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One Size Fits One: Approaches to School Violence

By Chris Morano, PhD

Over the past several weeks, much has been written and said about school violence. As the director of a mobile crisis team for youth and families in Milwaukee, I have talked with numerous children and teens who say their greatest fear is walking from home to the bus stop, to school, or back. Urban violence is a raw reality, but now there seems to be renewed interest in safety at schools, and if you subscribe to the views espoused in public forums like the media, you will no doubt be concerned about the burgeoning pattern of serious violence in schools. You may also have witnessed the march of experts who have detailed their plan to address this issue. Anxiety disorders are now the number 1 diagnosis for youth, according to numerous sources, and kids' apprehensions about school fuel this phenomenon. The purpose of this article is two-fold: 1) to dispel the myth that youth and school violence is increasing, and 2) to discuss a multi-pronged approach to a complex problem.

First, we must examine available data on the problem. Many sources have identified that, much like youth suicide, youth violence toward others has actually decreased over the past decade or so. Nationally, the US Department of Education, working with the Justice Department, has indicated that the rate of serious school violence has gone down over 40 percent since the early 1990s (US Dept. of Education, 2005). Lest one think that our state or our municipalities are insulated in aggression, and have not experienced this precipitous drop like the rest of the country, statistics from the Milwaukee County Children's Court show that teen violence in general dropped about 25 percent from 2001 to 2005. Bullying, however remains a problem, and occurs at an alarming frequency, most often right under the eye of supervising adults (Bully Project, 2004). As an aside, youth suicide has also decreased by about 25 percent in the past decade or so (CDC, 2005). The CDC suggested several factors they believe contribute to lower rates of youth suicide these days, including better access to community mental health options, more acceptance of alternative lifestyles and less access to firearms. A sound solution-focused approach should lead us to consider what factors contributed to the drop in youth violence, and how we can enhance those factors to do even better. I posit several below.

Second, the troubling phenomenon of school violence is not a uniform one. Each of the tragic incidents of the past few months has its own terrible set of predicates, each suggestive of multi-layered responses or solutions to prevent further episodes. These multiple-determined events warrant multi-pronged reactions by the community. Some involve disgruntled students with authority issues. Others emanate from youth who have experienced years of intimidation and rejection. One awful episode in Pennsylvania occurred at the hands of an adult who appeared to have no direct relationship to the school, but a history of violence toward young girls. The commonality between all instances might be that they occurred in a setting with a vulnerable population, and may spring from a sense of powerlessness on the part of the perpetrator.

There have been many forums and media excursions into what to do about such violence. Most have emphasized some key component related to a particular event. I submit that an approach to school violence has better odds at success if it contains elements of 1) preventative/proactive strategies, and 2) reactive/crisis response. Kids need to feel safe at school, and a combination of subtle as well as obvious measures may be the path to enhancing their sense of security.

Of course, there are many steps schools and communities can take that involve structured, visible safety and prevention planning. Schools can enlist undercover law enforcement personnel, employ metal detectors and lock doors if needed. One report estimated that over half of US schools lock doors now during operation hours. While these strategies can increase safety, they can also have the unintended effect of actually increasing students' apprehension. One school system in Texas took it to the next level, and has begun training students to disrupt and fight back against aggressors

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Saying Goodbye to CHS Advocate & Friend, Ed Levin, September 28, 2006

Reprinted from the University Wisconsin Milwaukee, College of Health Sciences Web site.

By Randall S. Lambrecht, PhD
Dean and Professor
College of Health Sciences
The University of Wisconsin-Milwaukee

A poem written by his daughter, Lisa, hung framed in his office at College of Health Sciences (CHS), the calligraphy was in her hand. It read: "A man is only complete when he has a true friend to understand him, to share all his passions and sorrows with, and to stand by him throughout his life." Ed Levin was such a friend.

Mr. Levin was a tireless promoter of College of Health Sciences. In his five-year tenure as Special Assistant to the Dean, he drew on his extensive network of colleagues and applied his savvy business skills to forge new partnerships and to bring greater visibility to the College and to the University. Prior to his work at CHS, he held a similar post for the School of Education, giving nearly 20 years of dedicated service to UW-Milwaukee.

For more than three decades, Mr. Levin was an attorney in private practice specializing in corporate real estate law. During this time, he taught law at UW-Madison and was a member of the Governor's Health Policy Council. He served as commissioner of Milwaukee County Human Relations Social Development Commission, as chair of the Milwaukee County Human Rights Commission, and as state counsel for the Wisconsin Psychiatric Association. Working closely with Milwaukee's Fr. Groppi, Mr. Levin was a diligent campaigner of local civil rights efforts.

Mr. Levin passed away in the presence of his beloved family on September 24th. Services were held (the week of September 25) at Temple Menorah. Mr. Levin's grandson, Sam, sang the traditional El Mal'ei Rachamim prayer in Hebrew, while his granddaughter, Sophie, translated in English. As a last act of promotion for the College, his family created the "Ed Levin Memorial" benefiting College of Health Sciences. He is remembered as a consummate teacher, a staunch supporter of the underrepresented, and as a dear friend.

