Residents and ECPs Abound at the 2009 WPA Annual Meeting

By Claudia Reardon, MD, Southern Chapter Early Career Psychiatrist (ECP) Representative on the WPA Executive Council

The WPA’s Annual Meeting on March 27-28th, 2009 saw many medical students, residents, and early career psychiatrists descend upon Kohler, Wisconsin. Thanks to an APA Member-in-Training Grant, we were again able to offer complimentary hotel rooms to the trainees in attendance. And the trainees made the most of the experience! During the conference seminars, and particularly during the psychologist prescribing panel, many audience questions and comments came directly from residents, who continue to show much passion and enthusiasm for legislative issues such as this.

After a jam-packed day of educational sessions, the young physicians and students were invited to a networking dinner event on Friday evening, March 27th, at the Horse and Plow restaurant in Kohler. Those in attendance were treated to not only delicious food and enjoyable company, but also were able to partake in a conversation led by Clarence Chou, MD on the hows, whys, whats, and who’s of organized medicine. Dr. Chou shared wisdom he has gleaned from his extensive involvement in the WPA, APA, WMS, AMA, and AACAP. The young doctors were also honored to be joined by special guest WPA President-Elect Kenneth Casimir, MD, who provided welcoming words to the attendees and urged them to continue their involvement in the WPA.

The WPA continues to work hard to make its youngest cohort of members feel valued and important. The Annual Meeting weekend was a perfect example of this.

Wisconsin Senator Jon Erpenbach Receives “Friend of WPA” Award

President-Elect Ken Casimir, MD thanked outgoing President Carl Chan, MD for his two years of service to WPA.

President Carl Chan, MD presented Michael McBride, MD with a distinguished service award from WPA.

WPA Legislative Chair, Jerry Halverson, MD, presented Senator Jon Erpenbach (D) the “Friend of WPA” award May 6th at the UW-Madison Department Clinic. The event was attended by 40 people.
Thank You WPA

By Carlyle H. Chan, MD, WPA President

I would like to thank the membership of the Wisconsin Psychiatric Association for giving me the opportunity to serve as President. It has been a privilege and honor to work with such a distinguished and hardworking Executive Council. Let me review some of our changes and accomplishments of the past two years.

After the Wisconsin Medical Society decided to get out of association management business, we selected Svinicki and Association Management, Inc, and moved the WPA Office to Milwaukee for the day to day running of the organization. Jane Svinicki and staff have transitioned into the role. Our new association website in conjunction with the APA will be online soon.

With the approval of our membership, we have rewritten our bylaws to update our procedures. The Executive Council has also discussed and approved procedures for succession planning. We welcome and appreciate the recent active participation of members-in-training and early career psychiatrists. Residents Claudia Reardon and Caroline Palmer have played pivotal roles in our recent legislative efforts.

Our Legislative Committee under the direction of Molli Rolli and Jerry Halverson has revitalized our advocacy efforts. With two Legislative Action Days along with an energetic and dedicated committee, they have been extremely busy addressing the psychology prescribing bill. We have also begun the process of initiating a Political Action Committee.

We have been successful in obtaining grants from the APA for both membership recruitment and legislative efforts. We have maintained a balanced budget during my watch.

Ed Krall has taken over the Newsletter Committee and with the help of the Editorial Committee, has maintained Dick Thurell’s tradition of an award winning publication.

Jerry Halverson has provided continuity in leading the Program Committee and has arranged several outstanding meetings. We are on the verge of having our first joint meeting with the Illinois Psychiatric Association. Through Art Walaszek’s guidance, we have also shifted our CME sponsorship.

The WPA is once again a vital organization advocating for the mental health of Wisconsin’s citizens. I look forward to continuing to work with the Executive Council and our next President, Ken Casimir.
Executive Director’s Message

Spring 2009

It Was the Best of Times; It Was the Worst of Times

By Jane A. Svinicki, CAE, WPA Executive Director

It was the best of times; it was the worst of times

You may recognize this quote from the book *A Tale of Two Cities* (1859) by Charles Dickens, set in London and Paris before and during the French Revolution. It is certainly true for WPA at this time!

We are all focused on the education and advocacy efforts necessary to oppose the psychologist prescribing legislation in the state legislature. A great deal of information is included in this newsletter on the issue to help members understand and support the WPA position.

I thought I would focus my message this quarter on another important issue dominating our lives – the economy.

