Ideas of reference

Jan/Feb 2008
Volume XLI

MINNESOTA PSYCHIATRIC SOCIETY

Working on behalf of psychiatric physicians and their patients

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Ideas of Reference is the newsletter of the Minnesota Psychiatric Society, a district branch of the American Psychiatric Association

VOTE!

Your MPS ballot is enclosed.

Please return it to the MPS office by March 15.

MINNESOTA PSYCHIATRIC SOCIETY

Working on behalf of psychiatric physicians and their patients

Our vision is physician leadership creating the nation's highest quality, affordable and accessible integrated system of mental health care.

www.mnpsychsoc.org

Minnesota Council of Health Plans Report Measures Mental Health Need

Report is a Call to Action

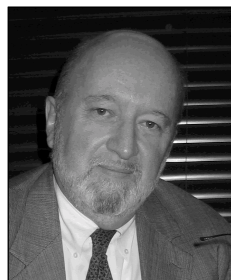
On February 6, the Minnesota Council of Health Plans released a report that showed the current need for children and adolescents exceeding resources, and the psychiatric care needs for our aging population continuing to grow. MPS appreciates the Minnesota Council of Health Plan's members who shared claims data for this report, and encourages their initiative and continued investment in this important issue. Much has been said about the broken system psychiatrists and their patients call home, and the data in this report illuminates the critical need for safe, timely and appropriate services.

The report also pointed to the promise of innovation by highlighting the DIAMOND Initiative. MPS, along with many other entities, has sought innovative ways to integrate and carve-in psychiatric care to improve access to quality care. Now is the time to pool our resources and invest in efforts to coordinate care as a way to provide access to the continuum of care needed by Minnesotans with psychiatric illnesses. MPS invites the health plans to join us in addressing these issues with concrete actions for the sake of the patients we serve.

The full report is available under the news and reports tab at www.mnhealthplans.org. ■

MPS Elections: Meet the Candidates

In March, MPS membership will elect a President-elect and two Councilors. The candidates for office have each submitted a statement for your review. The statements continue on page 6. Your ballot is inserted in this newsletter and must be returned by March 15 to be counted. Thank you for voting!



President Elect

James Jordan, MD

My Dear Psychiatrist Colleagues,

If elected President of the Minnesota Psychiatric Society in 2009, my job will be to follow through on the implementation of the strategic vision our society agreed to in January 2008. We are committed to setting an affordable, accessible, quality standard of mental health care for all Minnesotans. This is our ethical duty as a professional society. This year we are building alliances with legislators and consumer constituencies to be sure that the state benefit set includes sufficient psychiatric evaluation services and continuity of psychiatric care to stem the current hemorrhage into emergency rooms. As the Director of Hamm Clinic, I participated in the formulation of the Institute for Clinical Systems Integration (ICSI) depression guidelines that will be utilized by the Depression Improvement Accross Minnesota - Offering a New Direction (DIAMOND Project). It will be important that we clearly define the role of psychiatrists and monitor the implementation of these guidelines as they affect patient care. My special contribution is a career of working in an integrated practice model. This means that I will advocate that the mental health disciplines—psychiatry, psychology, social work and psychiatric nursing—work as a collaborative team to achieve enduring, cost effective, measurable outcomes for our patients. ■

***Candidates** Continued on page 6*

Ideas of Reference

The newsletter of the Minnesota Psychiatric Society is published bi-monthly: Jan-Feb, Mar-April, May-June, July-Aug, Sept-Oct and Nov-Dec 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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From the Editor:
Be Careful and Speak Up

With the Mental Health Report from the Minnesota Council of Health Plans, Minnesota purports again to reform the mental health system. The report rightly highlights the DIAMOND Program, which shows promise in improving care. However, there have been numerous previous efforts at reforming the system. The current report represents the third major attempt since 2003. The publication of the *MPS Task Force Report on the Shortage of Psychiatrists and of Inpatient Psychiatric Beds*, along with some other factors, led Attorney General Mike Hatch to convene the major payers with psychiatrists to come up with recommendations for reform. The process took new life in the Minnesota Mental Health Action Groups. In the meantime, life for patients and clinicians has not changed much, with some gains and losses. I urge us as clinicians to help put perspective on the health plans' findings.

