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RAMIFICATIONS



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## I am a person... not my illness

BY BONNIE NEIGHBOUR



What is normal? For me normal is a full life of ups and downs, fears and confidence, confusion and clarity, struggles and blessings, dreams and nightmares. For me “normal” has nothing to do (or not to do) with illness, it just *is*. The mental health world provides some tools that help my “normal” to be the best it can be, but I am so much more than a mental health patient or mental health consumer. I am a person. I am me.

Why am I examining “normal?” Because when I got my first mental health diagnosis in 1995—major depression, quickly followed by bipolar disorder—my definition of “normal” changed, and it remained changed for many years. I was given the message with my diagnosis that my life would never be the same, and I would never again be “normal.”

I was told my troubling symptoms would only get worse and my life would become harder and harder to manage. I entered into a new phase of life that revolved around appointments. Psychiatrist appointments. Therapy appointments. Primary care appointments. They affirmed that I was sick, and I was determined to be the best patient ever. I kept records every day of my medications, my mood, my sleep, and my activities. My complete focus was on my illness. And I got sicker, just as I'd been told I would.

My symptoms became harder to manage and the number of medications I was taking became greater. Eventually I was housebound, only leaving on Tuesdays for a myriad of doctors' appointments and support groups. On other days I was unable to leave my apartment. Safety was found behind window blinds and barricaded doors. My disability check paid my rent and Meals On Wheels brought me food. My world was getting smaller and smaller, and I was getting sicker.

By 2006, my list of mental health diagnoses had grown to six, including an anxiety disorder, a dissociative disorder

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# Our broke and broken mental health system

BY HELEN MONTAGUE FOSTER, MD



Helen Montague Foster, MD, is a psychiatrist in private psychotherapy practice, a clinical professor in the Department of Psychiatry at Virginia Commonwealth University, a volunteer at the Fan Free Clinic, and a RAM member.



One oft-repeated advertisement for an anti-psychotic drug shows a crevasse yawning in the granite floor behind an unsuspecting young man pushing a mop. The image offers an apt metaphor for a mental health system rearranging itself like terrain after the collision of tectonic plates. The young man is about to fall through an ever-widening crack, and his chances for recovery seem to be decreasing despite advances in psychopharmacology and in public community mental health treatment. The suicide rate is rising, psychiatric hospital beds have dropped to un-

safe levels, and the homelessness that followed the massive reduction of state mental hospitalization in the late 1950s and '60s remains a problem half a century later.

Fifty years ago, in 1963, President John F. Kennedy proposed replacing state mental hospitals with community mental health centers. With the introduction of Lithium, antidepressant, and antipsychotic medication, state mental hospitals began to discharge patients from custodial, often inhumane treatment. Reformers hoped for public community services to provide better, more humane, locally available treatment.

In the 1970s and 1980s, the private practice of psychiatry flourished. Community mental health centers grew to provide services not only to those discharged from state hospitals but to others who previously might not have been able to afford or have access to psychiatric treatment. Private insurance covered mental health services including intensive psychotherapy and allowed 30-day hospitalizations for the treatment of substance abuse. Private patients often received hospital treatment as long and, if necessary, longer than the month it took antidepressant medica-

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## Community services adapt to the 21st century

BY MARY ANN BERGERON



Mary Ann Bergeron is Executive Director of the Virginia Association of Community Services Boards (VACSB) in Richmond.

There wasn't a dry eye in the house after Lassen House members concluded their performance with the notes to “The Wind Beneath My Wings.”

The 18 performers from the Hampton-Newport News area, afflicted with serious mental illness, “sang” in sign language and took their bows to thunderous applause from citizen board members, mental health and

other professionals, state agency staff and program administrators at the 2013 Virginia Association of Community Services Boards (VACSB) Conference.

Each member of Lassen House, an evidence-based psycho-social service of the Hampton-Newport News CSB, has been robbed of much of his or her cognitive and functioning ability by serious and stigmatizing mental illness: schizophrenia, severe bipolar disorder, or severe major depression, related disorders and by accompanying, often disabling, medical conditions. Four of the members are deaf, and the hearing members learned to sign so they could communicate with their friends, giving birth to performing songs by signing

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Stigma has always shadowed mental health problems and discouraged people from seeking treatment, but success stories and advertising encouraged people with emotional problems to seek help.



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Virginia ranks  
**12th**  
among the 50 states in  
per capita income, but  
**37th**  
in per capita spending on  
mental health, with much  
of the spending on state  
institutions.

Source: Virginia Treatment Center for Children

## Letter to the editor

Dr. Martin Evans' letter (*Ramifications*, Vol. 19, No. 2) has highlighted the fact that referrals from one physician to another are often dictated by external factors that don't really involve the patient. There is another issue that Dr. Evans did not address, and that is the ethical responsibility of the physician.

Medical systems such as those we have in the Richmond area want the patients to stay within and utilize all the resources that they own. The decisions are based on the economics of medical practice or a healthcare system, and not necessarily on what is best for the patient. Take this scenario as an example: Dr. Yearlyexam, a gynecologist within ABC Health System, finds a worrisome breast lump on an examination. A mammogram done at ABC clinic shows it to be a probable cancer. The gynecologist refers you to Dr. Inhouse, a general surgeon within the ABC system.

Now, many doctors in the community know that Dr. Noname is one of the best breast surgeons in the area and is fellowship-trained in treating breast cancer. Everyone knows that Dr. Noname has very good outcomes compared to her peers. But the patient is not given the name of Dr. Noname since she is not in the ABC system. What is the ethical responsibility in this scenario? Physicians should want to have the best care for their patients and this is



not what may have happened in this situation.

As models of the Accountable Care Organization move forward, the ethical responsibility of the systems will need to be monitored. What is best for the system may not be what is best for the patient, and vice versa. Merely disclosing the relationship of ABC health system to a lab or X-ray or referring doctor may not be enough. Full disclosure may require telling the patient the whole story even if it costs the referring doctor or the system some money.

Proactive patients may be capable of finding out what is best for them but that is not guaranteed. An ethical

physician or healthcare system should be the proactive party and should offer what is best for the patient. The American College of Physicians' statement on ethics\* lists the following as one of its principles: "Identify and resolve or eliminate factors that might interfere with identified solutions, including reimbursement issues and misconceptions that patients may hold about treatment." In the final analysis, this statement encourages physicians to do what is "best" for the patient. **R**

*Ike Koziol, MD, is a volunteer physician and self-described healthcare activist. He can be reached at [ikekoziol@me.com](mailto:ikekoziol@me.com).*

\*Snyder L; American College of Physicians Ethics, Professionalism, and Human Rights Committee. American College of Physicians Ethics Manual: sixth edition. *Ann Intern Med.* 2012;156(1 Pt 2):73-104.

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and a personality disorder, and I had spent a week at a local hospital's psychiatric unit. My outlook was grim and I began making plans to protect my future. I was looking into more supportive living situations, and my family took action to protect my assets and future assets so that I could continue to qualify for disability benefits.

When a close friend committed suicide I could have given up too, but instead I got angry. There had to be another truth for me! There had to be more! One day, after a particularly frustrating meds management appointment where I unsuccessfully tried to address some of the more disturbing side effects I was experiencing, I went to a support group I had attended for several years. There I heard—for the first time—someone mention mental health recovery. I couldn't have been angrier. What was he talking about? Why was he raising people's hopes? I'd been told my illness would get worse, and it was. I'd been told my life would become harder to manage, and it was. How irresponsible of him to hold out that false hope.