Many people feel we are now in an ‘economic’ revolution. These are tumultuous times, but fortunately no one is having their head chopped off as they did during the French revolution.

Certainly, the current economic conditions are scary in a very real way and create financial uncertainty for the future. Conflicting opinions are constant and it is hard to know what to believe.

I do not have to tell you as psychiatrists that bad economic times create stress for many people. Perhaps you have also felt the drop of investment values, contraction of organizational budgets and reduction of benefits and services.

Whatever happens with the economy – we individually cannot control it. When we cannot control what is happening on the outside world, it is best to prepare for what we can do to meet the challenges it will bring on the inside of our organizations.

This is a time for WPA as in organization ‘play defense.’

What does that mean for WPA as the professional organization for psychiatrists in Wisconsin?

Prepare for the downturn: Know that revenues will shrink, meeting attendance may drop, and members will not renew. Be prepared for the impact that these issues will have on the current and future WPA budget.

Give back to our members: For years, many WPA members have been supporting our association. These may have been great years and they wanted to ‘give back’ to an organization that helped them advance their careers. Now is the time to put in place ways WPA can help members through the economic downturn.

Have a long-term outlook: This financial downturn will not be resolved in a year or two. The actions that brought us here will take a long time to turn around. Understanding and preparing for a multi-year downturn will help all of us develop realistic expectations for the future.

Take care of yourself: It is tempting to take this unrelenting flood of doom-and-gloom media reports and drink a toxic soup of anger, anxiety, and stress. When the outside reality becomes a frightening and stressful place, now is an important time to practice good self-care, both physically and mentally. Focus on the current moment, the current situation, and do what you can, then free yourself from the rest.

We are in it together! In times of great crisis, this country has always pulled together to right the ship. Have faith in America, it has served us very well and will continue to be a bright light for the rest of the world.

The Wisconsin Psychiatric Association would like to thank the following companies for Exhibiting at the 2009 Annual Meeting
March 27-28, 2009

AstraZeneca
Aurora Health Care
Bristol-Myers Squibb
Forest Pharmaceuticals
Janssen Pharmaceutica
Lilly USA
Novartis
Pfizer
Rogers Memorial Hospital
U.S. Army Healthcare Recruiting
On February 27th a group of concerned psychiatrists convened for a Legislative Advocacy Forum in Milwaukee. The goal of this meeting was to bring area psychiatrists together to express our concerns over the proposed legislation that would grant Psychologists prescriptive authority. I am happy to report it was a great success. Twenty area psychiatrists took time out of their busy schedules to attend. The group was made up of residents, fellows, early career and experienced psychiatrists. We are very grateful to Senator Tim Carpenter (D-Milwaukee) for making the time to hear our concerns.

The motivation for this meeting was the progress the psychologists have made in trying to convince some of our legislators that they should be allowed to have prescribing power. This is a very controversial topic even amongst psychologists. It is our understanding that they want the ability to prescribe complex medications after completing a 450 hour course which would allow much of the training time to be spent on-line or by watching videos.

It was very important to the twenty psychiatrists who attended and the many more who couldn’t appear in person that we express our concerns with this proposed legislation. We first stressed the differences between the training of a psychiatrist and a psychologist and why we feel medical training is essential for the safe prescribing of medications. We focused on the complexities of the human body and that no medication is without side-effects. The medications we use today are wonderful but the side-effects can be very serious, even deadly. In a time when a new black box warning seems to appear every month it is preposterous that we would allow someone with the time equivalent of ten weeks of medical school to prescribe medications. Medical training is essential to be able to order and interpret laboratory values, manage and triage symptoms and recognize the early signs of serious complications. Many of the psychiatrists shared personal stories and helped to illustrate that even the healthiest patients can have significant complications.

The psychologists have stressed that they want prescriptive authority to provide greater access to care. This is simply not the case. The distribution of psychologists in the state is focused mainly in the areas around Milwaukee and Madison. Very few psychologists practice in Northern Wisconsin. When one looks at the distribution of psychiatrists, nurse prescribers, physician assistants, pediatricians, internal medicine doctors and family practice doctors one can easily see that the state is well covered by prescribers with medical training. The access to care issue is an important one but it will not be impacted by allowing psychologist’s to prescribe.

