

THE PSYCHIATRIC SOCIETY OF VIRGINIA VIRGINIA NEWS



A DISTRICT BRANCH OF THE AMERICAN PSYCHIATRIC ASSOCIATION

FALL / WINTER 2007



Steve Brasington, MD
PSV President

A MESSAGE FROM THE PRESIDENT

The PSV Fall Meeting was held in Roanoke, VA on October 19-20. During the meeting, the following topics were discussed.

Virginia Tech: Lessons Learned and Implications for a Rational Policy was presented by Dr. Sood. She discussed her role as a panel member and mental health expert on the Governor's Panel investigating the Virginia Tech Tragedy that occurred on April 16. She noted the Freedom of Information Act limited members from gathering in groups greater than two. She observed the panel was under significant scrutiny with statements in the public eye from the very beginning. The Governor limited the scope of the inquiry to the case, not issues in the Mental Health System. Members conducted many first person interviews to gather accurate data, while avoiding hearsay evidence.

She noted the time commitment came at a cost for a practicing physician. Nonetheless, to represent Psychiatry well, she talked to experts around the country and made a commitment to remain neutral and separate from a personal agenda. The two major issues were mental illness and commitment law. Another important issue was diversity, understanding that the individual at the center of the event was an immigrant from South Korea. Jerald Kay, Chair of the APA's College Mental Health Committee addressed the panel and helped focus the panel on overcoming barriers to receiving medical records. After one month, legal intervention led to the release of records by Executive Order. To complete the report, the panel began meeting twice

a week. During the deliberations, gun control emerged as a secondary issue. She noted the most difficult days involved interviewing grieving survivors. After the report was published, she was pleased by feedback that the report fairly addressed areas requiring the attention of the legislature.

Dr. Reinhard presented *Violence, Mental Illness and Public Safety*. He started off by citing three studies from the Archives of General Psychiatry from the last 10 years, which supported an association between violence and mental illness, especially when patients used alcohol. Next, he highlighted an editorial published in the 2006 issue of *NEJM*, which shows 68 assaults (non-fatal job related violent acts per 1000 hours of Psychiatric work.) The editorial sent the message that substance abuse contributed much more to the risk of violence than serious mental illness, which has a documented attributed risk of 3-5%. Thus, the substance abuse history is a better predictor of violence than perception of threat by the patient.

Dr. Reinhard addressed the number of inpatient beds in the public system. There are 1,500 state mental health beds at present, compared to 12,000 beds in 1968. He commented that the vision for community health was not fully realized, as patients have been trans-institutionalized to the jail systems. There were now 24,000 in jail. Sixteen percent have mental illness. Only about 1,800 are in jail with serious mental illness. Few states spend more per capital on facilities for inpatient care than Virginia does. The national average spent on state psychiatric inpatient coverage was \$150 million, while Virginia spent twice as much. Virginia ranks at the bottom for community mental health expenditures. His mes-

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sage to the General Assembly was that incremental tweaks will not help.

Dr. Kantor presented *Behavioral Response to Crisis and Disaster* which focused on Eye Movement Desensitization and Reprocessing as an early mental health intervention, noting data indicated it should not be a routine part of the disaster response. Psychological debriefing may cause harm with "systemic ventilation of feelings" as the potentially most harmful phase. The term "debriefing" should only be used to describe operational debriefings, which are done for reasons other than treatment or prevention. A new approach, with an operational focus and intent, is "decompression". Decompression allows persons to get the big picture and share their individual experience, while asking how the disaster response could be better. The intent is to use it as a quality improvement tool in disaster response.

Psychological First Aid is an evidence informed modular approach to assist children, adolescents, adults and family in the immediate aftermath of a disaster or terrorism. It is designed to reduce initial distress caused by traumatic events. It fosters short and long

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A MESSAGE FROM THE EDITOR

The Death Rates of the Seriously Mentally Ill Require Our Advocacy

By Kathleen Stack, MD, DFAPA



Kathleen Stack, MD

In the January 2007 issue of *Current Psychiatry*, I read Dr. Nasrallah's editorial in which he suggested that people with schizophrenia should move to Virginia. This was not an endorsement of our wonderful climate and many historical and natural resources. It was in recognition of the quality of psychiatric care for those with SMI. In an October 2006 report published in *Morbidity and Mortality in People with Serious Mental Illness*, it was pointed out that in seven states, people with mental illness served by the public mental health system died an average of 25 years earlier than the general population. Virginia had the lowest rate of 13.5 years lost, while Arizona had 31.8 years lost, Missouri 27.9 years lost and Utah 26.9 years lost. While we would want the life expectancy of those with SMI in Virginia to be the same as others in the state, a closer examination is needed. While 30% of this increase is suicide, 60% of these deaths are due to natural causes, such as cardiovascular and pulmonary disease.

If both the general population and the SMI population die of the same illnesses, with a few exceptions like cancer, why are the rates so different? The majority of the risk factors for these diseases, such as obesity, smoking, sedentary life style and poor nutritional choices are modifiable. The problem is these issues are either not addressed at all or are inadequately addressed in our population.

It would not be appropriate to attribute the shorter life expectancy to the second generation antipsychotics, as the problem preceded their wide spread use. Additionally, it would not explain the state to state differences. I will exclude the complex issues of public health policy, funding and reimbursement issues and scarce resources as beyond the scope of my article and my ability to impact today. There are three main players in this health crisis; the patients, primary care providers and psychiatrists.