But the next week he was back, and he talked about his mental health journey. Like me, he lost everything when he started experiencing the symptoms that resulted in his diagnosis. But that night he talked about what he'd gotten back—and he had what I wanted. He had a home, friends, family, hobbies and a job. I only had Tuesdays—the day of my appointments and support group. He helped me believe I could get it back. He

**By 2006, my list of mental health diagnoses had grown to six, including an anxiety disorder, a dissociative disorder and a personality disorder, and I had spent a week at a local hospital's psychiatric unit.**

gave me hope. And slowly at first, I did start getting my life back. I was able to open the window blinds in my apartment. I got yet another diagnosis, PTSD. It's the diagnosis that has been most helpful to me in regaining a fulfilling life. Though I still meet the criteria for all the diagnoses I had received previously, understanding my symptoms through the PTSD lens has helped me. My world, which had been shrinking, now began to grow.

I came to meet more people who talked about their recovery journeys. And when I took a class in mental health leadership and empowerment, my life took off. I don't know if I learned anything in the class but I was reminded that *I am not my illness*. I am a whole person with gifts and talents and passions. Just two weeks after completing the course, I found a job that quickly led to a second job which I still have six years later—six years with no absences for mental health reasons.

In my job and in volunteer opportunities in the community I share my journey with others; I teach classes, much like the class that changed my life; I facilitate groups to

help others find the wellness tools that work for them; I help police officers learn how to respond to a person in a mental health crisis; I work with state policy experts and lawmakers to change mental health policies and laws in Virginia so others may avoid the years of hopelessness and illness that came with my diagnosis and prognosis. I help change lives.

People need to be told the story of hope instead of the story of illness. We all need to believe in our individual gifts and strengths and passions. Our dreams do not have to die with a mental health diagnosis. Our dreams are still alive.



*Bonnie Neighbour is Program Director of the VOCAL Network, Virginia's mental health consumer network. She can be reached at [bonnie@vocalvirginia.org](mailto:bonnie@vocalvirginia.org).*

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tion to take effect.

Television advertisements for private psychiatric hospitals showed patients walking on trails beside lakes, chatting with kind therapists. Some of the lakes may have been fiction and every therapist is not a great fit for every patient, but the treatment was genuine, often dramatically effective and easy to access through emergency “help lines.” Many individuals struggling with suicidal thoughts, impulses to harm others, or disabling mental illness received local inpatient services. The Supreme Court of Virginia paid for brief hospitalization under temporary detention orders. Private free-standing psychiatric hospitals and psychiatric wards in general hospitals provided extensive individual and group psychotherapy as well as somatic treatments, assertiveness training, social skills training, recreational therapy, occupational therapy, music therapy and/or art therapy. When suicidal intent, homicidal intent, or severe psychosis failed to remit before insurance benefits or private funds were exhausted, state hospitals provided expert care, albeit in a restrictive setting that most pa-

tients did not want to re-experience.

The community mental health movement made crisis management, outpatient case management, and medication available. Private-practice psychiatrists could render psychotherapy and choose from newly available SSRI antidepressants, somatic treatments like ECT, and many medications with antipsychotic and mood-stabilizing effects. Psychiatric hospitals offered transitional groups for patients after discharge, and psychiatrists, psychologists and other psychotherapists provided psychotherapy and practical help for their patients. For psychiatrists who had witnessed the ravages of untreated or primitively treated mental illness, this was a time of great hope and satisfaction. Yet hard times were ahead.

Stigma has always shadowed mental health problems and discouraged people from seeking treatment, but success stories and advertising encouraged people with emotional problems to seek help. Public perception of mental health treatment began to tip from fear to hope with the consequence that insurance companies paid more claims for psychotherapy, but lashed back with brutal managed-care denials.

Public sector costs and politi-

cal forces prompted budget cutting, and reduction in state hospital beds without transfer of equivalent funds to the community to provide local services. Advocates battled insurance companies for state requirements to retain outpatient benefits and coverage commensurate with benefits for physical illness, but coverage was only mandated for 20 medically necessary psychiatric sessions a year, much less than necessary to treat the sickest patients. Managed care companies reasoned that patients eligible for unlocked inpatient units did not need hospitalization, an “all-or-nothing” oversimplification that led to the near demise of the therapeutic milieu in private hospital mental health treatment. Patients stayed on locked units, were allowed fewer privileges, and the process of allowing pre-discharge trial passes declined. Less costly psychiatric day hospital programs seemed to be the wave of the future but closed for lack of profitability. Meanwhile insurance reimbursement for psychiatric care in general hospitals was so much lower than for medical or surgical care that, rather than increasing beds to meet the demand of deinstitutionalized patients, full-service hospitals tended to reduce or simply maintain their

psychiatric beds.

By 1997, total state spending for mental health care in the 50 states was 30 percent less than in 1955 when adjusted for population growth and inflation. In 1955, there were 340 public psychiatric beds per 100,000 residents. In 2002, the President’s New Freedom Commission on Mental Health declared, “America’s mental health delivery system is in shambles.” By 2005, there were only 17 beds per population of 100,000.

In Virginia, mental health spending was cut 9 percent between 2009 and 2011 despite dangerous shortages of psychiatric beds. Most experts agree that 50 public psychiatric beds are necessary per population of 100,000. By 2005, Virginia had only 22.2 state psychiatric hospital beds per 100,000 population, topping 80 percent of states in terms of numbers of beds per 100,000, yet falling into the serious shortage category. In 2011, Vermont became the first state to lose all of its state-operated psychiatric beds. News reports there decried the situation of a young man handcuffed to an exam bed “all night and all the next day” because every private psychiatric bed in the state was taken.

In Virginia, limits on support services and dramatic reductions

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in private psychiatric hospital beds thwarted hopes for short hospitalizations in private hospitals to supplement community mental health treatment in meeting the needs of the seriously mentally ill. Medicaid did not fund care in free-standing psychiatric hospitals for nonelderly adults, and in combination with managed care limitations on psychiatric hospitalization, the policy contributed to closure of many psychiatric hospitals. By the end of 2011, shortages of both public and private psychiatric beds in Virginia led to what became known as "streeting." On occasion, people who met criteria for involuntary commitment and for whom temporary detention orders were processed had to be released to non-hospital alternatives. Families, public community mental health centers, ER doctors, and private psychiatrists scrambled to prevent tragic suicides or homicides, and emergency personnel became, of necessity, more tolerant of turning away patients whose mental illness put them at risk for harm to themselves or others or for languishing because of inability to care for themselves. While the ramping down of state hospital beds continued, forensic beds had to be added. Jails and prisons became de facto mental hospitals. By 2012, 38 percent of state hospital beds were devoted to forensic services, but most inmates with mental illness are subjected to conditions that make their illnesses worse, rather than better.

Meanwhile managed care policies led many psychiatrists to limit the psychotherapy they provided to brief interventions during short medication evaluation appointments. The private intensive psychiatric treatment of the 1970s and 1980s by private psychia-

trists and other mental health professionals became unavailable except by self-pay or through academic institutions offering treatment with trainees to limited numbers of patients. Insurance reimbursement for psychotherapy fell so low that psychiatrists who had enjoyed private practice moved to jobs in community mental health centers, to academia, to employment with the Veterans Administration or to public or private hospital systems. With each change, some people have benefited, and others have tumbled into cracks.