An additional concern is the cost of mental health care. We feel allowing psychologists to prescribe will drive the cost of mental health care up. There will be significant expenses incurred during and after training and additional malpractice coverage. The additional liability insurance could cause the insurance costs of all psychologists to increase. As physicians we have been paying into the Injured Patient’s and Families Compensation Fund. This has helped us to keep our malpractice premiums well below those of other states. Who will insure the psychologist’s against medical malpractice? Their premiums could be expected to be much higher than the psychiatrists thus forcing them to charge higher prices. They may be faced with paying the rates seen in Florida or New York.

It is very important that we as psychiatrists advocate for our patients and our profession. There are many challenges facing the field of Psychiatry. I urge everyone to become active in issues that are important to them. If possible, host a meeting in your area or try to attend one of your legislator’s events. Now is the time to make your opinion heard on this important issue or it may end up becoming law.

To find out the names and contact information of your state representatives go to http://www.legis.state.wi.us/ and click on Who Represents Me?
Psychologist Prescribing Bill Introduced

By Alice O’Connor, WPA Legislative Advisor

Senator Judy Robson (D-Beloit) has introduced SB 180 and Freshman legislator, Rep. Sandy Pasch (D-Whitefish Bay) is likely to introduce an identical bill soon. SB 180 has been referred to the Senate Health Committee, chaired by Senator Jon Erpenbach (D-Waunakee). Senator Erpenbach says he has no immediate plans for a hearing. The bill authorizes the Psychology Examining Board in the Department of Regulation and Licensing to issue a certificate of prescriptive authority to a psychologist licensed by the Examining Board. “Prescriptive authority” will allow a “prescribing psychologist” to prescribe, distribute, and administer drugs to treat disorders identified within the practice of psychology which means any mental health issues. A person certified by the Examining Board may use the title, “prescribing psychologist”.

A lot will happen with the administrative rules process if the bill passes to determine rules governing the certification, supervision, and practice of prescribing psychologists. Under this bill, a second provision gives the Psychology Examining Board new powers to discipline prescribing psychologists and revoke or grant certification. The board also sets the limit for malpractice insurance and the supervision and education requirements for psychologists as determined by the psychology examining board.

It does one more thing. It changes the definition of practical nursing and professional nursing so nurses can take certain actions under the direction of a prescribing psychologist.

The bill says a psychologist may prescribe if a psychologist has:

- Three years of general practice following licensure as a doctoral-level psychologist.
- Completion of an American Psychology Association (APA) approved 450 credit-hour curriculum covering the foundational biological sciences, pharmacology and psychopharmacology, etc.
- Completion of a one-year, 100-patient preceptorship under supervision of an appropriate physician.
- Following certification, prescribing psychologists must maintain collaborative relationships with physicians and other prescribers.

The “access issue” is making some lawmakers extremely sympathetic, regardless of patient safety issues. Senator Robson says a recent study of county mental health clinics in Wisconsin found that, on average, a new patient has to wait more than nine weeks for an initial appointment with a psychiatrist. She says, in ten counties, the wait is three months, and in several more, the delay is greater than a year. She says vulnerable patients include elderly persons with dementia living at home and in group and nursing homes; chronically mentally ill persons who depend on county support to maintain stability; children and youth with a wide range of mental health problems; urban and rural poor who can’t afford private services; incarcerated persons at high risk for mental illness and repeat offenses; and families in crisis for any number of reasons.

The authors stretch the effectiveness of the pilot project used by the Department of Defense on 10 psychologists by saying “psychologist prescribing has been a successful mental health treatment model used by the U.S. Military, the U.S. Public Health Service, the Indian Health Service, and the states of Louisiana and New Mexico.”

The psychologists have lined up a variety of groups mostly impacted by lack of access, but medical shortage should be addressed as a separate issue. Some of these groups are not working proactively to help psychologists pass this legislation. These groups include:

ATTIC Correctional Service; Association for Retarded Citizens (ARC) Community Services; Bethesda Lutheran Homes & Services; Community Alliance of Providers of Wisconsin (CAPOW); Easter Seals of Southeast Wisconsin; Rehabilitation for Wisconsin (RFW); Residential Services Association of Wisconsin (RSA); Ryan Community, Inc.; Wisconsin Assisted Living Association (WALA); Wisconsin Association on Alcohol and Other Drug Abuse (WAAODA); Wisconsin Association of County Homes; Wisconsin Association of Homes and Services for the Aging (WAHSA); Wisconsin Council on Community Corrections (WCCC); Wisconsin Counties Association (WCA); Wisconsin Early Autism Project (WEAP –Eau Claire, Green Bay, La Crosse, Madison and Milwaukee); Wisconsin Health Care Association (WHCA); Wisconsin Psychology Examining Board

