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QUARTERLY PUBLICATION OF THE WISCONSIN PSYCHIATRIC ASSOCIATION: NORTHERN, SOUTHERN AND MILWAUKEE CHAPTERS

Doctor Treffert honored by Treatment Advocacy Center

Treatment Advocacy Center (TAC) honored three extraordinary community psychiatrists with the National Torrey Advocacy Commendation, awarded to psychiatric heroes. Doctor Darold Treffert was one of the winners of TAC's annual national mental illness advocacy award.

Doctor Treffert was honored by Dr. E. Fuller Torrey and the Treatment Advocacy Center for courage and conviction fighting for the right to treatment for those with severe mental illnesses: for blazing the way – in both concepts, like championing the belief that nobody should "die with their rights on," and in legislation, by working to create Wisconsin's "Fifth Standard," today a model for state commitment laws. For heroism on behalf of those with few real champions.

Doctor Treffert is a clinical professor at the University of Wisconsin Medical School and is on the staff of St Agnes Hospital in Fond du Lac, Wisconsin. He completed both his medical training and psychiatric residency at the University of Wisconsin Medical School. He then joined the staff of Winnebago Mental Health Institute in Oshkosh, Wisconsin. He was named superintendent in 1964, a position he held for 17 years. For the next 12 years, he served as director of a community mental health system for a county of 90,000 people.

As the superintendent of Winnebago, Dr. Treffert spoke out early and often about the adverse effects of weak mental illness treatment laws. As early as 1973, he published an article titled "Dying with one's rights on," a phrase that has become part of the lexicon. Dr. Treffert blazed the trail of documenting preventable tragedies to help keep the focus on the results of lack of treatment; his vision inspired TAC's on-line database of preventable tragedies. Beginning in the mid-1980s, he began promoting Wisconsin's "Fifth Standard," which later became law and was unanimously upheld by the Wisconsin Supreme Court. In numerous publications, he has clearly and forcefully described the consequences of failure to treat individuals with severe psychiatric disorders:

> The "freedom" to be penniless, helpless, ill and finally arrested, jailed and criminally committed is not freedom at all – it's abandonment. The "right" to be demented, agonized and terrorized in the face of treatment that cannot, because of legal prohibition, be applied is no right at all – it's a new form of imprisonment. The "liberty" to be naked in a padded cell, hallucinating, delusional and tormented, is not liberty – it is a folie a deux between pseudo-sophisticated liberals and an unrealizing public. The delusion is that if one changes the name of something to something else, or if one substitutes a jail for a hospital or a preoccupation with legal rites for honest concern over patients' rights, he has done something significant, useful and important, or at least something. ["Legal 'rites'" Criminalizing the mentally ill. *Hillside Journal of Clinical Psychiatry* 1982, 3: 123-137.]

This article, was originally printed in the Spring 2006 *Catalyst*, a publication of the Treatment Advocacy Center (www.psychlaws.org). Reprinted with permission.

The Human Dimension To Coerced Care

By Darold Treffert, MD

For 17 years, I was Director of Winnebago Mental Health Institute, Wisconsin. Then for 12 years, I was director of a community mental health system for a county of 90,000 persons. Throughout those years, I was also in private practice with both outpatients in the office and inpatients in a general hospital psychiatric unit when such care was necessary. So my vantage

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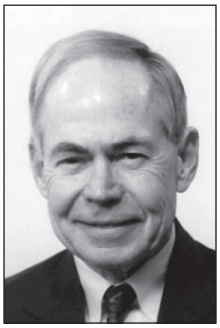
Prevention = Wisdom

By Jack C. Westman, MD



I recently returned to Miami after some 20 years. From the balcony of my room on the 24th floor of the Hyatt Regency, I saw a swarm of vultures circling the center of the city. The air pollution drove me back into my room where I scanned the front page of the *Miami Herald*. It featured a battle between developers and airport officials over building skyscrapers in the landing path.

How could beautiful Miami have deteriorated so much? Could it have been prevented?

Living in Florida for half of the year has convinced me there is too much money to be made from personal and public disasters to permit prevention. I knew that war was good for some industries, but I did not fully appreciate how good natural disasters are for the economy. Florida now has a budget surplus from the disaster insurance inflow and population growth in recent years.

What happens today when governments have surpluses? The legislative debate in Florida is on using the surplus for tax cuts, not to improve Florida's failing public schools and social services. Children have a high priority in rhetoric and a low priority in funding.

Children are growing up in struggling families throughout the United States with one, two, and three strikes against them because of the circumstances of their births. Imagine what it would be like if every child grew up in a thriving family. We would reduce state expenditures by at least 26% and county expenditures by 45%. We taxpayers would like that, but efforts to help struggling families meet strong resistance from the services and industries that have grown up around our social problems. They would lose money — and they have lobbyists who know how to exploit political sentiments. Here are two examples.

First, home visitation for the parents of newborns effectively prevents a range of personal and social problems. Yet it is resisted by those who fear that funding home visitation will reduce funding for their programs. That resistance is supported politically by the far right because home visitation invades the privacy of the family and by the far left because it limits personal freedom.

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President's Comments

By Edward Krall, MD

At the APA meeting in Toronto in May, I had the opportunity to attend an orientation for district branch presidents and president-elects where a membership recruitment and retention plan was presented. The APA is going through the same kind of introspection that we did last fall in our strategic planning process, and they have developed a strategic plan for the 21st century. It was gratifying to see that our identified roles of networking, advocacy and education are echoed in the national organization's mission of:

- Advocating for patients
- Advocating for the profession
- Supporting education, training and career development
- Defining and supporting professional values
- Enhancing the scientific basis of psychiatric care

Like us, the APA is also concerned about membership. There has been a significant loss of membership and decreased renewal rate, particularly among younger members. Likewise, despite the fact that psychiatry is becoming more diverse, with increasing percentages of women, international medical graduates and minorities, the average APA member in 2006 was a "54-year-old white male."

To deal with this troubling trend, the APA has developed a Recruitment and Retention Plan, the objective of which is to reinforce the position of the APA as the leading professional association for psychiatry and to try to demonstrate that the organization has a critical role in each stage of a member's personal and professional development.

It is no surprise, then, that the Wisconsin Psychiatric Association is suffering from the same demographic trend and has become an "old boy's club." Advocating for our patients and advocating for the profession are worthy goals, however it appears we have lost our audience and perhaps lost our voice locally and nationally. How can we regain our value? How can we tap into our diversity as a profession? If it is true that perception is everything in marketing, then we have some work to do. No one should be asked to join the WPA or APA unless we can demonstrate that we are aware of psychiatrists' concerns and serve them.

APA: "Money where their mouth is"
To that end, the APA is putting real money into the effort. The Board of Trustees has approved $300,000 for 2006 for grants available to District Branches to advance the strategic plan of the APA. More specifically the grant application should demonstrate: "The impact of the proposed activities on membership recruitment and retention."

The WPA has submitted a grant application to obtain funds to enhance our own membership recruiting and retention efforts and to advance our stated goals of education, advocacy and networking. In our strategic plan we identified several problems with our current membership and recruiting efforts:

- Like the APA, we too have a diverse membership. The organization identified the need to be more representative and inclusive of specific types of members, including Members-in-Training (MITs), female psychiatrists and Early Career Psychiatrists.
- Another obstacle for WPA is its geographic distribution. The vast majority of psychiatrists are centered in the larger urban and academic areas of Milwaukee and Madison, with the remainder scattered throughout the large rural area that is the rest of Wisconsin. As a result, the group realized that there is a disconnect between members in these different areas of the state, which negatively impacts WPA's ability to network, connect and advocate as a state.

WPA's outline to overcome these current deficiencies and make them strengths of the organization includes:

Target

- MITs pursuing psychiatric training
- early career psychiatrists
- female psychiatrists

Intent

- Organize activities to introduce new psychiatrists to the work of WPA
- Convey the importance and benefits of membership in a medical specialty society
- Improve recruitment and retention
- Improve participation of members in the organization
- Solicit greater support for community mental health issues

Strategy

- Funding stays and expenses of MITs at the off-site Executive Council meetings
- Funding stays and expenses of MITs at the Annual Conference and lodging for six residents per program
- Host one dinner gathering for the MITs at each medical school each year
- Host a career fair utilizing general members to share their experiences in the field with MITs and Early Career Psychiatrists

  Launch an annual female psychiatrists networking event/conference with a speaker

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President's Message

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Members-in Training
These strategic initiatives for MITs are designed to ensure inclusion by representatives from both of Wisconsin's psychiatric residency programs: the University of Wisconsin and the Medical College of Wisconsin. Special events would be free or at a minimal charge. This would hopefully attract a larger pool of attendees and provide WPA the opportunity to promote its activities to a broader audience.

The events would invite attendees to be matched with practicing WPA members in various psychiatric sub-specialties to provide opportunities for further career choice exploration, developing long-term mentoring relationships and offering real guidance and advice on issues related to setting up a private practice. A quality-networking event would close the fair, pairing general members and fair attendees for more specialized one-on-one interaction. The focus could be further developed to include other topics not covered in medical school, such as business practices, financial planning, etc.

This MIT program is very important to the WPA and eventually the APA, as well. If new members are made to see the value of membership and participation early in their schooling and career, they will continue to participate throughout their careers. These new members can also be a catalyst for other MITs to join.

Female Psychiatrists
To enhance its offerings to become more attractive to the female physician, WPA plans to host an event for female psychiatrists. This event could include a panel discussion by several prominent female psychiatrists and other related specialties discussing their struggles and opportunities. Similar to the MIT program, WPA would hope to collect information on the specific needs of the female population of its membership. WPA would use that information to ensure that opportunities and programs are developed to better support this segment of the membership, as well as garner more involvement from female psychiatrists in the association. Potential programs developing as a result of such a focus group might include a mentorship program, specifically targeted recruitment and retention pieces, and ongoing female psychiatrist topics at conferences.

Early Career Psychiatrists
The ongoing vitality of WPA is contingent on securing new members and getting and keeping them active. The active involvement of Early Career Psychiatrists in WPA is limited, and membership numbers are low. The specific perspectives of these segments need to be investigated and programming developed to attract additional members. This would improve the culture of WPA and reduce the current perception regarding the membership as an "old boys club."

My Hope
These are critical times for psychiatry and mental health issues. The work before us is important. Our patients need us to represent them. Our profession needs to stay abreast of issues and have a voice in the debates that will come. I can't help but feel that if psychiatrists can stand together they will be a force to be reckoned with and serve for the greater good.