So where do we go from here? Costs for people with mental illness involved with the criminal justice system are dramatically higher than for those without such involvement. Studies have shown that \$7 is saved for every dollar spent on substance abuse treatment and that programs offering stable living conditions before requiring abstinence from substance use lead to better outcomes. It is clear that intensive empathic treatment with outreach is more effective than treatment experienced as coercive. It is also clear that some people with mental illness and/or substance use disorders will not seek help voluntarily, often because they do not believe they are ill. Hence involuntary treatment is sometimes necessary yet must be used sparingly and benevolently to protect civil rights and avoid destroying a therapeutic alliance.

It is disturbingly easy to assume that problem patients are unworthy of care and to shove them into the cracks between service locales, leaving them to languish or enter jails and prisons. It is important to recognize that many difficult-to-treat patients do recover with comprehensive care. When economic forces such as pressure from for-profit employers, limits in government spending, man-

aged care limits on approved services, and low reimbursement rates push psychiatrists and primary care physicians to limit services to brief medication checks, the likelihood of full remission decreases, and the need for emergency services increases. Accounts of recovery from mental illness almost always include mention of helpers who believed in the possibility of recovery. Many of the most treatment-resistant patients with psychiatric illness suffer, not only from genetic vulnerability and biological illness, but also from trauma and adverse circumstances. The community mental health centers have been able to show what we believed all along: Good care and outreach work for people with serious mental illness. Programs of Assertive Community Treatment (PACT) teams with active outreach and frequent contacts lead to better outcomes than minimal case management and infrequent medication checks by rushed practitioners. Crisis intervention services are vital to preventing suicide and homicide, but many people with emerging mental health problems do not know how to access emergency psychiatric services. The Community Services Boards are legally mandated to provide short-term safety-net services to people who are suicidal, homicidal or unable to care for themselves because of mental illness. Once acute psychiatric crises have stabilized, much of the responsibility for providing care falls to the private sector, including primary care physicians (who already are caring for many with less serious mental illness), private and academic psychiatrists, and other mental health practitioners. Factors such as the aging of our population, availability of substances harmful to mental health, and the loss of many private psychiatric hospitals and practices make

By 2011 there were  
**42,385**  
patients  
in U.S. state mental  
hospitals down from  
**559,000**  
in 1955.



Source: Dr. Helen M. Foster

that task more difficult.

Psychiatry, like pediatrics, is a low-income specialty but has traditionally offered meaningful opportunities to get to know and understand patients. The combination of low pay and low morale resulting from the struggle to medicate away problems in those living without adequate resources lowers the appeal. This is also the case for child psychiatry, which has been a shortage specialty since its birth. Per a recent statement by Dr. Harold Koplewicz of the Child Mind Institute, 15 million children in the USA have mental disorders but only 7,500 child psychiatrists are available to treat them, although 50 percent of serious psychiatric illnesses begin before age 14.

Again and again the commonwealth organizes commissions to study the problems faced by those with mental illness, intellectual disabilities, and substance abuse disorders. We know many of the answers but have not found the political will,



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even in times of prosperity, to adequately fund necessary services. We have not provided adequate oversight for private insurance companies that squeeze every possible ounce of profit out of what has come to be known as “behavioral” health care.

Bottom line, we must recognize the moral and practical imperative for Virginia and the nation to fund community mental health services and must provide an environment that allows providers of mental health services economic sustenance while rendering good care. We must ensure a safe number of psychiatric beds, either by mandating community hospitals to provide them, by changing financial incentives, or by re-establishing public psychiatric beds to supplement community services. The parity bill that passed in 2008 and was integrated into the Accountable Care Act to ensure insurance mental health benefits equivalent to other medical benefits must be enforced, if necessary through court action. We must provide financial incentives for an adequate number of psychiatrists, other psychotherapy providers, and primary care physicians. For-profit insurance companies and pharmacies must be regulated to prevent denials of necessary care and time-consuming cost shifting to physicians’ offices.

We must ensure that the wisdom

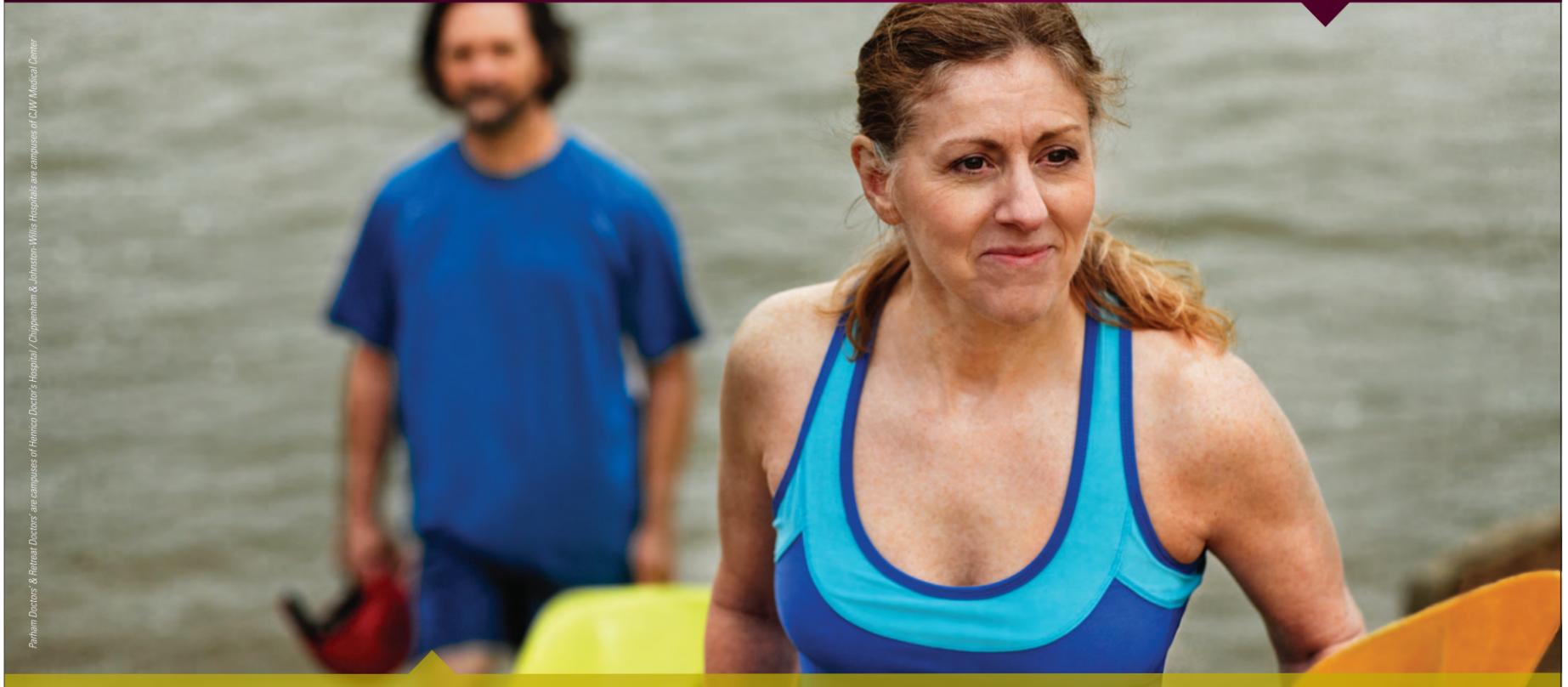
and experience of those who are able to shepherd patients to recovery is not lost. Psychiatrists should not only continue to be trained in psychotherapy and psychopharmacology but also should collaborate with other medical and mental health practitioners. Emergency room physicians, recently identified as belonging to the specialty highest in burnout, should never be forced to “street” patients or restrain them for excessive periods of time, because of lack of available psychiatric services. Public sector psychiatry and the community mental health system must be fully funded, and confidential psychiatric services must be available privately to supplement insurance-funded services. I would argue that a single payer system with preservation of the option for self-payment would supply the best prospects for mending the chasms that have patients with mental illness teetering on the edge. Psychiatry, like the rest of our healthcare system, is in the midst of upheavals and will require ongoing adjustments. Because of stigma and the economic decline experienced by many of our patients, the risk for this area of medicine to be unjustly left behind is large. We must ensure that, instead, we live up to the hopes expressed 50 years ago at the start of the community mental health movement. **R**