I believe psychiatrists know more about a patients' life, habits and abilities than their primary care providers. While we are obliged to focus on the symptoms our patient, their families and society report as problematic, we must also address the single more problematic health behavior which is present in 50-80% of our patient; smoking. While we cannot make someone stop smoking, we can point out the health benefits for quitting. We should provide nicotine replacement therapy and other medications and community resources which have been shown to help even the SMI population quit smoking.

I believe our patients' needs are not being met by the current primary care system. Our patients' health needs are not always addressed, their interactions with medical care are often when in a mental health crisis or under treatment for an acute condition. They are often not seen for screenings or routine health care. We must advocate for our patients and work within available systems to meet these needs for our patients. Refer your patients for primary care and routine screening examinations. One strategy is the DIGMA drop in group medical appointment. Here a primary care provider partners with mental health and homeless workers to provide routine medical and psychiatric care as well as patient education in a group setting. The time and location allows for bus transportation and "one stop" services. No prior scheduling is required, they can "drop in" for the clinic.

Our patients have the same rights and needs for medical care as other residents of our state. We need to be the patients' advocates for this to happen.

As highlighted in this newsletter, the cares of those with mental illness in the state of Virginia are being examined in great detail. We have many national experts as members of the Psychiatric Society of Virginia, who are helping to shape these policies. As these plans are designed, I encourage all involved to work to improve the total health care of those we serve across our diverse state.

INTELLECTUAL DISABILITY: THE STEP-CHILD OF PSYCHIATRY

By Ram Shenoy, MD, DLFAPA

Intellectual Disability, formerly known as Mental Retardation, affects 3% of the world's population. Its presence is found equally in rich countries and in poor societies. Even though malnutrition, inadequate pre-natal care and infant neglect play a role in its etiology, it can affect more affluent societies in the West by factors such as genetic disorders, exposure to viral illnesses during pregnancy including HIV, illegal drug consumption during the gestational months and by ingestion of alcohol in the first trimester of pregnancy. In spite of its ubiquitous presence, the recognition, assessment and treatment of individuals with intellectual disability and co-morbid mental illness lags far behind that of disorders like schizophrenia and bipolar disorder, each of which affect roughly 1% of the population of the world.

Mental illness affects roughly 50% of the persons with intellectual disability. Because many people with intellectual disability have difficulties with speech and hearing, communication is a problem that leads to significant behavioral issues which may also need clinical intervention. This huge cohort of patients with their complicated psychiatric and behavioral issues is often ignored by mainstream psychiatrists. If psychiatrists are available in localities, they are often untrained and are either unable or loath to deal with this population. The causes for the neglect are many and have their roots in history.

In the beginning of the 20th century, most psychiatric patients were treated in large state hospitals in an atmosphere of mistaken but benign paternalism. Patients lived in these mammoth institutions that resembled small communities for years, often encompassing most of their lives. The intellectually disabled were consigned to similar large institutions that were called training schools. The idea was to habilitate these individuals and train them to do simple tasks. Virginia had several of these training schools, the largest of which was the one in Lynchburg, now named The Central Virginia Training Center.

At one time, this was the largest institution of its kind in the Western Hemisphere, housing thousands of patients. One of the physicians who worked in the Lynchburg advocated the idea of sterilizing intellectually disabled women of child bearing age to prevent them from having 'defective children'. In this effort, hundreds of young women were sterilized with scant attention to human rights and due process. This so called 'The Lynchburg Experiment' led to the dubious 'science' of eugenics that was later adopted by Hitler to eliminate thousands of people in Nazi Germany. Eventually the courts ruled this illegal and the practice was stopped but not before inflicting a long lasting stain on Virginia's reputation.

Even with flaws like the 'Lynchburg Experiment', the system bumbled along providing a safe haven for the intellectually disabled. Human rights were adopted and the system revamped with the introduction of psychiatrists and psychologists to help with the management of the mentally ill in the population. The next big move came when deinstitutionalization became the buzz work in the 1970s. Many of the liberal thinkers were opposed to patients with intellectual disability or mental illness being 'warehoused in large institutions. Legal challenges were made to the status quo and patients were discharged to be taken care of by the communities where they resided. Initially this was an unmitigated disaster especially in states like Virginia where funding was inadequate for taking care of a large number of people who had complex mental health and medical problems. Waiting lists were long and service providers were in short supply. A series of legislative initiatives and legal rulings effected a drastic change to this scenario. The most important ones were the federal program known as the Medicaid 1915(c) home and community based waiver program which afforded funding to communities to implement housing and programs in the community, the Olmstead ruling of 1999 which, in summary, stated that any institutionalized person with disability had a

right to live in the community if such placement were beneficial to the individual and the state could reasonably accommodate those services and the Olmstead ruling implementing this decision, signed by President George W. Bush on June 18, 2001. Other legal or executive decisions like The Americans with Disabilities Act and the Assistive Technology Act of 1998 also helped.

To this day, the care of the intellectually disabled in Virginia is abysmally poor. Virginia ranks among the ten richest states in the nation but in the care of the intellectually disabled it is among the lowest among the fifty states. The reason for this failure is hard to fathom but is probably due to lack of political will to remedy the situation. Until recently, the intellectually disabled with mental illness were housed in the state hospitals and in the same units as patients with severe mental illnesses, aggression and predatory behaviors. As a result of the Department of Justice intervention in the year 2000, the state signed a consent agreement to shift these patients to community resources and provide them with adequate clinical support and funding to make that transition. A grant provided by CMS, the Center on Medicare and Medicaid provides federal funds for five years to improve access to disability services for the mentally ill, the intellectually disabled and the ageing population. It is called 'No Wrong Door'. Consumer directed initiatives are going to be encouraged. Web based technology will be implemented to coordinate services throughout the Commonwealth and to help providers with critical incidents. A committee recently made several suggestions to improve the Medicaid waiver system and this issue is being considered by the legislature.

