“Bringing Psychiatry into the Future” WPA/IPS Fall 2009 Meeting in Lake Geneva, October 16 & 17, 2009

By Jerry Halverson, MD, WPA Councilor at Large, WPA/IPS Fall 2009 Meeting Chair

The 2009 Fall meeting for the Wisconsin Psychiatric Association will be held at the Grand Geneva in Lake Geneva, Wisconsin on October 16th and 17th. This year, for the Fall Meeting, we decided to work on a joint meeting with the Illinois Psychiatric Society and I think that you’ll agree that it looks like a meeting not to be missed.

The idea for the theme came out of conversations that WPA executive council members had with the leadership of the IPS at a recent APA meeting. Both of our memberships have expressed interest in learning about how technology and the “winds of change” both political and ethical will affect their practices. We are bringing in both nationally known and regionally known speakers, that are at the center of the changes ahead, to give their predictions of what is coming and how those responses affect all of us and our future colleagues. Dr. Roberts will be followed by Michael Summerhill, JD, a health care attorney from Chicago who will discuss the ramifications, ethically and legally, of the new restrictions on the interactions between physicians and industry. His is a presentation that will surprise, and likely will bring some spirited question and answer.

Friday afternoon brings the “Quality Improvement” movement to mental health care in the Midwest. Many of us have heard about “QI” and how the payers are looking to use it to meter out payment to providers. We are bringing in a psychiatrist from Intermountain Health Care in Utah, a place that does QI very well, to teach us how to use QI to improve the care that we give to patients- which will ultimately improve your reimbursement. George Nikopoulos, MD has successfully implemented quality initiatives in both inpatient and outpatient settings and is one of the world’s experts in doing this right in mental health. We are happy to have Dr. Nikopoulos for two hours to pass on some of this to our members. In my opinion, this is going to be two hours that will be “gold” as far as clinical utility and making your practice survivable in the future. Friday afternoon will be finished by Dr. Louis Kraus, a child psychiatrist from Rush who will discuss evidence based treatment and advocacy for delinquents, now and in the future. This should be a very interesting and clinically relevant discussion.

Friday evening will be something different for WPA members. We have planned a party with dinner and an engaging speaker for the evening, so that members from both organizations have an opportunity to meet each other and network. We have lined up a very interesting speaker that takes our theme literally. Ilse Bick, MD is a child psychiatrist who has given up her practice to write science fiction novels. She has done very well writing Star Trek and Battletech novels and is a very interesting and humorous speaker. As a profession that likes to listen to people’s stories, psychiatrists will enjoy hearing from one of our own that chose a very different path.

continued on page 15
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The WPA Goes North

*By Edward Krall, MD*

As part of newly elected President Ken Casimir’s strategy to reach out to membership throughout the state, the WPA scheduled its quarterly, Summer Council meeting in Marshfield on Friday, July 24th. Council members Jerry Halverson, Ken Robbins, Molli Rolli, Joe Layde, Clarence Chou, and MIT’s Claudia Reardon and Nathan Valentine made the journey. It was the first meeting to be held in Marshfield in many years and was welcomed by Dr. Ed Krall, who hosted the group.

From the Northern membership, Northern Chapter President Justin Schoen attended by teleconferencing. Dr. Jenna Saul, Child Psychiatric in private practice in Auburndale, and Dr. Alpa Shah, psychiatrist at the Marshfield Clinic with special training in Women’s issues, also attended a council meeting for the first time.

The meeting was preceded by having Dr. Jerry Halverson give a grand rounds at the Marshfield Clinic Froelke Auditorium on Suicide Risk Assessment. His presentation was attended by over 100 Marshfield Clinic physicians and staff and was obviously very highly valued. Dr. Halverson provided a very practical approach to assessing this often difficult but delicate clinical issue and his message was well received. He touched on the issue of suicide for health care providers, which is a not often talked about but an ever more threatening reality. One comment from the audience was, “This info may be helpful with friends and family, etc. (maybe even co-workers)”. Clearly the presence of the WPA ‘up north’ was very much appreciated and underscores the shortage of psychiatrists in the rural sections of the state and the need for the WPA to continue its efforts to extend its visibility and availability. President Ken Casimir is off to a good start in this regard and his efforts are to be lauded.

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WPA Awarded Newsletter of the Year by the American Psychiatric Association

Newsletter of the Year recipients at the APA Annual Meeting in San Francisco, CA. Annette Schott accepted the award on behalf of WPA.
Making Psychiatry Available

By Kenneth C. Casimir, MD, WPA President

Greetings, members, friends, and allies of the WPA! It is an honor and a pleasure to address you in this, my first column as President of our organization. I thank Dr. Carlyle Chan for his strong leadership during the past two years, and I look forward to working with our dynamic Executive Council and increasingly active members to promote the mental health of the citizens of Wisconsin, and to support the practice of psychiatry as a medical specialty. To help focus our efforts, the theme for my presidency will be: Making Psychiatry Available.

Clearly, we have witnessed dramatic changes in the practice of psychiatry during the past several decades: diminishing emphasis of psychotherapy, greater role of psychopharmacology in psychiatric practice, challenges and limitations presented by managed care, advances in information technology, and expectations and anxieties regarding the influence of health care reform on psychiatric practice. If we are to thrive as a medical specialty, it is essential that we make ourselves more available as psychiatrists. The Wisconsin Psychiatric Association has identified at least three imperatives in this regard.

I will work as President, and I ask you to join me as officers and as members, to help me in working toward these goals:

1. To be more available to our patients,
2. To be more available to our colleagues in primary care, and
3. To be more available to legislators and policy makers.