# RAM events

DATE	MEETING/LOCATION/TIME
September 18, 2013 Tuesday	<i>The Trauma of Obama(care): Prognosis Shaken Not Stirred</i> Len Nichols, Ph.D., Professor of Health Policy & Director of the Center for Health Policy Research and Ethics, George Mason University University of Richmond’s Jepson Alumni Center 5:30–8:30 p.m.
October 8, 2013 Tuesday	<i>The Great Flu Pandemic of 1918-19: A Historical Perspective</i> , Charles F. Bryan, Ph.D., Managing Partner, Bryan & Jordan Consulting, LLC Westwood Club 6200 Westwood Club Lane 12:00 noon
October 17, 2013 Thursday	Member Wine Social Location TBD 5:30–7:30 p.m.
November 13, 2013 Wednesday	<i>Printing the Human Kidney</i> Anthony J. Atala, MD Director & Chair, Institute for Regenerative Medicine Wake Forest School of Medicine University of Richmond’s Jepson Alumni Center 5:30–8:30 p.m.

## LIFE / YOU ONLY GET ONE.

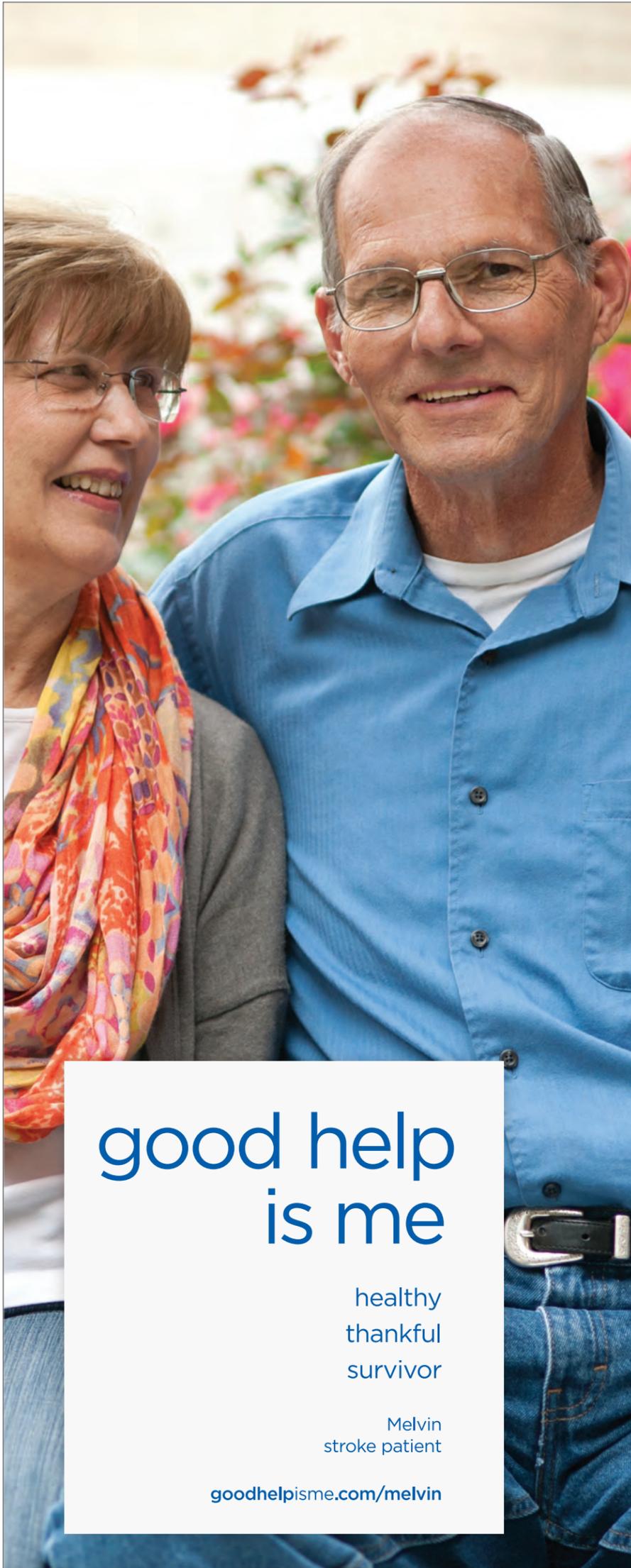


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BON SECOURS NEUROSCIENCE INSTITUTE

*"21st Century," continued from page 1*

rather than singing so that no member would be left out.

Applause followed the "Club-house" singers as they left the ballroom to return to Lassen House, debrief on the performance and to continue with their steps in recovery: relearning social skills, managing their health and hygiene, nutrition, finances, employment or volunteerism possibilities, and navigating their community—relearning activities we take for granted, even using transportation systems. Decisions such as taking medication are courageous when weight gain or obesity often results from the metabolic effects of the very medications that control psychiatric symptoms. Yet they have made the decision to take medication despite serious side effects. Add deafness and stigma over obesity to their list of burdens and, for a moment, imagine life in their often-tattered shoes.

**Defining 'recovery'**

Recovery, in terms of psychiatric and substance use disorders, occurs as an individual learns to manage the disease in daily life such that the disease is a factor in life, not the driver in life. Recovery paths vary in treatment modalities, community activities, and length of time on their paths as individuals make courageous choices to maintain their health, despite the stigma they suffer each day. Stigmatizing can come from well-intentioned individuals and among them, even some healthcare professionals, depending on the treatment or philosophy adopted.

The good news—here's what works well for this growing group of people:

- evidence-based psycho-social models
- Program of Assertive Community Treatment (PACT)
- wraparound supports including housing and supportive housing
- peer support by individuals who have lived experience with Serious Mental Illness (SMI) and have chosen to use their own experiences

- and expertise to assist others
- psychiatry, medications, and case management that assists in obtaining benefits
- wellness activities and practices
- employment and educational supports
- public safety training programs called Crisis Intervention Teams (CIT) and corresponding "drop off" centers to help avoid law enforcement involvement

Over time, such wraparound and intensive services improve outcomes and help avoid frequent and prolonged hospitalizations that can stabilize their conditions, but can create remembered trauma for them. Such services cost a fraction of what hospitalization costs. As recovery becomes possible, services can include educational, employment and social opportunities, giving greater meaning and purpose to life.

**With or without walls?**

Program of Assertive Community Treatment (PACT), sometimes called "a hospital without walls," is an evidence-based service using a team of 10 professionals, including psychiatric and nursing staff, to "wrap" care coordination, treatment services, rehabilitation services and social supports around 80-100 individuals who qualify for the service because of their frequent and/or lengthy hospitalizations, resistance to treatment, or intractable symptoms.