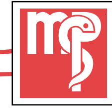
For example, what does it mean that "97% of children prescribed antidepressant medication did not receive followup care recommended by the FDA"? The real issue is that clinicians need to assess risk and provide appropriate followup for the individual patient. They must provide a plan that minimizes risk, as well as providing a sense of trust that patients can reach them or their on-call service in any emergency. All this obtains, whether or not a patient has been prescribed a medication.

Does having 7 psychiatric visits in the first 12 weeks, including 4 in the first 4 weeks, mean this will all happen? This was the original FDA recommendation as part of the antidepressant warning. Were there studies to show this made a difference? Do patients know the FDA warning was always about suicidal thoughts or behavior, and never about suicide? Do they know that in the first year after the FDA warning, the rate of antidepressant prescriptions to children went down 20 percent, and the rate of suicide in children went up for the first time in a decade? Should child clinicians insist on 7 visits in the first 12 weeks, realizing that this will reduce their ability to see new patients? Does anyone really see people this often? I have never had a parent feel this number of visits was necessary, even when I explain the FDA warning. How many families would comply if we insisted? In a pay-for-performance system, we and our patients lose if we drive them away.

As an epilogue, I emailed the FDA's Center for Drug Evaluation and Research to request an update on the current FDA guidelines for antidepressant followup, since I could not find these anywhere on the FDA site. They responded with, "Since we are a regulatory agency, we cannot provide medical advice. The FDA does not provide recommendations for followup regarding treatment in children". This represents a backing down from the "7 visits in 12 weeks" guideline that came with the original antidepressant warning. The statement from the health plans that 97% of children do not receive FDA-recommended followup is based on recommendations that are apparently no longer endorsed by the FDA. If this is true, the health plans' statement is inaccurate at best, and casts everyone, including patients, in a negative light while saying nothing about what

Continued on page 6

Talk about it! is a youth mental health education program offered by the Mental Health Association of MN that reaches out to teens with a MySpace website sharing information about depression, suicide and eating disorders. Contact Audrey Peer at 612-331-6840 or Myspace.com/teen_talk_about_it.



Mission, Vision and Values Offer Compass

by Jeff Hardwig, MD
MPS President

Nobody needs a compass on a sunny day while walking down a well-worn path. But when the way ahead is not marked and the sky is cloudy, the compass is essential to making it through safely. It still requires a mind's-eye view of where you are and in what direction your goal lies to use the compass. Our profession is still looking forward to finding both a clear path and sunny days. Fortunately, we do have a compass in the form of our Vision, Mission and Values Statements to guide us. It still requires a mind's-eye view of where we are and in what direction the goal lies to use the compass.

Our Vision, Mission and Values were reassessed by a group of MPS leaders who met on October 27, 2007. The words are best read slowly, pausing frequently in order to let the meaning sink in. The brevity of these lines belies the depth of the process of producing them.

We find ourselves, with our patients, in a carved-out wilderness outside of mainstream medicine. We envision that physician leadership will guide our patients back where they belong, to an accessible integrated system of safe and effective mental health care (safe and effective = quality, quote according to Dr. Jon Van Loon).

To achieve our vision, our mission calls for an increase in collaboration within the mental health care system. Primary care physicians, pediatricians, physician's assistants, nurses and advanced practice nurses, psychologists, social workers, and others all provide some level of access to care. Improvements in our systems of care begin with meaningful conversations among members and leaders to define shared goals, and to identify and remove obstacles to access collaboration and communication.

