

The Psychiatric Society of Virginia VIRGINIA NEWS

FALL

A District Branch of the American Psychiatric Association

2003

PSV PRESIDENT/J. Gregory Fisher, MD, DEAPA



PSV Virginia News From the President of PSV

Despite the recent beautiful weather, this has been a challenging fall. Several issues of interest to us have come up. I am most concerned by the closings of psychiatric beds. The state is “restructuring” (deinstitutionalization again?) which will mean fewer inpatient beds. There are plans to change or cut beds at Western State Hospital and Eastern State Hospital among other facilities. It is not only the “public” sector that is downsizing. Winchester’s hospital announced this summer they had closed their C&A inpatient unit. The hospital in Culpeper closed their adult psychiatry inpatient unit. Lastly, a hospital in Alexandria announced the closing of their unit.

We know the state system is closing beds largely because of the budget. The reason for the community hospitals closing beds is largely the same, lack of money. Culpeper cited a decline in reimbursement as well as difficulty recruiting and maintaining psychiatrists. Community hospitals face an increase in indigent or self-pay patients as well as lower reimbursement from Medicaid, Medicare and others. These trends will worsen with fewer state beds. Because of the poor payor mix and issues such as EMTALA, newer seclusion and restraint rules, etc., inpatient work is less appealing to psychiatrists. Many hospitals have to subsidize these units and psychiatrists who work there. As it becomes harder for

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hospitals to make profits in cardiology, orthopedics, etc., I am not sure where this will go.

With the state’s budget short-fall, there has been any number of committees to address various issues. As someone who should be current about such events, I have had difficulty deciphering the purpose and relative importance of each meeting. There was a major discussion related to the re-structuring of the public sector. There have also been meetings for the different regions of the state. Committees are working on issues related to Medicaid generally as well as a Medicaid preferred drug list or PDL to give some hierarchy to the use of medications. The PSV has been invited to many of the meetings. We are trying to make sure we are there. Several members have volunteered to attend.

In other matters, Dr. John Shemo led a conference call of members and drafted a letter to the APA on our experience in Virginia with managed care. Drs. Chesson and Jennings are trying to advance a Foundation project on alcoholism.

Isabel brought summer to a close and just preceded our fall meeting in Roanoke. Dr. Kantor led our disaster response to the storm in conjunction with the Red Cross. Despite the devastation from Isabel, particularly in Richmond and Tidewater, we had the meeting. Although I worried about attendance, we had 35 psychiatrists for the scientific program on Saturday (and a good turnout Friday night). While this is not the typical 65-70 we might have in Richmond, it was outstanding given that we were in a more remote area of the state and Isabel.

Although our numbers were diminished, we had a lively Board meeting on Friday. We finally agreed to a plan for our investments and will continue to work with UBS-Payne Webber and our new broker, Church Young. I thank Dr. Conell for researching this issue and making a recommendation. Cal Whitehead updated us on the new PAC (get your contributions in!) and the Medicaid PDL reporting there are no current restrictions of psychiatric medicines. We discussed the restructuring plan and the proposed shift of resources from state hospitals to the CSB’s and how this relates to coverage provided by CSB psychiatrists vs “private” psychiatrists on call to hospitals with emergency departments and psychiatric units. While the discussion was provocative, it raised good issues. Dr. Foster updated the Board on the much appreciated work of both the Coalition for the Mentally Ill and VMHE.

The reception and dinner that evening were well attended. Dr. Everett, who is leaving Virginia, was thanked for her diligent work, both as the Inspector General for the Commonwealth as well as a PSV Representative to the APA Assembly. Dr. Tom Morris, President of Emory and Henry College, gave an entertaining talk on the state of Virginia politics. Several legislators attended.

Both of the scientific talks on Saturday were well received. Dr. Eileen Ryan of UVA gave an update on juvenile crime and culpability. Dr. Victor Viewig of MCV gave an unsponsored overview on the atypicals. Both speakers were outstanding.

It seems we have been in a calm spell the last few weeks. The number of calls and e-mails I get have been diminished relative to summer. I suspect this is the lull between storms (hopefully not another Isabel!) with the legislative session upcoming and other issues. Nonetheless, there has been enough going on to deserve a respite.

Sincerely,

A handwritten signature in cursive script that reads "J. Gregory Fisher, MD".

J. Gregory Fisher, MD



James S. Reinhard, MD, DFAPA

De-institutionalization: A Failure?