Thank you once again, Ed.

Ed Levin with his grandchildren, Sam and Sophie.

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President's Comments

By Edward Krall, MD

The Wisconsin Psychiatric Association was approached by an official in the Doyle administration and asked to consider advocating for a change in the Medicaid reimbursement system for mental health. It was their impression that while insiders in the administration want to advocate for change, they can't do as much as they would like because we are silent on this issue. Other groups such as the dentists are very active and already lobbying hard to ask for changes with the new budget cycle.

So we agreed. On November 6, 2006, a group made up of Mike Blumenfeld, Karen Carney, our acting Executive Director, Molli Rolli, Jerry Halverson, Rachel Molander, resident, and I met with Kevin R. Hayden, Administrator, Division of Health Care Financing, and Sinikka Santala, Administrator, Division of Disability and Elder Services, at the Department of Health and Family Services (DHFS).

Our Issues

Our approach was to advocate for our members and our patients. We wanted this to be a friendly, open discussion to educate and find out DHFS's position and how we as an organization could work with them.

We represented different practices from urban to rural, academic to private, individual to group. Our discussion points were as follows:

- There has been no change in the Medicaid fee schedule for psychiatry since 2002.
- MA is not covering costs of providers and inadequate reimbursements result in fewer providers being willing to see Medicaid recipients, which in turn results in poor access and poor care.
- Nurse practitioners and primary care providers end up providing care by default, which they may not be comfortable with or competent to do.

The DHFS Position

Mr. Hayden had been in his post for 3 months and 3 days, having recently replaced Mark Moody. He previously was the president of Dean Health Care and has also served as the administrator of a mental health group and is aware of reimbursement concerns for mental health.

He acknowledged that there is an access problem and admitted that there has been no rate increase for a number of years. He alluded to incentive options with incremental adjustments in areas of need but he stated emphatically that, in his opinion "The answer is not just to throw money at the problems." There are multiple groups looking for increases. The short answer was that there would be no increases. However, he posed this question, "How can WPA and DHFS partner to improve care of their recipients and our patients?"

He suggested engaging in a dialogue on constructive programs to get at the issues and together to develop parameters for getting at solutions. He is interested in new "concept designs."

He challenged us. At the WPA level, what can we do to help advocate for and sell Medicaid to our members? Are we willing to 'evangelize' with our members? He is very big on teaching and educational partnerships. Here are some of his thoughts.

- Work with DFHS to develop strategic educational programs for rural primary care providers to partner with psychiatry and extend care to those in need. Dean did this with its primary care providers and apparently was quite successful.
- How can we leverage our overextended capacity to manage and triage patients with clear protocols for primary care to utilize?
- What about using telepsychiatry to link resources from areas of surplus to those with scarcity?
- He is open to a multi-year study with us to look at opportunities like psychiatric involvement with the Health Care Advantage in Dane County or grant proposals for providing care to children and adolescents in rural areas similar to what has been done in dentistry.
- There has been no medical director at the state level for mental health and substance abuse issues. They are developing a proposal for this position.

DHFS Concerns

Mr. Hayden and Ms. Santala outlined some of the areas of need on the DHFS radar screen.

- Rural mental health. There is a critical shortage of services in rural areas; 62 of 72 counties have shortages of mental health providers. The county-based system clearly is inadequate
- Atypical antipsychotics—The cost of and management of these medications are an ongoing concern. They value our input on this and emphasize the need to continue to be active.
- At a county level, there is a need for better crisis intervention services for hospital alternatives.
- DHFS is developing a Comprehensive Community Services program (CCS) that is intended to be an intermediate between Community Support Program (CSP) and outpatient treatment. This is a new benefit that will offer a kind of case management.
- Long-term care in the next 5 years will get a comprehensive overhaul. DHFS

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President's Message

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recognizes that elderly with substance abuse and mental health issues do not get adequate treatment. Of individuals with developmental disorders, 40 percent have mental health issues that need to be addressed.

- In Milwaukee, SED (severely emotionally disturbed) kids will get good wraparound care but other kids, like those in the juvenile justice system, do not get the care they need.

Next Steps

Ms. Santala observed that this was the first time that our Association, and in fact, the first time our profession, has been represented at the DHFS table. She emphasized that we need to be visible and active participants if we are to be heard. This is a good start.

They would welcome us back more frequently and are willing to brainstorm with us about 'designing a reconfigured model of care.' We are planning to go back in March.

Mr. Haden will talk with Helene Nelson, the Secretary for Health and Human Services, in the next week regarding financial indicators for our request of a rate increase.

We are also planning to meet with Jim Johnston, administrator for the Governor's staff, in the Department of Administration (DOA) hopefully before Thanksgiving as they are developing a budget for the next year, again with the intent of educating and advocating.