Thus far, the following organizations have publicly stated they are against SB180. They include:


Action: Without every single psychiatrist, physician, mental health advocate on deck

continued on page 6
Legislative Update  
continued from page 5

to help defeat this legislation, patient safety will be jeopardized. The current medical training of psychologists is woefully inadequate. For more information on materials you can use, talking points or who to contact please call the WPA office or email Annette Schott at schott@svinicki.com. Contact your legislators directly to voice your opposition to SB180. www.legis.wisconsin.gov/w3asp/waml/waml.aspx.

Health Care Reform Fall 2009

Once the issues surrounding passage of the governor’s budget bill comes to a close, likely by July 1, 2009, look to see a lot of summer activity related to finishing a variety of proposals related to health care reform as Democrats look to successfully craft a health care reform plan that they can run on in the 2010 elections.

Sen. Jon Erpenbach (D-Waunakee), Chair of the Senate Health Committee says, “Healthy Wisconsin, favored by some Senate Democrats but not by Democrat Governor Jim Doyle, will make a few changes to this plan before it is re-introduced, then a series of public hearings will be held around the state.” Erpenbach is also pushing for support of President Barack Obama’s budget, and he said he believes said Healthy Wisconsin must move forward despite signals that the federal government is pursuing health care reform.

“The care is pretty good that we get right now in the state, the insurance is awful.” Citizen Action of Wisconsin, Wisconsin Environment, WISPIRG and AFSCME also support. Erpenbach said without extensive reform, the average annual health insurance premium cost in Wisconsin will rise from $13,500 currently to $24,000 in the next seven years. He said reform would mean “wonderful things” for the nation’s economy because it would mean more money for employers to expand.

HHS Makes $268 Million in Recovery Act Funding Available to Support Hospitals Serving Uninsured, Vulnerable Americans

Building on President Barack Obama’s efforts to ensure access to health care for millions of uninsured Americans, the U.S. Department of Health and Human Services today announced that states can access an additional $268 million authorized by the American Recovery and Reinvestment Act to help pay hospitals to treat their most vulnerable patients.

Eligible hospitals are those that serve a disproportionate share of low-income or uninsured individuals and are known as Disproportionate Share Hospitals (DSH). States receive an annual allotment to make payments to DSH hospitals to account for higher costs associated with treating uninsured and low-income patients. This annual allotment is calculated by law and includes requirements to ensure that the DSH payments to hospitals are not higher than the actual costs incurred by the hospital to provide the uncompensated care. The Recovery Act increases the amount of allotments available to states from approximately $11.06 billion to $11.33 billion for 2009.

The Centers for Medicare & Medicaid Services (CMS) will notify states about the availability of the increased portion of allotments for hospitals. Not all states spend their full DSH allotments; so, before this new funding can be accessed, states must demonstrate they have used all of their existing fiscal year 2009 DSH allotments. States must request the additional funds from CMS as part of their quarterly Medicaid budget request and the funds will be distributed as separate Recovery Act DSH grants.

To see a complete list of the revised DSH allotments that include additional funding provided through the Recovery Act, please visit http://www.hhs.gov/recovery/cms/dshstates.html.

To track the progress of HHS activities funded through the Recovery Act, visit www.hhs.gov/recovery. To track all federal funds provided through the Recovery Act, visit www.recovery.gov.

State Mental Health Funds Cut $700,000 for 2009 Fiscal year

The Community Mental Health Services Block Grant (MHBG) allocated by a formula determined by Congress will cut Wisconsin state allocation $708,449 less for fiscal year 2009. This will be deducted from the 4th quarter allotment (July, August and September). The total federal mental health block grant remained unchanged. However, because of a complicated formula that is used to allocate the funds (and is adjusted periodically) Wisconsin’s proportion is decreasing. More cuts will be coming out of DHS Secretary’s office as a result of this funding cut.