The Council on Member and District Branch Relations was accepting grant applications with a deadline of June 30, 2006. Funding decisions will be made in the fall and funds will be distributed by the end of the year. Our application requested the sum of $19,570.56. Keep your fingers crossed.

Resident Listing 2006

Medical College of Wisconsin Residents – First Year

Meredith Dixon, MD
Travis Fisher, MD
Rebecca Harrison, MD
Mary-Anne Kowol, MD
Caroline Palmer, MD
Keyur Parikh, MD
Jessica Taylor, MD
George Lind, MD

University of Wisconsin Residents – First Year

Jennifer Alt, MD
Brian Berendes, MD
Ritu Bhatnagar, MD, MPH
Sara Black, MD
Geoffrey Hills, DO
Mitchell Illichmann, MD
Claudia Reardon, MD
Gayatri Vaidyanathan, MD

University of Wisconsin – Child Psychiatry Residents

Jennifer Friedberg, MD
Jeff Smarrella, MD
Erik Ulland, MD
Azhar Yunis, MD

Medical College of Wisconsin – Child Psychiatry Residents

Barbara Hale-Richlen, MD
Syed Rahim, MD
Moitreyee Reddy, MD
Benjamin Troy, MD

Volunteerism and the Wisconsin Psychiatric Association

By Molli Rolli, MD, Past President, and Steve Lorenz, CMP, Executive Director

If you have read any of Doctor Krall's recent articles, you can see that the Wisconsin Psychiatric Association is re-imagining itself and working on several projects to bring its new strategic plan to life. Several volunteer opportunities are currently available, as a result of the strategic plan's areas of focus, and more will be announced in the coming months, including a call for nominations to serve on the Executive Council. I encourage each of you to look at the current areas of focus of the WPA and contact Drs. Krall, Rolli or Steve Lorenz to let us know how you would like to volunteer your time. The benefits of volunteering can far outweigh the time commitment and really improve the return on your membership investment. Below are the comments of Steve Lorenz and Dr. Molli Rolli about what volunteerism has meant to them.

It has been over ten years since I attended my first Wisconsin Psychiatric Association meeting. I was a resident then. Being a part of this organization has been rewarding. It has also been fun, challenging, frustrating, funny, sad and heartwarming. Despite statistics that tell us volunteerism and membership in professional organizations is on the decline, the WPA has remained a strong and meaningful organization.

As an active member of the WPA, I have learned many things. The first and most important is that this organization is truly open to input from members. It is easy to be heard at the WPA. You may not always be agreed with, but you will be heard. As a member of the Executive Council it is possible to help shape the organization to better meet your needs.

Another very valuable lesson the WPA has taught me is that our voice does matter in the legislature. The winds of the political climate change and we have some goals that are not popular in the current state legislature. It is easy to get discouraged and feel powerless when it comes to political issues. What surprised me is how much our leaders value input from us. Again they don't always agree but they do listen.

As a psychiatrist, I have really appreciated the fellowship of other psychiatrists. Once residency is over our practices can isolate us. Volunteering with the WPA offers any psychiatrist an opportunity to spend time with other psychiatrists from around the state. Despite the fact that I am in a large group practice and an academic environment, it has been enlightening to talk with people who practice in other places, or in other types of settings. As a member of the executive council I have made some great long-lasting friendships with psychiatrists I may never have met if I hadn't joined the council.

Last, but not least: it is fun to do the work of the council. Organizing conferences, re-inventing our organization, fellowship with our peers, and mentoring early career psychiatrists all are rewarding and fun experiences I got when I volunteered to be a part of the leadership of the Wisconsin Psychiatric Association.

As a member of a professional organization, I feel one of the most important member benefits is the opportunity to volunteer and participate. I have served in a variety of roles in Meeting Professionals International-Wisconsin Chapter (MPI-WI) since joining in 1999. However, for the first year of my membership in MPI-WI, I did not participate in a volunteer role. I only attended a meeting or two and I did not feel that I was getting much from my membership. When I was convinced to volunteer, I felt like I was part of the group and began to truly reap the benefits of membership.

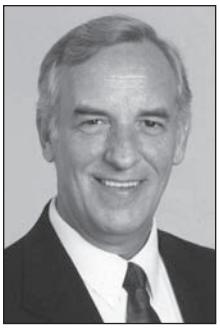
Some of the roles I volunteered for were small things that helped keep the organization's cost down and enhanced membership, such as the membership committee, where I made approximately five to 10 phone calls per month to welcome new members and encourage existing members to renew. Some roles were more involved, such as serving on an ad hoc committee that developed curriculum for a two-year associate degree program, which promoted our organization to new members. Still other roles were very involved, such as my current role as President of the Wisconsin Chapter. As my level of involvement increased, so did the benefits I received from my participation.

Each of my volunteer roles gave me opportunities to interact with my peers at a different level. I learned valuable skills I would not have learned had I not volunteered in my organization. I have earned awards as a result of my involvement that I would not otherwise have ever been considered for. I have my current job at the Wisconsin Medical Society as a direct result of my involvement in my professional organization and networking with peers. I have been able to use the skills I acquired from my involvement to the benefit of all of my clients, including the WPA.

I would not have been able to do any of these things, or even imagined some of them happening to me, when I first joined my professional organization. My involvement in MPI-WI has opened a door that led to one opportunity after another. I cannot wait to see what door opens next and how to leverage that into a new skill or benefit that I can deliver to my clients.

The Public Mental Health System's Mission: What It Is...and Isn't

By James Hill



In March of this year, the *Milwaukee Journal-Sentinel* published the first of what has become an ongoing series of articles ("Abandoning Our Mentally Ill") depicting the abject living conditions of people in Milwaukee County who are poor and who suffer the added debilitating effects of severe mental illnesses. The series' graphic narrative and its accompanying photographs distressed readers, and rightly so. It documented people with mental illnesses living in unsafe, rat- and roach-infested rooming houses and apartments not fit for human habitation; people eating rotted food or having no food at all; people sitting and sleeping in their own urine and feces; people being exploited and abused by landlords; landlords doling out medications without proper licensure and qualifications…the list went on.

The series has served a valuable purpose by both directing public attention to the challenges of surviving in an urban community if you are poor and have a serious mental illness, and by putting a heart-breaking human face on poverty. Conditions just like these are a part of life in cities all across this country where poverty is rampant. They are an inexcusable disgrace in this, the wealthiest nation on the planet. In the series' wake, the Behavioral Health Division has heard from many individuals offering housing and wanting to know what else they can do to help individuals with mental illnesses. We are most grateful for these offers. The public interest in our mission to serve the needs of individuals who live with these illnesses in our community has never been higher, and that is a very positive development.

The causes underlying these deplorable conditions specifically as they relate to people with mental illnesses are found in history, medicine, law and economics. The interactions among them are multilayered and complex. Their roots are buried deep in the soil of many generations and are wrapped tightly around some of the most toxic and intractable human attitudes, namely ignorance and stigma. The lack of safe, decent and affordable housing for people with mental illnesses, too many of whom live in poverty, is but one of the manifestations of this legacy.

Despite this well-recognized etiology, one recent editorial has reinforced the mistaken idea embedded in the articles that solving the problems of poverty and the dearth of safe, decent and affordable housing in the community rests on the shoulders of the public mental health system. Both the follow-up articles and the editorial, published a few months after the original series, expressed shock that the Behavioral Health Division had not yet fixed these problems, and suggested that the public mental health system needs only to throw more government bureaucrats and regulations at it and the problem will disappear. This "solution" can best be diplomatically described as implausible.

There are stories of many hundreds of individuals with mental illnesses who live successfully and thrive in the community thanks to extensive community-based services currently being provided by the public mental health system, but they're not being told. Recognizing the critical importance of safe, permanent and affordable housing to the ability of persons to effectively manage and recover from mental illnesses, the Behavioral Health Division provides more than $6 million annually in housing assistance alone to our consumers, making us the largest de facto housing agency in the state serving people with mental illnesses. Unfortunately, that story is not being told, either. Instead, repeatedly framing the issue in its most negative terms hardens the understandable but wrong perception that the public mental health system has utterly failed both the community and the people it is intended to help.

From this erroneous impression, it is a short intellectual walk to the conclusion that it is time to bring back the asylums. In fact, the writer of a recent letter to the editor of the *Milwaukee Journal-Sentinel* illustrated just how easy a walk it is. After expressing dismay at the living conditions continually depicted in the series – conditions no one denies and no one should tolerate – the letter writer observed, "My solution would be to return to the Mental Health Complex we had in the past…" While insisting she did not mean "institutionalization," no one acquainted with the history of the public mental health system and the treatment of mental illnesses could miss the allusion. Granted, a single letter writer's opinion does not necessarily reflect the attitude of an entire community, but it is not difficult to track the logic, or to imagine that others – perhaps many others – draw similar conclusions.

There are several contentious questions of seminal importance that the community and its policymakers ought to be debating on the subject of public mental health services, but these issues are also being ignored in the series. It is fair to ask, for example, whether deinstitutionalization went too far. It is reasonable to debate whether legal standards relating to involuntarily commitment are too stringent and whether those standards, in fact, work against the health and safety of the individual in crisis and against the interest of the community.

continued next page

Mission *continued from page 6*

It is legitimate to question whether more public resources should be directed at community-based support services so that all people with mental illnesses, no matter how severe, are able to live as independently in the community as their illness allows, or whether we should con-cede that there are individuals whose mental illnesses are so severe and so resistant or unresponsive to treatment that the only safe place to care properly for them is in an institutional setting. It is proper to ask whether the current mental health treatment protocols, therapies and support services are achieving overall positive results for consumers and taxpayers.

It is incumbent upon the federal government, and state and local agencies whose core mission is making affordable housing available to people who need it, to meet their responsibilities, and it is appropriate to question these entities and their policymakers when they don't.

It is not only fitting but essential that the community examine its zoning laws to ensure that they are free of all biases, including those directed against people with mental illnesses, and that the community resolves to oppose discrimination against and stigmatization of these individuals wherever these forces are at work.

And ultimately, it is fully appropriate to hold the public mental health system accountable when it fails to fulfill its mandate. There are more than enough mandates and failures we need to address. Low-income housing development and the eradication of poverty, however, are not among them.