In the past month I have seen at least two articles or letters published in prominent papers where our colleagues have bashed “De-institutionalization”. One of our members pronounced that “De-institutionalization is neither cost-effective nor does it improve services. . . It is the threat to human life that is most troubling.” (Psychiatric News, October 17, 2003) In a letter to the editor, a state hospital psychiatrist confirmed, “De-institutionalization was a failure.” (Newport News Daily Press)

I suppose as we just completed one local election this month and gear up for another presidential election next November we had better get used to sound bites. Those pithy choice words that get so much attention—yet say so little. They say so little, particularly around issues that are extremely complicated. For every complex problem there is a cute little sound bite—and it is usually wrong. De-institutionalization was a failure? Really?

Try telling that to my neighbor down the street in Salem who now lives happily with his family, but who spent the first part of his life in the (brace yourself) “State Colony for Epileptics and the Feeble Minded” as the training center in Lynchburg was called prior to 1940 when it had thousands of residents. My Salem neighbor greets me every time he sees me with “Have they let you out of Catawba yet, Doc?” We laugh. But its not so funny when he tells me how he used to be called to the med line by his number (which he can still proudly rattle off to me) and how many of his fellow residents were left undressed for days because of understaffing and it being too much trouble to attend to resident’s daily needs.

Try telling the thousands that benefited from the “new” anti-psychotics of the 1960’s that allowed them to leave the backwards of our largest state institutions, like (brace yourself again) “Eastern State Lunatic Asylum” that services haven’t been improved and that this whole process was a failure.

To be sure, dollars have not always followed the person leaving an institution. And I would be the last person to say that the transition from institutional based care across the nation to an attempt at community-based care has been flawless. There are major problems in our system. It is in shambles, as the President’s New Freedom Commission final report declared. There has not been the capacity in the community for every person who has left the institutions. The amount we are spending per person for community based mental health treatment in the Commonwealth of Virginia is shameful. The chronic homeless population, the majority of whom suffer from a mental illness, not only need housing but also need mainstream sources of funding for services. We need to focus on demonstrated best practices that keep people in the community—including a focus on recovery and illness self management, supported employment, and much more Assertive Community Treatment (ACT) teams than we currently have.

But does that mean getting people out of crowded, understaffed institutions was a

failure? On the contrary, the United States Supreme Court stated in their landmark Olmstead decision in 1999 that, in fact, it was a right under ADA and that people should have a choice to be in the most integrated setting possible.

So I suggest we focus on the real problem, rather decrying the death of the dinosaurs. Unless we revise history, we have to acknowledge psychiatric institutions were called “snake-pits”. The largest of the asylums and colonies are now gone. And I say, “good riddance!” rather than calling it a failure. Yes, smaller institutions may always be an integral part of a community-based system of care. Indeed we should stop referring to the separate “silos” of institutions versus community care. Institutions are the community, or should be an important part of the continuum of care that a community has to offer individuals with disabilities. Getting institutions to that point has not been a failure. It has been life saving, and life-giving to thousands.

And, yes, we need to be aware that our largest “mental health institutions” are now our jails and prisons. Is that because De-institutionalization was a failure? Should we go back and re-open our own institutions to prevent this “trans-institutionalization?” On the contrary, the jail and prison crisis – as well as the much of the concern about bed shortage – is because our society (and its resources) has not been committed to the concept that we can provide for people with disabilities in our communities. Currently there is too much “MIMBYism” regarding community-based treatment. Society may be “ok” with people with disabilities living and working in community settings, as long as it is not in their backyard.

We do have the tools and expertise to provide supported housing, supported employment, PACT teams, and other community capacity. Adequate funding of community based alternatives to institutions will prevent the bemoaning of de-institutionalization and allow society to see that treatment and recovery in a community setting, for even our most serious and persistently ill individuals, works.

VIRGINIA NEWS

President

J. Gregory Fisher, MD, DFAPA

Editor

James Reinhard, MD, DFAPA

Executive Director

Sandra Peterson

Executive Office

PO Box 71656

Richmond, VA 23255-1656

(804) 754-1200 Fax (804) 754-2321

e-mail: spetersonpsv@comcast.net

www.psva.org

*We welcome letters to the editor
and editorial contributions.*

PsychMD PAC off to Solid Start

Virginia's only political action committee (PAC) for psychiatrists has received over \$2000 in contributions since being formed in July. Now, psychiatrists have organized a way to pool resources with colleagues and impact state politics. Targeted political giving provides access to elected officials and recognizes those policymakers who share our views on a better psychiatric care system. Thanks to the following physicians who have contributed or pledged to PsychMD PAC!