Mike Blumenfeld, our legislative lobbyist, commented that this was a very positive meeting. We have their ears. We have an excellent opportunity to partner. This gives us the chance to be innovative with areas of identified need and better serve our patients. The WPA needs its members now more then ever to step forward and work with the Council in this endeavor.

School Violence

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with guns. This idea, along with arming teachers, is dubious. It is hard enough for teachers to inculcate the day's lesson, and get students to attend to it, let alone protect against potential guerrilla tactics. Even SWAT teams are sometimes confounded in such situations.

Other measures could involve more deliberate and proactive components that address some of the roots of student aggression. To begin, schools should focus on developing meaningful relationships and connections with families and communities. Students who demonstrate early warning signs of trouble (isolation, rejection, victimizing behaviors, intolerance of differences) could be identified and helped with early intervention strategies targeting bullying dynamics. Students could be encouraged to form leadership groups (call them "Young Heroes"), to mentor and support peers, and provide a link to school administration. Administrators could more fully support mental health, school social work, guidance and other staff to more deeply impact students who show early warning signs, and dialogue proactively with kids about fear, violence and safety concerns. Further, schools could more directly facilitate connections between staff and students, by offering training in basic communication, to improve trust. It's very challenging to have a difficult, but crucial, conversation with a youth unless you have some "relationship capital" in the bank. The time to talk with youth is now, six months prior to a problem, not when the problem is erupting. Finally, schools should create, and practice, a safety plan. Everyone loses some of their planning and reactive capacity in a crisis, and rehearsal is one of the best antidotes.

In short, our children are our most precious assets, and we entrust them to schools every day. Serious school violence and rampage killings have captured the national attention of late. There has been increasing alarm about the safety of today's school, and to some extent it is an unfounded alarm. Sometimes, as professionals, we are called on to lend meaning and support in times of high challenge. This is a daunting task, but in the case of school violence, we know a few things that should serve as a guide:

- The CDC and other sources note that violence, self- and other-directed in youth, has decreased over the past decade or so.
- Community-based and individually tailored approaches have shown sound promise in helping youth with serious emotional disturbance, and have likely contributed to the decline in overall youth violence.

When tragedy strikes, one of the most profoundly comforting experiences a child can have is the calm and certitude of the adults around them who matter the most. Every effort should be made to help, teach and support schools, communities and families early in the sequence, before tragedy strikes. Keep recent events in perspective, work with schools and communities using a multifaceted plan, and create a positive expectation of the future for youth. The bottom line is that kids who feel safer, learn better.

Chris Morano, PhD—Dr. Morano is the Clinical Program Director for the Mobile Urgent Treatment Team (MUTT) of Wraparound and Milwaukee County, a service of Milwaukee County aimed at responding to child and family crises in the community. Raised in upstate New York, Dr. Morano completed master's and doctoral programs at the University of Wisconsin-Milwaukee. Dr. Morano is a licensed psychologist and has worked in various capacities in the mental health field over the last 15 years. Currently with Milwaukee County, he has been employed at both private and public psychiatric facilities, and is a consultant for the Children's Court of Milwaukee, as well as with the Wisconsin State Disability Bureau. Dr. Morano was recently appointed to the National Association of Counties Board for Early Childhood Development. In addition to community mental health for children, he is also very interested in forensic psychology, and consults frequently with the courts on issues of competency to stand trial, waiver and NGRI. Dr. Morano has published research on adolescent suicidal behavior, and authored articles on community mental health issues for high-risk children. Finally, he has presented locally and nationally on the mental health and behavioral needs of high-risk youth.

The Other Dual Diagnosis: Part 2

By Nancy Shook, RN, LCSW, APNP

Part 1 of this article, published in the summer 2005 issue of Wisconsin Psychiatrist *discussed the problems and challenges associated with providing accurate diagnosis and care to individuals with the "other" dual diagnosis. Part 2 discusses some of the benefits of providing this care, and makes some recommendations.*

The term "dual diagnosis" in psychiatric circles usually refers to an individual with both a primary mental illness and a substance-related disorder. There is, however, another dual diagnosis: that of mental illness combined with a developmental disability.

What recommendations can be made regarding the provision of comprehensive and appropriate mental health care to persons dually diagnosed with developmental disabilities and mental illness?

First: One significant challenge to obtaining psychiatric treatment for persons with developmental disabilities is the inadequate reimbursement under the current Medical Assistance program. This disincentive is especially acute when the person's needs require more than the average time allotment and may require environmental or personnel modifications. Increasing reimbursement and adding more flexible billing arrangements require advocacy for policy reforms.