AAGP Urges Congress to Amend Medicare Part D to Rectify a Coverage Gap

Press Release:

*** Due to the "doughnut hole," an estimated seven million seniors may be unable to pay for their medications ***

The American Association for Geriatric Psychiatry (AAGP) is calling on Congress to implement a solution to the gap in insurance coverage that is estimated to affect 7 million seniors before the end of the year. When Medicare Part D beneficiaries reach a certain limit in their plan, they must pay all out-of-pocket costs for drugs before another limit is reached and benefits kick in again. This gap in coverage is commonly referred to as the doughnut hole.

"This provision of the standard Medicare Part D plan is a terrible miscalculation on the part of the Administration and the Congress that enacted the law, and needs to be addressed immediately," said Gary Moak, MD, AAGP president-elect and a clinician practicing in Massachusetts.

Fee-for-service plans in Medicare's new Part D prescription drug program, offered for the first time this year, have this gap in coverage. Medicare pays 75 percent of eligible drug costs after a deductible, up to a $2,250 limit. Coverage then ends until the beneficiary's expenses reach $5,100 (at which point Medicare pays 95 percent of eligible prescription drug costs). This leaves many seniors in a predicament — in addition to paying for the Part D insurance, they must pay thousands of dollars from their own pockets for their medications, which many of them simply cannot afford.

While some beneficiaries were advised to anticipate and plan for this gap in coverage, this expectation has proven unrealistic. Older adults on low and even moderate fixed incomes, who are managing chronic illnesses, especially those with mental illness, may find this additional barrier overwhelming.

"Many of my patients are in the doughnut hole. It's a senior citizen black hole. Fixed income dollars can't escape its gravitational pull," said Moak. "I have patients who ask to be switched to cheaper medication alternatives with the intention of going back once they emerge from the other side. The doughnut hole forces seniors to make decisions regarding their medication based solely on money rather than therapeutic efficacy."

"This is a huge problem for our patients. Several have asked how to wean off medications that they can no longer afford," said Eve Byrd, MSN, MPH, RN, FNP, associate director of the Fuqua Center for Late-Life Depression in Atlanta, Georgia. She added: "For many, there is no way they can come up with $1,000 and more for all their medications when their Social Security checks are less than that. Sending them back to the drawing board to re-evaluate their plan is overwhelming to our patients at this point."

Solutions to the doughnut hole are currently being discussed on Capitol Hill. One option would have Medicare, not the drug plans, negotiate directly with the pharmaceutical companies. Proponents say the savings could help eliminate the coverage gap. Another proposal would waive the premium for any month when a senior lacks coverage. Christopher Colenda, MD, MPH, president of AAGP notes, "AAGP supports the efforts of legislators who are working to correct the Medicare coverage gap and encourages its membership and consumers to write to their local legislators to support these measures."

The American Association for Geriatric Psychiatry (www.AAGPonline.org) is a national association representing and serving its members and the field of geriatric psychiatry. AAGP's mission is to enhance the knowledge base and standard of practice in geriatric psychiatry through education and research and to advocate for meeting the mental health needs of older Americans.

Dr. Jon Berlin nominated for Bruno Lima Award

By Edward Krall, MD

Earlier this spring, the Wisconsin Psychiatric Association proudly submitted to the American Psychiatric Association the name of one of its members, Dr. Jon Berlin, for the Bruno Lima Award for Excellence in Disaster Psychiatry.

Dr. Berlin was nominated for consideration by Dr. Carlyle Chan at our Council Meeting of February 3, 2006. His contributions to the field of disaster psychiatry on a local and national level are well known locally and were reviewed by Council members. His nomination was confirmed unanimously.

His commitment to the field of emergency psychiatry is truly impressive. He is president of the American Association of Emergency Psychiatry. He teaches a medical student clerkship and resident training experiences in emergency psychiatry. He is a contributing editor of *Emergency Psychiatry*, a guest editor of *Emergency Psychiatry*, and a peer reviewer for *Psychiatric Issues in Emergency Care*. He also sits on an Editorial Boards for P*sychiatric Issues in Emergency Care Settings*. He participated in the 2002 "Educational and Training Issues in Emergency Psychiatry," Sixth World Congress, International Association for Emergency Psychiatry, in Barcelona, Spain.

He is founder and director of the Disaster Mental Health Task Force of Milwaukee and provided direct service and leadership to the Milwaukee Katrina Evacuee Psychiatric Clinic as well as at the Houston Astrodome, which is quite an interesting story.

Creation of the Disaster Mental Health Task Force of Milwaukee

Following September 11, 2001, Dr. Berlin visited emergency psychiatrists in New York City to investigate the lessons learned in their disaster relief efforts. He observed that the problems they experienced included such things as the influx of untrained counselors, the difficulty that licensed professionals had gaining entry to the emergency response zone, and the lack of cooperation and coordination among different disciplines and agencies. (The latter problem occurred on a much smaller scale in Milwaukee after 9/11). The most unanticipated finding was the need to be mobile and to provide mental services where the survivors were working and living; people did not flock to their Comprehensive Emergency Psychiatric Programs as expected. A later finding was the important advisory role that psychiatry played with Mayor Giuliani.

Upon his return, Dr. Berlin met with the Milwaukee County Office of Emergency Management, Milwaukee County Emergency Medical System (EMS) and the local Red Cross chapter. With their input, he then helped create a local Task Force that included all of the major public and private organizations and hospitals providing mental health services. Its mission was to lead an organized, collaborative, multi-agency, non-proprietary response to a major disaster.

Previously, Milwaukee County had designed disaster mental health efforts to be ancillary to Red Cross and delivered primarily by the Milwaukee County Behavioral Health division. With the creation of the Task Force, the Office of Emergency Management recognized it had a useful new entity and placed it in the Health Annex alongside EMS and Emergency Public Health. As director of the Task Force and as the Medical Director of Psychiatric Crisis Services in Milwaukee, his position was added to the advisory group of medical directors from the other sections.

Leadership of the Tommy Thompson Center Clinic

When 400-plus Hurricane Katrina survivors were evacuated or came on their own to Milwaukee, Dr. Berlin was medical director of a successful clinic for them in a facility being run by Red Cross and the Salvation Army. This project was notable in 2 ways:

- The Disaster Mental Health Task Force was activated for the first time and met its goal of promoting an effective, multi-agency response. Private psychiatrists, a large health organization and the Department of Psychiatry at the Medical College of Wisconsin were involved.
- It was an unprecedented "first" for Milwaukee's Red Cross to allow physicians to operate a clinic treating patients in one of its facilities.

Medical Director Services at the Houston Astrodome, September 1-8, 2005

Immediately preceding the Tommy Thompson Center experience, Dr. Berlin spent a week assisting Houston psychiatrists Avrim Fishkind, MD, and John Burruss, MD, in running the emergency psychiatric service for Katrina evacuees at the Houston Astrodome.

Debriefing following the Brookfield, Wisconsin Rampage Killing

On March 12, 2005, a distraught gunman shot and killed 7 religious services attendees and then turned the gun on himself in Brookfield, Wisconsin in what has been called the Sheraton Hotel massacre. Dr. Berlin again took the initiative and led the debriefing for the Brookfield Police Department.

Jon has authored a number of disaster-related publications, some of which are noted following this article. Jon is current-

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Berlin *continued from page 8*

ly assistant clinical professor, Department of Psychiatry & Behavioral Medicine at the Medical College of Wisconsin. Last but not least, he has served the Wisconsin Psychiatric Association with distinction as treasurer, and as president of the Milwaukee Chapter and we are honored to have him as a colleague.

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"New Dimensions in Disaster Psychiatry." *Psychiatric Issues in Emergency Care Settings*, Cliggott Publishing Group, Vol.4, No.2, May 05.

"The Role of Emergency Psychiatry in Disaster Management," A. Ng. Roundtable discussant.

Psychiatric Issues in Emergency Care Settings, Cliggott Publishing Group, Vol.3, No.1, July 04.

"President's Column." *Emergency Psychiatry Newsletter*, Winter, 2006. (Addressing the range of emergency psychiatry activities, from evidence-based medicine to improvised disaster response).

Podcasting: How to Use it, How to do it

By S. G. Zelenski, DO, PhD

You have all heard the term "podcasts" and certainly most of you have or know someone who has an iPod or some other MP3 player. Some of your patients may even be telling you about information that they gleaned from a podcast. But what is a podcast, and can it benefit you in your private or clinical lives or maybe both?

The term "podcast" originated by combining two popular words – "iPod," the most recognizable portable audio device at the time the term was coined in 2004, and "broadcast." Many feel that the term "podcasting" originated with Adam Curry, one of MTV's first DJs. Despite the name, you do not have to have Apple's iPod player to create or listen to podcasts and you don't need to broadcast it. A podcast episode is nothing more than an MP3 audio file that you download from the Internet. Once you download the file, you can either listen to it on your computer or transfer it to an MP3 player to listen on the go. Podcasts grew in popularity among enthusiastic computer users as a way to send stories out for others to listen to easily. The technology grew quickly and you can now find podcasts from HBO, Comedy Central, NPR, ESPN and VH1.

Okay, let's practice. First thing you will need is an aggregator (simply a piece of free software like iTunes or Juice). Go to the site (CTRL – click on one of these two links). Follow the directions on the site after checking your operating system and system requirements to run the software. Once you have the software installed, open your browser (if it is not already open) and go to a site where you can subscribe to podcasts. If you do subscribe to a podcast, your computer will automatically update the files to which you subscribe whenever you are connected to the Internet. You don't have to do anything more. Remember, these are just MP3 files. Once downloaded to your computer you can even "burn" the files to a CD if your computer has that capability and you don't have a MP3 player. That way you can play the CD on a CD player in your car. Alternatively, the aggregator will let you search through its collection and subscribe to a podcast that will then be downloaded to your computer and you can play. There are both audio and video podcasts and many are free. Most aggregators don't index medical sites, however. If you want one of these, you will have to go to the site directly. Several good sites to get you started with medical podcasts are: *http://books.mcgraw-hill.com/podcast/acm/* or *The New England Journal of Medicine*.

The Bare Bones

The only things you absolutely need to obtain and listen to podcasts are a broadband Internet connection and a computer. If you want to listen to the podcast while jogging, driving or otherwise on-the-go, you will have to move it from your computer to a portable MP3 player, like an iPod. This can be as simple as attaching the MP3 player to your computer per the manufacturer's directions and clicking a button. You can pretty much forget about downloading podcasts if you use dialup net access, unless the episodes you wish to download are very small files (say 2MB or less).

Next issue:

How to create your own podcast.