Beginning with our patients, I believe that we’d all agree that in our current state of affairs, there are not sufficient psychiatrists to meet existing clinical needs. Stated simply: there are just not enough psychiatrists to go around. While training programs and ECFMG are working to increase the supply of psychiatrists, in the meantime, we must maximize our ability to interact with patients. I encourage you as colleagues to be flexible when considering your practice options with regard to scheduling and reimbursement. Volunteering even a little clinical and/or didactic time is always a positive contribution. Also, consider utilizing technological advances such as tele-psychiatry and e-mail to improve your ability to interact with patients. WPA is committed to increasing the use of tele-psychiatry, and to promoting the use of technology to increase our availability as psychiatrists for our patients. The newly-updated WPA website will also help in this regard, improving communication, networking, and referral capabilities.

Secondly, we must make ourselves more available to our colleagues in primary care. In 2005, data from the Medical Expenditure Panel Survey, conducted by the Agency for Healthcare Research and Quality show the following percentages for prescription of antidepressants among outpatients: Psychiatry (29.3%), General Practice (22.6%), Family Practice (20.5%), and Internal Medicine (10.0%). It is striking to note that over 70% of all antidepressant prescriptions were by non-psychiatrists. Whether because of lack of availability, or stigma, or managed care constraints, many patients are obtaining psychiatric care from primary care clinicians (WAFP). It is essential that we as psychiatrists provide education and consultation to our colleagues in primary care. WPA is actively collaborating in such efforts with the Wisconsin Academy of Family Physicians, and we will remain committed to supporting primary care clinicians in their delivery of initial psychiatric care to the patients of Wisconsin.

Finally, it is evident that the delivery of psychiatric care is significantly influenced by the law and public policy. We must increase our availability to legislators and public administrators to make them aware of requirements for safe practice and expectations relating to standard of care, thus helping them to make informed decisions which will benefit our patients. WPA has been involved in advocating for parity legislation, fair Medicare and Medicaid reimbursement, and a rational approach to scope of practice in psychiatry. Through activities such as Advocacy Days in Madison, establishment of a Political Action Committee (PAC), and ongoing dialogue with our state legislators and administrators, WPA will continue to advocate for our patients by making psychiatry available in the arenas of legislation and public policy.

In summary, I ask you to join with me in making psychiatry more available to our patients, our colleagues, and our leaders. Building on a solid tradition, guided by an experienced, yet dynamic Executive Council, and invigorated by increasingly active members, the WPA is in a position to provide an effective framework within which you can contribute your particular talent and expertise. I know that your schedule is full, and that your time is precious. However, I am also quite certain that you entered the field of psychiatry in order to effectively influence the mental health of your patients.

Come and join with us in the new WPA, as we go beyond our clinics and hospital units to improve the mental health of all of our citizens by supporting the practice of psychiatry throughout Wisconsin.
Getting Away…for Our Own Sanity!

By Jane A. Svinicki, CAE, WPA Executive Director

Summer is the time of year for personal vacations and no matter what the economic situation, we all need to relax, reflect and re-ignite ourselves on an annual basis.

Whether a stay-cation at home or a trip to an exotic locale, I received as many ‘out of office’ messages this summer as I have in the past. We all benefit from the occasional opportunity to zone out of the working life, whether we visit Pardeeville or Paris, Minocqua or Minsk!

I was very fortunate to have the opportunity to visit Barcelona, Spain this summer with some family. Yes, we did take in the local cathedrals and museums, but that is not where I learned the more important lessons of the trip.

Take time to relax and enjoy: Those Spaniards really know how to live. I quickly got into the 10am breakfast, 3pm lunch with Sangria and 9pm dinner schedule. The luxury of so much free time over 10 days was great. I had time to people watch in the town square, eat a gelato (daily) or enjoy a two-hour dinner with stimulating conversation (and wine).

Communication is not just about words: No matter what the language, with enough gesturing, and pointing at signs and maps you can get an answer to any question. A few basic words in another language will go a long way towards creating good will. Everyone, even with limited English, was willing and able to help me with my limited, fractured Spanish.

The best travel experiences are not about money: After one of those two-hour dinners, we stopped by the town square for a nightcap. A group of British lads were enjoying the nightlife and snapping photos. We offered to get a photo of their entire group and they returned the favor for our group. A couple hours of lively conversation about our two countries followed. I realized again, we are all just people, citizens of a big world who are trying to understand and live with our fellow travelers on this beautiful planet.

It’s good to be home: Coming back to the United States through customs processing, I felt a warm pride in being a US citizen. Although I admired Spain and its people, history and accomplishments, in my heart I feel part of the American spirit. We care about the rest of the world and we want this to be a better place for ourselves and future generations.

May all of you relax and enjoy what the your next vacation has to offer!

Jane A. Svinicki, CAE
Executive Director

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The Department of Corrections is seeking board eligible and board certified psychiatrists for part time work. Positions are available in a variety of settings from maximum to minimum security. Psychiatrists will work with a multidisciplinary team treating inmates in an outpatient clinic. There are no call responsibilities.

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By Carlyle Chan, MD, WPA Immediate Past President

Dr. Harold Harsch and I have been colleagues at the Medical College of Wisconsin for almost 30 years. He is a highly regarded psychopharmacologist and I consult with him often on cases. His recent editorial on Pharma, Physicians and Conflict of Interest is part of a discussion we have been having for the past several years, one where I respectfully disagree.

His editorial outlines his concerns about the “continuing attack on pharmaceutical industries and their ties to physicians”. He feels that doctors working with pharma have “certain expertise and knowledge” that is “needed for the development of drug guidelines, teaching programs, and leadership positions”. He feels that concerns over conflict of interest are overblown, asking “Are we prescribing medications because of a name on a notepad?” He believes most industry research is ethical and unbiased. Finally, he feels the real enemy is insurance companies. Permit me to respond to his concerns.