With all the new initiatives, Virginia is finally trying to join the 21st century in providing care to the intellectually disabled. One aspect that is lacking and has not been addressed so far, despite several efforts on my part, is the founding of a tertiary care and training center

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IN THE NEWS

WELCOME TO OUR NEW MEMBERS

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HELPING PARENTS HELP THEIR KIDS

The American Academy of Child and Adolescent Psychiatry (AACAP) and the American Psychiatric Association (APA) announced the release of a new Attention-Deficit/Hyperactivity Disorder (ADHD) Medication Guide. The guide provides information on symptoms, treatment options, types of medications, side effects, and co-occurring disorders.

The ADHD Parents Medication Guide is the latest addition to the ParentsMedGuide.org online resource center that provides practical advice for parents of children and adolescents with mental health disorders. The guide is available in English and Spanish.

ADHD is a neurobehavioral disorder characterized by excessive restlessness, inattention, distraction, and impulsivity. Estimates show that between three and seven percent of school-aged children and approximately four percent of adults have ADHD. Consequences of untreated ADHD in children include increased risk of school failure and dropout, behavior and discipline problems, alcohol and drug abuse, depression, relationship difficulties, employment problems, driving accidents, and delinquency, criminality, and arrest.

Following the U.S. Food and Drug Administration (FDA) hearings regarding medications used to treat this condition, many parents and guardians of children and adolescents living with ADHD were left with questions about the treatment options for ADHD. While the FDA found that the medications used to treat ADHD are generally safe and effective, many children and teenagers who take medication for ADHD do experience side effects at one time or another.

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PUBLIC AFFAIRS NEWS...

Steve J. Brasington, MD, DFAPA, Capt. USN, MC & President, Psychiatric Society of Virginia, recently reported to the Board of Trustees re: MH efforts to help returning veterans. **Antony Fernandez, MD, DFAPA** was quoted in the *Richmond Times-Dispatch*, commenting on Combat Traumatic Brain Injury. **Edward M. Kantor, MD, FAPA**, PSV Chair of Disaster Psychiatry, has been interviewed in several venues that include *Charlottesville Weekly*, *Daily Progress* and *Psychiatric News* regarding events at Virginia Tech. **Aradhana Bela Sood, MD, MSHA, FAACAP** served on the Governor's Panel to review events at Virginia Tech, and she has also been interviewed on several media venues. **Kathleen M. Stack, MD, DFAPA** appeared as a keynote speaker at the Obici Hospital and Hampton University National Recovery Celebration. **Jorge A. Cortina, MD, DFAPA** has been invited to answer questions about Alzheimers during *Health Journal* in local Public Radio. **J. Edwin Nieves, MD, FAPA** participated in Puerto Rico Public Radio *Medical Report* program following events at Virginia Tech.

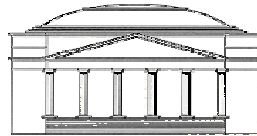
THANKS GO TO DAVID B. TRINKLE, MD, DFAPA!

On behalf of the Board of Directors and membership of the Psychiatric Society of Virginia, we salute our colleague David Trinkle, MD, DFAPA, for his service as the first mandated psychiatrist member of the Board of the Department of Mental Health, Mental Retardation & Substance Abuse Services.

PSV successfully lobbied the General Assembly to pass legislation in 2002 that required the Governor to appoint a psychiatrist to the Board of DMHMRSAS. Dr. Trinkle was an invaluable resource to both his fellow PSV Board members, the Department of Mental Health & Retardation, and practicing psychiatrists. Patients in the public mental health system benefited from Dr. Trinkle's tenure.

THANKS FOR CONTRIBUTING TO PSYCHMD-PAC IN 2007!

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Advanced Research & Clinical Topics in Forensic Practice

January 31 - February 1, 2008 Omni Hotel, Charlottesville, VA

January 31- Treating and Managing Psychopathy: An Innovative Perspective, Jennifer Skeem, PhD

February 1 - Reflections Upon the Virginia Tech Tragedy, Roger Depue, PhD, James Reinhard, MD, Richard Bonnie, LLB

Prosecution of a Terrorist: The Case of Abu Ali, Gregory Saathoff, MD, Rob Spencer JD, Dave Laufman, JD, Steve Campbell, JD

Assessing the Risk for Violence in Clinical Practice

February 15, 2008 Charlottesville, VA

Assessing Risk for Violence with Juveniles

March 14, 2008 Charlottesville, VA

Risk Assessment of Sexually Violent Predators

April 18, 2008 Charlottesville, VA

A Review of States' Sexually Violent Predator Laws, Larry Fitch, JD &
Issues in Assessment of Levels of Risk with Sex Offenders, David Thornton, PhD

An Overview of Civil Commitment Law and Changes Made by the 2008 Virginia General Assembly

June 4-5, 2008 Doubletree Hotel, Charlottesville VA

Review of issues arising out of work done by Virginia's Commission on Mental Health Law Reform
and the Virginia Tech Review Panel

For program & continuing education information please contact els2e@virginia.edu or (434) 924-5126.

For registration information, including dates, locations, and costs please contact smw9w@virginia.edu or (434) 924-5435.

NAMI VA UPDATE

New Consumer Recovery Education Program: Peer to Peer

By Mira Signer

NAMI Virginia Executive Director

NAMI Virginia is getting ready to embark on an exciting new statewide program – Peer to Peer. Peer to Peer is a 9 week experiential education course on recovery for any person with serious mental illness who is interested in establishing and maintaining wellness. The course is based upon the idea that living with a serious mental illness is, among many other things, an experience in trauma, and the recovery path occurs in predictable stages. The course is designed to offer an opportunity for growth regardless of individual stage, and the diversity of experience among course participants affords for a lively dynamic that moves the course along. Courses are taught by teams of three trained “mentors”, or peer-teachers, who are themselves experienced at living well with mental illness.

