waxing and waning, and exhibiting a fluctuating course, as seen in schizophrenia. Disturbances of CNS blood flow have repeatedly been observed in people with schizophrenia using old and new technologies. To account for the myriad of behavioral and other curious findings in schizophrenia such as minor physical anomalies, or reported decreased rates of rheumatoid arthritis and highly visible nail fold capillaries, we would have to evoke a process that is systemic such as the vascular and immune/inflammatory systems.

Summary

A vascular-inflammatory theory of schizophrenia brings together environmental and genetic factors in a

way that can explain the diversity of symptoms and outcomes observed. If these ideas are confirmed, they would lead in new directions for treatments or preventions by avoiding inducers of inflammation or by way of inflammatory modulating agents, thus preventing exaggerated inflammation and consequent triggering of a psychotic episode in genetically predisposed persons. ■

Scientific smorgasboard



Minnesota Association of Community Mental Health Programs

Annual Community Mental Health Conference

September 28 - 30, 2005

Pre-Conference Institutes on September 27 & 28
DECC • Duluth, MN

Community Psychiatric Services

- Covering the Bases with Sex Offenders: Support Networks & Community Safety Issues, Beth Jones, PhD, LP; Troy Larson & William Tregaskis, PhD, LP
- Understanding Mental Status Exams, sicko, MA, LP
- How to Use Your Consulting Docket, Simon, MD
- Juggling with Fire: Tips & Strategies for Managing Outpatient Bipolar Mood Disorders, Farnsworth, MD
- Depression Update: What's New?, Farnsworth, MD
- Primer on the Newer Antipsychotics & Newer Antidepressants, Simon, MD
- Treatment of Individuals with Co-Occurring Disorders: ACT Teams, Harker, MD, Tracey Wilkins, LICSW
- Psychotropic Medications: Achieving the Promise of Remission, LaKosky, MD

Child & Adolescent Psychiatric Services

- Bipolar Disorder in Children & Adolescents: What's What's "True", Sutherland, MD & Charles Orsak, PhD, LP
- Calming the Emotionally Reactive Brain, Brankin, MD
- Lawyers, Psychiatrists & Schools - When the Law & Mental Health Issues Collide, Dikel, MD
- Autism Spectrum Disorders, Aqar Azeem, MD
- The Misunderstood Child - Suffering from Secondary Problems, Atkinson & Jean O'Malley-Laursen, MSEd, LP
- Understanding the Relationship Between ADHD & Bipolar Disorder, Staton, MD

Programs will be mailed out in mid August

For more information visit www.macmhp.org or call the Association office at (651) 642-1903

Legislative Update *Continued from page 10*

gist to assess the mental health needs of Minnesotans was deemed to be too expensive while the state was facing a budget shortfall.

Flexible Health Insurance Plans – Small Employers -

A bill sponsored by the Minnesota Chamber of Commerce and the National Federation of Independent Business to allow health plans to skip some of the state's mandated health insurance benefits when selling insurance to small employers was passed. Health insurers would now be authorized to offer flexible benefit health plans to employers of fewer than 50 employees. The business community suggested that small employers want the same ability as large employers to design their own health benefit packages. Large employers are already exempt from state mandates under the ERISA law. The most expensive state mandates are maternity and mental health benefits.

Although it is effective immediately, it will take health plans some time to develop and file minimum benefit plans and have them approved by the commissioner of commerce. Prior to the sale of a minimum benefit product, the employer and its employees must be informed of the mandated benefits that are being excluded. Whether health plans will offer striped down benefit sets without mental health coverage remains to be seen. Minnesota's health plans seem more interested in marketing health saving accounts and the high deductible products that are part of HSAs than minimum benefit plans. [Minnesota 2005 Session Laws, Chapter 132]

Smoking - Mental Health Units - The issue of

smoking in hospital mental health units was again addressed by the legislature and continues to be somewhat divisive among the MPS membership. This year's legislation would have reinstated an exemption from the clean indoor air act that allows for smoking in mental health and chemical dependency treatment units within hospitals. This legislation did not pass and the complete hospital smoking will continue.

MPS also supported a bill to implement a statewide ban on smoking in bars and restaurants. The "Freedom to Breathe Act" was supported by most health care professional organizations in the state. Considerable opposition from the hospitality industry and bars was able to defeat this proposal this year.