Dr. Harsch is perfectly correct that physicians working with pharma have a certain expertise and knowledge which pharma needs for developing new treatments. The problem lies in the distinction between research and marketing. Dr. Harsch has argued that once the research is completed, there is no one better to present the research findings. However, pharmaceutical companies rely on the imprimatur of a speaker with academic credentials to lend credence to their marketing presentations. Should an academic professor really be part of a product promotion? This is why some medical schools long ago instituted a firewall by proscribing clinical researchers from making commercial presentations on their clinical research. As one resident asked me not long ago, “How do I rely on a faculty member’s psychopharm class lecture when that faculty member was giving a dinner talk the night before?”

That resident’s concern brings up the issue of conflict of interest. Dr. Harsch’s 1940’s based definition relates to a legal concept of conflict of interest (and anti-kickback regulations). As defined in Wikipedia: “A conflict of interest occurs when an individual or organization has an interest that might compromise their actions. The presence of a conflict of interest is independent from the execution of impropriety.” Columbia University states that a COI “involves the abuse – actual, apparent, or potential – of the trust people have in professionals.” From an ethical standpoint, it is the appearance of a conflict of interest that is also problematic. (Emphasis added.)

As an example from the not too distant past, before the generic SSRIs became commonplace, I staffed an intake with a resident on a patient with depression. We agreed that an antidepressant was a logical treatment decision and the resident’s choice of an SSRI was appropriate. Then I glanced at the wall of the resident’s office and noticed a clock featuring that same logo of that drug. This is not to say that the resident’s selection was based on the tchotchkes adorning the room, but their presence was not conducive to explaining to the patient why that particular drug was chosen. (I subsequently went to Ikea and purchased $1.79 clocks for all the resident offices and asked them to no longer use pens and notepads with logos.)

The resident proceeded to write the prescription with a pen embossed with that same SSRI logo and on the resident’s desk was a notepad with yet another logo of that drug. This is not to say that the resident’s selection was based on the tchotchkes adorning the room, but their presence was not conducive to explaining to the patient why that particular drug was chosen. (I subsequently went to Ikea and purchased $1.79 clocks for all the resident offices and asked them to no longer use pens and notepads with logos.)

Most physicians believe that their prescribing patterns are not influenced by small gifts or dinner talks. Yet, there is an abundance of social science literature as well as pharma’s own evidence-based marketing data that shows that these techniques are extremely effective in changing doctor prescribing habits. Gifting conveys a social sense of reciprocity. One pharmaceutical representative turned anthropologist reported on how the simple act of distributing certificates to physicians for a free cup of coffee at the hospital kiosk raised his sagging antibiotic sales to above quota. Pharmaceutical companies have access to the exact number of prescriptions written by a particular physician for a specific drug and use that information to closely monitor the impact and effectiveness of their dinner talks. That’s why there are so many dinner talks. They work.

Dr. Harsch places significant faith in industry research, but as new evidence based research reveals, some of the faith may be misguided. Research bias is not synonymous with fraud. Bias simply refers to the multiple intentional and unintentional ways research results may be skewed in either a positive or a negative direction. Experienced research design teams have not totally eliminated bias. For example, Leucht’s recent meta-analysis in Lancet (Jan 3, 2009) of 150 randomized controlled drug trials found that five of nine second generation antipsychotics when compared to first generation antipsychotics, were not more efficacious; most didn’t improve negative symptoms; few possessed lower extrapyramidal side-effect profiles when compared to low potency first generation antipsychotic drugs and all were less cost-effective. Yet, why are second generation antipsychotics considered an advance?

This Lancet study further noted that 95 of the 150 studies reviewed compared the second generation antipsychotic to haloperidol, a high potency first generation antipsychotic with a high incidence of extra pyramidal side-effects. Thus, these studies had a side effect bias in favor of

continued on page 6
Pharma, Physicians, and Conflicts of Interest, Part II
continued from page 5

the second generation drugs. Similarly, studies avoided comparisons with low potency first generation antipsychotics because these drugs had lower incidences of drug induced Parkinsonism. However, when low to medium potency drugs were compared, they were used in high doses, causing a higher frequency of side effects. This, too, biased studies in favor of second generation drugs. Hence, bias can be introduced into seemingly rigorous randomized controlled clinical trials. A study “closely monitored by the company and a clinical research organization” (paid for by the company) does not change this type of bias embedded in a study design.

Although all studies (including ones with negative outcomes) are now being registered by pharmaceutical companies, they are not necessarily being published. While many may be printed on various web sites, some are simply listed. This is also a recent practice prompted by the very criticisms with which Dr. Harsch disagrees. However, few busy practitioners have the time not only to locate a negative study, but also contact the authors for the results. Newer EBM (Evidence-based Medicine) reviews are now making the effort to include the unpublished negative studies in their reviews. This may explain why a recent review and meta-analysis (Cipriani, 2009) of twelve antidepressant medications reveals that not all antidepressants are of equal efficacy. Some drugs demonstrated a higher level of effectiveness than others. Which of these antidepressants are you prescribing?

All of this discussion does not address the core concerns central to our profession’s recent scrutiny (both internal and external). The purpose is not to demonize pharmaceutical companies (or device manufacturers) or psychiatrists who work with them. Rather, it is to remind us of our social contract with society (Charter on Medical Professionalism). The medical profession has been given an important responsibility in regulating itself because it holds a fiduciary relationship with society. We are trusted to put the interests of our patients above all other interests, including our personal income. Even the appearance of conflict of interest erodes that trust. Despite industry’s professed values, their ultimate responsibility is maximizing return on investment for their shareholders. That is just the nature of business. Our professionalism demands that we not confuse these two separate responsibilities.

It is interesting to note that a large push for renewed professionalism comes from medical students. The American Medical Student Association’s report card ranking of U.S. medical schools’ policies on pharmaceutical companies access and influence has, to a significant degree, shamed Academic Medicine into action. In keeping with our social contract, if we fail to police ourselves, society will respond with new legislative initiatives.