Second: Psychiatrists and other mental health care providers need access to necessary information about developmental disabilities. They need to know about community support systems for people with developmental disabilities. Extensive educational material is available: internet resources, classes, seminars and interested specialists. This information is not always well disseminated to the psychiatric community. In some cases it is not available in a format (time, dates, locations, or certification for physician continuing education) that promotes use by busy professionals. Creating opportunities for specialists providing day-to-day support to individuals with developmental disabilities and psychiatrists and other mental health practitioners to share perspectives, knowledge, and practice tips would "demystify" the two aspects of this dual diagnosis for both groups.

Third: The settings that are available for providing mental health care are sometimes not well designed for persons with developmental disabilities. Larger rooms may be needed to accommodate presence of support teams at appointments. Some individuals with developmental disabilities may need room to move about or maintain additional personal space during the appointment. Accessible entrances and facilities are necessary for people who require physical accessibility due to brain injury, cerebral palsy or other mobility problems. Design of rooms and furnishings needs to be done with consideration to safety for people with unusual behaviors. Reception personnel need methods to adapt their interactions to meet the needs of people with a dual diagnosis. Waiting rooms and clinic rooms need to have entertainment activities that are cognitively, developmentally and age appropriate. Information about diagnoses and treatments needs to be provided in forms accessible to persons who may not read, or whose cognitive level is below the average.

Fourth: Ability to provide effective psychiatric services to persons with developmental disabilities is greatly improved by a knowledge of how the developmental disability community support system functions. One needs to know how medications and treatments are delivered in the supported living community and what resources are available to provide assistance to the person, provider and team. The presence of community behavioral support specialists can provide adjunct support in modifying behaviors and can help patients learn to generalize desired behaviors in different settings. Crisis support teams and "safe houses" can help avoid unnecessary institutionalization during behavioral or environmental crises.

What are the benefits of providing psychiatric care to persons who are dually diagnosed with developmental disabilities and mental illness?

There are many benefits to be gained from providing psychiatric care to persons dually diagnosed with developmental disabilities and mental illness. Access to appropriate psychiatric care can make the difference between successful community living versus a lifetime in an institution or in a very restricted setting. Successful treatment for mental illness can be the beginning of wonderful new life opportunities. Observing the person's symptoms decrease and watching him or her make progress toward life goals can be very professionally satisfying for providers and teams.

The presence of support teams in a person's life can help to improve compliance with medication regimens. It can also improve reliability of attendance at appointments and provide assistance in helping a person learn new coping strategies. Collaborating with support providers can make the role of the psychiatric provider much more satisfying and less stressful. Knowing how to best utilize all the members of the support team can result in better care for the individual involved.

Community support providers can provide helpful assistance and suggestions. They may be able to give important information about the person's behavioral history, previous reactions to medication, or periods in the person's life when they were more emotionally and behavior-

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Podcasting Part 2: Creating Your Own Podcast

By S. G. Zelenski, DO, PhD

Okay, now you have listened to a bunch of podcasts and are itching to make one yourself. "Why?" you say. The reasons vary from "because" to "spreading the word to family and friends" to "expanding your ability to reach your patients with specific information in your own voice (remember transitional objects) and accurately." So, how to do it? In this article, I will talk about creating a podcast that someone might want to listen to, and in the final article I will show you how to publish one. This piece is based on a course in Podcasting originally published by CNet.com.

In order to create your own podcast, I recommend that you have the following hardware and software:

- A home computer (Mac or PC)
- A headset with a noise-canceling microphone
- A portable MP3 voice recorder
- Audio recording/podcasting software (such as Audacity, Propaganda, or iPodcast Producer)

First, we'll learn some tips on developing a podcast, as well as discuss microphone basics. What will your podcast be about? It could be something personal like an interview with an elderly family member that you want the rest of the family to hear, or maybe your standup comedy act, or something professional like a "live" report of a conference you are attending or your comments about an interesting grand rounds. But before you pick up the microphone, you should do some planning. Start by listening to professionals on radio or TV. Pay attention to what makes the presentation "fluid" and interesting.

You are not just presenting information; a podcast should be entertaining so that people will want to listen to it. What annoys you when you listen to a speaker? Maybe long, embarrassing pauses, ums, uhs, hesitation, repetition, rambling, an uninteresting topic or just too long. Once you have decided on the theme for your podcast, it is important to think about and understand your audience, then present your content in a way they can relate to. Writing an outline will help you to avoid any awkward silences, and also help you to formulate your ideas into a strong presentation. Obviously, you don't have to do any of this; you can just jump in and try some ideas and see how they come out.

Let's take a look at hardware. The better the quality of the microphone input and sound card and the quieter the recording environment, the better the quality of the recorded podcast. A few recommendations include Senheiser's PC 150 headset. Price can be as low as $40 with shipping from an internet store, or Logitech USB Headset 250 with prices as low as $30. Compare specifications and shop for a good deal. Make sure that the headset is comfortable and that it is compatible with your computer. If you record your podcast on the road, use a good MP3 player that has an audio jack and use a good external microphone. Make sure you record at a sampling rate no lower than 32Kbps for MP3 and 44.1 KHz for WAV.