PsychMD PAC Founding Members: Greg Fisher, Helen Foster, Richard Oliver, Joel Silverman, John Hendrickson, and Yaacov Pushkin

PsychMD PAC Advocates: Anita Everett and Bernard Williams

PsychMD PAC Members: Rebecca Lindsay

Please visit http://www.psva.org/legis_psychmd.htm for information and contribution forms.

General Assembly Elections Results and Another Budget Fight Shaping Up

The 2003 General Assembly elections were held on November 4. Republicans picked up one seat in the Senate with Delegate Jeannemarie Devolites win giving the GOP a 26-14 advantage. Democrats achieved their first net gain in House seats in over 25 years by picking up 3 seats; Republicans have a 61-37 majority and 2 independents who typically vote with them. Delegate Tom Bolvin (R-Fairfax) was the only incumbent to lose; Democrat Mark Sickles will now represent the 43rd House District.

With elections behind them, Governor Warner and Democrats are lining up against the Republican Leadership in the General Assembly over tax structure reform. Both sides will position themselves for and against, respectively, tax-revenue increases until the General Assembly convenes on January 14.

Legislative Priorities for Psychiatrists

Organized psychiatry and allies will have a full agenda this session on issues affecting your practices and your patients. PSV and Northern Virginia Chapter of WPS are working with Virginians for Mental Health Equity (VMHE) to maintain parity law for reimbursement of psychiatric services. We continue to educate legislators and agency officials about the need for a broad psychiatric medicine exemption from Medicaid Preferred Drug List (PDL) prior authorization requirements. As a member of the Coalition for Mentally Disabled Citizens, we support increased funding for mental health services provided through the state system.

New Addition to Psychiatry's Advocacy Team

Whitehead Consulting is pleased to announce the addition of Stefan Cox to the firm. Stefan, who spent 3 years in financial consulting, will help with client government relations services.

For more information on any of these issues or questions about organized psychiatry's advocacy efforts, please contact me at cwhitehead@whiteheadconsulting.net.

PsychMD-PAC

The Political Voice for Virginia's Psychiatrists

PsychMD-PAC raises money from Virginia psychiatrists to fund the General Assembly and statewide candidates with positions that promote a better environment for psychiatric care delivery.

Political contributions help offset the expenses of campaigns and allow psychiatrists to target our message to important decision-makers.

Without your support of PsychMD-PAC we cannot achieve our mission of educating candidates about our professional concerns.

Please accept my contribution of:

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PSV IN THE NEWS

PSV Past-President David Trinkle, Medical Director at Carilion Center for the Healthy Aging of Roanoke was appointed this past summer by Governor Mark R. Warner to serve on the State Mental Health, Mental Retardation and Substance Abuse Services Board (DMHMRSAS).

Growing, Growing, Gone...

Anita Everett, M.D. has once more expanded her horizons. After 4.5 years as Virginia's first Inspector General she resigned and since mid October has moved from Charlottesville to Maryland where she is working as the first Senior Medical Adviser to the Director of the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA) in Rockville, MD. Her husband will be working at Johns Hopkins continuing his research in pediatric cardiology.

Anita has been very dedicated to public psychiatry acting as a leader in the PSV and at the national level with the APA as an Area 5 Assembly Representative for the past 4 years. She has also been very involved as a representative and Board Member of the American Association of Community Psychiatrists and was one of the inspirations behind the establishment of the Virginia Association of Community Psychiatrists (VACP).

At the PSV meeting in Roanoke, 9/19/03 the PSV in conjunction with the VACP gave Anita a plaque honoring her work and achievements in Virginia. We will greatly miss her in Virginia but it is clear that her contributions to the field of psychiatry and her advocacy for those with psychiatric illness will continue to grow. **Anita's email is aeveretmd@msn.com.**

What are the criteria for Fellows & Distinguished Fellows now?



To become a Fellow, a member must have five years as a general member; Board certification; three letters of recommendations from current Fellows or Distinguished Fellows; and approval by the APA Membership Committee and Board of Trustees. A Fellows application is completed and submitted by the applicant solely.