Medicine’s relationship with industry remains vital to the establishment of new treatments. Our current relationship evolved gradually and perhaps seductively. In her 2004 book, former NEJM Editor-in Chief Dr. Marcia Angell calculates that in 2001 with $200 billion in sales, pharma spend $50 billion on marketing (including CME and dinner presentations) compared to $30 billion on Research and Development. To quote former U.S. Senator Everett Dirksen, “Pretty soon we’re talking about real money.” The opportunity to give “tuition talks”, as one colleague describes them, with honoraria ranging from several hundred to several thousand dollars for a one hour talk, has been enticing to many (including myself).

However, the time has come to re-define our relationship with industry to one that is more transparent and more rigorously structured. We may not be able to totally eliminate conflicts of interest, but we can certainly do more to disclose, mitigate, and eliminate many.

Regarding Dr. Harsch’s critique of the insurance industry, I have no quarrel.

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Cipriani et al., Comparative efficacy and acceptability of 12 new-generation antidepressants: a multiple-treatments meta-analysis, Lancet 2009; 373: 746–58


Leucht et al., Second-generation versus first-generation antipsychotic drugs for schizophrenia: a meta-analysis, Lancet 2009; 373: 31-41

*I have no current conflicts to disclose, although I did give some industry supported talks ten years ago. There’s no sinner like a repentant sinner.*
The Amytal Interview – a lost art?

By Harold Harsch, MD

After thinking about the Amytal interviews I had done over the years, I felt that the procedure was ripe for a review. Over my career I had agreed to do Amytal interviews for recovering lost memories, a murder not remembered, fugue states, catatonia, conversion reactions, diagnostic questions, attempts to reintegrate alters in multiple personality disorder and even explore resistance in stalled long term psychotherapy. I have not had a request or felt a need to use the technique in over two years. After a literature search it became evident that most everything written about the Amytal interview dated back at least a decade. At the Medical College of Wisconsin, the psychiatric training program covers this topic in a half hour every two years during the Advanced Psychopharmacology course. Most graduating psychiatric residents over the last decade have never seen an Amytal interview, much less have any clinical familiarity with the technique.

Have clinical approaches to some psychiatric syndromes changed over the last decade? Catatonia is one that is now routinely treated with intravenous lorazepam. I have never seen this intervention fail and it is, at least theoretically, a safer and more common clinical procedure in the hospital setting than an intravenous barbiturate. Multiple personality disorder, or dissociative identity disorder, is becoming as rare as fugue states. This trend started after a number of malpractice cases in the 1990s. An early notable case was of Holly Ramona, a young woman being treated for bulimia, who “recovered memories” of sexual abuse by her father during an Amytal interview. Her father successfully sued the therapist for malpractice for recovering “false memories.”

Conversion reactions often respond to suggestion as in hypnosis or brief stays in physical rehabilitation programs. Does an Amytal interview still have a clinical role? A review of the history of this technique is enlightening.

William J Bleckwenn, a faculty member at the University of Wisconsin Medical School, pioneered the use of Amytal for the treatment of neuropsychiatric disorders. His initial observations were published in JAMA and the Wisconsin Medical Journal in 1930. He reported the dramatic observation that intravenous amobarbital could reverse, for a time, catatonic stupor. Two years later Erich Lindemann described the disinhibition induced by Amytal as a possible method to investigate emotional problems in non-psychotic individuals.

Amytal (sodium amobarbital) and Pentothal (sodium pentobarbital) are intermediate half-life barbiturates that have been most often used, historically, for psychiatric interviews. Amytal had become known as the “truth serum” based on the erroneous belief that chemically induced disinhibition resulted in the “truth” being reported by subjects—unfortunately or fortunately, humans are much more complex creatures, rich in good as well as bad dreams and fantasies.

Briefly the technique itself involves slowly infusing 200 to 1000 mg sodium amobarbital intravenously. Generally one speaks with the patient and infuses about half the total drug dose over around five minutes. When the patient begins showing clinical symptoms of disinhibition or intoxication (slurring of words) one stops or slows the infusion for the next 30 to 40 minutes. Many conversion reactions are the result of trauma and a historical review is an easy avenue to often intense emotions. Generally one “follows the affect” to traumatic and emotional memories. If the material produced is relevant one can encourage abreaction and/or leave a posthypnotic suggestion. Resolution of the conversion symptoms is the clinical goal. Information obtained can be integrated into the ongoing psychotherapy of the patient. Caveats are that although repressed material and memories are often obtained, these do not necessarily reflect real accounts of events. At the end of the interview the patient generally feels tired can be asked to take a nap until the drug effect wears off. Often the patient does not recall what was said or what topics were explored—one reason that some clinicians videotape the procedure. Contrary to what was a psychoanalytic concern, symptom substitution does not occur with the resolution of the original conversion “symptoms.”

The response of catatonia to Amytal infusion is often dramatic allowing an immobile and mute patient to begin to move and speak within ten to fifteen minutes of the drug administration. The technique and doses are the same. Once the catatonic patient begins speaking a clinical interview aimed at finding an affective or psychotic illness can be obtained to determine subsequent treatment. Clearing of the catatonia with Amytal or lorazepam sometimes results in only a few hours of a relative normal mental status before the catatonia returns. Techniques for fugue states and traumatic amnesia are all similar with a historical review providing the easiest access to the desired information.

Case: A 52 y/o engineer had a history of a cerebral vascular accident (CVA) during a motor vehicle accident (MVA) six months ago. He presented to a new neurologist with dysarthria and partial right hemiparesis using a cane to walk. The neurologist admitted the patient to the hospital because the neurological exam was not consistent with an old CVA. A psychiatric consult was requested to evaluate for a possible conversion reaction.