The course uses a combination of lecture, interactive exercises, and structured group processes to promote awareness, provide information, and offer opportunities to reflect on the impact of mental illness as it expresses itself uniquely through each participant’s life. Relapse prevention plans are devised in the first six weeks of the program, in order that participants gain knowledge, insight and coping strategies for living with their disorders. Each week builds upon the previous week’s explorations, bringing participants through a progression of awareness that has its roots in the universals of experience associated with the process of recovery with serious mental illness.

To implement this program NAMI Virginia will hold a statewide mentor training December 14 – 16 in Richmond, VA. NAMI Virginia covers the cost of the training for 15 people (5 teams of 3 people). The Peer to Peer course currently exists in 24 states around the country and NAMI Virginia is pleased to hold the first statewide training so mentor teams can take the training back to their communities. For more information contact namiva@comcast.net or visit www.namivirginia.org.

MARK YOUR CALENDAR!



2008 Spring Meeting

March 28-29, 2008

Crowne Plaza • Richmond, VA

RESIDENTS RESEARCH SYMPOSIUM WAS A SUCCESS

By Andrea Bandfield, MD

MIT Representative

The fall meeting this year held a new and unique experience for the residents – the first annual PSV Residents’ Research Symposium. Both residents and medical students were invited to present research posters during an allotted one hour time slot during the meeting. The response from the members-in-training was much greater than anticipated – there were 17 posters presented altogether. Presenters traveled from all over Virginia, many from as far as Virginia Beach. Five judges chose a first and second prize winner. A first prize of \$300 went to trainee Michelle Friebe, MD, and a second prize of \$150 went to trainee Matthew Morgan.

Several physicians attending the meeting commented that it was “exciting” to have such a presence of members-in-training at the meeting, and to be able to view their research ideas.

PSV wishes to thank all of the residents and students who traveled long distances to present their work, and to those residency programs who encouraged, supported, and sponsored their trainees in this endeavor.

Due to the success of the First Annual Residents’ Research Symposium, PSV has already set in motion the plans for next year’s Second Annual Research Symposium.

President’s Message

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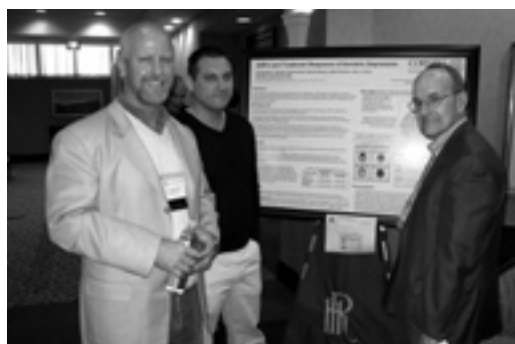
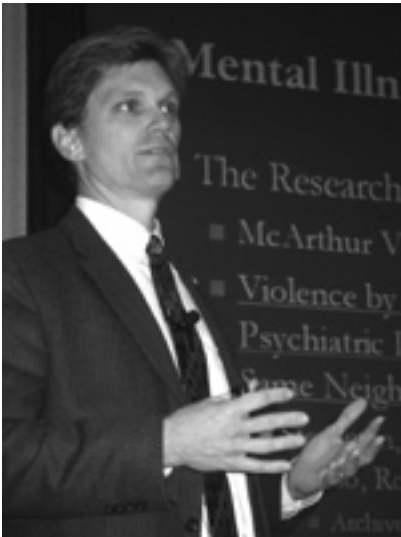
term adaptive functioning and coping. Given that few people have gotten through difficult times in their lives, so they are asked to tap into their own resilience. Plans need to be situationally based and attuned to developmentally and culturally appropriate interventions for survivors of various age groups. For example, workers should understand putting a hand on another’s wheelchair violates that person’s personal space.

Dr. Vieweg presented *Neurobiology of PTSD*. He noted that from an evolutionary perspective, key tasks included selection of a mate, bearing of viable offspring, parental commitment to sustain offspring, plus threat detection and response inhibition to enhance survival. Components of stress vulnerability are pre-existing factors that are psychological or biological and involve regulation of emotions, impulses and executive functioning. Allostasis is the process by which our bodies maintain stability and include other systems that change to maintain homeostasis. Maintenance of allostatic changes over a long period of time may result in allostatic load. Body systems will wear out if not rescued in time. So allostasis is the capacity to achieve stability through change. Four major factors are genetics, development, early adult experiences; state of neurobehavioral systems; midlife issues of employment and family change; and finally, memories of ourselves and our world before the trauma. Resiliency factors include optimism, self-sufficiency, lack of cognitive impairment coupled with a strong set of beliefs. In summary, PTSD was described as a recovery failure from a universal set of emotions associated with danger or threat.



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PSV 2007 Fall Meeting • OCTOBER 19-20, 2007



FOR MORE PHOTOS OF THE MEETING, VISIT WWW.PSVA.ORG

MENTAL HEALTH IN MEDICAL EDUCATION: PROBLEMS AND POSSIBILITIES

By Sarah Kattakuzhy
Eastern Virginia Medical School
Class of 2009

Modern psychiatry is in crisis, facing challenges on a variety of fronts—the burden of mental illness, the lack of funding, the stigma of treatment. But one issue unifies and perhaps underlies the rest: the deficit of students entering psychiatry.