To become a Distinguished Fellow, a candidate must have at least eight years as a member and three letters of recommendation from current Distinguished Fellows. Candidates also must meet more comprehensive criteria including demonstrated excellence in at least 5 of several specific areas, generally covering clinical, professional, educational, and research activities, and community service. A Distinguished Fellows application comes through the PSV. **Please contact the PSV office for more information at 804-754-1200.**

For Sale

Tranz 330 Visa/Mastercard/American Express machine. Good condition; includes a manual, roll paper, credit cards slips. Easy to use. Was previously set up with United Merchant Services of Virginia Beach. Asking \$100.00 plus shipping. **Call Sandra Peterson at the PSV office or e-mail at: spetersonpsv@comcast.net.**

Spring 2004 Meeting – Mark the Date

Friday, March 26 & Saturday, March 27 at the Richmond Marriott West in Glen Allen, VA

FRIDAY EVENTS INCLUDE:

10:00 am golfing at Willow Oaks Country Club

4:00 pm Board of Directors Meeting

6:30 pm Reception with local Legislators

SATURDAY EVENTS INCLUDE:

7:00 am Committee Breakfast Meetings

8:15 am CME program (6 CME credits) featuring

Elizabeth B. Weller, MD, University of Pennsylvania, Children's Hospital of Philadelphia "Bipolarity in Children and Adolescents: Diagnostics" and "Therapeutic Dilemmas & Depression in Children & Adolescents: Diagnosis & Treatment".

Dr. Weller is being co-sponsored by the VA Council of the AACAP.

James Levenson, MD, MCV/VCU, Richmond "Delirium and IV Neuroleptics: Myths, Mistakes, and Malpractice"

James H. Scully, MD, Medical Director of the American Psychiatric Association "APA Update"

Edward Kantor, MD, University of Virginia, Charlottesville "Disaster Mental Health—Virginia and Beyond"

Deadline for room reservations is March 5.

Call 804.965.9500 for room reservations. Rates for single and double/double \$85.00 for Friday, March 26, 2004. **There is no fee for PSV members except for golf. PSV welcomes all non-PSV members. Contact Sandra Peterson for more details at 804.754.1200. A registration fee of \$50 for non-members includes break and lunch. Resident's welcome. There is no fee for non-member residents.**

Virginia Medicaid Announces Pharmacy Changes

The Virginia Department of Medical Assistance Services (DMAS) is implementing a Preferred Drug List (PDL) Program for the Medicaid and MEDALLION fee-for-service population. Details regarding the PDL program are contained in a Medicaid Memo being sent, along with related materials, to all Medicaid providers prior to the program implementation in January 2004. It is important that medical providers read all the data in the packet in order to become familiar with the changes in how prescription drugs are authorized for payment. Prescribers and pharmacies can find up-to-date information related to the PDL program on the Department of Medical Assistance Services' web site at www.dmas.state.va.us or at the First Health Services' web site at <http://virginia.fhsc.com>.

A PDL program is a type of prior authorization plan that divides Medicaid covered prescription drugs into two categories: those that require prior authorization before they can be dispensed, and those that do not.

While there are many classifications of drugs that are not subject to the PDL or prior authorization, a PDL contains a wide range of generic and brand name products that have been approved by the Food and Drug Administration (FDA). The design of the PDL program must ensure access to prescription drugs for Medicaid clients.

The DMAS Pharmacy and Therapeutics Committee (P&T) conducts comprehensive clinical reviews of therapeutic drug classes to determine whether a drug should be on the Preferred Drug List. In general, a medication becomes a preferred drug based on safety and efficacy first, then on cost-effectiveness.

Beginning January 5, 2004, pharmacists will receive a message when filling a patient's prescription for a drug that requires prior authorization. Prescribers will receive a call from the pharmacy provider as a result. This provides an opportunity for the patient's medications to be reviewed and changed or for the prescriber to contact First Health Services to

provide medical justification. Prior authorization is available by telephone, fax or mail.

A complete list of preferred drugs in each of these therapeutic classes is included with the Medicaid Memo mailed to prescribers and pharmacies. This memo also will provide a suggested format for calls and faxes requesting authorization of drugs. Prescribers are encouraged to review their Medicaid patients' drug regimens immediately and consider moving appropriate patients to the preferred drugs before the program begins. Virginia Medicaid has the ability to process a proactive prior authorization request when the treating physician determines that continued use of drug is medically necessary. Prescribers' early participation in this program will help DMAS continue to offer quality medical services through the Medicaid program while conserving limited Medicaid funds.