Consider the more costly alternative of a hospital *with* walls. A state hospital bed in Virginia costs about \$167,000 per year. By comparison, the annual average cost per person of the 17 Virginia PACTs is \$16,694. Add housing supports through vouchers or rental assistance and the cost reaches about \$25,000 per year, often less than a single crisis episode if all crisis costs are included.

PACT relies on grant funding to seed the program as well as reimbursements from every funding stream possible. Because 50 percent of the individuals served in CSBs are not eligible for Medicaid due to

**PACT vs. Hospital Beds: An Affordable Approach**

Annual average cost per person in a Program of Assertive Community Treatment (PACT): \$16,694 – 10% of the annual cost of a state hospital bed in Virginia, or a 90% savings to taxpayers.



Virginia's stringent income requirements, and since private insurance does not cover these wraparound supports, ongoing general funds from the state are needed to provide the service. Clients in PACT rarely, if ever, present in emergency rooms in psychiatric crisis.

Another strategy adopted in Virginia to divert individuals with mental illness from jail or inappropriate hospitalization is the use of law enforcement officers trained as Crisis Intervention Teams. After a 40-hour course in dealing with crisis situations as a result of mental illness, the CITs are able to better address a crisis at the scene itself. More than 2,642 police officers from 31 localities, and another 1,695 first responders, have completed this certification training.

While Medicaid expansion has not yet become a reality in Virginia, if and when it is implemented, an essential health benefits package *must* contain basic behavioral health services on par with other medical services. The greatest promise for increased access and stigma-busting is through the Affordable Care Act and Medicaid expansion. When we can feel as comfortable seeking behavioral health care as we would seeking care for respiratory ailments or high blood pressure, the epic battle against stigma will have gained the higher ground.

The bad news: insufficient grant or insurance funding for the very services that assist people to avoid the high cost hospitalization. Simply put, many more citizens need these services than existing funding permits.

Insufficient funding directs services toward crisis orientation.

And more bad news is that, in the short-term, effective services and supports may be limited as funding streams and regulatory changes compromise the ability of providers to deliver these precise services.

For primary care providers, an integrated care project in Arlington and Alexandria is especially noteworthy. At the CSB sites, it extends primary and specialty medical care to individuals with SMI who are indigent, perhaps have Medicaid but who will not seek PCP services at all or are unable to access a PCP who will accept them as patients. According to individuals with SMI involved in this project, they feel respected by CSB staff, comfortable in the reception areas despite any personal idiosyncrasies they may exhibit, and respected by the PCP practicing in the CSB enough to trust that professional with their medical treatment.

Working with SMI adults obviously doesn't work for all PCPs. Once the "right fit" professionals were discovered and able to work with adults with SMI, six physical diagnoses per person became the limit. Control of those symptoms with behavioral health care occurs before moving to lesser medical conditions. As one would imagine, untreated diabetes,

heart disease, hypertension, obesity, and COPD are among the diagnoses. It is no wonder that adults with SMI die 2.5 years earlier than adults without serious mental illness!

In this integrated care project, individuals felt welcomed, their treatment preferences had value, and they accepted medical care, improving their health outcomes, even in the first year of the project.

Some of the adults treated by the project provided invaluable insights into how they view treatment. One 38-year-old woman reflected that people with mental illness may be defensive in such a setting because they expect the worst, going only as a last resort. Thus, the woman admitted that, even when she may need it, hospitalization is so traumatizing to her that she will avoid it.

A 47-year-old man said when he goes to an emergency room for a crisis of any kind, he feels defined by his mental illness and believes that the possibility of getting good care for a physical condition is diminished. When asked what would be helpful to assist emergency room and/or hospital and healthcare personnel in addressing his needs, he responded that he would like to be asked:

- What has happened?
- Has this happened before?
- If so, what has worked in the past to assist you?
- What is most troubling to you now?
- How can we best help you?

**A**s physicians look for tools to help people with SMI, they should know that Virginia now allows, in law, the use of psychiatric advance directives that put forth the individuals' preferences and choices for treatment when they are unable to make those choices for themselves. In addition, adults with SMI are learning to choose and appoint health care agents who can act for them when needed. Research derived by the Institute for Law, Psychiatry, and Public Policy at the University of Virginia indicates that adults who have and are able to use psychiatric advance directives actually experience fewer crises and consume fewer crisis services because, in the process of creating the directive for treatment in advance of an emergency, they can better identify and avoid the triggers that precipitate a crisis.

Additionally, a value-added practice used by a number of CSBs is peer support through a crisis and follow-up in the community. A peer in recovery with lived experience who has been trained in peer support can be a critical component of success in assisting an individual through a crisis. Peer "bridgers" are used to assist in hospital planning for discharge as well. The benefits of peer support outweigh scarce funds and operational issues.

Here is a short list of tools that assist all those involved in health care to become more aware of the role stigma plays in our lives, and of how adults with SMI can become effective and willing "partners" with professionals in their own planning and treatment:

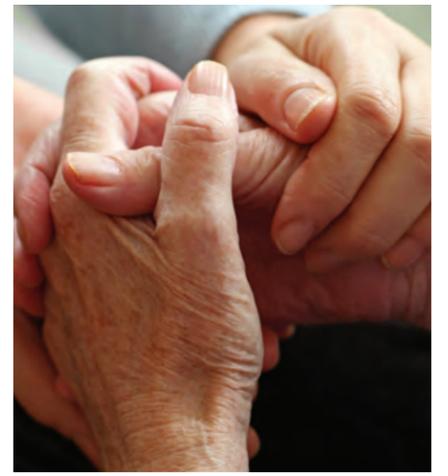
- Develop a more person-centered approach as described above.
- Learn about the use of advance psychiatric directives.
- Use peer support service for those in crisis.
- Ask how we might contribute to stigmas and become conscious about how our thoughts and vocabulary can and should change with patients.

I encourage RAM members to advocate for additional community services and Medicaid expansion with elected or appointed officials or *any* decision-makers, since we know that at any time, one of us, our family members, our friends or our neighbors could experience a critical need for behavioral health services.

We're all in this together! **R**

Mary Ann Bergeron can be reached at [mabergeron@vacsb.org](mailto:mabergeron@vacsb.org).

## Pressing needs



**More than half a million Virginians have severe and disabling conditions but less than half (206,616) receive community services.**

*Source: Virginia Association of Community Services Boards*



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# Child and adolescent psychiatry: 'A certain knowledge that should be shared'



*Editor's Note: We recently asked veteran child/adolescent psychiatrist Dr. David W. Gould, president of Tucker Psychiatric Clinic, to reflect on the most important issues facing clinicians. Gould begins by offering some thoughts, followed by replies to our questions.*



David W. Gould, MD

**C**hild and Adolescent Psychiatrists (CAAPs) in clinical practice have the opportunity to promote the mission of our field: to educate, advocate and serve.

Dr. George Orvin, my attending at the Medical University of South Carolina, told me, "You are gaining a certain knowledge that should be shared." CAAPs educate our communities and help eradicate the stigma of mental illness by giving talks at churches, PTAs, service clubs, and professional meetings.

When I joined the Tucker Psychiatric Clinic in 1990, I was blessed with many excellent mentors. Dr. James Asa Shield Jr. told me that participation in organized medicine was vital to the advocacy of our patients' needs. We attend small group meetings with state senators and delegates sponsored by the Richmond Academy of Medicine. The Psychiatric Society provides us with opportunities to make contacts with government officials.