The latest statistics from the 2007 Match are dismal. Of the 1057 PGY-1 positions offered, only 633 were filled by US students - and only 1000 were filled at all. Why aren't more US medical students entering psychiatry? In my experience, the root of this problem lies in medical education.

The majority of U.S medical schools condense their mental health curriculum into one course per academic year. These confines set up an inherent apathy that is carried into the clinical years. During the psychiatry rotation, students are often placed in acute care centers such as lock-down units - settings which reinforce preconceived notions of psychiatry and narrow their perspective further. For most students, this is the extent of their mental health education, and simply put, it is not enough. Even when students express interest,

they are discouraged by both peers and other physicians, told to be "too normal" or "too smart" to enter psychiatry. The stigma of mental health extends to both patient and provider, and in the field of medicine, reputation matters.

While it is difficult to transform a system that is already hard pressed for time and resources, there are simple ways clinical educators can work within the curriculum to overcome these road blocks.

1) Educate to interest: In the dry science of academic years, medical students feed off clinical correlation. Teach through case studies, patient interviews, and host local organizations. Demonstrate the pervasiveness of mental illness, and its relationship with other fields. Make courses challenging and engaging enough to be taken seriously.

2) Teach with variety: Demonstrate the diversity of mental healthcare. On the wards, extend involvement to consult, substance abuse, and follow up clinics. In these settings, challenge students to make independent medical decisions and follow with discussion.

3) Sell psychiatry: While it is impossible to prevent negativity, psychiatrists can combat this by touting their

field. Be the example of why students should choose psychiatry. Discuss benefits including lifestyle, compensation, job opportunities. Encourage questions and answer with personal insight. Never underestimate the power of positive feedback.

While psychiatrists must lead the battle for improved mental health education, they are not alone. The American Medical Student Association is taking aggressive steps towards changing the status quo. AMSA's stance endorses the principals of transformation embodied by SAMHSA- a recovery-oriented medical education, with an emphasis on decreasing the stigma facing mental health consumers. Leaders are working with a myriad of mental health organizations, including the APA, ADMSEP, AACAP, and the Federal Government to make this a reality.

Where there are problems, there are possibilities. A concerted effort on the part of interest groups, clinical educators and medical students is required to revolutionize the system. But the fight can begin, in small ways, one student at a time. Only then will mental health in medical education become the solution to this crisis, rather than its source.

**SINCERE THANKS TO OUR COMMERCIAL SUPPORTERS & EXHIBITORS
FOR THE PSV FALL CONFERENCE - OCTOBER 19-20, 2007!**

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SHORTAGE OF BEDS AND PSYCHIATRISTS PLAGUES MUCH OF VIRGINIA - REIMBURSEMENT ALSO SITED

By Chris L. Jenkins

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Virginia lacks experienced psychiatrists to evaluate the mentally ill, there aren't enough beds for those seeking emergency treatment in many areas and hospitals are losing money on mentally ill patients, according to a state government report.

Several findings in the 230-page report released this week by the General Assembly's auditing agency echo earlier examinations of the state's mental health system, which has come under scrutiny since the Virginia Tech shootings, in which a student killed 32 students and faculty and himself 16 months after being admitted to a mental health clinic for a night.

The report, prepared by the Joint Legislative Audit Review Commission, states that 47 of Virginia's 135 localities do not have public psychiatrists and that 87 do not have public child psychiatrists. In addition, half of the state's psychiatrists are in seven Virginia localities, according to the report, and one in five are in Fairfax County, Fairfax City and Falls Church.

The report suggests that the shortage floods emergency rooms with mentally ill people in crisis and prevents the system from adding beds or discharging people on time.

"Additional psychiatric beds cannot be opened unless there are psychiatrists available and willing to staff them," the report says. It adds: "On the outpatient side . . . a lack of psychiatrists affects licensed hospitals because individuals in need of psychiatric service cannot find them in the community and . . . turn to emergency departments."

A higher percentage of people live an hour's drive from a psychiatric hospital in rural areas than in such areas as Northern Virginia and Tidewater, the report finds. It also says that in Northern Virginia, more psychiatric beds are needed for children and adolescents.

Some of the report's other key points, including its call for more emergency crisis beds and services, have been raised

by several state commissions. Since the massacre at Virginia Tech, each branch of government has studied the system, and Gov. Timothy M. Kaine (D) and General Assembly lawmakers have pledged to address the issues raised during next year's legislative session.

Some findings will not be easy to address. The study, which began months before the shootings, also found that on a single day in 2005, 60 percent of the 6,350 mentally ill people in state hospitals or jails were in jails. Previous state reports have found that approximately 16 percent of the people in Virginia jails are mentally ill.

"This was one of the most shocking things to me," said Sen. Charles J. Colgan (D-Prince William), who sits on the Joint Audit and Review Committee. "The jails aren't equipped to handle these kinds of numbers. . . . This is a bad situation."

The study found that private hospitals licensed to take care of the mentally ill are losing money because they are not being reimbursed for the care they provide. It found that 24 of the state's 26 hospitals licensed to admit mentally ill patients reported unreimbursed fees of \$61 million in 2005; 14 emergency departments reported \$45 million in unreimbursed costs.

To address these shortfalls, the report suggests that the state "examine its potential role in . . . assuring an adequate supply of beds . . . [by] increasing financial support for uninsured psychiatric patients."

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NEW AJP STUDY ON SPANISH-SPEAKING LATINOS

Spanish-speaking Latino patients in a large California public mental health system were more likely to receive initial treatment for severe mental illnesses in outpatient settings than were English-speaking Latinos or Caucasians. A higher proportion of Spanish speaking patients had major depression, and lower proportions had bipolar disorder and schizophrenia, compared with the two other ethnic groups. They also had a lower rate of substance use disorders.