Prescribers and pharmacists can have questions answered or begin the proactive prior authorization process by calling the toll-free number 800-932-6648.

Employment Opportunity

CLINICAL ASSOCIATES OF TIDEWATER, a multispecialty mental health practice in Newport News, is interested in recruiting a child or adult psychiatrist to join our practice.

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Report on Area V Council Meeting & APA Assembly Meeting

This was Anita's last meeting as Psychiatric Society of Virginia representative to the APA Assembly and the Area V Council. As I stated in my District Branch report, Anita will be missed; Virginia's loss will certainly be Maryland's gain. Dr. Ram Shenoy from Richmond has been appointed by the Board of Directors to complete the final two and a half years of Anita's term.

The meetings as usual were lengthy and fast-paced.

The Assembly speakers forum preceding the first plenary session focused on the problem of the "criminalization" of the mentally ill, the increasing number of the mentally ill who wind up in the prison system because of the absence of adequate psychiatric treatment.

On an extremely good note, the APA for this year will have a significant budget surplus. This seems related to several factors. The APA has done a very good job of decreasing expenditures. Additionally, revenues have been significantly better than expected. These increased revenues are related to excellent sales of APA publications as well as higher than expected revenues from the last scientific meeting in San Francisco. At that meeting there were 17,000 registered clinicians and over 21,000 registrants including exhibitors. Over 7,000 of the registrants were from overseas. Additionally, there has been an actual slight increase in APA membership in the past year, reversing a trend of decreasing membership over the past several years. The surplus for this year is projected to be \$5.2 million. Additionally, the APA has \$23.1 million in its investment portfolio. Having these levels of reserves are, of course, extremely important in discouraging "scope of practice" assaults on the profession. This good news is tempered by the fact that a significant part of publishing revenue comes from the DSM and DSM V is not expected to be published until 2010 or 2011. Additionally, a significant stream of revenue comes from the annual meeting and especially from the overseas participation in that meeting. The federal government is apparently currently making it very difficult for foreigners to come to the United States for meetings and this could have a significant

impact on the upcoming New York meeting.

Another item of good news is that the APA was able to successfully address the impending implementation of the next "phase" of HIPPA regulations. Specifically, HHS did agree to allow the DSM to remain the basis for diagnosis coding. This was referred to as "the attack that did not occur" because of APA intervention. A tremendous amount of work went into this effort and if it had not been successful, the implications would have been significant. It would have both undermined the privacy of DSM in diagnostic nomenclature but also would have been extremely expensive to facilities and practitioners, especially given the poor compatibility of ICD-9. In this vein, the issue of "electronic prescribing" was addressed. The House version would mandate electronic prescribing while the Senate bill "encourages" but does not mandate electronic prescribing. The complications for solo practitioners and small groups would be that the software needed for doing electronic prescribing would be very expensive and would open the door for pharmacies to "charge" physicians for access to their computers. As a side issue, at the Area V Council meeting we did discuss the increasing problem of patients becoming addicted to controlled substances they are obtaining over the internet without ever being seen by the "internet physician" who prescribes the medication. It is unclear why the DEA has been so absent in addressing this problem.

Psychosomatic medicine has been designated a new sub-specialty. Some members would have preferred that the more traditional term of consultation liaison psychiatry be retained. Apparently issues of obtaining sub-specialty certification and availability of "grandfathering" remains to be worked out. It was also announced that a recognition award for both full-time and voluntary psychiatric resident supervisors was going to be made available, although the details of the criteria for this were not yet specified.

The issue of the projection of a 4.5 percent decrease in Medicare payment rates for psychiatric codes was discussed. The problem of this system's devaluation of cognitive services

over procedures remains. An elimination of this reduction is part of the Medicare prescription drug coverage plan that is before Congress. This is an over 1,000 page bill which has a lot of unfortunately negative aspects. Overall, APA leadership is leaning towards supporting the bill primarily because some of its more positive aspects will have fairly immediate impact, while some of the more negative aspects are delayed and therefore may still be alterable even after the bill is passed.