The final calculation specifies that Wisconsin will receive an allocation of $7,349,062 in fiscal year 2009. This amount represents a 0.9% decrease from the State’s allocation in fiscal year 2008. Wisconsin will receive $2,545,715 for the 3rd quarter award and $1,837,266 for the 4th quarter award.
Pharma, Physicians, and Conflicts of Interest

By Harold Harsch, MD, WPA Editorial Board Member

I offered to comment on the article by Rothman et al. suggesting further limitations of interactions between “industry” and professional medical associations (Rothman, DJ, et al. JAMA, 2009, 301, 1367-72). This is part of a continuing attack on pharmaceutical industries and their ties to physicians. Their recommendations include limiting Pharma involved physicians, who have developed or are working with new drugs for many disease states, from being on committees that formulate guidelines, program chairs, and serving in top elected positions of professional societies. They also recommend that any sponsorship, such as fellowships, not have the name of the sponsor, if it is a drug company, to be associated with the grant. All of the authors of this paper have no “conflicts of interest” to disclose.

What does that mean – none of the people who have authored this paper have worked or are working on studies of new medications, have never consulted for a company on a new drug for potential treatments, or have given a sponsored pharmaceutically related talk in an area of their expertise. My view is very different. Physicians working with Pharma are physicians with certain expertise and knowledge. This expertise and knowledge is exactly what is needed in the development of drug guidelines, teaching programs and leadership positions. Also since donors have sports stadiums named after themselves I would think that Pfizer, if sponsoring a series of fellowships for physicians in training, would have the same privilege. Why one would be offended by being awarded the Pfizer neuropsychiatry fellowship. Only the professionals seemingly caught up in the recent “conflict of interest” hysteria have found this a “problem.”

My first exposure to the industry vs. physician debate dates back over 20 years during my medical student training. Eli Lilly distributed a free stethoscope to every medical student. There were a number of medical students who vocally protested this gesture as it would “taint physicians forever.” But not only did they just refuse the gift, which I felt was their right; they wanted the gift banned for all medical students. They lost that battle and I accepted the stethoscope and I became “tainted forever.” My subsequent career as a psychiatrist with a strong interest in psychopharmacology has been intertwined with the pharmaceutical industry over the years with being part of over 80 clinical trials and also being a speaker and consultant for most major Pharma players in the area of psychoactive drugs.

“Conflict of interest” is a term originating in the 1940s describing a problem when one’s desires influence decisions that become self-serving rather than in the best interest of who is being served. For example the physician who has significant financial interest in a MRI center and refers all his patients to the site for an MRI to “just be sure.”

Now what is the “conflict of interest” with psychiatrists and pharmaceutical companies? Are we prescribing medications because of a name on a notepad? Pharmaceutical companies fund over half of drug related research in the United States. They also advertise and promote their drugs. They fund phase 4 research (studies after FDA approval) looking at new potential areas where their agent might be efficacious. The majority of drug development programs are headed by ethical physicians.

A recent column in Clinical Psychiatry News (April 2009) states: “Funding by industry biases research” referencing a study published in the American Journal of Psychiatry. Having been part of many clinical studies for years – how do you bias results of clinical drug research? One can be frankly unethical and break double-blinds, enroll subjects that really don’t have the disorder being studied, one can slant their ratings of the subject, but none of this is due to industry funding. If one cheats or designs a bad study, that researcher should be removed – and that has happened. Why then do industry-sponsored studies seem to be five times as likely to be favorable to the sponsor’s drug as non-industry sponsored studies of the same condition? Possibilities – consider a better study design? Most industry studies have an experienced team of researchers that plan the study design. The FDA is usually consulted as to their impression of study design and at times they mandate what is done. Once started, the clinical study is closely monitored by the company and usually also by a clinical research organization to make sure the protocol is followed and all data points are documented in site records. Non-industry sponsored studies rarely have that type of oversight. It is true that failed studies have often not been published in the past but now all clinical studies are being made available by industry. When one looks closely at the cited article (Perlis, RH; et. al. Am J Psychiatry 2005; 162: 1957-60) they actually report that “Industry support itself was not significantly associated with a positive outcome.” A positive outcome was associated with the investigators prior experience with industry affiliated studies (which they label “conflict of interest”). Of course, experienced investigators with twenty schizophrenia studies behind them are more likely to produce reliable results than someone who is trying to do a first study.

continued on page 8
How do psychiatrists choose a medication? My last two patients provide an interesting but sad note to this process. The first patient I wanted to start on a SNRI and picked venlafaxine (Effexor XR) – thinking duloxetine (Cymbalta) would most likely not be covered. As I was writing out the prescription the patient handed me a sheet of paper from his insurance company listing “Allowed medications” – it had Cymbalta but not Effexor. The other patient had many failed medication trials over the years and nicely became stable on lamotrigine. As she was relating how well she was doing she remarked that she had some “bad” news. Her insurance’s pharmacy had called her stating that they would not cover lamotrigine but suggested carbamazepine. That is where our outrage should be directed, not at the companies that develop new medications. All medications will go generic; where will the next generation of antipsychotics, antidepressants, and antibiotics come from without the Pharma – physician partnership?