This process has already begun again in earnest in Minnesota. Conversations have changed from a definition of the problem to a search for solutions by a number of groups including MPS, The Institute for Clinical Systems Integration (ICSI), the Minnesota Mental Health Action Groups (MMHAG), and the Minnesota Society of Child and Adolescent Psychiatry (MSCAP). Outside the system of clinical care, we must also connect more effectively with legislators, advocacy groups, health plans, and the public to make them aware of our patients' needs and the consequences of lack of care.

We remain committed as always to our traditional mission of patient advocacy and to providing timely educational outreach as we have in the past. In addition to the many educational opportunities available to our members, our focus is often on challenging issues. Readers may recall programs on Scientology and the black-box warning on SSRIs. In the same vein, we are looking forward to upcoming topics such as conflict of interest, very brief psychotherapy, and child psychiatry for the general psychiatrist.

MPS's values define our professional identity, and the input from our membership this year helped us refine that identity. We are grateful. As Minnesotans seek various solutions to the access problems our patients face, it is essential that we not compromise our values to achieve access. It is here where we must use our compass—our mission, vision, and values—where it will be most necessary to guide us. The need for access is so great that some may be tempted to risk patient safety and the effectiveness of care in order to provide at least some kind of access. MPS believes that the prescribing of medication should only be done by physicians or advanced practice healthcare professionals, within the boundaries of their professional licenses. As we increase our collaboration with other medical providers, patient-centered ethical and clinical standards will be our guide. MPS is working hard to provide practice resources online. If you have any ideas or would like to get involved with this, please contact us. ■

VISION: Physician leadership creating the nation's highest quality, affordable and accessible integrated system of mental health care.

MISSION: Our physician leadership promotes patient advocacy and educational outreach to support: psychiatry as a profession, strong collaboration among entities within and outside the health care system, efforts to improve patient access, and rational development of Minnesota's health care delivery system.

VALUES:

- Highest ethical and clinical standards
- Barrier free, safe and effective care
- Supportive collegial workplace
- Effective communication and networking with health care professionals, as well as patient/family advocacy groups
- Continuing medical education that promotes safe and effective care
- Responsive leadership with long-term vision

Psychiatry, the "Art" or the "Science"?

William H. Reid, MD, MPH, President, Texas Society of Psychiatric Physicians
Reprinted with permission: Dec/Jan 2008, *Texas Psychiatrist*.

Our specialty – our *medical* specialty – occasionally catches flak for being "different" from the other specialties. We've all been pulled into the philosophical question: Is psychiatry an "art" or a "science"? I'm often asked that question by lawyers attacking the credibility of psychiatric testimony. Just last week, a vigorous defense attorney tried to dilute my opinions in a murder trial by demanding that I agree with him that psychiatry is an "inexact" branch of medicine, compared to neurology or surgery.

Don't fall for that. Don't even allow listeners to take the question seriously. Once such a premise is given credence, especially in an "either-or" format, the audience (be they colleagues, patients, or jury members) becomes primed to pigeonhole psychiatry as something very limited, and something it's not.

Like many of us, I learned early that psychiatry has far more similarities to, than differences from, the rest of medicine. Our primary tasks, which we can fulfill admirably for most patients, are consistent with all the important medical traditions, from Hippocrates' exhortations to the present.

We strive to alleviate pain. People have sought out physicians for the relief of pain since ancient times. Good psychiatrists listen to their patients, and often recognize more kinds of pain than do other doctors. In the best Hippocratic tradition, we see, we listen, and we feel what our patients have to convey. Then we do something about it. We have an armamentarium of "analgesics" – and not just drugs – that address the body, the mind, and the spirit. Alleviate pain. I can't think of a higher calling for medicine, and we do it well.

We mitigate, attenuate, and sometimes cure, illness. Quality psychiatric treatment does a good job of treating mental illness. The stereotype many of us endured years ago, of the supposed impotence of psychiatry in the face of severe illness, just doesn't apply when good clinicians take advantage of modern therapeutic techniques. It's true that some of our patients don't get much better, and some of the disorders we treat are refractory to our efforts, but we should not forget that the same is true of other specialties as well. Like our colleagues in cardiology, nephrology, and oncology, we can relieve the pain, attenuate the pathology, and change the disease course for most of the patients we see.