The patient was pleasant and cooperative. He was dysarthric and did not move his right arm and hand. He denied any prior psychiatric contact and reported not being able to work since the MVA. He did not report any current emotional distress about the MVA or any other event over the past year. He reported some fleeting suicidal ideation about his current state in life but no other depressive symptoms. He consented to an Amytal interview. Within a few minutes after drug infusion his af-

continued on page 8
The Amytal Interview – a lost art?

continued from page 7

ffect changed, he looked distressed and began speaking about walking into a lake to kill himself. Interview content was directed to the MVA and his CVA. It seems he was struck on a highway while driving a van by several young women in a convertible. No one died but the scene was bloody and he developed his “stroke” symptoms within hours of the event. He spoke about feeling incredible guilt about the accident. The events were reframed for him as the crash was clearly not his fault. It was suggested that his physical symptoms would dissipate. He fell asleep at the end of the interview. Once he woke up his voice was normal, he used his right hand normally and had a normal gait.

In this case, perhaps, two to four days of speech and physical therapy would have reached the same endpoint but most likely without any emotional insight. The Amytal interview remains a unique tool for a number of neuropsychiatric conditions. With the understanding that it is not a “truth serum” it is a safe and often valuable intervention for the selected patient. However, unless young psychiatrists are taught the technique and have availability of a senior mentor the Amytal interview will become a “lost art.”

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Lindeman E: Psychological changes in normal and abnormal individuals under the influence of sodium Amytal. Am J Psych. 88: 1083, 1932


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With the budget bill now done and signed into law, the legislature has turned its attention to separate legislation, spending criteria for the economic stimulus money and positioning for the 2010 Fall elections. The projected $3 billion shortfall by June 2010 also means there will be what is called a “budget repair bill” in the Spring 2010 session. There are not remaining pots of state money to raid so this will be an interesting challenge for lawmakers who may not have the political will to impose additional cuts beyond the 16 day state furlough already in place.

Health Care reform proposals

State health care reform proposals are on hold while Congress bounces around what reform proposals have enough votes to pass. Different groups at the state level are all jockeying for what should be in any reform proposal Wisconsin lawmakers might propose. Its clear for now, the payroll tax proposal from Senate Democrats last session that would Finance health care for everyone – is not likely to move forward in its current form. There isn’t a big push coming from the executive branch or legislative leadership in either house either.

At the same time there is a lot of skepticism about a government run health care system that wipes out the private insurance market: You can expect more transparency and incentives to control costs but the details have not yet cemented into a crisp proposal that a majority of lawmakers can endorse and comfortably run for re-election. While voters want health care reform, they also do not want increased taxes to pay for it. Wisconsin’s economy has not yet turned around based on reduced tax collections so lawmakers are trying to be sensitive to the hard times many families are still facing. Health care reform remains a dilemma conversation.

Other legislative issues

At the last council meeting a number of members indicated they wanted to see more effort spent on issues other than psychologist prescribing legislation. With that in mind, the only thing to say about SB 180, (Senator Robson’s psychology prescribing legislation) is that it is not moving forward until there is a compromise with psychiatrists.

The main author of the Assembly legislation, Rep. Sandra Pasch (D-Whitefish Bay) has indicated she wants a bill that is more specific about training standards than is contained in Senator Robson’s bill. Rep. Pasch is working with all sides to try to forge a compromise bill that would result in legislation on psychology prescribing being introduced and moving forward. Draft language is no where near completion yet so the WPA legislative committee has nothing it can react to. Rep. Pasch intends to be rationale and deliberate in her approach to ensure patient safety is not compromised and she has indicated a desire to work with psychiatrists. A number of you know Rep. Pasch outside of her role as a lawmaker and have routine communication with her, which is good. She is a very thoughtful, thorough legislator and I have every confidence she will not move a bill forward unless there is true compromise amongst all parties.

You may recall to date, the psychologists have been unwilling to budge on the training requirements contained in their draft legislation. Rep. Pasch has said she will not move any bill forward that psychiatrists are not comfortable with. Silence on this issue does not mean that I am not watching for movement. It just means that right now that this specific legislative issue “needs more work.” before it will move forward. The bill is still alive until the legislature adjourns, sometime next year likely by July 2010.

Chapter 51 Work group rewrite.

The WPA along with a number of other groups has been asked to participate in a work group that Rep. Pasch has pulled together to address a complete rewrite of the mental health statutes that relate to emergency detentions.

Rep. Pasch believes the stigma surrounding mental illness prevents many people from obtaining necessary help, and the treatment of mental illness is often precipitated by a crisis occurrence involving law enforcement. Therefore, Rep. Pasch has created a Chapter 51 Review Work group in order to address concerns relating to emergency detention procedures as well as inconsistencies in the interpretation of the chapter. This group will take an incremental approach toward examining a number of issue areas affected by Chapter 51, with the first matter of investigation pertaining to juveniles.

Groups involved in this work group include but are not limited to a representative or two from the WPA, psychologists, law enforcement, NAMI, mental health advocates and others. The group is likely to come together for its first work group meeting early fall.

If you have questions on anything please do not hesitate to contact me at Dewitt Ross & Stevens, 608-255-8891 or via email at aoc@dewittross.com.
Friend of the Wisconsin Psychiatric Association Award Nomination Form

The Friend of the WPA Award is presented to someone, often a Wisconsin legislator, who has been responsible for outstanding work as an advocate for patients with mental illness. The award recipient is chosen via solicitation of nominations from the WPA membership, followed by WPA Executive Council voting. The award is presented at the WPA Annual Meeting. Nominations are due January 1, 2010 and can be emailed to Annette Schott at: schott@svinicki.com.

Nominees should demonstrate 1 or more of the following criteria:

- Authored or co-authored legislation impacting mental health issues.
- Proven track record of voting in favor of pro-mental health legislation.
- Public support of issues concerning the health and well-being of patients with mental illness.
- Singular proponent of a particularly complex or relevant legislative initiative.