(Many “conflicts of interests” are available on request)

A copy of the JAMA article can be accessed via the WPA website, www.thewpa.org.
One of the byproducts of the psychologist prescribing issue for me has been the clear reminder of how much of a problem access to competent psychiatric care is in some areas of Wisconsin. I have heard this from patients, legislators and our more rural medical and psychiatric colleagues who sometimes feel isolated. This is not a new issue, but it has largely ignored by our legislators until the idea of psychology prescribing was brought up as a quick and easy, yet risky and not clearly valid fix. The WPA is working on reasonable solutions with concerned stakeholders, but we feel strongly that the solution cannot include the risks to public health that would come with granting undeveloped psychologists independent medical practice by legislative fiat. The shortage of mental health providers (which includes psychologists performing psychotherapy, incidentally) is a very real systemic issue caused by many years of stigma, poor reimbursement and the preference of some providers to practice in a more urban setting. Looking at, and attempting to address the access issue in a meaningful way is a clear way to benefit patients and decrease the need for alternative prescribers (aka, “a win-win”). In order to work on the issue, we felt that we had to understand it first.

Members of the WPA Executive Council recently had an opportunity to sit down with members of the governing council of the Wisconsin Academy of Family Practitioners. We were very interested in hearing what their concerns were and what the state’s psychiatrists could do to assist our primary care colleagues. We had an excellent discussion getting to know each other’s practices and came out of the conversation with; I felt a better understanding on both sides.

It was a very useful and eye-opening meeting. Our primary care colleagues feel a lack of access to psychiatric expertise. Primary care feels the access problem not only with the geographic location of psychiatrists (as there are shortages of many medical and surgical subspecialties in the rural areas), but also, they feel a lack of “access” to our knowledge and collegiality even when we are in the same town. There is a concern that they do not receive updates on their patients and their progress in our care. They are often locked out of access to some mental health records where electronic medical records exist and don’t receive notes. They described great frustration being able to contact psychiatrists treating their patients and how left out to dry they can feel when unable to get psychiatric advice or to get their patient seen. It sounds certainly similar to the feeling that we have waiting for a colleague to “medically clear” a patient going into a psychiatric unit.

This conversation left me with several thoughts regarding things that individual members can do, short of moving (although that remains an option), to improve access to adequate psychiatric care.

- Having a more collegial attitude with our primary care colleagues and paying more attention to the needs of our primary care colleagues would go far in improving access as far as primary care docs are concerned.
- Making sure our notes are copied to primary care, seems to be a big problem with an easy solution and would be very much appreciated.
- Communicating directly with primary care also would be very much appreciated. Being busy is not an adequate excuse. Who isn’t busy these days? We know coordinated care leads to better outcomes and we owe it to our patients to be more connected with their primary physicians.
- Some primary care docs taking care of behavioral issues in their patients feel less prepared to treat the psychiatric disorder. We feel that this can addressed with more support and education that we can help to provide to our colleagues, reminding them that these are medical issues. Not every stomach ache sees a gastroenterologist. There have been ideas such as putting educational programs (a combined annual meeting?) on for our primary care colleagues or volunteering times to give a “treatment” talk for the docs over a lunch at a neighboring primary care clinic. These are ways that we can help to support our colleagues comfort level and knowledge base. They clearly have the medical background to be able to successfully treat most patients, but could use a “curbside” from time to time on challenging patients.

Meet your colleagues! Put a face to a name. Misunderstandings are much less likely to occur if you know the primary care doc. A useful way to meet your primary care colleagues is to attend your hospital medical staff meetings or your county medical society meetings. Be active in the Wisconsin Medical Society. Through my activity in the Dane County Medical Society and Wisconsin Medical Society, I have valued the opportunity to meet my primary care colleagues in my group practice and in other group and solo practices across the city. It helps to foster an understanding that we are all in this together, we each addressing a part of our patient’s health - but we have to function together for the optimum patient outcomes to occur. The single specialty clinics that we often practice in make this collegiality more difficult, but not impossible. These types of relationships, the “liaisoning” which takes only a minor effort, would go far in
improving access to psychiatric help and can increase primary care confidence that they can provide it.