PODCAST RECORDING SOFTWARE

One of the best things about podcasting is that it doesn't cost you an arm and a leg to get in and test the waters. While it's certainly possible to spend thousands on high-end mics and recording software, the part-time podcaster can easily create professional sounding recordings on the cheap. There are two schools of thought on recording your podcast: you can purchase an all-in-one program that can record, edit, and distribute your podcasts from a single interface. Or you can save money by using a general purpose audio recording program—even free programs are available. However, with this option, there will be more steps involved in creating your podcast, since the program isn't designed specifically for podcasting.

The all-in-one option

A favorite all-in-one podcasting solution is **Propaganda** (*www.download.com/Propaganda/3000-2170_4-10509667.html*). This well-designed program features multitrack recording, sound effects and transitions, a very functional arrangement window, and plenty of tools for exporting your show. The simplified step-by-step process makes it easier to handle the more technically advanced elements of podcasting, such as the creation of the XML files RSS requires ($49.95). On the Mac, **Garage Band** (*www.apple.com/ilife/garageband/*) is also very effective with a simple, intuitive interface allowing you to mix tracks and sound effects and, for many Mac users, it is free. Purchase of the entire iLife suite including Garage Band is $79.

Another option is Industrial Audio Software's aptly named **ePodcast Producer** (*www.industrialaudiosoftware.com/products/ipodcastproducer.html*). This program is a start-to-finish solution that lets you record and edit podcasts, create RSS feeds, and upload the finished product via a built-in FTP client—all in one interface. It's priced at $249.95, but the same company also produces a slightly less robust and more consumer-oriented version called the ePodcast Creator, for $89.95.

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The general purpose software option

Audacity (*www.download.com/Audacity/3000-2170_4-10514927.html*) is a free, open-source multi-track audio editor and recorder that is widely used by podcasters. It includes a number of useful features and plug-ins, and has an interface that is intuitive and easy to use. It's available for Windows, Mac and Linux.

So what's best for you?

If you are an experienced computer user and enjoy having control over all segments of making and publishing a podcast, and you don't like to spend money, then Audacity and other freeware products are best for you.

If you are less technical, have a few bucks to spend and want to be guided through the project by the software, then Propaganda or ePodcast Producer or Garage Band are for you.

Remember, be honest as you can get easily frustrated by the project and abandon it if it becomes too much of a nuisance. Ideally, you could do your first podcast in someone else's studio and once you had built up some confidence, then choose the best method for you.

The Wisconsin Psychiatric Association

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RECORD YOUR PODCAST

First, know your recording software and use the default settings the first time. Technical glitches can ruin an otherwise perfect podcast, so start by making a few sample recordings to test the software, adjust volume levels appropriately, and make sure everything works.

Sample rates

Set the sample rates for your recording. If you're just recording voice, anything higher than 44.1KHz and 16-bit sampling is overkill for most noncommercial purposes. If music factors heavily into your podcast, however, consider higher rates, but keep in mind the resulting file will be larger.

Sound effects

Many people also like to incorporate sound effects into their podcasts. If you want to import sound effects or intro and exit music with Audacity, you need to first record your podcast, then locate the audio on your computer's hard drive, and finally bring the audio into the program by clicking on the 'import audio' tab in the project menu. With Propaganda or ePodcast Producer or Garage Band, you can add intro music, sound effects, and other audio into your podcast in real time, as well as other features that let you produce your podcast as if you were in a radio studio. It goes without saying that if you include music in your podcast, you must respect copyright laws. Under US law, podcasters may not use copyrighted music in their podcasts or videoblogs (except for music permitted under fair use [*www.ourmedia.org/rules/fair-use*] and except for music licensed by ASCAP [*www.ascap.com/weblicense/*], BMI [*www.bmi.com/licensing/podcasting/index.asp?source=Overture&OVRAW=music%20licensing&OVKEY=music%20licensing&OVMTC=standard&OVRAW=podcasting&OVKEY=podcasting&OVMTC=standard],* SESAC [*www.sesac.com/licensing/obtain_a_license.aspx* , or other licensing groups). The same restrictions apply to copyrighted films and television shows.

TIP: Try to keep your show casual, conversational and continuous. And remember that if you make mistakes, you can always edit them out later, but planning, an outline and practice before the actual recording can save a lot of frustration and time later. It's usually easier to do it right first than try to fix it later.

Edit your Podcast

Now, you'll learn how to edit your podcast, and the proper way to save the file for correct indexing on the Internet.

Once you've recorded your show, you might identify some parts that you'd like to remove, like long stretches of silence, or mistakes that you'd like to clean up. Whether you are using Audacity, Propaganda, GarageBand, or ePodcast Producer, editing your sound file is an easy fix, and works the same way.