Our advocacy also includes negotiations with insurance companies: We must plead for office visits, hospi-

been given to serve our community and our patients. Access to care can be extremely limited in fields with shortages. Our numbers keep dwindling through death and retirements, while the number of those needing our care steadily grows. The challenge continues to be placing the needs of others ahead of our own. Telling parents of a psychotic or suicidal child that they must wait several months for an appointment serves no one. Emergency visits and work-in appointments are the order of the day.

In this, CAAPs share a common calling with all medical fields. We all must educate our communities and patients. We all must advocate for better care. And we all strive to serve despite shrinking numbers. I thank everyone for their ongoing participation in this mission. In the movie "The Outlaw Josie Wales," a Cherokee said, "We were encouraged to endeavor to persevere."

**Editor:** Recent research indicated that parents who believe that their

## The challenge continues to be placing the needs of others ahead of our own.

We share our experience in written publications as well as participate in forum discussions broadcast by WCVE public radio. We teach our patients and families about the causes and treatments for psychiatric disorders.

tals stays, and even the prior authorization for prescriptions of generic medications.

Dr. Shield and another mentor, Dr. Graenum Schiff, frequently reminded me of the privilege I have

children will deliberately cause them difficulties are harsher disciplinarians, and their children have more problems. As a child psychiatrist, what is your take on this? What should be done about it?

**Gould:** Making pre-emptive plans can often result in actions that don't fit the reality of the situation. I tell people they have to work with the child in front of them. That child can go through phases of being easy to work with and those of being quite difficult. Strive for clarity of expectations and consistency with consequences, but harshness is not necessary.

**Editor:** Child psychiatry is a shortage specialty. What do you think can be done to fill in the gaps?

**Gould:** CAAPs can help by providing educational opportunities for primary care physicians and nurse practitioners. We can be more flexible with our schedules, meeting the acute needs of our communities. We can develop better working relationships with nurse practitioners.

**Editor:** What are the communication barriers between child psychiatrists and pediatricians?

**Gould:** I send letters to referring physicians. I am available by phone when pediatricians call throughout the day. Communications become difficult if one is more concerned with one's schedule than with taking care of patients.

**Editor:** What do you see as the biggest preventable causes of mental illness in children?

**Gould:** I don't think we are currently able to prevent mental illness. What we work toward is early recognition and intervention. We reach out to those who work with children to be aware of the signs and symptoms of mental illness. Early treatment of anxiety disorders and depression disorders can help to improve outcomes. We can avoid disastrous school experiences and decrease suicide completions.

**Editor:** Do we have enough hospital psychiatric beds for children in communities?

**Gould:** Since I moved here in 1990, three hospitals with youth beds have closed. Others have limited acute care beds. State beds continue to close. There are many times when all the



Currently there are only

**7,000** child and adolescent psychiatrists in the U.S. The need is estimated at more than

**30,000 nationwide.**

Source: Virginia Treatment Center for Children

beds are full. To make matters worse, if a child is able to access a bed, the insurance companies micromanage the care. I have had local psychiatrists employed by managed care companies review my treatment plans and deny coverage for hospitalization.

**Editor:** Do you see a need for expanded community-based mental health services for children?

**Gould:** I read a newspaper article recently that reported a waiting period of 120 days to be seen at a community mental health center. If that is true, we have a big problem. CAAPS don't roll off the assembly line. Those practicing in public and private systems must become more flexible in their scheduling practices. We must become more responsive to emergencies and make space for new patients. **R**

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# The new VTCC: A solution to a problem

BY CHIP JONES



Dr. James A. Shield (left) is working with Dr. Joel J. Silverman to build a new Virginia Treatment Center for Children.

**A**fter the tragic shootings at Virginia Tech in 2007, Dr. James A. “Jimmy” Shield, a psychiatrist and former president of the Medical Society of Virginia, checked to see how many psychiatrists were in private practice in Blacksburg at that time.

“You know how many were practicing?” Shield asks, answering his own question by circling his thumb and forefinger into a zero.

If a university town can be so understaffed to treat children and ado-

long drive and an even longer waiting list to receive treatment.

Even the Virginia Treatment Center for Children (VTCC) in Richmond, the child and adolescent division of VCU’s Department of Psychiatry, has the capacity to serve only a small fraction of patients in need. VTCC was established in 1958 to preserve and restore health for families, to seek the cause and cure of diseases through innovative research and to educate those who will become the next generation of

patients each month. “This reflects the severe shortage of specialized psychiatrists in Virginia and the nation,” according to Dr. Joel J. Silverman, professor and chairman of the Department of Psychiatry at VCU.

Things are going to change for the better, though, declare Drs. Shield and Silverman. They are part of a team spearheading the Healthy Minds Campaign. Community leaders including Eva Teig Hardy and Martha Grover plan to raise at least \$15 million in private donations to leverage an additional \$56 million allocated by the 2013 General Assembly. These funds will replace VTCC’s aging facility as well as expand mental health services available to families throughout the commonwealth. When complete, Virginia will be home to “the nation’s most innovative behavioral health facility for children and families,” says Silverman.

In mid-July, VCU Health System announced plans to build the new VTCC on its Brook Road campus near the existing Children’s Hospital. The proposed replacement facility will be about 116,600 square feet, or about 35 percent bigger than the existing center downtown.

Healthy Minds will fund new research and faculty posts to explore a range of mental health issues—from

## In mid-July, VCU Health System announced plans to build the new VTCC on its Brook Road campus near the existing Children’s Hospital.

lescents—especially those with mental health issues—then consider what the situation is like in even more remote parts of Virginia. “From the Eastern Shore to far southwest, there may be no pediatricians and certainly no child psychiatrists,” says Shield, past president of the Psychiatric Society of Virginia. This means that, when a child or adolescent is in crisis, they often face a

mental healthcare providers. In 2011, the VTCC stabilized 728 children on their darkest days. VTCC physicians and staff treated another 1,012 children on an outpatient basis.

However, those service statistics are reaching only the tip of the iceberg. Each month the Department of Psychiatry receives 1,200 calls for service and has the capacity to serve 200 new

early intervention into addictions and substance abuse to genetics research to build a better understanding of the origins of mental illness and the connections between psychiatric disorders and other illnesses (cancer, heart disease and juvenile diabetes).

The statewide effort includes new telemedicine clinics to reach families across Virginia, development of specialty clinics to support families facing behavioral health issues across the whole diagnostic spectrum, and programs helping children and families transition from inpatient to outpatient care.

“This is good news!” notes Shield, “The VCU Department of Psychiatry is positioning itself so all Virginians have a really effective resource.”

He continues, “The exciting thing is that the General Assembly is giving us money for the building, and we’re raising money to make it work better and better and better. It’s the start to finding a solution to what politicians have been searching for—that is, ways to help children and adolescents’ mental health. It’s nice to have something in a medical journal that says, ‘Here’s a problem and here’s a solution.’”

The Healthy Minds Campaign

seeks to make the VTCC the primary resource for treating childhood and adolescent mental illness in Virginia. With treatment and research serving the first two legs of its triangular mission, training is the third leg. Silverman’s staff trains a wide array of specialists—from child psychiatrists to social workers to psychiatric nurses. Their goal is to address the current shortage of providers, as well as to improve services to pediatricians “so that their ability to diagnose, manage and refer patients is as good as it can be,” Silverman says.