As mentioned above, there is clearly a macro issue here also. The WPA is looking at other ways to address the “access issue” such as obtaining funds for telepsychiatry and setting up primary care “help lines”, akin to a program in Maine where there is a formal agreement between psychiatrists and FPs to have assistance available via phone for the FPs with psychiatric questions. Ongoing or stepped up recruitment efforts to get more psychiatrists into the state and possibly increasing psychiatry GME positions are other bigger picture ideas. Everybody is talking about telepsychiatry, but nobody is doing it on a large scale. Start up costs can be high and the reimbursement can be a challenge. There are other more novel ways to improve access by working together in multidisciplinary teams, such as the pilot program at the University of Wisconsin Department of Psychiatry, the Immediate Treatment Clinic where the whole model of care delivery has been shifted to increase access to psychiatric care without hiring additional providers.

Trying to improve access can seem overwhelming at times, but as I mentioned above, there are concrete steps that you could take today to become more helpful to your primary care colleagues in helping them to provide better care for their patients. You truly can improve access to qualified psychiatric care by being more available to your colleagues.

I am on a task force for the Wisconsin Hospital Association looking at ways to improve access to qualified psychiatric care. The WPA and the Wisconsin Medical Society are organizing a task force to work with the WAFP and other stakeholders on this very important access issue, if you are interested in participating in this very important endeavor, please email me. We would love to hear any concerns or ideas that you may have on this topic.

Psychiatry is Not an Island
continued from page 9

Eau Claire, Wisconsin: Luther Midelfort – Mayo Health System, is seeking a bc/be adult Psychiatrist who is collaborative in his/her approach and engages the non-physician team and patient in a collegial manner. Position is primarily outpatient, but call involves inpatient coverage. Call of 1:6. Outpatient and inpatient unit are on the same floor of the hospital. This position involves travel one day/week for outreach. Luther Midelfort - Mayo Health System is a vertically integrated, physician directed hospital and multispecialty clinic of 237 physicians owned by Mayo Clinic. Our physicians practice evidence-based, protocol-driven medicine. Eau Claire is a university community with a metro area of 95,000, located 90 minutes east of Minneapolis. Business Week ranked Eau Claire as the best place to raise your kids in the State of Wisconsin (11/10/08). Outstanding schools, a family oriented community, a state with a favorable malpractice climate, and a strong compensation and benefits package may be expected. For more information, contact Cyndi Edwards 800-573-2580, fax 715-838-6192, or e-mail edwards.cyndi@mayo.edu. You may also visit our website at www.luthermidelfort.org

Luther Midelfort

Mayo Health System

Eau Claire, Wisconsin: Luther Midelfort – Mayo Health System, is seeking a BC/BE Adult Psychiatrist who is collaborative in his/her approach and engages the non-physician team and patient in a collegial manner. Position is primarily outpatient, but call involves inpatient coverage. Call of 1:6. Outpatient and inpatient unit are on the same floor of the hospital. This position involves travel one day/week for outreach. Luther Midelfort - Mayo Health System is a vertically integrated, physician directed hospital and multispecialty clinic of 237 physicians owned by Mayo Clinic. Our physicians practice evidence-based, protocol-driven medicine. Eau Claire is a university community with a metro area of 95,000, located 90 minutes east of Minneapolis. Business Week ranked Eau Claire as the best place to raise your kids in the State of Wisconsin (11/10/08). Outstanding schools, a family oriented community, a state with a favorable malpractice climate, and a strong compensation and benefits package may be expected. For more information, contact Cyndi Edwards 800-573-2580, fax 715-838-6192, or e-mail edwards.cyndi@mayo.edu. You may also visit our website at www.luthermidelfort.org
Equine Therapy
By Jenna Saul, MD

When my husband, Troy and I first met, he thought my ideas about developing an equine assisted psychotherapy program were evidence of how weird we psychiatrists must be. He wondered, “What do you want the horse to do?”