1. To find stretches of silence, look for areas in the voice track where the waveform becomes an almost straight line.
2. Use your cursor to highlight the region you want to remove (much the same way you select text in a word processor).
3. Verify that this section is the one you want removed by hitting play and listening to it.
4. Hit delete.
5. Listen to that portion of the track to make sure that the deletion hasn't caused any clicks or other undesirable effects. If you're dissatisfied for any reason, undo the edit and try again. Prevent awkward moments by deleting stretches of silence in your podcast. You can use this same technique to get rid of "uhs and ahs". After you've cleaned up the file, the next step is to combine your tracks into a final mix. This combines everything you've recorded into a single stereo track. Generally you will save the mix as an uncompressed WAV or AIFF file (either one will work)

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that will give you a "master" file to work from and a backup in case you have a problem exporting to MP3.

NOTE: Before mixing to a single stereo track, carefully review the balance of your voice and any music or sound effects. This is your one chance to alter the relative levels between your voice and any other audio tracks you've added. Once you have created a single stereo track, you won't be able to make individual track adjustments.

Turn your final mix into an MP3

The last step is to take your final mix and convert it into an MP3 file—the standard format of all podcasts. Open your final mix in your recording software, and export the file as an MP3. To do this in Audacity, you simply choose File -> export as MP3. Be sure to export using a 32Kbps to 64Kbps bit rate. You will be prompted to name the file, and pick a location to save it on your computer.

IMPORTANT: In Audacity, when exporting an MP3, this is your chance to add ID3-tag information: your name, the name of the podcast, and so on. Be sure to enter this information because without it, listeners won't be able to find your show on their MP3 players. Podcasting software like Propaganda is a bit more intuitive, and allows you to save the file with some additional information that will help you with your next step: publishing your podcast. If you upload your file to one of the free servers that I will describe in the next article, they will also ask for this information.

BE PREPARED: Due to patent restrictions, Audacity cannot automatically export MP3 files by itself. In order to export your file as an MP3, you'll have to download the "libmp3lamelibrary" (*audacity.sourceforge.net/manual-1.2/exportmp3.html*) and choose a location for it (preferably your Audacity directory). The first time you export a file as an MP3, Audacity will ask you to locate your MP3 encoder. Point Audacity to wherever you saved the file, and you're ready to go.

TIP: Make your podcast jazzier and more professional by adding loops: snippets of music used for everything from opening the show to introducing specific segments. Find thousands of freely available loops at Flash Kit. (*www.flashkit.com/loops/*) or *folktunes.org* or Cylinder Preservation and Digitization Project (*cylinders.library.ucsb.edu/index.php*).

Well, that's it for now. If you have questions e-mail me at *Ask.Zelenski@gmail.com* and if they might be of general interest, I will publish them with my best answer in the next issue. If you don't want your name included, please tell me that as well. Next issue we will finish up with how to publish your podcast.

Wisconsin Medicaid Preferred Drug List—Atypical Antipsychotics

By Harold Harsch, MD

The Medicaid Pharmacy Prior Authorization (PA) Committee met on March 29, 2006, to review the class of Atypical Antipsychotics for the state's Preferred Drug List (PDL). From that meeting, Clozaril, Fazaclo, Risperdal, Geodon, Seroquel and Abilify were recommended to be preferred and Symbyax with Zyprexa as non-preferred. The PA committee passed this motion 6-0.

Earlier this year, the Secretary of the Wisconsin Department of Health and Family Services, Helene Nelson, established a "Mental Health Drug Advisory Group" to further review and comment on recommendations from the PA committee concerning pharmaceutics prescribed for mental health issues. This group consists of seven psychiatrists from both community and academic settings in addition to mental health consumers and members of mental health advocacy groups. This committee had a lively discussion about the Atypical Antipsychotics and the PDL in April 2006. Sentiments ranged from advocating open access to all atypicals because of individual response and the lack of evidence supporting superiority of one over another, to feelings that Zyprexa was unsuitable for long-term use and should be non-preferred. Secretary Nelson subsequently made the decision that Fazaclo, Symbyax, Zyprexa and Abilify would be considered non-preferred drugs on the Medicaid PDL effective July 5, 2006.

Wisconsin had spent about $7.5 million on Atypical Antipsychotics in the first quarter of 2006. Abilify and Zyprexa had the highest "per patient cost" to Wisconsin of the atypical agents.

To minimize the impact of this decision on patients, the department also recommended the following:

- Patients stabilized on a non-preferred agent will be allowed to continue this medication without PA.
- If it is medically necessary to use a non-preferred agent that it be "simple and easy" to obtain PA.

Your WPA Lobbyist Election Update

Michael Blumenfeld, WPA Public Affairs Counselor

November 10, 2006

November 7 was a big day for Democrats both in Wisconsin and nationwide. Governor Doyle won re-election with nearly 53 percent of the vote, and control of the Senate will be in Democratic hands next session. Senator Judy Robson (D-Beloit) will be Senate Majority Leader. Senator Dave Hansen (D-Green Bay) will be Assistant Majority Leader. Senator Fred Risser (D-Madison) will be Senate President. Republicans elected Senator Scott Fitzgerald (R-Juneau) to serve as Minority Leader and Senator Joe Leibham (R-Sheboygan) as Assistant Minority Leader.