These findings are reported in the August issue of The American Journal of Psychiatry (AJP), the official journal of the American Psychiatric Association (APA). The examination of mental health services use by Spanish-speaking Latinos appears in "A Longitudinal Study of the Use of Mental Health Services by Persons with Serious Mental Illness: Do Spanish-Speaking Latinos Differ From English-Speaking Latinos and Caucasians?" by David Folsom, M.D., and colleagues of the University of California, San Diego.

The data are from San Diego County's Adult Mental Health Services program, which serves people with Medical or no health insurance. During the period 2000–2005, treatment for schizophrenia, bipolar disorder or major depression was initiated for 4,638 Caucasians, 1,144 English-speaking Latinos, and 539 Spanish-speaking Latinos. In the analysis, mental health services were consolidated into four categories: hospital, emergency room, jail and outpatient settings.

Hospitalization rates were similar in the three groups, but the Spanish-speaking Latinos were less likely to enter care through jail or emergency rooms than were English-speaking Latinos or Caucasians. Although they had the highest proportion of patients receiving outpatient services, they had the lowest number of visits. They were also more likely to live independently or with family.

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A PSYCHIATRIST DEFENDS HIS PATIENT'S RIGHT TO PRIVACY: A QUICK REVIEW OF PRIVACY LAWS AND STATUTORY RIGHTS

By J. Edwin Nieves, MD

We all know the importance of protecting patient information, but what happens when the agency requesting the medical records claims to have a statutory right to it?

Harold I. Eist, MD, DLFAPA, Past President of APA and a Maryland Psychiatrist, had been treating a female patient and her two children for some time. She was involved in a bitter custody battle with her husband, who complained to the Board of Medicine that Dr. Eist was "overmedicating the wife and children." These comments seem to have followed a report by Dr. Eist, presumably reflecting favorably on his patient's (the mother) ability to keep her children. Acting on the complaint from the father, the Maryland Board of Medicine issued a subpoena for the records. Dr. Eist refused to release the records after his patients declined to sign a release. The Board of Medicine adopted the position that they had a statutory right to obtain the records without the patient's consent, and charged Dr. Eist with "failure to cooperate with a lawful investigation." Following several communications between the Board, Dr. Eist's attorney and the attorneys for his patients, the records were eventually released. A review of the patients' records by his peers determined that the care provided were within the standards. Nevertheless, the Board of Medicine moved to prosecute Dr. Eist on the "failure to cooperate" charge imposing a \$5,000.00 fine. Dr. Eist contested the charge. On appeal, the Circuit Court for Montgomery County, reversed the Board of Medicine's decision, citing an "error of law". The Board of Medicine did not have statutory authority without the patients consent to obtain the patients' records, according to the "Westinghouse Factors".

Now, a quick review of privacy laws and statutory rights might help explain the ruling. As psychiatrists, we are familiar with the essentials of privacy governing our communications with patients. The conversations between a physician and his patients are protected by privacy laws to promote a climate of trust and eliminate the fear that the information contained in them could be later used against the person making the communication. There are only a few other conversations that enjoy such a high degree of privilege and protection under most laws. These include the attorney-client and the clergy-confidential conversations.

There are some instances where this privilege would not apply, for example, in the course of seeking or planning to place the patient in a psychiatric facility a psychiatrist may describe certain aspects of the communication (patients' condition), to admission staff. Another instance would be when a psychiatrist suspects or there is a civil or criminal proceeding in which there is child abuse or neglect.

The patient may make the privilege inapplicable if "their mental condition" is introduced in a civil or criminal proceeding. In this instance, the courts may request or subpoena records documenting the patients mental condition. Another example occurs when the patient makes a claim of malpractice against the psychiatrist.

Less known are the "Westinghouse Factors" that regulate the release of medical information to a state or government agency when there is a "statutory right" to protect the public. This was the case law that the Board of Medicine was citing in the Eist case. The case arose out of a labor union complaint that a chemical being produced at a Westinghouse factory was harming, (causing allergies) among the workforce in the 1980's. The U.S. Government (under OSHA) requested the records of all Westinghouse employees at the factory. Westinghouse refused, claiming that to do so, would breach the employees' right to privacy. In finding for the U.S. Government in 1980, the U.S. Third Court of Appeals determined that there are seven factors now known as the "Westinghouse Factors" that qualify the release of information to a government or government agency when the interests of the public are at stake.

These include:

- * The type of record & information contained in the records requested.
- * Is there potential for subsequent disclosure?
Is there injury to the doctor-patient relationship?
- * Does the agency to which the records are released to have adequate safeguards to maintain record privacy?
- * Is the need for access to the documents greater than the privacy right of the individual?

These factors qualify the release of patient information when balanced against the "public good" or need to obtain the information by a private, state or federal government agency. For example, the Westinghouse Factors have been cited when employers want to get access to an employee health records when potentially damaging medical conditions are suspected, (i.e. HIV) that may harm other employees or when excessive medical payments are made on behalf of an employee.

The error in law cited by the Montgomery County Circuit Court was the application of these factors to the privacy of records in this case. The articles reviewed for this case did not report the cost to Dr. Eist in his defense, but the fact that he had to do so as all should be very concerning to all psychiatrists.

Intellectual Disability

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that can help with research, train psychiatrists and other providers to deliver state of the art care and help to coordinate high quality care for all of the intellectually disabled citizens of the state. The reluctance to take this step is probably born out of prejudice against a segment of society that cannot defend itself. The lack of funds may be an excuse but poorer states have taken this step and have reaped its rewards. All patients with intellectual disability have medical insurance, either through Medicaid or through their parents. It is my ardent hope that we can overcome this last prejudice against this step-child of psychiatry.