We diagnose or clarify symptoms. Psychiatric symptoms are routinely confusing, and often frightening, to patients and those around them. Simply clarifying symptoms and helping patients see that they are logical and controllable, not random and chaotic, alleviates a lot of suffering. Good psychiatrists are among the best diagnosticians in medicine. Perhaps that's because we're trained to spend *time* with patients, listen closely to them, gather information from disparate sources, and recognize even the unspoken symptoms that are reflected in our patients' feelings and behaviors.

We see and attend to the whole patient, within himself, his family, and his larger environment. No specialty covers the patient more completely than psychiatry. Our work often must take other body systems into account. Our clinical bailiwick includes not only "mental" illness but also the psychiatric aspects of virtually every other medical condition, physical trauma, and sociocultural experience encountered by people at every age and stage of life. We take the concept of "biopsychosocial" seriously.

We study medical and scientific topics to expand the boundaries of our clinical knowledge. The breadth and depth of clinical education available to, and expected of, psychiatrists is staggering. The educational programs at Texas Society of Psychiatric Physicians, APA, and other professional meetings run the gamut from the emotional impact of disasters to psychotherapies, biological treatments, genetic and molecular research, and far beyond. The National Institute of Mental Health is the largest single part of the National Institutes of Health. Psychiatry has more peer-reviewed journals catalogued by the National Library of Medicine than any other specialty. No specialty pursues more, or more varied, clinical, social, and epidemiological research endeavors.

We *help* people, and place that help before virtually everything else when working with patients. We help people in more different clinical and social settings than any other specialty, from hospital to outpatient care, from day program to correctional institution, from academia to rural outreach, from salaried position to private practice, from direct care to administrative oversight. Medical students going into psychiatry, residents who have made a commitment to our specialty, and seasoned practitioners alike are generally infused with the concept of helping others. We're not in it for the money or the status. We don't spend our careers out of sight of patients. We have chosen to meet our patients head-on, to see their symptoms and their plights first-hand, not filtered through laboratory tests or radiographic images or isolated in some sterile, draped surgical field. We see our patients' personal responses, good or bad, to the care we give. Sometimes that's hard to do; sometimes we burn out; but we stick with it as long as we can, because our patients and their families matter.

We lead the patient's treatment team. With a few exceptions (such as when we are consultants or work in consultation-liaison

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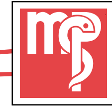

Scientific Smorgasbord

Is Telepsychiatry Equivalent to Face-to-Face Psychiatry? Results From a Randomized Controlled Equivalence Trial

Richard O'Reilly, MB, FRCPC, Joan Bishop, MD, FRCPC, Karen Maddox, RN, MA, Lois Hutchinson, MD, FRCPC, Michael Fisman, MB, FRCPC and Jatinder Takhar, MD, FRCPC

OBJECTIVE: The use of interactive videoconferencing to provide psychiatric services to geographically remote regions, often referred to as telepsychiatry, has gained wide acceptance. However, it is not known whether clinical outcomes of telepsychiatry are as good as those achieved through face-to-face contact. This study compared a variety of clinical outcomes after psychiatric consultation and, where needed, brief follow-up for outpatients referred to a psychiatric clinic in Canada who were randomly assigned to be examined face to face or by telepsychiatry.

METHODS: A total of 495 patients in Ontario, Canada, referred by their family physician for psychiatric consultation were randomly assigned to be examined face to face (N=254) or by telepsychiatry (N=241). The treating psychiatrists had the option of providing monthly follow-up appointments for up to four months. The study tested the equivalence of the two forms of service delivery on a variety of outcome measures.

RESULTS: Psychiatric consultation and follow-up delivered by telepsychiatry produced clinical outcomes that were equivalent to those achieved when the service was provided face to face. Patients in the two groups expressed similar levels of satisfaction with service. An analysis limited to the cost of providing the clinical service indicated that telepsychiatry was at least 10% less expensive per patient than service provided face to face.