The Art of Psychiatry: A Discussion with Kenneth Burg, MD

New Member Profile

By Linda DiRaimondo, MD

Who is better suited to explore the human oscillation between narcissism and nihilism, artist or scientist?

Doctor Kenneth Burg, recent graduate from the University of Wisconsin Psychiatry Residency, would argue: *both*.

Doctor Burg's career as an artist began in the early 1960s in grade school where a creative detour in art class, using paints, paper and glue to construct "primitive" masks, led to his first confrontation with convention. His innovation was more than his Wauwatosa parochial school teacher could handle. "I got in trouble," he said wryly as we sat recently amongst the jungle of plants in his living room.

With a love of the mountains, the young artist found himself at a fork in the road a few years later, during college in the 1970s, choosing geology over philosophy with the promise from his advisors that he'd be "more employable." He has no regrets regarding his time with soil and rocks and became a certified mudlogger, examining plugs of earth for metal and gas. With pride and another mischievous grin he notes that, in the late 70s, he had a "bad reputation as an environmentalist" for speaking out in opposition to oil companies.

With the scientific methodology from geology in tow, he returned to the UW Madison in 1982 to obtain his masters of Fine Arts degree in Sculpture. "*Why am I so obsessed with making objects?*" he recalls wondering at that time. No sooner had he pondered this than his path crossed with Dennis Merritt, PhD, a Jungian psychologist in Madison, sparking a collaborative exploration that led to the co-production of a video on Jungian Sand Therapy in 1983. He obtained his MFA in 1984 with a final project exploring "the forces of opposites," specifically, *love/hate* and *life/death*.

Between 1986 and 1990, Dr. Burg was granted seven Artist-in-Residencies by the Illinois Arts Council and the National Endowment for the Arts, working with Chicago students to develop interactive sculpture. He describes his work at that time as "*site specific architectural environments that are kinetic and interactive and conceptualize the transition from adolescence to adulthood,*" focusing on the social, spiritual and developmental issues of the students.

In 1991, Dr. Burg moved to New York City where he was employed as a full-time art therapist at St. Francis, a 100-bed residence for the chronic mentally ill. His creative work with schizophrenics became the impetus to seek formal medical training to become a psychiatrist. Prior to returning to UW Madison to start medical school in 1996, he also helped develop the New York Prison Council Project, a personal growth and rehabilitation project for inmates at Sing Sing Prison.

Regarding leaving the art world for the pursuit of a medical degree, Dr. Burg notes, "I sold my soul 10 years ago. I made a deal with the devil…. *The biggest piece of artwork is to transform yourself, but you have to come back.*" The question he has kept in sharp focus over the past 10 years is, "*How can a psychiatrist be creative?*"

Dr. Burg continues to find delight in the forces of opposites and has recently

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Below, Dr. Burg in his backyard sculpture garden.

Below, middle and right, artwork from Dr. Burg's sculpture garden.

Nation Needs to Prioritize Mental Health

By Fannie LaFlore, MS, LPC, CADC-D

Former U.S. Surgeon General Dr. Joycelyn Elders Says Nation must Prioritize Mental Health Education, Intervention, Research and Adequate Resources for Treatment

ST. LOUIS, MO. — Whether it's psychologically fragile soldiers returning from Iraq, children and families shattered by domestic abuse, residents of inner cities impacted by random community violence, displaced families suffering financially after last year's Gulf Coast hurricanes, post-9/11 survivors still struggling to cope, relatives dealing with the sudden disability or death of a loved one, senior citizens who are medically-vulnerable and socially-isolated, or retired executives who are depressed and contemplate suicide, the lives of many Americans can become increasingly unhinged by adversity, upheaval, loss, distress and existential angst that puts them at risk.

In addressing such examples and the unmet treatment needs in a country where an estimated 1 in 5 people will be affected by a mental disorder at some point in their lives, former Surgeon General Dr. Joycelyn Elders said unequivocally that the nation needs to prioritize mental health.

Dr. Elders gave the keynote speech at the annual American Mental Health Counselors Association (AMHCA) conference, which took place July 20-22 in St. Louis. The day before, residents of the metropolitan area were caught by surprise as severe winds and thunderstorms resulted in a historic power outage, and critical heat discomfort due to temperatures near or above 100 degrees with few options for immediate relief, according to officials quoted in the St. Louis Post-Dispatch.

Several injuries and two deaths were reported the first day, with additional deaths in the aftermath of storms. Major businesses, including hotels, were without power for hours or days. Significant structural damage to small businesses and homes made them inhabitable. A state of emergency was declared by St. Louis Mayor Francis G. Slay, who requested assistance from the state's governor, resulting in activation of the Missouri National Guard to assist in cleanup efforts.

With all these events as a backdrop, as well as similar incidents nationwide in past years that have tested and strained the stability and fortitude of Americans, perhaps few would dispute Dr. Elders' major point that mental health should maintain high priority on the public health agenda.

"Due to the stigma associated with mental illness and mental health issues, many times the public doesn't want to pay for services, but it's important that we increase knowledge, awareness and public education about this crucial need," she said.

Dr. Elders cited sobering statistics: Mental illness is the second leading cause of disability in America, resulting in a $100 billion cost to the economy based on lost productivity; arthritis is the number one cause of disability. Mental disorders are as disabling as physical illnesses such as cancer and heart disease, yet insurance coverage for mental health is restricted in comparison. Up to half of all visits to primary care doctors are due to conditions caused or exacerbated by mental health issues including depression and anxiety disorders. White males over the age of 65 have the highest rate of suicide, often after retiring, due to depression related to crises of self-worth and identity loss. One in 10 children has a serious, diagnosable mental health problem, but less than 1 in 3 get appropriate treatment.

The Substance Abuse and Mental Health Services Administration (SAMHSA) released data in 2005, in a special report on youth ages 12-17, showing that approximately 900,000 youth had made a plan to commit suicide during their worst or most recent episode of major depression, and 712,000 attempted suicide during such an episode of depression.

In 1993, Dr. Elders' views on masturbation and sexual health, including making condoms available to youth to prevent teen pregnancy and STDs, and other comments or aspects of her background came under fire after former President Bill Clinton recommended her for the post of U.S. Surgeon General. Dr. Elders had been Director of the Arkansas Health Department for six years, and previously a professor of a pediatric endocrinology.

Having grown up poor in a small rural community, she never visited a doctor's office until after adolescence, so she knows from both personal and professional perspectives that major barriers to health care services exist. Many people encounter obstacles due to lack of economic resources and insurance coverage, and limited access based on culture/language among diverse ethnic minorities, and sparse transportation and service provider options in rural communities, among other factors, Dr. Elders said.

"When between 80% and 90% of people need services but don't get them, we have a huge, unfinished agenda ahead of us in this 21st century," she said. "We need to become more committed, consistent and courageous, with a plan of action that involves ongoing communication, cooperation and collaboration."

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Mental Health *continued from page 11*

Dr. Elders said that leadership at the national, state and local levels needs to be held more accountable, and mental health and other professionals, as well as average citizens, should find opportunities in daily encounters, both in large and small ways, to educate others and advocate on behalf of those who are powerless and most vulnerable.

Challenging the stigma associated with mental illness – by countering myths and simplistic ideas such that having a problem means one is simply weak or irresponsible – will also play a major role in shifting perceptions and removing barriers, she said.

Dr. Elders outlined several solution-focused strategies including visionary political and community leadership to support adequate funding and improve access to resources for all; promoting parity for mental health coverage similar to insurance for physical health; utilization of best practices integrating holistic treatment approaches; ongoing research that combines medical and psycho-social factors for the most effective therapeutic benefits; enhanced standards and monitoring to ensure professionals in the field are well-qualified; comprehensive education for the general public about the medical and genetic components of mental illness; and prevention education and early intervention in schools and community settings to reach young people and their families.

"It's interesting that for two of the most important areas of our lives – being a good parent and a good citizen – these are among the only areas where you're not required to have a license for undertaking the many responsibilities that come with them," she said. "If we start with treating children, that's the best investment we can make. Research shows that 80% to 90% of mental health disorders are treatable, and we've got to treat the whole person, not just their symptoms."

Dr. Elders said she strongly believes treatment makes a difference in saving lives and improving quality of life. Yet, even with her professional credentials, including making history as both the first woman and first African-American U.S. Surgeon General, Dr. Elders is acutely aware that anyone can be vulnerable. Her own family dealt with turmoil when her college-educated son's life spiraled out of control due to addiction and undiagnosed mental health problems. Her son has been in recovery over six years now, due to consistent treatment that combined medical, pharmacological and psychotherapy interventions, along with competent and caring professionals, she said.

After her presentation, she autographed copies of her book, *Joycelyn Elders, M.D.: From Sharecropper's Daughter to Surgeon General of the United States of America*, published in 1996, but currently out of print. In the introduction, she discusses the August 1993 Senate debate over her confirmation as Surgeon General, writing that she was unprepared for unwarranted attacks on her personal character and misrepresentations on some positions she took on public health issues. "When it was over, I wasn't positive people knew who I was much better than they had when it started. After only fifteen months as surgeon general, I'm not sure they ever really did get to find out," she wrote.

The theme of the conference, "Gateway to Healing, Keys for Recovery," was encapsulated both in Elders' speech and through the many facets of mental health theory, research and practice explored in various workshops. The American Mental Health Counselors Association (AMHCA), headquartered in Alexandria, Va., is the only national organization working exclusively for the mental health counseling profession, according to W. Mark Hamilton, PhD, Executive Director and CEO.

In a letter to the AMHCA, Slay, the mayor of St. Louis, said he was proud the organization chose St. Louis to host the mental health conference, and indicated that "it is our responsibility both as individuals and a community to support and care for those in need and assist people in finding mental health resources they need for themselves, family and friends."

The conference theme also captured the symbolic meaning of the St. Louis Gateway Arch, designated the tallest structure in a city widely associated with the westward expansion of the United States between 1803 and 1890. St. Louis is also where the first of the Dred Scott trials involving a black man and his wife fighting for freedom from slavery, was held at the old Courthouse two blocks from the Arch.

The Arch site at the Jefferson National Expansion Memorial along the Mississippi River includes a historical museum with displays on the significant roles of Thomas Jefferson and other U.S. presidents, the Louisiana Purchase, pioneer explorers Lewis and Clark, and thousands of people including Native Americans, African-American cowboys and soldiers, and European immigrants who settled in the new territory of the American West. An awe-inspiring documentary film, "Monument to the Dream," details the Arch construction, which was begun in 1962 and completed three years later without loss of life or major injury among the team of men who made up the crew.