Democrats took control of the Senate by picking up four seats. Gone are Senators Tom Reynolds, Dave Zien, Ron Brown, and Cathy Stepp, who decided not to seek re-election. Replacing them are Jim Sullivan, Pat Kreitlow, Kathleen Vinehout, and John Lehman, respectively.

In the Assembly, Democrats gained eight seats, which cut the Republican majority from 60-39 at the beginning of the 2005-2006 session to 52-47 for the 2007-2008 session. Both parties plan to caucus next week to elect leadership.

The one bright spot for Republicans in Wisconsin was the election of J.B. Van Hollen as Attorney General. Van Hollen defeated Dane County Executive Kathleen Falk by just over 9000 votes out of over 2 million cast.

On the federal front, the big news nationally was both the House and Senate control switching to the Democrats; in Wisconsin it was Democrat Steve Kagen defeating John Gard in the 8th Congressional District. Democrats will control the Senate with a thin 51-49 majority. At the time of this writing, there are still several House races that are too close to call, but the Democrat majority is expected to be 232-203 (or close to that), which means the Democrats picked up 30 seats.

State Budget Process Underway

The process of developing the state's 2007-2009 biennial budget formally began in mid-September when state agencies submitted their requests and recommendations to the Department of Administration (DOA). The DOA is working closely with the Governor's office to consider the agency requests and develop the Governor's budget proposal. The Governor's budget will be released in February and sent to the Legislature as proposed legislation. It will be referred to the Joint Committee on Finance, which will hold public hearings and begin the process of amending and passing its own version of the budget during the spring. Usually the budget is passed by the full legislature in late June or early July and sent back to the Governor for his review and vetoes.

Here are highlights from the Department of Health and Family Services budget request:

- DHFS is seeking a $343 million "cost to continue" increase in state general purpose revenue (GPR) dollars for Medical Assistance-related programs, which break down as follows:
- $305 million over two years to maintain Medicaid ($90 million in FY 2008 and an additional $215 million the next year, relative to the FY 2007 base).
- $16.6 million over two years for BadgerCare.
- $21.3 million for SeniorCare.
- Total MA spending from all sources is expected to reach $4.62 billion in FY 2007 and $4.88 billion in FY 2009.
- The proposal maintains Community Aids at its base 2006 level. Community Aids provides funding to counties to use for social, mental health, alcohol/drug abuse and disability services.
- Two major initiatives from DHFS are continuing statewide expansion of Family Care and expanding BadgerCare pursuant to the Governor's BadgerCare Plus proposal.

Some of the factors that will boost the cost of maintaining the MA program include the following:

- After falling by an estimated 0.7 percent this year, MA caseloads are expected to grow by 4.3 percent in FY 08 and 3.2 percent in FY 09, causing a two-year spending increase of about $93 million GPR.
- Changes in "service intensity" (i.e., the amount and types of services used) are expected to increase GPR spending by more than $91 million over two years.
- Gradual reductions in the federal matching rate will increase GPR spending by about $9.4 million.

The entire DHFS budget request can be found at: http://dhfs.wisconsin.gov/about-dhfs/OSF/Budget/DHFS07-09Budget.pdf

Senate Health Care Reform Committee Update

The Senate Select Committee on Health Care Reform, which was formed earlier this year, held the last in a series of six public (but invited speakers only) hearings on October 17. The committee has been hearing about high health care costs and various proposals to reform the system, from comprehensive to incremental. Later this month, the committee will begin to consider legislative proposals from members that it may introduce during the 2007-2008 session.

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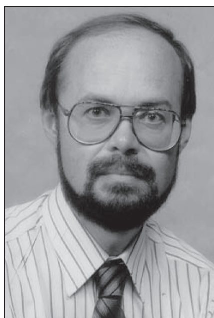
Editorial: The Formulary Mess—

Can psychiatrists still practice medicine?

By Harold Harsch, MD



Several psychiatrists have come to me and asked if the WPA could do anything about the increasing requests for prior authorization for psychiatric medications. I have recently seen this include a prior authorization request for Cytomel, used as an augmentation agent, and carnitine, used in a patient with elevated ammonia levels while on divalproex. What is happening through the prior authorization process? I found one company "Navitus Health Solutions" on the Internet listing the purposes of this process:

- Increase appropriate utilization of certain drugs
- Promote treatment or step-therapy protocols
- Actively "risk manage drugs" with serious side effects
- Positively influence the process of managing drug costs

I also had the prior authorization form, which a psychiatrist gave me, from Navitus Health Solutions for Cymbalta. To allow the possible use of Cymbalta the form states that Effexor XR, fluoxetine, citalopram, amitriptyline, and paroxetine all need to be tried with dose, duration and side effects to be listed on the form. The best science, to date, is that if over months to years a patient has failed five antidepressants, their needs are beyond Cymbalta, they are candidates for VNS therapy—which, to date, most insurance companies have also denied. There is little doubt that the major driving force behind formularies is cost containment. The reason fluoxetine became preferred in the Wisconsin Medicaid program was that it was the first SSRI to become available as a generic, not because it was the best SSRI for Medicaid and Seniorcare patients. However, why an insurance company would ask for prior authorization for generic medications or agents such as Cytomel escapes normal logic.