Person filling out application:

Name:________________________________________________________________

Address:______________________________________________________________

City:_______________________________  State:___________  Zip Code:__________

Phone Number: ________________________ Email:___________________________

Nominee:

Name:________________________________________________________________

Position:______________________________________________________________

Description of how nominee meets 1 or more of above criteria and thus has been a supporter of mental health issues (attach additional sheet and/or write below):
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________
APA Fall Components Meeting: Changes and Challenges

By Claudia L. Reardon, M.D., WPA Southern Chapter ECP Representative

In my Wisconsin Psychiatrist article last fall recapping the APA Components meeting, I described our parent organization’s ‘components’ as the 90+ committees and councils with specific charges related to various aspects of our profession. Things change quickly! As many of you know, the APA governance structure has been ‘streamlined’ into a much more svelte 23 components. Admittedly there was a significant amount of financial pressure to make this change, but beyond that, it was felt that our organization had become too cumbersome and inefficient with such a large number of disparate groups working on their own projects. Enter this September’s components meeting, with a noticeably thinner crowd, and with much longer ‘to do’ lists for each of the remaining components.

I joined our WPA’s Legislative Chair, Jerry Halverson, M.D., in sitting on the Council on Advocacy and Government Relations (CAGR). What an exciting time to be in our nation’s Capital discussing advocacy issues! We discussed issues of importance for psychiatrists at both the state and federal levels over the course of two full days of meetings.

APA staff reported that at the state level, the main issue continues to be the push from psychologists to gain prescriptive authority. Most such introduced bills have already been defeated this year, with notable exceptions Ohio (where the Governor and First Lady are both psychologists), Oregon (where a “task force” of psychiatrists and psychologists has been appointed to further study this issue), and Wisconsin (where a bill was introduced but then revoked, with uncertain future plans for the bill). The other issue of note at the state level is that of parity. While most states have some form of mental health parity already enacted (Wisconsin is an important exception), those that have been looking to refine or expand such provisions are largely waiting to see what happens at the national level once federal parity legislation takes effect at the start of 2010.

Discussion of federal legislative issues focused on health care reform (HCR), of course. Here were the highlights:

- There are 3 Congressional groups charged with drafting HCR legislation: the House ‘Tri-Committee’, the Senate HELP Committee, and the Senate Finance Committee. As of press time for this article, only the Tri-Committee has released a bill (HR 3200). The AMA has officially endorsed this legislation, and at this Components meeting, the APA decided to do the same. It contains many items consistent with AMA principles for health care reform (expanding the availability of affordable health care coverage to the uninsured, increased support for prevention and wellness services, investments in the physician workforce, increased Medicare payments for primary care services without cutting payments for other services and, as explained below, it eliminates the current sustainable growth rate (SGR) formula for updating Medicare physician payments) and APA principles for health care reform (most notably mental health and substance abuse parity).

- HR 3200 includes a ‘public option’, which has proven to be one of the more controversial issues in HCR. This public plan would compete with private insurance plans, the former thereby presumably keeping the latter accountable in terms of maintaining profit margins at reasonable levels. HR 3200’s public plan would be an option for those who otherwise do not have insurance and could be purchased by those of limited means with federally funded affordability credits. Notably, the APA Board of Directors voted at this meeting to support the notion of a ‘public plan’, though many physicians and patients alike remain concerned that a public plan could end up too ‘Medicare-like’ in a number of ways.

- HR 3200 also delineates a ‘fix’ for the very flawed SGR formula that is used to determine Medicare payments. The SGR formula is based on the GDP and NOT on actual health care expenses. If actual Medicare expenditures in a given year exceed the SGR, physicians’ Medicare reimbursement rates for the following year are cut accordingly. As such, for many years in a row now, physicians have been slated to receive exorbitant cuts in Medicare reimbursement rates. Every year, via extensive lobbying efforts by physicians reminding legislators that they will no longer be able to see Medicare patients if such cuts are enacted, temporary delays in the scheduled cuts have been passed. Unfortunately, this ‘patchwork’ remedy is cumbersome, inefficient, and unsustainable. HR 3200 includes a more reasonable approach to determination of Medicare reimbursement rates.

Besides HCR, other federal legislative matters were discussed, including health information technology (HIT, essentially referring to electronic medical records). The federal stimulus bill provides significant financing for physicians who wish to purchase and implement HIT. In fact, physicians treating Medicare patients will soon have newfound motivation to adopt “meaningful use” of HIT, with the stick being a 5% cut in Medicare reimbursement if they do not within the next few years.

There are a number of factors of particular relevance to psychiatry when discussing HIT. Your WPA has taken note of this and will be addressing the issue at their upcoming joint meeting with the Illinois Psychiatric Society (reminder: visit www.thewpa.org to register!). Across all specialties, 10-20% of physicians use HIT, with psychiatry as a whole lower than this. Besides extra concerns about confidentiality for psychiatric patients, some also feel that HIT tends not to be psychiatry-
Mark your calendars! The WPA Annual Meeting is planned for Friday-Saturday, April 23-24, 2010. Make plans to come to the elegant American Club in Kohler for this meeting entitled “Where Psychiatry and Medicine Overlap: Seeing the Big Picture of Our Patients’ Health.” The conference will include numerous educational seminars on topics that straddle the border between psychiatry and general medicine.

We are very fortunate to have as our headline speaker Virginia Commonwealth University’s James Levenson, M.D., author of the APA’s text on psychosomatic medicine. Dr. Levenson is known for his entertaining presentations, which at our meeting will include 3 seminars: “Psychopharmacology in the Medically Ill”; “Myths, Mistakes, and Malpractice: Neuroleptics in the Treatment of Delirium”; and “Legal Issues at the Interface between Psychiatry and Medicine.”