I have resisted efforts by insurers to reduce my therapeutic role to “prescriber,” and I’ve struggled with families who, given the paucity of behavioral and therapeutic services available, look to me to perform miracles with 12 or fewer short office visits each year. What seemed to be missing was programming to assist children and families practice problem solving and self-management skills in real time with a therapeutic presence, rather than hearing about skills in a therapist’s office, and later being expected to implement them when emotions are high.

Few of us would choose to be cared for by a physician who has only studied medicine in books. We prefer that trainees practice while an experienced physician guides them. Similarly, patients will be more successful at replacing maladaptive behaviors in their repertoire with adaptive ones when guided by a therapist who has developed suitable tasks for patient and equine.

The equine is an asset when creating real-time challenges for a patient needing skill development in frustration tolerance, anger management, impulse control, or problem solving. Horses do not respond to a person’s escalating frustration and anger by becoming more accommodating. To succeed with a horse requires flexibility, persistence, and responsiveness; a person who wants a horse to comply must relate to the horse on the horse’s terms. The desire to succeed with the horse inspires the patient to persevere, tolerate frustration, and this in turn facilitates the development of emotional and behavioral self management.

Some equine therapists speak of the effects that a horse’s spirit, and emotional responsiveness can have on promoting emotional growth and awareness in the humans they work with, and I believe the relationship between human and horse can facilitate the development of improved interpersonal skills, but this is difficult to empirically measure. At the least, equine assisted therapy decreases the need to directly confront past behaviors and feelings; instead, patient and therapist form a trusting alliance, set goals for horsemanship, and work together to problem solve and process the patient’s emotional and behavioral responses to the horse’s efforts to understand what is being requested. The therapist can provide observation and reflection about adaptive and maladaptive responses, and the horse provides real-time feedback. The result is improved self-regulation and self-efficacy through success in horsemanship.

Troy, a horseman since he was in diapers, was moved to tears (he’ll tell you it was the sun) when he saw the positive effects of equine therapy at a 4-H horse show. One boy with autism and anxiety tried more than 15 times before successfully mounting his horse. He eventually succeeded with the assistance of his father whose efficacy as a parent was bolstered through this opportunity to help his son. He held and stroked the shiny trophy, and his parents glowed. We imagined what it meant to be like for them to go to work on Monday and talk with co-workers about their son’s accomplishment; an opportunity for “normalcy” that is uncommon for parents of kids with special needs.

Troy and I renovated our barn to house a child and adolescent psychiatric clinic and designed the facility to accommodate our equine assisted therapy program. Called HORSES TREAT (Human Optimism, Resilience, Self-Efficacy and Strength Through Equine Assisted Therapy), we develop treatment plans to optimize our patient’s strengths, and nurture self-management and self-efficacy through work with horses. We’ve watched a youth who was aggressive, defiant, and destructive in a traditional clinical setting respond to expectations and rules to become calm, engaging and respectful in our barn; he was motivated by the desire to interact with our horses.

We have seen therapy-resistant adolescents smile, engage, and share feelings about losses and disappointments. One child with OCD and sensory defensive ness worries less about germs and the feel of her boots and clothing while with the animals.

While Troy works with the families and horses, my own interactions with these families benefits. I have a window to their real-life interactions and responses to challenges. Because patients are less inhibited while engaging the horses, I learn about their thoughts and feelings in greater depth and detail. Their enjoyment of the equine work enhances patients’ therapeutic alliance with me through a positive transference toward the program.

Equine assisted therapy is a tool for increasing the self-efficacy of the patients and families who participate. My sense of clinical efficacy is also enhanced as we utilize a therapeutic resource capable of solidifying meaningful and comprehensive clinical change.
Calendar of Professional & Clinically-Oriented Events

Upcoming Events

October 2009
16-17 – WPA Joint Meeting with Illinois Psychiatric Society
23-24 – Fall 2009 Psychiatric Update

March 2010
19-20 – Spring 2010 Psychiatric Update

November 2010
5-6 – Fall 2010 Psychiatric Update

Wisconsin Psychiatric Association & Illinois Psychiatric Society Joint Meeting

October 16-17, 2009, Grand Geneva Hotel – Lake Geneva, WI
Watch for additional details at www.thewpa.org

Note to readers and publicists: If you wish to have a professional meeting listed in future issues of the Wisconsin Psychiatrist, please send it to the WPA Office, 6737 W. Washington St., Suite 1300, Milwaukee, WI 53214, Phone: 414-755-6294 | FAX: 414-276-7704