Also at the conference, representatives from the U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration and Center for Mental Health Services, offered free brochures and publications, timely with their relevance to recent events, including "Psychosocial Issues for Children and Adolescents in Disasters,"

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Mental Health *continued from page 12*

"Psychosocial Issues for Older Adults in Disasters," and "Dealing with the Effects of Trauma."

Dr. David Satcher, who was originally scheduled to speak but unable to attend the conference, is widely regarded for starting a national dialogue on mental health when he released a landmark report while U.S. Surgeon General from 1998-2002. Satcher is now Director of the National Center for Primary Care at Morehouse School of Medicine in Atlanta.

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The author, Fannie LeFlore, MS, LPC, CADC-D, is a former newspaper reporter/journalist for 10 years, and also a licensed Professional Mental Health and Substance Abuse Counselor in Wisconsin.

She is based in Milwaukee, Wisconsin, where she is President of LeFlore Communications, LLC, a small business focused on Writing/Editing and Corporate Communications Consulting, as well as Special Projects in Human Services.

Ms. LeFlore formerly worked as freelance Co-Writer/Editor on the 1997 book, "*The Road Less Traveled and Beyond*," with the internationally-known author, M. Scott Peck, MD.

Ms. LeFlore can be reached at *fannie@leflorecommunications.com* or at 414.526.0908.

Submissions for the Winter 2006 issue of The Wisconsin Psychiatrist are due November 7. Please forward your submissions or items of interest to Steve Lorenz at SteveL@wismed.org.

Part D Update for DB Newsletters

By Ellen Jaffe, Office of Healthcare Systems and Financing, APA

Is Medicare Part D really working better or is it just that everyone has gotten so frustrated with it that they're not protesting anymore? That's a question the APA's Office of Healthcare Systems and Financing (OHSF) would like to have answered about the new prescription drug benefit.

According to Irvin L. "Sam" Muszynski, director of OHSF, "We've been able to get CMS [the Centers for Medicare and Medicaid Services, which oversees Medicare] to respond favorably with new guidelines to some of our concerns about patient access to psychiatric medications, and they've been willing to intervene on a case-by-case basis when we've communicated specific problems to them. We'd like them to tackle problems at a more systemic level or target companies that are not performing as they should, but we can't pressure them to act without reports from large numbers of prescribers supporting the need for this. We really need to hear from any members who continue to have problems getting their Medicare patients appropriate medications."

Prior to Part D's debut in January 2006, the APA was very successful in getting CMS to identify antipsychotics, antidepressants and anticonvulsants as three of the six classes of drugs of special interest under Part D. All drugs in these classes had to be included on each Part D prescription drug plan's (PDP's) formulary, instead of just the two drugs that were required for other drug classes. This designation has been carried over to 2007, and the 2007 transition guidance is an improvement over the 2006 guidance.

Since January, OHSF has been having ongoing, regularly scheduled calls with CMS staff, keeping them apprised of the problems the office has been hearing about through its designated Part D phoneline, 866.882.6227, and e-mail address, *PartD@psych.org*, and trying to work with them to get necessary changes made. According to Muszynski, a constructive relationship has developed, with CMS asking for help on mental health issues as well as OHSF asking CMS for assistance.

Unfortunately, CMS's apparent concern about access to psychiatric drugs has not kept the PDP's from finding ways to deny patients their medically necessary drugs, especially if those drugs are newer, brandname drugs. Although each prescription drug plan is a private insurer with its own formulary and set of rules, in most cases the more expensive drugs cannot be accessed without receiving prior authorization from the drug plan. And if the dosage of the brandname drug required exceeds the FDA-recommended dose, Muszynski reports that it is highly unlikely the prior authorization will be automatically granted. It may well be necessary to appeal the PDP's decision through several levels of appeal to obtain the necessary number of pills. OHSF has been actively involved in helping a number of physicians with successful appeals on their patients' behalf, and is available to assist with others.

OHSF is currently looking ahead to November 15, when the six-week open enrollment season begins for 2007. If you are experiencing any problems with Part D, please contact OHSF by writing *partd@psych.org* or calling 866.882.6227. For information about Part D exceptions and appeals and the latest news, visit *www.MentalHealthPartD.org*.

2005-2006 Legislative Session Adjourns

By Michael Blumenfeld, WPA Public Affairs Counselor

Both the Assembly and Senate have adjourned their regular and extraordinary legislative sessions for the 2005-2006 session as candidates in all 99 Assembly districts and the 17 odd number Senate districts focus on their fall election campaigns. Legislative committees may continue to meet for the remainder of the year, but legislators have limited ability to take official action on any measure. This means that bills that have not passed both houses are considered "dead" for the 2005-2006 session. If legislators wish to pursue bills that were not approved, these proposals will need to be reintroduced during the next session, which begins in January of 2007.

Doyle Signs Malpractice Liability Cap Legislation

In March, Governor Doyle signed legislation to reinstate a cap on liability for noneconomic damages in medical malpractice cases. As you probably know, an earlier attempt failed when the Legislature was unable to override a veto by Governor Doyle.

The new law sets the cap at $750,000. In addition, it requires the board that approves any fee changes to the Injured Patients and Families Compensation Fund to report to the legislature every two years any suggested changes to the noneconomic damage cap. The new law will undoubtedly be subject to legal challenge in the future.

Taxpayer Protection Amendment/ TABOR Defeated

Once again the Taxpayer Bill of Rights (TABOR) was a very hot topic at the Capitol. TABOR has been introduced in several forms over the years, but all have the following features in common: an amendment to the state's constitution to include strict, formula-driven limitations on state and local governments' ability to raise revenue and allow that formula to be exceeded only through a public referendum. WPA is opposed to the concept of TABOR because the constitution is not the place for complex fiscal policy and TABOR will have a negative impact on the full range of Wisconsin's public programs, including Medicaid where the present system of under-funded services and cost shifting would be made permanent, resulting in a "hidden Medicaid tax" as private pay patients in effect subsidize the Medicaid program through cost shifting.

A new proposal was unveiled in February called the Taxpayer Protection Amendment (TPA), which became the focus of the debate this session. After much anticipation, the measure gained surprisingly little support in the Legislature. On May 4, the Senate failed to pass the TPA by a vote of 11-21, effectively killing it for the session. Previously, the Assembly approved an amended version of the measure in the early hours of April 28 by a vote of 50-48. This differed from earlier versions of TPA and TABOR in that it applied only to state government. Local governments would have been exempt from the revenue controls. Before this vote, a much more restrictive version of the TPA that did apply to local governments failed in the Assembly by a wide margin of 32 in favor and 66 opposed. So, the strict, Colorado-style version of the amendment gained 11 of 33 votes in the Senate and 32 of 99 votes in the Assembly.

Other Bills of Interest to WPA

SB: 128: The "COLA" bill for minimum mental health benefit limits under private insurance policies made little progress this session. The measure came out of the Senate Health Committee on a 5-0 vote with an amendment to phase-in the coverage increase over five years. Nonetheless, Senate leaders refused to schedule the bill for a vote on the Senate floor. The Coalition for Fairness, of which WPA is a member, lobbied heavily to get the bill scheduled and held a well-received press conference on February 22 to call for a floor vote.

SB 226: SB 226 requires parental consent for mental health treatment for children age 14-17. Under current law, children in that age range may refuse treatment and may sign themselves out of treatment. The bill came out of the Legislature late in the session and was signed into law by Governor Doyle as 2005 Wisconsin Act 444. Before passage, the Assembly adopted a significant amendment that eliminates the bill's provisions regarding consent for administration of psychotropic drugs and access to medical records. As amended, current law related to informed consent for drug treatment and access to records is retained.

SB 391: Senate Bill 391 is the major rewrite of Wisconsin's guardianship statutes. An amended version passed the Legislature and was signed into law by Governor Doyle as 2005 Wisconsin Act 387. Among several other provisions, the amended version clarifies that a guardian may consent to the involuntary administration of psychotropic medication only under a court order under the laws relating to protective placement and protective services. The bill establishes an exclusive procedure for involuntary administration of psychotropic medication as a protective service to an individual who has been protectively placed.

Cigarette Tax: The WPA-supported proposal to raise cigarette and chewing

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Legislative Update

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tobacco taxes in order to fund Medicaid and tobacco cessation programs did not gain any traction this session. Proposals were introduced but never made it out of committee. With Medicaid funding once again looking very tight in the next budget, it is likely that similar proposals will be made again next session.

Senate Health Committee Holds Hearing on Housing Issues

On July 13, the Senate Committee on Health, Children, Families, Aging and Long Term Care held a public hearing on community living for people with mental illness. Invited speakers provided an update regarding steps taken to address issues raised at an earlier public hearing in April. Speakers included: Sinikka Santala, administrator of the Division of Disability and Elder Services; Jim Hill, administrator, Milwaukee County Behavioral Health Division; Mitch Vesaas, vice president of Tellurian UCAN, Inc. and past president of NAMI Dane County; Bob Wrenn, Transitional Living Services in Milwaukee; and Shirin Cabraal, Managing Attorney, Disability Rights Wisconsin. A Milwaukee Journal Sentinel article on the hearing can be found at: http://www.jsonline.com/story/index.aspx?id=466974

Profile

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added *good/evil* to his list of dualities. Since graduating from residency earlier this summer, he has taken a job as a psychiatrist with the Wisconsin Department of Corrections. When not at work, he can be found pondering the contents of his book in progress, "*The Existential Clash between Narcissism and Nihilism*," or cultivating trees, perennials and artwork in the acre plot sculpture garden around his Madison home.

By the way, did I mention that Dr. Burg holds first degree black belts in Tamiki Aikido and Zujitzu-Ryu?

Treffert article

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point is that of a clinician and an administrator in a wide variety of public and private, hospital and community, outpatient, and inpatient settings. In each of those settings, the vast majority of patients were voluntary. But mental illness being what it is, in relatively few instances, involuntary or coerced treatment becomes necessary.

In the early 1970s, Wisconsin commitment law was changed to make coerced treatment virtually impossible until a patient was an imminent danger to self or others. It soon became apparent to me that too often, treatment came too late and patients were falling through the cracks.

In 1973 I wrote an article called "Dying With Their Rights On," in which I described a few of the hundreds of cases I catalogued. (TAC's online "Preventable Tragedies" database houses a similar collection.) Many of these "dying with your rights on" cases demonstrate graphically, and tragically, that freedom can be a hazard – or another form of imprisonment – for persons who are obviously ill and in need of treatment; who are not yet dangerous but well on their way to being so; or who, because of that obviously and permeating illness, are unable to care for themselves.