Dr. Levenson will be joined by several other key speakers, including Olympic runner Suzy Favor-Hamilton, who will address her struggles with depression, anxiety, eating disorders, and obsessionality. She will give a dramatic multi-media presentation of her own ‘crashing and burning’ despite having appeared to “have it all”, including a huge NIKE contract and several modeling contracts. UW’s Ruth Benca, M.D., Ph.D. will share her international expertise on sleep medicine. Eric Heiligenstein, M.D., an expert on ADHD and tobacco dependence, will share his wisdom on those two topics.

Tom Heinrich, M.D. is a consultation-liaison psychiatrist who will both entertain and educate the crowd with his talk entitled “If It’s Not One Thing, It’s Another: Antipsychotics and the Metabolic Syndrome.” Art Walaszek, M.D., Program Director of the UW Psychiatry Residency, will share his respected knowledge on geriatric depression. Ted Weltzin, M.D. of Rogers Memorial Hospital is a widely-published author on eating disorders and will discuss that topic. We will close with a panel of psychiatrists and family physicians leading a lively discussion on issues related to access to psychiatric care.

Registration and hotel information will be available soon. In the meantime, save the date for what promises to be a practice-changing and inspiring weekend.

In summary, medicine is a changing beast, with HCR, mandated HIT, and federal mental health parity likely just over the horizon. Likewise, organized medicine, including our APA, is an evolving entity, and that was indeed evident at this APA Components Meeting. The combination of increased skepticism about industry funding and the economic downturn has resulted in the perfect storm of a seemingly gaunt Fall Meeting as compared to the much fatter events of past years. Ways to keep members involved, with much less money to offer member benefits and leadership opportunities, is an important issue not only for our APA but of course also for our WPA. Share your thoughts on this and any of the above matters with your Executive Council leadership at any time.
Program Objectives

By the end of this conference, attendees will:
1. Recognize challenges and opportunities in the future of psychiatric practice and education.
2. Describe how a psychiatrist can implement continuous quality improvement strategies, electronic medical records and telepsychiatry in one’s own practice.
3. Describe the evidence-based treatment options for youths with behavioral problems.
4. Understand guidelines for interacting with the pharmaceutical industry, and identify potential conflicts of interest in one’s own practice.

Target audience

This program is designed for psychiatrists and other mental health professionals.

CME Information

This activity has been planned and implemented in accordance with the Essential Areas and policies of the Accreditation Council for Continuing Medical Education (ACCME) through the joint sponsorship of the Medical College of Wisconsin and the Wisconsin Psychiatric Association. 

CME Credits apply in both Illinois and Wisconsin.

The Medical College of Wisconsin is an accredited body of the Accreditation Council for Continuing Medical Education (ACCME)

The Medical College of Wisconsin designates this educational activity for AMA PRA Category 1 Credits.™ Physicians should only claim credit commensurate with the extent of their participation in the activity.

Practice Gaps

The field of medicine has identified outcome measures, set benchmarks for performance and monitored the quality of care being delivered. Unfortunately, psychiatric practice has not kept pace with these changes.

Especially in the setting of smaller offices, psychiatrists have not implemented quality improvement measures or embraced new technologies that could improve quality of care. This conference seeks to address this gap in knowledge and skills.

Overall Needs Statement

The practice of medicine is changing rapidly; these changes will accelerate with health care reform. It is essential that psychiatrists reflect on their practices and implement methods of improving quality and efficiency of care, while reducing costs.

Overall Goal Statement

By the end of this conference, attendees will recognize trends in the practice of psychiatry, learn how to implement technologies, and reduce conflicts of interest related to the pharmaceutical industry.

Friday, October 16, 2009

7:30 am
Registration with Exhibitors

8:15 am
Welcome and Introductions
WPA & IPS

8:20–9:30 am
The APA: Supporting and Advocating for Patients, Members, and Profession
James Scully, MD, Medical Director and CEO of the American Psychiatric Association

9:30–10:30 am
Academic Psychiatry: New Perspectives, New Imperatives
Laura Roberts, MD, Professor & Chairman of the Department of Psychiatry & Behavioral Medicine at the Medical College of Wisconsin.

10:45–11:45 am
They Apply to Doctors Too: Ethical, Legal and Industry Restrictions on Interactions between Health Care Providers and Pharmaceutical, Medical Device and Life Science Companies
Michael J. Summerhill, JD, Partner at SmithAmundsen, Chicago, IL

12:00–1:00 pm
Lunch

1:00–3:00 pm
Continuous Quality Improvement and the Psychiatrist
George J. Nikopoulos, MD, Medical Director of the Behavioral Health Clinical Program at Intermountain Healthcare, as well as the Medical Director of the Behavioral Health Team at SelectHealth

3:00–3:15 pm
Break with Exhibitors

3:15–4:15 pm
Evidence Based Treatment and Advocacy for Delinquents – What does the Future Hold?
Louis Kraus, MD, Chief of Child and Adolescent Psychiatry, Rush University Medical School, Member of American Medical Association Council on Science and Public Health

6:00 pm
Dinner

Presentation to Follow: “The Write Stuff: How I Quit Psychiatry and Learned to Love My Unconscious”
Iliza Bick, MD, Child Psychiatrist and Award-winning author

Saturday, October 17, 2009

7:30 am
Registration with Exhibitors

8:00–11:00 am
Exploring Technologies in Psychiatry
Carlyle Chan, MD, Professor and Vice Chair for Professional Development and Educational Outreach Medical College of Wisconsin
John Luo, MD, University of California – Los Angeles
Robert Kennedy MA, Scientific Director and Director of Medical Strategy at CCG Metamedia and Clinical Instructor of Psychiatry and Behavioral Medicine at the Medical College of Wisconsin.

11:00 am–12:00 pm
Telepsychiatry in Action: A Panel Discussion
What has been working in Wisconsin and Illinois?