#### Difficult diagnoses

Silverman, who has served as chairman of VCU’s Department of Psychiatry since 1984, says “it can be difficult for physicians to diagnose symptoms that could range from mood swings to bullying, to exhibiting other problems at school, to making suicidal statements.” Substance abuse among adolescents, for example, has become a common problem seen by pediatricians and family practitioners. Silverman continues, “Addiction itself is a psychiatric condition, but sometimes kids, like adults, use substances to help themselves feel better. So a kid having

trouble sleeping may drink alcohol before they go to bed, or use substances like marijuana to reduce anxiety.”

The same could be said of food and how it’s tied to patients, generally young women, who suffer from anorexia nervosa. But whether it’s the abuse of drugs or food, Silverman says, “Diagnosis is not simple; and without the right diagnosis, you don’t get the right treatment.”

As VCU psychiatry researchers probe for the underlying causes of mental illness, they increasingly are focusing on genetic research and imaging. Silverman explains: “The idea in medicine is if you understand what you’re treating, and the biological and environmental origins of what you’re treating, then you’re going to treat patients better. This is true of diabetes or hypertension, and it’s true of schizophrenia.

“The good news is our ability to diagnose and treat these problems has improved dramatically,” Silverman says.

VTCC has a global reach, with its own Dr. Kenneth Kendler winning the 2011 World Psychiatric Association’s highest prize for research as well as the 2012 Virginia Scientist of

the Year award. VCU psychiatry is currently studying the entire population of Finland and training researchers in nearly 50 hospitals in China.

Its “Spit for Science” project at VCU has led to a surge in donations of DNA for study of the genetics of stress, substance abuse, and post-traumatic stress disorder. New studies delve into these issues within the military population and their families.

As he looks at the wide array of projects and services that stand to be expanded, Shield puts it this way: “As a psychiatrist, I’m not comfortable treating dermatology or orthopedic illness. But I’d like to know where to send someone.” Ultimately, when young people present a complaint to their doctor, he said, “Doctors want to be helpful and do the right thing,” sending them to the right place for the right care.

VTCC, he said, is the right place—and soon to become even better. **R**



Chip Jones is RAM’s communications and marketing director.



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# Can we break the cycle in ERs?

BY MARK A. RAUSCH, MD, FACEP



Several years ago, a middle-aged woman named Patricia began to visit my emergency department almost every time I worked a shift. She called 911 and came by ambulance once a week with a multitude of complaints: chest pain, shortness of breath, ankle pain, headache, or blurry vision. All her treating physicians knew there was no medical condition that could explain such complaints except for her psychiatric status and diagnosis of bipolar disorder.



Mark A. Rausch, MD, FACEP

**In Virginia, mental health spending was cut 9% between 2009 and 2011, despite dangerous shortages of psychiatric beds.**

Her weekly visits turned into bi-weekly visits which soon turned into daily visits. I spoke with the EMS personnel who transported Patricia and discovered that she went to several different hospitals each day, including St. Mary's, MCV, Henrico Doctors' Hospital Forest Campus, and Memorial Regional. During one ER visit with me, she called 911 from the emergency department bed requesting to be transferred to another emergency department. I consulted with Henrico Mental Health to evaluate her for a temporary detaining order. A TDO commits a patient to the psychiatric hospital for a minimum of 72 hours. The TDO was accepted,

and we stopped seeing Patricia for a few days. However, the cycle began all over again the following week. This behavior persisted for several years, with Patricia calling 911 several times a day and being transported to several different emergency departments. She was exhausting the county EMS and ER resources.

Why was she using the emergency department as a revolving door to care for her psychiatric illness? Why wasn't there a medical/psychiatric resource for her? What was happening while she was in the psychiatric facilities? Where was the breakdown? Was she someone who needed to be placed in an institution mandated by the state

to care for her? Was she a candidate for a community psychiatric outreach center? If so, where were they?

Over the past few years, funding for the care of the mentally ill has been diverted elsewhere with major cuts in the federal and state budgets. State institutions have closed and been replaced with community centers set up in the 1970s as a new way to care for the mentally ill. Furthermore, thousands of beds in hospitals have been eliminated.

Dr. Helen Foster states earlier in this edition that by 1977 spending for mental health in the U.S. was 30 percent less than it was in 1955 when adjusted for population growth and inflation. Furthermore, in 1955 there were 340 public psychiatric beds per 100,000 residents. In 2005, there were 17 beds per 100,000 residents and since then it has only gotten worse. In Virginia, mental health spending was cut 9 percent between 2009 and 2011, despite dangerous shortages of psychiatric beds. Because of these cuts, in the emergency department, we are practicing with very little assistance to care for these severely ill and highly dangerous individuals.

In calling for a TDO, a physician is making the grave decision to take away a patient's rights. Yet patients do need some sort of protection. Secondly, placing a TDO inevitably hastens negative consequences to the flow and efficiency of the emergency department. With the severe shortage of beds, the ED becomes a holding center for psychiatric patients who

**Between 1998 and 2006, the number of mentally ill people incarcerated in federal, state and local prisons and jails more than quadrupled to**

**1,264,300.**

Source: Mother Jones, May/June 2013, p. 26

must wait several hours to several days for a bed to become available. Even after the diagnosis and treatment plan is established, the psychiatric patient often needs a higher level of care than other patients seen in the ER. At a minimum, they need two police officers to watch them directly at all times as these patients occasionally try to act on their wishes to harm themselves or others. Two police sitting in an ER are two less officers on the street, so it strains our community resources as well.

Furthermore, a psychiatric facility has better staff and design layout to assist in caring for these acute patients. An emergency department lacks such trained staff and resources. In addition, nursing care and ER rooms are strained during the holding of psychiatric patients. There is also pressure on the ER physician from the hospital administration to maximize the efficiency of the ER by avoiding TDOs.

After admission, the psychiatric patient's stay is too short. Finding the proper effective medication can take weeks of observation. Once pushed back into the community, the support system to help them maintain their medications is woefully inadequate. The psychiatric patient continues to

struggle until another psychiatric exacerbation brings them back to the ER, and the cycle continues.

There are several solutions, but unfortunately they all require funding and added resources. Certainly, we need more publicly-funded psychiatric beds. A longer duration of stay is also necessary until the proper medications take effect. Community resource centers need to be adequately staffed in order to keep a close eye after discharge to prevent a readmission.

The role of the emergency physician in the care of potentially psychiatric patients is to rule out an organic cause. For instance, acutely confused or erratic patients can have a subdural hematoma, thyroid storm or poisoning with bath salts. However, now emergency physicians are being expected to make psychiatric evaluations. The emergency physician is usually seeing this patient for the first time and has no ongoing relationship with them. The doctor also is crunched for time to discern whether a TDO is necessary.

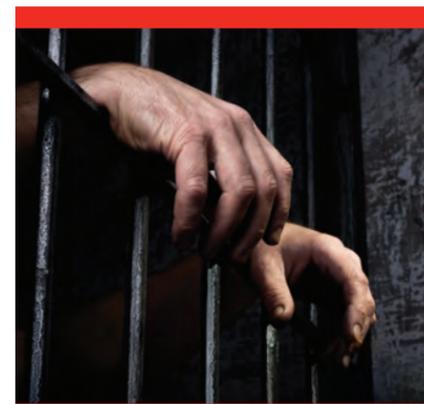
The risks of being incorrect include homicide and suicide, not to mention medical liability. Thus, most physicians err on the side of caution. Many times, ER physicians are wrong with dire results. ER physicians

are not trained in psychiatric evaluations. Once an organic cause is ruled out, community resources and a psychiatrist from the local jurisdiction should be making the determination of a TDO.