The ongoing problem with the APA-endorsed insurance program was discussed. There are approximately 7,000 APA members enrolled in this program in that in some states it is the only professional liability insurance available to psychiatrists. There are currently through AIG two companies issuing policies under this program, both of which are rated A++ . However, the prior insurer, Legion, is in liquidation. This creates a serious "tail" problem for individuals in at least some states who had coverage with Legion.

No states beyond New Mexico have so far passed legislation related to prescriptive privileges for psychologists. Bills are pending in numerous states. For example, a bill is being introduced for the seventh straight year in Tennessee since they "only have to win once." The New Mexico plan for qualifying psychologists for prescriptive privileges was described by Dr. Sculley as a "parody of medical education—a joke."

Gavin Andrews, M.D., a psychiatric health-care researcher from Australia, did a very interesting presentation. He presented data documenting that mental illness is the largest cause of disability worldwide. It accounts for 17 percent of the "burden of disease" but receives less than seven percent of revenues for treatment. He also discussed the Australian system of healthcare. He states that under this system the government reimburses psychiatrists \$120 a hour for psychiatric services. If the psychiatrist accepts that fee the payment is sent directly to the clinician. If the psychiatrist does not accept that fee as full payment, the psychiatrist bills the patient directly and the health system reimburses the patient \$120

(Continued on page 8)

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an hour for psychiatric services. If the psychiatrist accepts that fee the payment is sent directly to the clinician. If the psychiatrist does not accept that fee as full payment, the psychiatrist bills the patient directly and the health system reimburses the patient \$120 for each hour of care received and the patient is responsible for paying the psychiatrist's bill. He states that the average charge by a psychiatrist in Australia is approximately \$200 an hour. He states that the Australian system limits access (i.e., rations) by controlling the number of medical school and residency slots and by not allowing foreign-trained physicians to tie into their reimbursement system. A foreign-trained physician generally can take a salaried position in Australia but cannot bill privately under the above-referenced system.

The APA-endorsed privacy lawsuit related to HIPPA regulations is continuing. On a positive note, the government has acknowledged in their initial response that they have taken away privacy rights that had been in place. It is

unclear at this point where this will lead. The RICO lawsuit against a number of managed care companies under racketeering statutes has led to several insurance companies so far electing to settle out of court, agreeing to changes in their policies and procedures. Again, how this will "trickle down" remains to be seen.

There were a somewhat lesser number of action papers submitted at this meeting. Included among these was a paper supporting an industrywide requirement that managed care organizations collect data reflecting the actual access to psychiatric care within their systems. This obviously addresses inadequate and even "phantom" panels. This represented, in part, the overall theme of the Assembly meeting being on access problems.

Another passed paper requested that the APA explore the expansion of Medicare to the more than 44 million individuals in this country who lack any form of health insurance. In this debate it was pointed out that managed care is a \$40 billion "industry" that spends approximately 50 percent of their revenues

on administration, profits and marketing. In contrast, Medicare spends less than two percent on administration. A paper addressing discrimination against psychiatric consultation was passed. A paper was also passed related to fairness and accuracy in expert witness testimony regarding standards of practice. It was pointed out in this regard that one of the "forensic experts" in the case of a North Carolina student who committed suicide had testified that the standard of care was such that the Student Health psychiatrist should have personally taken the patient to his first appointment in his home town even though the student lived several hours away. Another action paper requested that the DSM V committee develop clear criteria for adult attention deficit disorder since the condition does manifest differently inside and outside the school setting and across age groups.

As always, I remain available to discuss local issues which members may wish to be brought to the larger APA Assembly forum or to discuss the development of potential action papers.

Joan Esnayra, Ph.D.

Psychiatric Service Dogs

- A patient does not leave her home, because she is fearful of having a panic attack in public.
- A patient becomes suspicious when her husband suggests that she may be getting manic
- A child with Asperger's syndrome has difficulty interacting with peers

What do these three scenarios have in common? The symptoms experienced by these patients may be mitigated through ongoing partnership with a Psychiatric Service Dog (PSD). Like guide dogs, PSD are a type of service animal trained to perform tasks that mitigate the functional impairments associated with psychiatric disability.

What tasks might a PSD perform for the individuals described, above? For panic disorder, a PSD may be trained to alert his handler to incipient panic attacks. This advance notice affords the handler the opportunity to get to a safe and private location, in order to wait-out the attack. Similarly, some PSD may be trained to alert to incipient mania in their bipolar handler. This critical information cues the at times incredulous

bipolar handler to take antipsychotic medication, call her doctor, and/or make pre-emptive behavioral choices. For children with Asperger's a PSD may be trained to facilitate social interactions with peers. Children are naturally drawn to dogs and enjoy asking questions of those who handle them.