Civil libertarians and other critics refer to these cases as Treffert's "anecdotes." They dislike them. They are "out-liers," not common, and do not represent the mainstream circumstance, these critics say. But the instances are real. These persons, with such tragic outcomes, are not "anecdotes" to their families and loved ones, or to innocent persons or bystanders sometimes harmed by them.

So it was a relief when, in 1999 the MacArthur Coercion Studies systematically, dispassionately, and meticulously examined the nature of – and need for – coerced treatment in an overdue and enlightened fashion. These Coercion Studies provide studies in place of slogans, data in place of diatribe, and recommendations in place of recriminations.

The Coercion Studies revealed that involuntarily committed patients do not invariably deny their illness and protest the hospitalization process. Approximately one half (47 percent) agreed there was no reasonable alternative to hospitalization and 35 percent of patients who were legally committed did not perceive themselves as having been coerced into the hospital.

They reinterviewed 270 of the patients in one sample of the study between four to eight weeks after discharge. More than 50 percent of the patients who said initially that they did not need to be hospitalized reported that, in retrospect, the decision for their hospitalization was the correct one. Thus, the patient's view of hospitalization, even when coerced, can change in a positive direction over time and need not be a lingering deterrent to future care, should that become necessary. The Studies also found a low level of perceived coercion if:

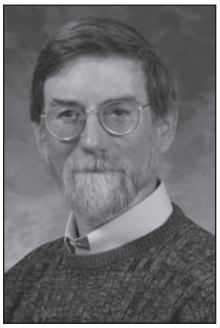
- persuasion and inducement are used, not threats or force;
- others, including friends and family, are involved in the decisionmaking as a form of caring;
- the patient believes others acted out of genuine concern;
- the patient believes he or she was treated respectfully and in good faith;
- the patient was afforded a chance to tell his or her side of the story.

Thus, coerced care need not be an oxymoron. To achieve that, coercion, whenever it is used, must be the least intrusive possible, and should always contain elements of procedural justice such as genuine concern, good faith, respect, listening to the patient's side of the story, and involvement of important persons in the patient's life in the decisionmaking process.

Those elements remind me of the inscription above the door of a mental hospital in Europe: "To cure sometimes – to help often – to comfort always." These studies, and the concept of procedural justice, usefully remind everyone involved in the coerced care transaction that there is a vital human dimension to that stringent legal process.

Medicaid Fee-For-Service and SeniorCare PA Process

By Ronald J. Diamond, MD, and Carrie Gray



The number of different formularies and prior authorization forms required by the various HMOs, PBMs and insurance companies is overwhelming. The information outlined in this article pertains only to Medicaid and BadgerCare fee-for-service recipients and SeniorCare participants. For the most part, Medicaid and BadgerCare fee-for-service has a more open list of available medications, and a much easier process for using non-preferred medications than most other plans. Even so, it is important to understand the plan, know where to look for needed forms, and to know how to use the process to prescribe a prior authorization for a medication not on the state's preferred drug list. Note that Medicaid HMO programs and Medicare Part D PDPs have their own pharmacy benefits and prior authorization procedures and are not covered in this article.

Preferred Drug List

The majority of medications are preferred medications on the Preferred Drug List (PDL) and do not require prior authorization (PA). A recipient can go to any pharmacy to get a prescription filled. Recipients may be charged a $1 co-pay for a generic medication or $3 for a brand name medication. A relatively small number of non-preferred medications require PA. These are medications within drug classes where less expensive and equally efficacious medications may be available. Most medications are available, although non-preferred drugs require a physician to complete the appropriate PA/PDL form and either attach it to the prescription or FAX it to the pharmacy where the recipient will be filling their prescription.

Unlike some of the private HMOs and PBMs (pharmacy benefit managers), the Wisconsin Medicaid Fee for Service program makes most medications available. A preferred drug list, such as the one used for Wisconsin Medicaid fee-for-service means that some medications are preferred and do not require PA, but non-preferred medications are still available if the appropriate PA/PDL Exemption form is completed and approved. This is very different from a formulary system, where a medication that is not on a formulary is simply not available.

The PA process for the Wisconsin Medicaid fee-for-service program uses an electronic process called STAT-PA. In many cases, this process is fast and easy and allows a non-preferred medication to be authorized rapidly with minimum problems for either the prescriber or patient. Pharmacies can enter the information from the PA/PDL form and the PA can be approved quickly if all the information is present and correct.

How to find and fill out a PA/PDL Exemption Request Form

The state is in the process of moving the PA/PDL Exemption forms for all medications to a single web page. Most of the PA/PDL Exemption forms can be found at: *http://dhfs.wisconsin.gov/medicaid/pharmacy/pdl/index.htm*

The forms include:

- PA/PDL for Stimulants and Related Agents — diagnosis restricted
- STAT–PA Worksheet for SSRI Drugs
- PA/PDL for NSAIDs
- PA/PDL for Growth Hormone Drugs
- PA/PDL for Proton Pump Inhibitor Drugs — diagnosis restricted
- PA/PDL Exemption Form
- PA/PDL for Cytokine and CAM Antagonists
- All of the generic SSRIs are available without a PA. The URL for the form for a brand name SSRIs including Lexapro, Pexeva, Paxil CR, and Prozac Weekly is at *http://dhfs.wisconsin.gov/forms/DHCF/HCF11064.pdf*.

Patients stabilized on a stimulant in the Wisconsin Medicaid claims system are grandfathered and allowed to remain on the drug without a PA. Patients on a stimulant for more than 30 days outside the Wisconsin Medicaid system and who have had a measurable, therapeutic response can also remain on the drug, but a PA is required.

Patients stabilized on an SSRI only available as a branded medication can remain on that medication, but a PA is required. The STAT-PA may be approved if the prescriber indicates this is for continuation of a medication.

PA criterion varies depending on the class. In general, it is expected that a preferred medication will be tried before requesting the use of a non-preferred medication. If you have a sound clinical reason for wanting to prescribe a non-preferred medication explain it on the appropriate PA/PDL Exemption form. Failure of an adequate trial of one or more medications on the PDL is generally considered adequate documentation to try a non-preferred medication. On the other hand, general clinician preference for a particular non-preferred medication without documentation for why this medication is required for this patient is not adequate. For most mental health medications, approval can be expected if the reason for the request is documented.

In certain drug classes, diagnosis restrictions are applied. The prescriber should indicate the appropriate diagnosis on the prescription order or the PA/PDL Exemption form. If the medication is being prescribed for a diagnosis outside approved indications, a paper PA is

continued on next page

required and providers must submit peer reviewed medical literature to support the proven efficacy of the requested use of the drug. Diagnosis restricted drug information can be found at *http://dhfs.wisconsin.gov/medicaid4/pharmacy/data_tables/pdfs/diagnosis.pdf*.

Brand Medically Necessary (BMN) PA: Prior Authorization (PA) is required for all brand name medications when a generic equivalent is available. The PA process for BMN is a paper process and may take additional time for the PA to be approved or denied at the state. Prescribers are required to complete and sign the PA/BMNA (*http://dhfs.wisconsin.gov/forms/DHCF/HCF11083.pdf*) and send the form to the pharmacy where the prescription will be filled. In cases where the prescriber is requesting the use of a brand name medication when a generic is available, the burden of proof is higher because the FDA has determined that the drugs are equivalent.

What happens if Prior Authorization is NOT approved.
Prescribers should begin by contacting Provider Services at 800.947.9627 if they have problems with a prior authorization. If you are not able to resolve the situation by contacting Provider Services, you may contact Carrie Gray at 608.266.3901 or via e-mail at *graycl@dhfs.state.wi.us*. If the PA is denied, a recipient can appeal the decision.

A sample PA/PDL Exemption form is shown on page 23.

WPA Conference — A Focus on Biological Issues

By Richard P. Barthel, MD – Chair, Conference Coordinating Committee

"Biological Issues" were the focus of the WPA 2006 conference, held at the American Club in Kohler. Conference Chair **Molli Rolli, MD**, with major assistance from **Jerry Halverson, MD**, engaged talented Wisconsin resources and guest speaker **Bradley Peterson, MD**, to present a cutting edge look at a mix of neuropsychiatric issues.

The focus of Friday morning's presentations was neuroimaging. **Robert Risinger, MD**, (Medical College of Wisconsin) and **Darold Treffert, MD**, (St. Agnes Hospital) presented fascinating views of neuroimaging in specialty areas of drug dependence and the "savant" syndrome. As a cap to the morning, the Charles Landis Memorial Lecture returned to the WPA venue. This lecture honors the memory of the long-time director of mental health services in Milwaukee County. Fittingly, Dr. Peterson – a Milwaukee area native – was the presenter. Currently the Suzanne Crosby Murphy Professor of Child Psychiatry at Columbia in New York, Dr. Peterson is an internationally respected researcher in neuroimaging. His wide-ranging review of "modalities and methodologies" was a summarizing cap to the earlier presentations.

The luncheon business meeting was the forum used by WPA President **Ed Krall, MD**, (Marshfield) to announce the new strategic plan for the WPA (discussed in his President's column) and to poll members present about the site and timing of the yearly meeting.

Afternoon presentations addressed "brain stimulation" as an intervention for psychiatry. Three University of Wisconsin faculty – **Michael Peterson, MD**, and **Jerry Halverson, MD**, of the Department of Psychiatry, and **Erwin Montgomery, MD**, Professor of Neurology and director of the Movement Disorders program at UW – were the speakers. They reviewed the research and presented experience from the UW programs for the use of Transcranial Magnetic Stimulation (TMS), Vagus Nerve Stimulation (VNS), and Deep Brain Stimulation (DBS) in affective and other disorders. All speakers indicated that these treatments will become more common in our practices over the next few years.

Friday evening was a time of celebration to salute retiring Executive Director **Ed Levin, Esq**. for his long and faithful service to the WPA. Ed and his family were honored at a reception (see previous issue), and multiple presentations by past and current officers highlighted his contributions over time. Also on Friday evening was a presentation by Dr. Bradley Peterson for the Wisconsin Council of Child and Adolescent Psychiatry (WCCAP), which continued their recent tradition of holding their yearly meeting in conjunction with the WPA. Dr Peterson talked about his carefully thought out neuroimaging studies and the other clinical research that has led to our current developmental understanding of Tourette syndrome.