CONCLUSIONS: Psychiatric consultation and short-term follow-up can be as effective when delivered by telepsychiatry as when provided face to face. These findings do not necessarily mean that other types of mental health services, for example, various types of psychotherapy, are as effective when provided by telepsychiatry. ■

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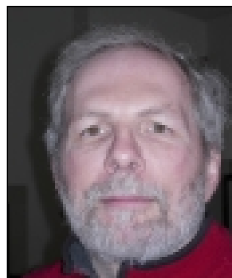


Candidate for Councilor

George Dawson, MD

I know political rhetoric and I have a long memory. These are two skills that most voters lack when it comes to trying to figure out how politicians move public policy farther and farther from reality.

I was the MPS public affairs representative at a meeting in 1994. The theme of the meeting was how managed care companies were taking over. A managed care consultant was one of the leading speakers. He talked about how specialty practices would be bought out or closed and all of the emphasis would be on primary care. Psychiatrists would be relegated to med checks and a minimal amount of talking to patients. We all know how that worked out. Now managed care companies employ specialists and build a lot of specialty care centers. As it turns out psychiatry is harder to practice.

During the course of my career, I have noticed the disconnect between reality and public policy. A great example is utilization review. I was a Medicare PRO reviewer. All reviewers in that program were screened for conflicts of interest and could not review hospitalizations in any facilities that they were affiliated with. This program was eventually discontinued because the reviewers did not find that the number of unnecessary hospital days was enough to pay for the program. There is no scientific justification for utilization review – it is strictly a business practice. That business practice and how it can be applied now sits squarely in the Minnesota statutes.

I think that we have to be politically smarter. I have been told that part of the Councilor position that I am running for involves political strategy and advice to the President. I think that I can do that job and provide a unique perspective.

Be Careful and Speak Up *Continued from page 2*

good followup really is.

We psychiatrists need to be careful and speak up as this process proceeds. By the way, please vote in the election and thank your MPS candidates, who have agreed to devote significant time and energy to serving all of us.

Eric Larson, MD

Behavioral Health clinics and individual practices are invited to participate in a statewide collaborative to improve depression care. It involves using the PHQ-9 to measure symptom severity and 6 and 12 month response and remission rates. The Minnesota Community Measurement website will be the data repository. If interested contact Linda Vukelich at l.vukelich@comcast.net or 651-407-1873.

Candidate for Councilor

Eric Brown, MD

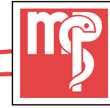
I am a native Minnesotan, was raised in Stillwater, and attended Macalester College in St. Paul and the U of M medical school and residency. I completed residency in 2003 and completed a yearlong research fellowship in the Department of Psychiatry in 2004, focused on borderline personality disorder. I am currently a staff psychiatrist at the Minneapolis VA in the Post-Traumatic Stress Recovery program. I am the site director for the medical student rotation there, and stay active in residency education as well.

I have been involved in MPS since my time as MIT representative on the Council in 2002-2003. In 2004 I began to co-edit our newsletter, *Ideas of Reference*, a collaborative effort which I have found to be quite interesting and enjoyable, and which has helped broaden my perspective of the important issues facing our profession. I recently agreed to fill the Councilor position vacated by Ann Felde, MD after her departure to Germany, and I'm now running to continue in this position.

My main desire in working with MPS has been to improve the standing of psychiatry among other professionals, students, and the public. This goal, for me, encapsulates most of the major challenges we face today. One aspect of this goal is the reduction of stigma attached to mental illness, and I think we should continue to educate other professionals and the public about mental illness with this goal in mind, with CME events, discussions with government officials, and public advocacy. Partnering with other advocacy groups might be an effective way to supplement our own efforts as well. Recognition of our expertise and our contribution to the well being of the public by reimbursers and government entities, and integration of psychiatric care with other medical care systems, is key. We need to continue to recruit talented and compassionate students to join us, and we need to continue to advocate for our importance on the mental health treatment team, at a time when other disciplines seem, intentionally and unintentionally, to be vying to replace us. I believe strongly that we should maintain our expertise in all effective treatment modalities, because this is the only way, I believe, that we can prevent ourselves from being marginalized among the larger team of mental health providers out there.