Emergency Health Powers Act - This Department of Health bill clarifies the liability of health care providers who assist local officials during a public health emergency or disaster. Under this new law a provider shall be considered an employee of the political subdivision for purposes of liability and workers' compensation when providing care under a public health emergency declared by the governor. By being considered a state employee, the liability of physician responding to a declared emergency would be capped at the state liability limit. Also, health care providers will be required to notify individuals before performing examinations of their right to refuse examination, treatment or vaccination and the consequences of this refusal. [Minnesota 2005 Session Laws, Chapter 150]

National Provider Identifier - Minnesota will require

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Adult and Child Psychiatrists

HealthPartners Medical Group is one of Minnesota's largest practice groups with more than 600 physicians practicing in 35 specialties. Our Behavioral Health Division seeks to add board certified Psychiatrists to provide quality care in our outpatient department and assume teaching roles in the Hennepin-Regions Residency Training Program. We will support application for faculty appointment with the University of Minnesota Medical School.

We offer an excellent salary/benefits package, a rewarding practice environment and a total commitment to providing exceptional care. To pursue with us, submit your CV and cover letter by fax to 952-883-5395, by email to lori.m.fake@healthpartners.com, or mail to HealthPartners, Physician Services, Attn: Lori Fake, Mail Stop 21110Q, P.O. Box 1309, Minneapolis, MN 55440-1309. For more information call 952-883-5337 or 800-472-4695. EO Employer



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Combat Stress Control

Continued from page 1

with their ability to handle the stress," adds Roberts.

The day-to-day grind of wartime, which of course is not a "nine to five" type of job, also led to much distress for soldiers. Many of the younger soldiers did not have what Roberts calls the "this too shall pass mentality," but rather tended to see everything as a crisis. "You have to make your available energy last," he would tell them. "You can choose how you react to this." A particularly challenging issue was soldiers' trying to deal with family problems from afar. Such problems were perhaps multiplied by the heretofore unheard-of ability to communicate instantly with family back home. Roberts describes this as a double-edged sword. "The ability to keep in touch is really important", he says, "but I think there are certain circumstances where they were more interested in what was going on at home, in situations where they had no control over it." Roberts saw this detract from their ability to do their jobs effectively, and he often worked with soldiers to decrease this behavior. "It was either a good support or a very major distraction," Bacon agrees, and adds "a lot of that was determined by how the relationship stood before they came over to Iraq."

One hope regarding the Combat Stress Control units is that they will be able to reduce the incidence post-traumatic stress disorder. In discussing this issue, Bacon was cautiously optimistic. "I do know that when we processed [the trauma] with them, they weren't denying it away, they were talking amongst each other, finding that support. They were obviously more comfortable after our interventions. So I'd like to think we're also helping prevent longer term problems." Another important service available to overwhelmed soldiers was the "restoration site," also referred to as a "fitness center." This was a "de-escalation place", according to Roberts and Bacon, where a soldier could spend up to 72 hours getting some counseling and rest after a particularly difficult experience. However, after 72 hours the expectation was very clear that the soldier would return to duty. "They noticed all the way back into World War I," says Bacon, "that if you pulled a soldier out from the front, you weren't very likely to get him to go back. So these restoration/fitness sites were places they could go to that were safe, where they could stay for a couple days, but that were still close to where they were from."

Division Mental Health continued to play an important role, particularly when a soldier needed extra help. Roberts saw several cases of full-blown PTSD, a soldier who turned out to have bipolar disorder, and one who had a first psychotic break. Suicidality, while rare, was a particularly tricky issue, due to the fact that weapons were ever-present. Many of these soldiers needed evacuation and eventual removal from combat. However, evacuation was never simple, and always involved a significant

amount of risk in itself. For these reasons, it was especially important for the Combat Stress Control units to work closely with Division Mental Health, while often by default taking on many of the functions formerly performed by them.

Roberts and Bacon are both clearly proud that they were able to return the vast majority, about 98%, of their patients to duty. This high success rate in returning soldiers to duty allowed the 785th to serve as "combat multipliers", according to Roberts, meaning they enhanced the ability of the combat units to carry out their missions. This helped increase the acceptance of mental health treatment among the commanders, many of whom initially resisted the presence of Combat Stress Control personnel. According to Roberts, "their biggest fear is that you're going to evacuate all these people." But once it became clear that the primary focus of Combat Stress Control was to support the soldiers and return them to duty, some of the commanders became more welcoming. Bacon had such an experience when visiting a unit that had suffered a number of casualties. The commander made it clear that his presence was not wanted, but Bacon says that once he did his briefings and one to one counseling with the soldiers, the commander called him a "force multiplier" and told him he was welcome to come back anytime.