Patricia had continued her revolving door into and out of different emergency rooms for several more months. Suddenly her visits stopped. I never found out what happened to her. Did she die by suicide or go to prison like many of our psychiatric patients?

Or, was she finally put on a medication that was effective, and today is participating in society? Certainly, I hope so. But unfortunately, ER beds are likely to keep being used by people like Patricia. That is, until we all somehow find a way to break this troubling cycle. **R**

*Mark Rausch, MD, FACEP, has 13 years of experience as an emergency physician. He is currently the medical director of Emergency Physicians Immediate Care Center (EPICC), which provides the convenience of a walk-in clinic with the expertise and technology necessary to respond to both routine health needs and medical emergencies.*



**For every \$2,000 to \$3,000 per year spent on treating the mentally ill, \$50,000 is saved on incarceration.**

*Source: Mother Jones, May/June 2013, p. 26*

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# Treating the whole patient—the 13-minute dilemma for PCPs

BY LISA CRUTCHFIELD

Dr. Anand Lothe was trained to diagnose and treat a variety of physical conditions.

But the primary care physician at Virginia Physicians, Inc. has discovered in his 15 years of practice that he frequently treats the mind as well as the body, creating challenges he didn't anticipate when he was in medical school.

Lothe isn't alone. A recent report from the Center for American Progress, a public policy and advocacy organization, shows that more than a third of patients who receive treatment for mental health disorders rely solely on primary care physicians.



Anand Lothe, MD

The reasons vary: Many patients are satisfied with their primary care physician and don't want to search for another doctor. Many don't need the specialization of a psychiatrist—and even if they did, finding one can be difficult. According to 2010 data from the American Medical Association, the number of practicing psychiatrists hasn't kept up with demand.

And often, patients don't realize that they need mental health services.

"I would say 30 percent of my patients are coming in with a mental health issue," said Lothe. "Often, I'm seeing it as the root cause of their problems—they don't say 'I'm depressed.'"

Usually it's 'I can't sleep,' 'my back always hurts,' or 'I'm fighting with my spouse.'"

The American Academy of Family Physicians stated in a recent position paper, "Because family physicians treat the whole family, they are often better able to recognize problems and provide interventions in the family system. Family physicians are also able to treat individuals who would

not access traditional mental health services because of the social stigma associated with mental illness."

Treating the whole person is, of course, what primary care and family physicians do.

And some do expect to see a significantly higher percentage of patients needing treatment for psychological issues.

Dr. Stephen C. Young, a primary care physician and internist, is an owner of Virginia Diabetes & Endocrinology, P.C. "A large part of my day-to-day practice is people with diabetes and blood pressure and things of that nature. It's very common for people with chronic diseases such as diabetes or heart disease to have depression. It's hard to ignore."

After years of practice, Young knows how to spot the signs of depression and is comfortable treating it.

Ferretting out many mental health issues, however, is a learned skill. Though all students received training in psychiatry in medical school, many weren't taught the signs of mild psychological distress.

"When you do psychiatry, you

tend to see people who are over the edge, on the other side of the line,” said Lothe. “They’ve got serious issues. [Primary care doctors] see the people who are on this side of the line, people who are still functioning, but not functioning optimally.”

The flip side of that is that psychiatrists often diagnose physical disorders along with mental ones. They’re sometimes the ones to find neurological disorders, endocrine disorders, vitamin deficiencies, drug interactions and many other diagnoses.

Dr. Ken Lucas, medical director of Patient First on Parham Road, credits years of work as a country doctor and military physician for teaching him to spot issues needing attention. “You learn to take care of a whole lot of everything,” he said. “You certainly get a feel for what is real.”

Mental health issues—like physical ones—must be addressed, said Young. “For example, if patients are depressed, they may not eat right and exercise, so their sugars and weight go up—and they get more depressed. It’s a vicious cycle.”

For most physicians, learning to recognize and treat mental issues is the easy part. The tougher part is getting compensated for it.

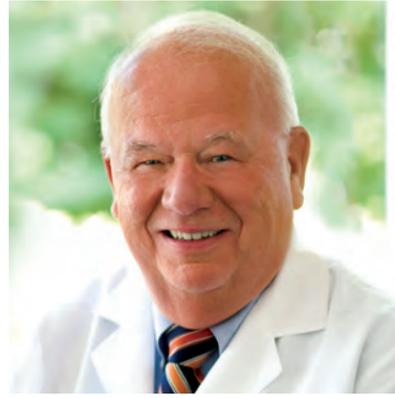
According to the AAFP, primary

care physicians are the major providers of psychiatric care, but payment mechanisms create a disincentive to comprehensive mental health screening. Data show that a typical visit to a psychiatric professional runs at least 30 minutes and is billed for a clearly defined issue. In contrast, primary care visits last an average of 13 minutes and include an average of six patient problems, said an AAFP report.

But that data doesn’t tell the whole story, and primary care physicians aren’t the only ones having trouble receiving compensation.

The American Psychiatric Association (APA) advocated for 20 years for psychiatrists to be paid on an equal basis with other physicians. Even after passage of parity legislation in 2008, many insurance companies retain discriminatory policies against psychiatric patients. Until then, psychiatrists often coded for one problem because they weren’t paid—and sometimes were penalized—for including more codes.

Some patients being treated by psychiatrists pay privately, and some psychiatrists discount fees for patients to pay for necessary services not funded by insurance. Recent reports suggest that a number of mental health professionals have had



Ken Lucas, MD

insurance claims denied and payments withheld because of nationwide changes in psychotherapy treatment codes that took effect January 1. These require psychiatrists to use the same evaluation and management codes as other physicians, despite lack of cooperation by some mental health insurance divisions.

The APA has protested insurance companies’ interpretation of compensation legislation. “This policy violates the spirit, intent, and the letter of federal and state legislation that was designed specifically to prohibit insurers from discriminating against mental health and substance abuse patients through non-quantitative treatment limitations such as inequi-

“Patient,” continued on page 16

Dr. Ken Lucas, medical director of Patient First on Parham Road, credits years of work as a country doctor and military physician for teaching him to spot issues needing attention. “You learn to take care of a whole lot of everything,” he said. “You certainly get a feel for what is real.”



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Left to right, Dr. Trent, Dr. Gonzalez, Dr. Lewkow, Dr. Friedman

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table rates for mental health physicians, and requires that mental health benefits be covered in a manner that is equal to benefits provided for medical/surgical issues,” wrote the APA in a March, 2013 news release.

The system still irks many—and ultimately it’s the patients who suffer.

“[Mental health services] are something patients really need, but the insurance companies don’t want to pay for it,” said Lothe.

The AAFP takes a strong stance in defending its members, stating, “Denying or discounting payment to family physicians and other primary

care physicians is, in fact, denying access to care for a significant percentage of patients. Payment for office visits with a mental health diagnosis code has traditionally been discounted by Medicare for primary care. Many managed care plans do not pay family physicians for the provision of psychiatric care, even though family physicians are frequently in the position to diagnose and provide the care.”

Most physicians believe these health carve-outs are too heavily managed and shouldn’t happen under parity.

Despite the challenges of compensation, promotion of mental health and treatment of illness remains an integral component of family medicine and the healthcare continuum.

And determining a patient’s needs is more than just science, said Lucas. “One of the nice things about primary care is you do get to know your patients, and part of doing that is talking about more than what their ache or pain is. Many times, I have been able to pick up signals that something is going on that the patient is not telling me. That’s the art of medicine.” **R**



Lisa Crutchfield is a Richmond-based freelance writer



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