I am thankful to have had the opportunity to work with the dedicated group of people I have come to know in MPS, who have been role models and friends to me. I hope to serve all of you well.

APA Patient and Family Resource: The Let's Talk Facts fact sheet on schizophrenia is now available at www.healthyminds.org/factsheets/LTF-Schizophrenia.pdf



PSYCHIATRIC NEWS / January 18, 2008

Be Careful With Your Signature

Every so often, staff of APA's Office of Healthcare Systems and Financing feel the need to remind APA members about the importance of not signing off on patient care in which they do not participate and not letting their signature be used in stamp or electronic form to validate care that they are not in charge of. APA's Managed Care Help Line recently received a call from a psychiatrist serving as medical director of a rural mental health clinic where he had been placed by the Health Resources and Services Administration. The physician was concerned because although he held the title of medical director, he was not involved in the clinic's decision-making process. He was told by the clinic's administrator that the psychiatrist's job is to sign off on the psychiatric evaluations being done by licensed counselors employed by the clinic so they could be billed under his name and to see patients who needed prescriptions. The psychiatrist said he felt very uncomfortable about being asked to sign off on diagnostic and counseling work done by the counselors and did not want to do as asked. He was correct in his refusal to allow his name, and his medical degree, to be used to validate evaluations and treatment for payment when he had had no involvement with them. Physicians should never permit their signature to be used in this way; one reason is that it makes them legally responsible for the patient's care. If problems are later identified and legal action results, the physician whose signature appears on the patient's record is the responsible party. Under Medicare, physicians' signing off on patient services when not involved in overseeing the patient's care is illegal. Medicare does allow for services to be billed under a physician's name as "incident to" the physician's care, but this means that the physician is in charge of the care, reviews treatment provided by other clinicians under his or her direction, and is present on the premises when the treatment is provided. **So take care: If you are not in charge of a patient's care, be sure that you don't inadvertently sign something that makes you the patient's physician and do not permit facilities that you work for to use your signature either in stamp or electronic form on a patient record or for billing justification.** *For more information, call the APA's Managed Care Help Line at (800) 343-4671.* ■

Psychiatry Art or Science *Continued from page 4*

with other physicians), patients and their families should view their psychiatrists as the leaders of their treatment teams, using and modeling our skills in interviewing, examining, communicating, diagnosing, prescribing, performing psychotherapy, and generally being doctors. If your patients, your team colleagues, or your employers or supervisors think otherwise, or treat you as if you *don't* have those skills and expertise (or as if you and your specialty were merely adjuncts to psychiatric patient care), think about why they've formed such an impression. **What are you doing to make sure your patients get the same level of care, expertise, and sophistication from psychiatry that they expect from other specialties? Accept your leadership role in your patients' care. Don't let anyone tell you that you're just another member of the treatment team, working in an "inexact" profession, or resigned to some neither-fish-nor-fowl position between art and science. Take psychiatry and its position in the pantheon of medicine seriously, and practice well.** ■

DHS Issues Bulletin on ACT Teams

DHS has issued a bulletin providing additional information about ACT Teams (Assertive Community Treatment Teams). As an evidence-based psychiatric rehabilitation practice, ACT provides a comprehensive approach to service delivery to consumers with serious mental illness who have demonstrated their need for this most intensive level of nonresidential community service. ACT uses a multidisciplinary team that typically includes a psychiatrist, a mental health professional who serves as the team leader, and one or more nurses, substance abuse specialists, supported employment specialists, peer recovery specialists, and other mental health professionals, practitioners, or rehabilitation workers. The team is responsible for providing virtually all needed community services to a designated group of recipients. The bulletin contains a list of revised standards. To view the entire bulletin go to *www.dhs.state.mn.us.* ■