Psychiatric Service Dogs are a novel therapeutic adjunct intended to be used in combination with ongoing medication and talk therapy. They are a cognitive tool aimed at developing the patient's level of insight, which in turn facilitates their ability to make healthier behavioral choices at critical moments. The PSD partnership is a 24/7 lifestyle commitment, and one must work the program, in order to reap the benefits. This involves being an active participant in the selection and training of the dog, involving one's clinicians in their use of the dog, and participating in an online service dog community in order to learn about relevant laws and for ongoing peer support.

The Arlington-based Psychiatric Service Dog Society is a 501(c)3 organization devoted

to educational outreach to prospective PSD handlers, mental health practitioners and members of the business community. PSDS is preparing to conduct peer-reviewed clinical research on the efficacy of PSD and will implement its first trial on patients with panic disorder next year. PSDS is also developing training modules for use with the professional dog trainer community, in order to build capacity for a new cadre of qualified trainers capable of working with mental health clients.

What can you do to support your patient's decision to begin using a PSD? Visit our website and download our providers' brochure to become educated about PSD. Write your patient a letter of support so that she can begin training her dog responsibly, in places of public accommodation. The PSDS website provides model language for such a letter that balances the interests of clinicians and patients, alike. Finally, stay tuned as there is certainly more to come!

Psychiatric Service Dog Society

1911 Key Blvd, #568 • Arlington, VA 22201
www.psychdog.org • (571) 216-1589

Disaster Mental Health—Planning for the Future

Disaster mental health is coming of age. The sad truth is that it took the catastrophe of September 11th to move the concepts into the mainstream consciousness of the public health community. Even there, it has been barely noticed in the zealous preparation for the variety of potential hazards that might evolve in the event of bioterrorism. The good news is that there are efforts underway to include mental health in the planning and preparation for the evolving Virginia Disaster Plan. With cooperation from VDH and Department of Mental Health, Mental Retardation and Substance Abuse Service (DMHMRSAS), PSV has been able to participate in the formation of an Advisory Council for Disaster Mental Health. The Council will report to the disaster hierarchy and advise and recommend planning and response strategies for local communities. The project is still in its infancy, but speaks to what appears to be an unprecedented level of cooperation by many agencies and agendas—in the Commonwealth and across the country. For years many competent, but disparate movements and organizations have provided components of care with little coordination and little evidence as to efficacy. As one might imagine, research in the midst of any disaster is difficult to coordinate and often even hard to justify, when the humanitarian goals supercede all else.

Recently, mental health researchers have been able to perform limited small scale studies and conduct meta-analyses of multiple past disasters in an attempt to provide the field with a better idea of what works and what might be harmful. This research is beginning to translate into some evidence-based guidance for practice (5, 6, 7, 9) in some areas of disaster mental health. Integrating the evolving body of literature into a reasonable standard with cross training instructors and interagency partnerships will hopefully be established to this end. Implementation and coordination the response and training needs of the Commonwealth require liaison with both the Health Department's Office of Emergency Preparedness and Response (OEP&R) and the s (DMHMRSAS). Both

agencies have agreed to work toward a cooperative plan for mental health response and education in disaster and bioterror.

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Professional organizations in psychiatry (8), psychology (Yes, I said psychology—far more active than us in disaster work for many years), and several advocacy groups are developing guidelines for best practices. (Several of these are listed below)

Even with our lack of a comprehensive mental health plan, there was a call by the Red Cross for psychiatry assistance in the aftermath of Hurricane Isabel. A number of PSV psychiatrists volunteered to assist in shelters and in the coordination of various parts of the recovery efforts. Hopefully over the next few months we will be able to develop better planning and integration of the psychiatric response. Toward this end, we will be looking for a representative from each PSV chapter to serve on the Disaster Committee and help direct PSV participation in state planning and, even more importantly, the mental health response at the local level.

We will be having a Disaster Committee Planning and Organizing meeting at the March PSV meeting. I invite all interested members to participate.

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The Psychiatric Society of Virginia
PO Box 71656
Richmond, VA 23255-1656
Tel: 804-754-1200 Fax: 804-754-2321
spetersonpsv@comcast.net
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