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IN VIRGINIA, MORE MENTALLY ILL IN JAILS THAN STATE HOSPITALS

By Kathleen Stack, MD, DFAPA

This headline is representative of articles seen across the state of Virginia in the last few weeks. Chris L. Jenkins of the Washington Post, Bill McKelway of the Times-Dispatch and our own Helen M. Foster, MD, in this newsletter, are among those who have written on some aspects of the Joint Legislative Audit Review and its implication. I will provide a brief overview of the findings in the hope that it will provide the newly published facts about the psychiatric care in the state of Virginia to our readers. This may also provide a broader context for appreciating Dr. Foster's article.

The report was requested by joint resolution of the Senate (185) during the 2006 session to determine, *Availability and Cost of Psychiatric Services in Virginia*. The study mandates were to examine the Medicaid rate setting process, adequacy of and funding for licensed psychiatric beds and CSB contracts with licensed psychiatric facilities. The study was based on concerns about the decrease in acute psychiatric care beds in licensed hospitals and CSB's using licensed hospital beds to replace state hospital beds. The report was published on October 7, 2007.

The report showed that since 1991, the state has lost approximately 2,500 acute inpatient beds; approximately 1/3 from private facilities and 2/3 from the state system. Approximately 20% of licensed beds are not being staffed. Of the staffed beds, occupancy rates are from 68% in Northern Virginia to 81% in Central Virginia, which is below the goal of 90% set by the state. There is believed to be unmet need for beds in upper Central Virginia and the upper Tidewater part of the state, but overall bed needs were felt to be met.

Costs for acute care emergency care and admission were often not reimbursed or under reimbursed. Psychiatric care is paid at a per diem rate for facilities, unlike other forms of medical care. The plan to establish a TDO payment rate is required by code since 1995, but has not been established and the review recommends a rate be established.

Medicaid rates for psychiatric services, unlike other medical care rates, have been nearly flat for the past six years. There is a shortage of psychiatrists in many areas, with seven localities having one half of all the psychiatrists and 47 areas having none. There are no child psychiatrists in 87 areas of the state. The report recognized that this may effect the need for psychiatrists and recommends an adjustment in rates for physician psychiatric services.

State hospitals no longer serve populations who were served before deinstitution; those with dementia, substance abuse, traumatic brain injuries and non-psychiatric medical conditions. Those not treated at the state hospitals become the financial responsibilities of the local agencies. Changes were offered in 1980 for pre-admission criteria to be established by regulation, but they were not adopted. It is recommended that state mental health and substance abuse services board should develop these criteria and use them.

A one day snap-shot survey on September 13, 2005 revealed that 59% of those receiving mental health services

are in jails, with 23% at state hospitals and 17% in licensed hospitals. CSB did not provide any services to 29 of 67 jails. Also, the state beds use for forensic reasons had increased 26 percent, while that for civil bed use had decreased 31%. It is recommended that the state work with facilities and the criminal justice system to plan for the needs for civil and forensic beds at the different state hospitals.

It was also made clear that the roles and responsibilities of CSB regional partners need to be clarified. This was in reference to the Local Inpatient Purchasing of Services, which work for the CSB's to purchase beds in licensed hospitals. The eligibility criteria vary and data is not kept on those admitted, or denied admission under these LIPOS. Additionally, these organizations have been assuming duties assigned to others in statutes. The recommendation was that the control for admission to state hospitals be clarified. Readers interested in a complete review of this report can visit:

<http://jlarc.state.va.us/Meetings/October07/PsychRpt.pdf>

<http://jlarc.state.va.us/Meetings/October07/psychbrf.pdf>

REPORT FROM THE COALITION OCTOBER BOARD MEETING

By Helen Montague Foster, MD, DFAPA

Sometimes I see myself tipping toward learned helplessness as our profession and the people we serve limp to more cliffhangers. We elect a governor who cares. Legislators rally to our side after Virginia Tech, but the budget comes up short or the President vetoes the children's health insurance program. I have to remind myself that change is the way of the world, a hard truth for someone as motivated by nostalgia as I am. Besides even if there is a bottom-line population for whom re-institutionalization would be a humane solution, it doesn't look as if the money for it is coming any time soon. I'm thinking of the folks we saw featured in the recent Times-Dispatch article on mentally ill inmates in the Richmond jail. The Virginia General Assembly's Joint Legislative Audit and Review Committee (JLARC, pronounced Jay-Lark like the birds) correctly notes that hospitals are losing millions of dollars in caring for the mentally ill and that in vast areas of Virginia hospital beds for the mentally ill don't exist. In Virginia more mentally ill people are in jails than in state and private hospitals combined, but 43% of jails do not provide mental health services.

This afternoon I looked into old files seeking to confirm the date that I was appointed as the Psychiatric Society of Virginia's representative to the organization now known as the Coalition for Virginians with Mental Disabilities. It turned out to be 1990 rather than 1988 as I recalled, but all that rummaging made me remember PSV board meetings at the

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Report from the Coalition

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home of former PSV president Bill McDonough and his wife Ruth, our executive director for many years. They were mentors who knew you don't give up just because things don't go your way. I recall the survey I did in 1996 about the impact of a new law passed the year before requiring that CSB representatives evaluate our patients prior to issuance of a temporary detention order. The response that stood out was a description by a jail psychiatrist about his dilemma with suicidal patients: If he classified them as at risk for suicide, they would be stripped and held in four-point restraints, because there weren't enough guards to do fifteen-minute checks.