A new booklet is available through NAMI – **Advocating for People with Mental Illnesses in the Minnesota Criminal Justice System**. Copies are free to families and others; however, NAMI encourages people to send a $1 donation per copy when requesting multiple copies. The new NAMI video entitled "Coming Home: Supporting Your Soldier" is also available for $20 plus shipping and handling. To order one or both, please e-mail libsen@nami.org

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CALENDAR

March 5 Mental Health Legislative Network 2008 Day on the Hill
Contact MPS at 651-407-1873 or MMA at 612-378-1875

March 6 Minnesota Medical Association Day At The Capitol
Contact MPS at 651-407-1873 or NAMI at 651-645-2948.

March 8 MPS Council Meeting
MPS Council Meetings are open to interested MPS members. For more information, contact MPS at 651-407-1873 or l.vukelich@comcast.net.

Recruit and Win!

APA Member Get-a-Member Campaign

APA MEMBERS - Refer a potential new member to APA in 2008 and win special prizes for your recruitment efforts!

Refer at least one colleague and be eligible for quarterly drawings to win a $100 American Express Gift Card and other special prizes!

PLUS: All recruiters whose referrals are approved and enrolled for membership will be eligible for the grand prize drawing to ***win Complimentary Registration for the APA Annual Meeting in May 2009 or a free year of membership*!***

Recruitment Guidelines:

- Campaign will run from January 1 – December 31, 2008.
- Contest is open to all APA members in good standing.
- Eligible referrals include psychiatry residents (Members-in-Training) and fully trained psychiatrists (General Members). Former members who have not been members for at least one year are also eligible.
- Medical students and international psychiatrists are not eligible.

Referrals must be approved and enrolled for membership by December 31, 2008 in order for the recruiter to be eligible for the grand prize drawing.

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DHS Consolidating Statewide Child and Adolescent Behavioral Services

Wes Kooistra, the assistant commissioner for DHS, announced the consolidation of State Operated Child and Adolescent Inpatient psychiatric beds (CABHS) on February 1. The two sites of service at Willmar and Brainerd will be combined at Willmar. Bed totals will decrease from 37 to 26 beds. There were several causes for the move including declining census over several years, which resulted in significant budget shortfalls. Kooistra noted the high quality of services offered at Brainerd but also the need to improve the viability of state operated inpatient beds through the consolidation.

This closing takes place in an environment in which hospital emergency rooms have at times sent children and adolescents out of state or at some distance from their homes because psychiatric beds, especially in the metro, were full. Recently, concerns about the need for hospital beds in the child mental health system were reviewed by a task force headed by Glenace Edwall. Members included child psychiatrists and administrators across the metro area. Data showed that patient flow into and out of hospitals is hampered by too few step-down programs. As a result, children stay in hospitals, awaiting specialized community placements. A clear shortage of child psychiatrists is another cause for delays in obtaining a bed when a mental health crisis requires hospitalization. CABHS is expected to reinvent itself as it has done many times since the Brainerd campus shifted from a state run orphanage in the 1970's to its current function as an acute care hospital. Future directions for CABHS could be facilitating the growth of Partial Hospital Programs and the identification of gaps not well served by acute hospitals including serving youth with Autism Spectrum Disorder and those with neurocognitive disabilities with psychiatric disorders.

CABHS provides comprehensive hospital and community-based mental health services to children and adolescents ages 6 to 18 who have a serious emotional disturbance and whose needs may exceed the capacities of their families and local communities

Development of a variety of community-based alternatives to the CABHS program has resulted in decreased use of inpatient services at both the Brainerd and Willmar CABHS sites since 2004, said DHS Assistant Commissioner Wes Kooistra.

The dedicated staff of this program has enabled CABHS to become a valued component of children's mental health services in Minnesota, Kooistra said. This consolidation ensures that the hospital service will remain viable and continue to meet families' needs. ■