Roberts and Bacon also tried to practice what they preached. "You take care of each other," said Bacon. Taking time for themselves, exercising, reading books, and maintaining a sense of humor were important. "Care packages were huge," says Roberts. For Bacon, like many other soldiers he met, faith was an important source of resilience and strength. Roberts kept a journal, but is waiting a while before he looks at it, preferring to give himself some space from the experience first. "I saw some things I never thought I'd see, and some things I thought I'd see, I didn't," he says. "The bottom line is that everyone in our company came back alive, which is huge." After spending a year in Iraq, he says, "some things become more important, a lot of things become less important," he says. "And that's OK." ■

Legislative Update

Continued from page 13

all health care providers to employ a unique national provider identification number when submitting paper or electronic claims. This requirement will become effective 24 months after national provider identifiers are adopted by the U S Secretary of Health and Human Services. Health plans will be required to use provider identification numbers at the same time. National provider numbers seem a few years off. [Minnesota 2005 Session Laws, Chapter 106] ■

Continued ...

Legislative Addendum

Continued from page 10

- percent effective July 1, 2005. Mental health DRGs 424 to 432 will not be reduced.
- Emergency room visits will not be paid under Medical Assistance unless they are for emergency and emergency post-stabilization care, reducing hospital payments by \$3.3 million.
 - The commissioner of human services was given the authority to restructure state mental health services. He can develop pilot projects, implement enterprise activities for adult mental health, add sites for the Minnesota Security Hospital and close regional treatment centers. He also was given flexibility in shifting funding when restructuring mental health services.
 - A hospital must complete an evaluation regarding appropriate level of care to anyone admitted to the facility within three working days.
 - A patient with autism or pervasive development disorder may receive a diagnostic assessment every three years instead of annually, if a mental health provider attests that there has been little change in the condition.
 - Physicians, hospitals, midwives and other licensed providers of pre-natal care must make information available on postpartum depression to new mothers and fathers. The commissioner of health was directed to work with providers to develop information on post partum depression.

- The Medical Assistance program will be changed to comply with the new Medicare Part D drug benefit. Dual eligibles will be required to obtain their prescriptions from Medicare Part D or Medicare Advantage Plans.
- The Department of Human Services will have a Medical Director who will work with a Medical Advisory Committee to reduce inappropriate medical services and improve health outcomes.
- The Department of Human Services will establish a 13 member Health Services Policy Committee which shall advise the commissioner on the administration of health care benefits under state programs. The committee shall elect a physician chair from its membership and meet at least quarterly.
- The suicide prevention program at the Department of Health was eliminated (\$900,000).
- All hospital and physician group practices must have interoperable electronic medical record systems in place by January 1, 2015.
- One hundred and sixty five million dollars from the Health Care Access Fund was transferred to the state general revenue fund to help with the state budget deficit. ■



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Calendar

- September 13** **Primary Care Approach to Integrated Care of Depression, Mankato** Mankato Clinic.
Call 651-407-1873 for more information or to register for this lunch meeting at noon.
- September 15-16** **Minnesota Medical Association Annual Meeting** Minneapolis Marriott City Center,
Minneapolis. Call 612-378-1875 for more information.
- September 19-20** **Sixth Annual Psychiatry Review: An Entertaining and Eclectic Elucidation of Psychiatric
Erudition.** Presented by the University of Minnesota. Radisson Metrodome Hotel,
Minneapolis, MN. Call 612-626-7600 or 1-800-776-8636 or go to www.cme.umn.edu
for more information.
- September 30 -
October 1** **Golden Gleanings from Gracious, Galvanizing Gurus** Psychiatric Update/Fall 2005,
Monona Terrace and Convention Center, Madison, Wisconsin. Jointly sponsored by
the University of Wisconsin Medical School and the Madison Institute of Medicine,
Inc. For more information, please contact Lynn Tobias at 608-827-2462 or go to
www.miminc.org/cmeconferences.html.
- October 10-11** **Integrating General Medical and Behavioral Health Care in the Medical Setting,**
Embassy Suites Minneapolis Airport, Bloomington, MN For more information or to
register, go to www.mnpsychsoc.org or call 651-407-1873.

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