Saturday morning, there was a split focus in the presentations. **Timothy Jeurgens, MD**, (UW Psychiatry) began the "biorhythms" section by addressing the psychiatric aspects of sleep disorders from his perspective as director of the Madison VA sleep laboratory. His UW colleague, **Art Walaszek, MD**, then addressed the often difficult problem of management of behavioral symptoms in dementia.

The conference closing section was on the "attention deficit disorders." Dr. Bradley Peterson reviewed the neuroimaging of the attentional disorders, with an emphasis on the developmental aspects across the life span. **Mariellen Fischer, PhD**, (Professor of Neurology at the Medical College of Wisconsin in Neuropsychology) presented data from her internationally known long term follow-up study, and WPA member **Marjorie Hawkins, MD**, discussed the treatment of adults with "ADD".

Audience participation was strong throughout the conference and feedback about structure and content was positive. As always, the officers and members of the Conference Coordinating Committee are eager for input on our conferences. Please contact the office in Madison to provide your ideas or e-mail me directly at *rbarthel@mcw.edu*.

Wisdom *continued from page 2*

Second, most everyone agrees that preventing adolescent pregnancy is a high public priority. Yet when a girl does give planned or unplanned birth, she and her baby are supported by a variety of educational and social services that have constituencies. Adolescent parenthood is supported politically by the far right as preferable to abortion and by the far left as a cultural procreative right.

Without question, much headway has been made in the prevention of a number of diseases. But our service economy thrives on things going wrong. When it comes to social problems - and military and natural disasters - powerful forces divert attention from preventing them. In addition to inertia, there are active forces that resist preventing problems of all kinds.

In my own life and the lives of my friends and colleagues, prevention has been a high priority. Perhaps wisdom comes with aging, but it does not take decades of experience to know that an ounce of prevention is better than a pound of cure – except when you sell the cure!

Vagus Nerve Stimulation: One Year of Experience

By Jerry L. Halverson, MD

Vagus Nerve Stimulation was approved by the FDA for treatment-resistant depression almost one year ago. VNS therapy represents, arguably, the most significant advance in treating mood disorders in over 20 years. Such an aggressive departure from treatment as usual is rarely easily accepted, and VNS has been no different. Rather than being met with open arms as a needed new addition to the armamentarium, neurostimulation for refractory depression in the form of VNS therapy has been met with substantial resistance by insurance companies and also some of our colleagues. Some say that the evidence is not strong enough to warrant the risk and cost and these people continue to recommend treatment as usual (ECT, creative polypharmacy and therapies), which have even less "evidence" available for efficacy in this population. I have a research and clinical interest in brain stimulation in mood disorders and have had many patients referred to me for evaluation for VNS implantation. Regardless of what insurance companies will tell you, I have had many (8) patients implanted with VNS in this state who have been reimbursed by many of those same insurers. That is not to say that obtaining coverage has been easy. The denial/appeal process can take up to a year to complete, and is filled with onerous paperwork for the doctor and a rollercoaster of emotions for the patients. Almost one year into my experience with VNS, I have seen evidence that the implant is worth all of the trouble. I have seen palpable and measurable affective and anxiety improvement in MOST of my implanted patients. Whether the improvements will last is yet to be seen. What I have seen and experienced in my own practice has been impressive, especially considering the refractory nature of these patients. As far as the benefit that I have seen, it is not like "turning on a light"; it is a more subtle change. It is not instantaneous, but rather a gradual change. The "bad days" seem to occur less frequently, and aren't quite as "bad." Sleep improves. Energy improves. Quality of life improves. (I like to use scales!) These responses have been enough to change lives and outlooks. I am excited to see if this "early response" (my first implant is only 9 months out) plateaus or grows. I have seen enough in my small population to convince me that it is definitely worth a try in patients where nothing else has worked. The evidence base is growing everyday. As far as risks to weigh against the possible benefits, the risks of the procedure are minimal and VNS has been safely used in epilepsy for over 10 years. Depression can lead to death by suicide and worsening comorbid medical problems. Depression is a very serious medical problem that in my judgment justifies aggressive treatment. All of my VNS patients' one-year experience with VNS has been positive. They feel that the implant has been beneficial, and they would all do it again. My one-year experience with VNS has been positive. I have seen promising responses. I am looking forward to the next year, where hopefully more patients will be implanted and we will see more success stories. Is it worth it? Ask your long suffering patients and their families, not the insurance company or their agents.

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WPA Early Career Psychiatrist
Southern Chapter
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Resistant Depression Program
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VNS Dosing Trial at UW
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School of Medicine and Public Health
jhalverson@wisc.edu

Area 4 Council Meeting: Minutes

By Clarence Chou, MD

Kansas City, MO
July 29-30, 2006

The Area 4 Council met in Kansas City on July 29-30, 2006. Presiding was Jo-Ellen Ryall of Missouri. Guests included the current speaker Michael Blumenfield, MD, and the speaker-elect Jeffrey Akaka, MD. Nicholas Meyers of APA government relations also was in attendance. There was also a reception for Bob Moore, a Democratic Representative from Kansas.

Prior to the Council meeting, there was a special meeting of the women's caucus, with representatives of 9 states present, including some MITs. An award was presented to Ron Burd, MD, for his assistance and support of the initiative.

The treasurer, Daniel Anzia, MD, reported no activity in the past quarter. Area 4 remains financially solvent. Trustee Sid Weissman, MD, reiterated President Ruiz's themes of humane care, parity and access to care, which will be the themes of the next annual meeting of the APA to be held in San Diego, California in May 2007. It was noted that only 5000 of the 18,000 attendees at the annual meeting in Toronto were APA members. Discussion was held as to why the figure was so low for APA members, and what would be needed to increase attendance of this group. There was a mention of increasing the representation of the assembly at the executive committee level, with the potential for the speaker-elect to have a vote. The issue of state and national PACs was discussed. JohnWernert, MD, gave the reports of the legislative council and the APA PAC, announcing changes in leadership in the former and continuing efforts to connect with legislators on a national level in the latter. Judith Kashtan, MD, led a lengthy discussion of the function of the Public Affairs Council and its mission. The history of the function of the council and later changes in its role were given, with further discussion as to how to make it relevant and worthwhile. It was felt that some clarification of the charge of the council was needed. There was a lively discussion about action papers. There had been a call for increasing the production of papers from the Area council. There was a sense by some members that the Area was being criticized for producing fewer papers than other councils. The discussion then moved to addressing the function of action papers, the actions requested by them and the timeliness of papers. The issue of ownership was also discussed again. An Area 4 task force was appointed to study this issue and to come up with recommendations.

Michael Blumenfield gave the AEC report. He was given support by the council to proceed in developing an electronic voting system, similar to the one he had used while representing the APA at the AMA meeting in Chicago. There was discussion regarding solicitation of assembly members for PAC and Foundation funds at the assembly meetings (it will no longer be allowed).

Nick Meyers gave the legislative report, talking about initiatives in different states, addressing the scope of practice issue in particular. The situation in Ohio was shared by their representatives. Area 4 was noted to be far more involved politically than other Areas. The state reports were presented. Various political races and their implications were addressed, as well as the training of non-psychiatric physicians to more effectively care for their patients with psychiatric disorders. Funding remains a challenge, as well as parity and access to medications, among other issues.

The next Area 4 meeting will be held during the next assembly meeting in Washington D.C. during the first weekend in November 2006.

Treating Pediatric Psychiatric Illness With Selective Serotonin Reuptake Inhibitors

By Russell Scheffer, MD

Selective serotonin reuptake inhibitors (SSRIs) have been approved for a variety of conditions in adults and, in some instances, children. Hundreds of uses have been documented in the published literature. In general, the FDA registration trials for SSRIs demonstrated approximately a 60 to 70 percent response rate for major depression. Unfortunately, there was a very high placebo response rate. This high placebo response rate in youth is thought to be a direct result of the fact that in clinical trials the positive interactions with a variety of clinicians, mobilization of the family to address the youth's problems and safety net all result in a very high level of care. The high placebo response rate and waxing and waning of symptom severity have resulted in a resounding endorsement of placebo-controlled trials for youth with psychiatric illnesses. In fact, we often have parents who want us to violate protocols by giving placebo first.

In the last 2 to 3 years much concern has arisen regarding the use of the SSRIs and buproprion. One area of concern is that of suicidal thoughts. In more than 20 placebo-controlled trials of antidepressants in youth with more than 4,000 patients, no one committed suicide. What was found was, on average, a difference between 2 percent (placebo) and 4 percent (medication) of patients who expressed suicidal thoughts. In these same studies there were statistically significant decreases in instrument measures of suicidality in the medication group as compared to the placebo group. In addition, consistent data from across the country and western world indicate that since the introduction of SSRIs the suicide rate has fallen steadily after a steady rise since World War II. This decline since the early 1990s has no other logical explanation. Other supporting data include the fact that when census tracts are examined, the increased rate of SSRIs prescriptions is inversely related to the suicide rate.

Even given these facts, psychiatric illnesses often are associated with suicidality. Patients should be monitored, informed of emergency services and told to discuss these thoughts, should they arise, with a responsible adult. Paroxetine and venlafaxine appeared to be somewhat more problematic in the onset of suicidality data and should be used only after other medications have been tried.An adequate trial of an antidepressant is 6 to 12 weeks. Patients should be maintained for 9 to 12 months after symptoms improve.

Chart — Pediatric use of antidepressants

Generic	Brand Name	Indications	Starting dose	Target dose
fluoxetine	Prozac	MD, OCD	5-10 mg/day	10-40 mg/day
sertraline	Zoloft	OCD	12.5-25	50-100
paroxetine	Paxil	NI	Last line	
citralopram	Celexa	NI	5-10 mg/day	10-40 mg/day
escitralopram	Lexapro	NI	5 mg/day	10-20 mg/day
buproprion	Wellbutrin XL	NI	100 bid	150 bid
fluvoxamine	Luvox	OCD	25 mg/day	100-300 mg/day

For more information: Child and Adolescent Psychiatry and Behavioral Medicine Center 414.266.2932.

Russell Scheffer, MD, is the Chucker Aring Chair in Child and Adolescent Psychiatry and medical director of Psychiatry at Children's Hospital of Wisconsin. He also is an associate professor of Psychiatry at the Medical College of Wisconsin.