DISCLOSURE

It is the policy of the MCW to comply with the ACCME standards for commercial support of CME. Planning Committee members and related staff disclosures must be on file annually with disclosures made available on program materials. Faculty participating in sponsored or jointly sponsored programs by MCW are required to disclose to the program audience any real or apparent financial relationships with commercial interests related to the content of their presentation(s). Faculty also are responsible for disclosing any discussion of off-label or investigational use of a product.
WPA/IPS Event Registration

Register Online at
www.thewpa.org
OR
www.illinoispsychiatricsociety.com

Online Registration Accepted until October 9, 2009

MAIL OR FAX REGISTRATION FORM
This is how your name will appear on your name badge.

*FIRST NAME: ___________________________  *LAST NAME: ___________________________

*SUFFIX (JR., SR., ETC.): ___________________________

*COMPANY/INSTITUTIONAL AFFILIATION: ___________________________

*SPECIALTY: ___________________________  *PLEASE STATE YOUR HIGHEST DEGREE(S): ___________________________

*ADDRESS: ___________________________  *CITY: ___________________________  *STATE: ______  *ZIP: ______

WORK: _______ – FAX: _______

*EMAIL ADDRESS: ___________________________

*Required for CME credits

Special Needs: □ Hearing Impaired  □ Sight Impaired  □ Other: ___________________________

□ Dietary (Please Specify)

PLEASE CHECK
□ WI Member  □ IL Member  □ Non-Member

REGISTRATION FEES
(Includes Sessions, syllabus, lunch, and dinner)

□ WPA/IPS Member Registration ....................... $195.00
□ Non-Member Registration ............................ $295.00
□ WPA Resident ........................................... $30.00
□ IPS Resident ............................................. $30.00
□ Additional Friday Night Dinner Ticket .............. $75.00

PAYMENT MUST ACCOMPANY REGISTRATION.  TOTAL DUE: ___________________________

METHOD OF PAYMENT
The following methods of payment are acceptable for the registration fee:

1. Check: Make payable to your district branch.
   Employer Check Included □  Personal Check Included □
   Employer or Personal Check to Arrive Under Separate Cover □
   There is a $25.00 returned check fee.

2. Credit Card Payments:
   □ Visa  □ MasterCard  □ American Express  □ Discover
   No. ___________________________  Sec. Code ___________________________
   Exp. Date _______ / _______

Paper Registrations By Fax Or Mail
(SEE CONTACT INFORMATION BELOW)
If you are unable to register online please mail your paper registration form.

Onsite Registrations
Online registrations accepted until October 9, 2009. After October 9, 2009, you may register onsite.

Registration Cancellation
All cancellations must be in writing and sent to us via U.S. mail, e-mail or fax.
Tuition for cancellations postmarked or dated stamped before October 10, 2009 will be completely refunded with an administrative fee of $25.00. NO REFUNDS WILL BE MADE AFTER OCTOBER 10, 2009.

For Additional Information, Contact:
Wisconsin Psychiatric Association
6736 W. Washington Street, Suite 1300
Milwaukee, WI 53214
info@thewpa.org
Office: 414-755-6294
Fax: 414-276-7704

Illinois Psychiatric Society
230 East Ohio Street, Suite 400
Chicago, IL 60611-3265
ips@ilpsych.org
Office: 312-244-2600
Fax: 312-644-8557

PLEASE NOTE: Registration is not complete until you receive the confirmation letter/email for your pre-registration. It is recommended to bring your confirmation of registration with you to the conference.

Payment Via Check Must be Mailed to: Your district branch along with registration.

CME Credits
CME Credits apply in both Illinois and Wisconsin. The Medical College of Wisconsin is an accredited body of the Accreditation Council for Continuing Medical Education (ACCME)

Registration Fee Includes:
• Continuing Medical Education Credits
• Registration and Course Materials
• Lunch, Dinner, 3 Coffee/Soda Breaks
Saturday is our technology day. We are fortunate to have our own Carlyle Chan, MD as well as John Luo, MD and Robert Kennedy, MA offering a shortened version of their popular APA Workshop “Exploring Technologies in Psychiatry”. This is your opportunity to get a “technology tune-up!” They will discuss technology and how it can and will improve our care delivery. Electronic Medical Records, Telemedicine and hand held technologies for the psychiatrists and more will be covered. These are all topics that members have asked to hear more about. The conference then finishes with a panel of our colleagues from Illinois and Wisconsin discussing what has worked in telepsychiatry, which could be a very important tool to increase access to qualified psychiatric care in the rural areas.

So, please join your colleagues from both the north and the south as the WPA Fall meeting makes an appearance at the Grand Geneva. The Lake Geneva area is the perfect spot for the joint meeting. There is a water park for the kids and plenty of other activities for your family members to keep themselves entertained while you are at the meeting (or while you are getting a massage). The program promises to be very interesting and will help you to keep your practice ahead of the times. You will also have an opportunity to network with our colleagues to the south, and harass them about another losing season for the Bears. This is an exciting time to be a psychiatrist. Get the tools that you need to keep your practice fit. See you in Lake Geneva!
Calendar of Professional & Clinically-Oriented Events

Upcoming Events

**October 2009**
16-17 – WPA Joint Meeting with Illinois Psychiatric Society
Grand Geneva Hotel, Lake Geneva, Wisconsin

23-24 – Fall 2009 Psychiatric Update

**April 2010**
23-24 – WPA Annual Meeting
The American Club
Kohler, Wisconsin

**November 2010**
5-6 – Fall 2010 Psychiatric Update

**March 2010**
19-20 – Spring 2010 Psychiatric Update

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**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

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**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

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The WPA Goes North

The Amytal Interview – a lost art?

Legislative Update

Exciting Spring WPA Annual Meeting:

Getting Away…for Our Own Sanity!

President’s Blog

Association Year by the American Psychiatric Association

The WPA Goes North

WPA Wins Award for the Newsletter of the Year!