The Coalition composition has varied over the years, but here are the current members: FACES (Family Advocacy Creating Education & Services), the Federation of Families of Virginia, Mental Health America of Virginia (formerly the Mental Health Association of Virginia), NAMI-Virginia, Parents & Associates of the Institutionalized Retarded, the Psychiatric Society of Virginia, the Substance Abuse & Addiction Recovery Alliance of Virginia, The Arc of Virginia, VaACCSES, the Virginia Network of Private Providers, the Virginia Organization of Consumers Asserting Leadership (VOCAL), the Virginia Psychiatric Rehabilitation Association, the Virginia Rehabilitation Association, and Voices for Virginia's Children. Mary Ann Bergeron, executive director of the Virginia Community Services Board and Paul Gilding of the Department of Mental Health, Mental Retardation & Substance Abuse Services brief us at each meeting. The Coalition lobbyist, Leslie Herd-egen, used to come too and share tactics for getting our issues through the Virginia General Assembly, but she has stage IV lung cancer, so she sends her advice and saves her energies for chemotherapy and direct work with the legislators. Under that headscarf is a bundle of courage, and to quote Mary Ann Bergeron, Leslie gets paid about one and a half cents an hour for the work she does for us. This spring PSV gave her our Human Rights award for her dedicated service on behalf of our patients.

The Coalition's purpose is advocacy, because—to put it mildly—funding for mental health services is not exactly the most popular cause. Why else have we experienced such an ongoing decline in funding since 1955? Per the October JLARC report, in 1936 one person with mental illness was in jail for every six persons in state hospitals. By 2005 the ratio had risen from five mentally ill people in jail for every two in a hospital. Without political pressure, mental health funding ekes away like a sandcastle in the tide. Here we are again, crafting the Coalition Legislative proposals in preparation for the 2008 Virginia General Assembly. We have a governor motivated to help and the Virginia Tech shootings as an impetus for change, but the real estate market isn't doing so well. State revenues are down. The war in Iraq is draining national funds and adding to mental health casualties. Section 8 housing is at risk. Since 1962 the average daily number of mentally ill adults in state hospitals has dropped 87%, which would be good if those people were getting adequate services elsewhere, but many are not. Most local mental health

centers don't provide psychotherapy services and have long waiting lists. Since 1991 licensed psychiatric hospital beds at non-profit and for-profit hospitals declined by almost 800 beds, a 31% decrease.

From the founding of the Coalition in the 1980's, its goals have included housing and funding services for people in the three disability areas, and at several key moments the Coalition and its members have successfully lobbied for an influx of state funds - no easy task during the march of deinstitutionalization, the influence of managed care, the dwindling of private psychiatric beds, and campaign cries for tax cuts. Overall, even though the CSBs have grown, we have lost ground. This year the Coalition will lobby as usual for more funds for the public sector, and PSV has another opportunity to ask the Coalition to include some of our legislative issues in its formal agenda. Not too many years ago the Coalition signed onto the PSV bill that became law requiring that one of the members of the DMHMRSAS board be a psychiatrist. All of us should be grateful to Dr. David Trinkle, the first to accept the psychiatrist slot on the board. Please congratulate Governor Kaine's new appointee to the board, Dr. Anand Pandurangi and thank Dr. Bela Sood, who served on the Virginia Tech Review Panel. These three, your PSV officers, and our public system colleagues such as Commissioner Jim Reinhard wrestle with funding issues politically against great odds, and we should help them.

A major highlight of the Coalition work plan is a yearly rally on Martin Luther King, Jr. Day. The next rally will be January 21, 2008, in Richmond at St. Paul's Episcopal Church across from Capital Square. We expect a jam-packed auditorium with more than 400 people and music. You're invited to crowd in, walk over to the General Assembly building and call on your legislators. MLK day is a federal and state holiday, but the legislature is in session, and we need psychiatrists as well as family members and consumers to help legislators understand our requests for funding. The actual requests will be based on needs assessments by the CSBs and Department. The draft of the VACSB budget requests includes requests for funding for medications and psychiatrists, for crisis stabilization services and units, for urgent care triage and access to care for children, for case management, permanent housing, for day treatment, job training, life skills support, for home-based intensive services, for MR waiver slots, and many other services.

Visiting legislators in the General Assembly building can seem a little like hospital rounds—short to the point visits, sometimes with an aide rather than the person you came to see. It helps to make an appointment with your own delegate and senator in advance, but if you've neglected to do that, you can take a copy of the Coalition legislative agenda, stuff your pockets with business cards, pick up a "facebook" at the General Assembly front desk, and follow directories to the legislative offices. Don't know who represents you? Use the Find-your-legislator link on the Commonwealth of Virginia website. All you have to provide is your home address and zip code. You might get even more time with your representatives if you call now while they are campaigning or after Election Day when they are new on the job.



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New AJP Study

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In their use of mental health services, the English-speaking Latinos more closely resembled the Caucasians than they resemble the Spanish-speaking Latinos. An editorial by APA Immediate Past President Pedro Ruiz, M.D., of the University of Texas, appears in the same issue. *AJP* Editor-in-Chief Robert Freedman, M.D., stated, "This article is a fascinating snapshot of the process of integration of Hispanic people into the culture of the United States. Preservation of their native language—either because of recent immigration or due to a family decision—appears to be a better predictor of Hispanics' use of mental health care services than is ethnicity."

This study was supported in part by grants MH-067895 and MH-066248 from the National Institute of Mental Health and by the Mental Illness Research, Education, and Clinical Center of Veterans Integrated Service Network 22, Department of Veterans Affairs.

Contact Jim Rosack at 703-907-7862 or jrosack@psych.org for more information.



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