2006 Membership Transactions

New MIT
Jennifer M. Alt, MD; UW Madison Medical School
Jonathan E. Benaknin, MD; Medical College of Wisconsin – Milwaukee
Travis J. Fisher, MD; Medical College of Wisconsin – Milwaukee
George H. Lind, MD; Medical College of Wisconsin – Milwaukee
Caroline N. Palmer, MD; Medical College of Wisconsin – Milwaukee
Keyur H. Parikh, MD; Medical College of Wisconsin – Milwaukee
Claudia L. Reardon, MD; UW Madison Medical School

Reinstate MIT
Marie A. Casey, MD

Reinstate GM
Ashraf N. Ahmed, MD
Bruce R. Stevens, MD

Reinstate and Upgrade to GM
Lidija Petrovic-Dovat, MD

Transfer to WI - MIT
Charlotte O. Ladd, MD

Transfer to WI - GM
Shehzad Khan Niazi, MD

Permanent Inactive Status
CE McDaniel Moore, MD

Members of the Wisconsin District Branch Serving on APA Councils, Boards, Committees and Components

Jon Berlin, MD	Committee on Psychiatric Dimensions of Disasters
Carlyle Chan, MD	Council of Medical Specialty Societies
	Ad Hoc Work Group on Information Systems
Clarence Chou, MD	Assembly Rules Committee
Jerry Halverson, MD	APA/AMA Delegation
Harold Harsch, MD	Medicare Advisory Corresponding Committee
Steven Moffic, MD	Committee on Reimbursement for Psychiatric Care
Harry Prosen, MD	Council on Advocacy and Public Policy
Laura Roberts, MD	Task Force to Update the Ethics Annotations Ethics Committee APPI Board of Directors Council on Medical Education and Lifelong Learning Corresponding Committee on Research Ethics Council on Research
Marcia Slattery, MD, MHS	Corresponding Committee on Health Services Research Corresponding Committee on Mental Health and Schools Council on Children, Adolescents and Their Families

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Clinical Director
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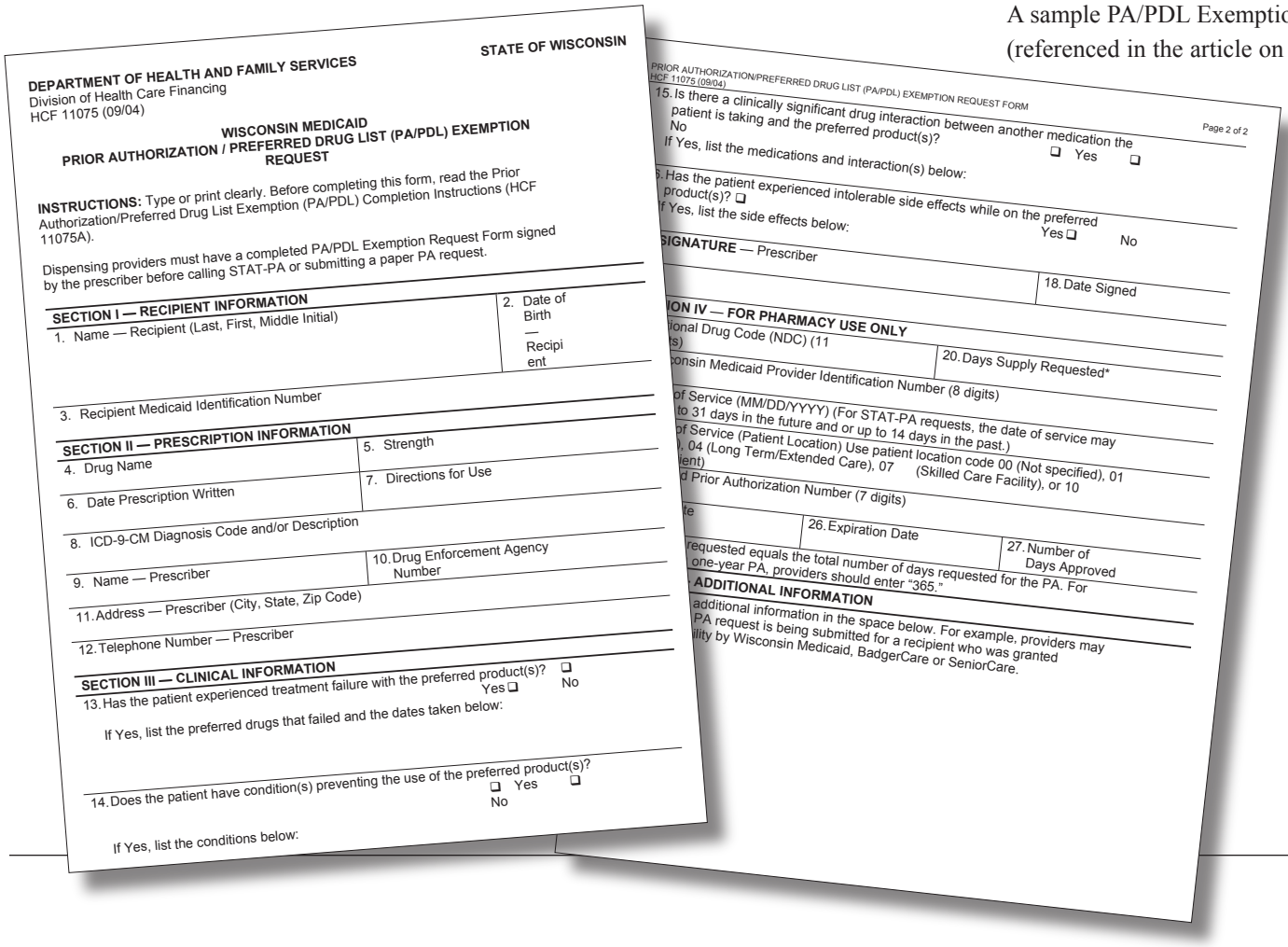
1100 Lakeview Dr.
Wausau, WI 54403

Fax: 715.842.3630; Phone: 715.848.4455; E-mail: gticho@norcen.org



DEPARTMENT OF HEALTH AND FAMILY SERVICES
Division of Health Care Financing
HCF 11075 (09/04)

STATE OF WISCONSIN

WISCONSIN MEDICAID
PRIOR AUTHORIZATION / PREFERRED DRUG LIST (PA/PDL) EXEMPTION REQUEST

INSTRUCTIONS: Type or print clearly. Before completing this form, read the Prior Authorization/Preferred Drug List Exemption (PA/PDL) Completion Instructions (HCF 11075A).

Dispensing providers must have a completed PA/PDL Exemption Request Form signed by the prescriber before calling STAT-PA or submitting a paper PA request.

SECTION I — RECIPIENT INFORMATION
1. Name — Recipient (Last, First, Middle Initial)
2. Date of Birth — Recipient
3. Recipient Medicaid Identification Number

SECTION II — PRESCRIPTION INFORMATION
4. Drug Name
5. Strength
6. Date Prescription Written
7. Directions for Use
8. ICD-9-CM Diagnosis Code and/or Description
9. Name — Prescriber
10. Drug Enforcement Agency Number
11. Address — Prescriber (City, State, Zip Code)
12. Telephone Number — Prescriber

SECTION III — CLINICAL INFORMATION
13. Has the patient experienced treatment failure with the preferred product(s)? ❑ Yes ❑ No
If Yes, list the preferred drugs that failed and the dates taken below:
14. Does the patient have condition(s) preventing the use of the preferred product(s)? ❑ Yes ❑ No
If Yes, list the conditions below:

PRIOR AUTHORIZATION/PREFERRED DRUG LIST (PA/PDL) EXEMPTION REQUEST FORM
HCF 11075 (09/04)
Page 2 of 2

15. Is there a clinically significant drug interaction between another medication the patient is taking and the preferred product(s)? ❑ Yes ❑ No
If Yes, list the medications and interaction(s) below:
16. Has the patient experienced intolerable side effects while on the preferred product(s)? ❑ Yes ❑ No
If Yes, list the side effects below:
SIGNATURE — Prescriber
18. Date Signed
SECTION IV — FOR PHARMACY USE ONLY
National Drug Code (NDC) (11 digits)
20. Days Supply Requested*
Wisconsin Medicaid Provider Identification Number (8 digits)
Date of Service (MM/DD/YYYY) (For STAT-PA requests, the date of service may be up to 31 days in the future and or up to 14 days in the past.)
Place of Service (Patient Location) Use patient location code 00 (Not specified), 01 (Inpatient), 04 (Long Term/Extended Care), 07 (Skilled Care Facility), or 10
Prior Authorization Number (7 digits)
26. Expiration Date
27. Number of Days Approved
*If the number requested equals the total number of days requested for the PA. For example, a one-year PA, providers should enter "365."
ADDITIONAL INFORMATION
Use additional information in the space below. For example, providers may indicate if a PA request is being submitted for a recipient who was granted eligibility by Wisconsin Medicaid, BadgerCare or SeniorCare.

A sample PA/PDL Exemption form (referenced in the article on page 16.)

Calendar of Professional & Clinically Oriented Events

September 14, 2006
Menninger Continuing
Education Event
Minneapolis Airport Marriott
Bloomington, MN

October 5-8, 2006
APA Institute on Psychiatric Services
Marriott Marquis Hotel
New York, NY

October 13-14, 2006
Fall 2006 Psychiatric Update
Transcendent Tangible Truths
from Talented Translucent Teachers
UW School of Medicine and Public Health
and Madison Institute of Medicine, Inc.
Monona Terrace and Convention Center
Madison, WI

October 20-22, 2006
2006 Annual Meeting
Wisconsin Neurological Society
Kalahari Resort
Wisconsin Dells, WI

October 24-29, 2006
American Academy of Child
and Adolescent Psychiatry
San Diego Marriott Hotel and Marina
San Diego, CA

November 11-14, 2006
2006 Interim Meeting
American Medical Association
Bally's Hotel
Las Vegas, NV

March 1-4, 2007
2007 Annual Meeting
American Association for Geriatric Psychiatry
New Orleans, LA

March 2-3, 2007
Spring 2007 Psychiatric Update
UW School of Medicine and
Public Health and Madison
Institute of Medicine, Inc.
Monona Terrace and Convention Center
Madison, WI

March 30-31, 2007
2007 Annual Conference
Wisconsin Psychiatric Association
Osthoff Resort
Elkhart Lake, WI

April 27-28, 2007
2007 Annual Meeting
Wisconsin Medical Society
Monona Terrace Convention Center
Madison, WI

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 Editorial Office, WPA, PO Box 1109, Madison, WI 53701, Fax 608.283.5424.

Wisconsin Psychiatric Association
PO Box 1109
Madison, WI 53701

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