I have found that the new Medicare Part D program created a nightmare of prior authorization requests and denials. Let me share some frustrating cases.

Case One: A women in her middle 70s was stabilized and doing relatively well for a number of years on 22.5 mg of mirtazapine per night.

A lower dose did not work and she complained of problems with the 30 mg dose. Her Medicare part D program would only allow her 30 pills per month, although this is a cheap, generic medication. To get to her dose she needs 45 pills. She pays for 15 pills by herself and pays the co-pay to this company for the other 30 pills. I have appealed to her Medicare part D carrier and it was denied. Subsequently I attempted to have it investigated through CMS. Nothing has changed in this situation over the past year. What is this new restriction that counts your coverage as the number of "pills" given per month? What enterprising MBA came up with this approach to save money?

Case Two: A young patient with schizophrenia was hospitalized on a police hold for dangerous behavior. He was treated with three different atypical antipsychotics during his hospitalization for various clinical reasons. He was discharged stabilized on Zyprexa, a nonpreferred agent for Medicaid since July. His prescription for Zyprexa was refused by the pharmacy. The outpatient physician had not yet seen him and the inpatient physician had not known about the pharmacy's failure to fill this prescription. He was in the hospital for weeks, my estimate that it cost $30,000 to stabilize this patient. He was off of medications for days. I don't know the outcome of this scenario for the patient.

Case Three: A former nurse was admitted for depression and suicidal ideation.

She had problems with recurrent depression and had been maintained on Serzone for almost a decade. I was told that for insurance reasons she was changed to Paxil, and recently for the same reason changed to Celexa. It is not possible to prove that the medication changes resulted in hospitalization but it is certainly possible. The hospitalization, by my estimate, cost $20,000. She was stabilized and discharged on venlafaxine. APA guidelines clearly state that antidepressants are not interchangeable for individual patients.

These are only three examples of patients' stories over the past year. Many patients have had psychoactive medications changed because of insurance or formulary issues. One of my patients brought me a simple letter from Medico stating that they "no longer will cover Effexor" and asked her to talk to her doctor about alternative medications. Again these medications are not interchangeable without a risk of relapse. I have no knowledge of whether individual patient response is a clinical issue with statins, calcium channel blockers or other non-psychiatric medications. Perhaps we should err on the side of patient stability. Many psychoactive medications such as antipsychotics, antidepressants, and antianxiety agents are not interchangeabale. Can we practice our specialty?

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Dual Diagnosis *continued from page 5*

ally stable. Support persons can also be very valuable in reporting the benefits and adverse effects of medications. The psychiatric provider can request (from the support staff) documentation of symptoms or side effects, and reports of how these things differ in different settings (work, recreation, home).

In summary, individuals with developmental disabilities are as susceptible to mental illness as any other person is, and they can and do benefit from treatment for their mental illness. The dual diagnosis of developmental disability and mental illness can present challenges to accurate diagnosis and treatment. However, with careful history taking, thorough documentation of symptoms and treatment effects, appropriate use of treatments and effective use of support teams, successful treatment is not only possible, but often life-changing for the individual and professionally satisfying for the provider.

Editing by Howard Mandeville, Wisconsin Council on Developmental Disabilities and Jeff Marcus, MD, Central Wisconsin Center. Written with consultation by members of the Wisconsin Mental Health and Developmental Disabilities Workgroup.

* * *

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For information about use of psychotropic medications by persons with developmental disabilities, see: *wcdd.org/Publications/noeasyanswers.pdf.*

For information about developmental disabilities and resources see: *www.familyvillage.wisc.edu* or *www.wcdd.org*

Letter to the Editor

Response to The Public Mental Health System's Mission: What It Is…and Isn't by James Hill
(From the Wisconsin Psychiatrist, Summer-Fall, 2006)

In James Hill's recent article, "The Public Mental Health System's Mission: What It Is…and Isn't," he states, "There are more than enough mandates and failures we need to address. **Low-income housing, development** (my emphasis) and the eradication of poverty, however, is not among them." I greatly respect the work that Mr. Hill is doing and recognize the pressures he is under. But I would like to disagree with him with regard to the development of housing for the mentally ill. Let me offer a little background reason for this disagreement.

In 1967, as the Center Director of a public sector mental health center in Boston (Massachusetts Mental Health Center) my colleagues and I recognized that with deinstitutionalization, patients needed a system of care in the community that replaced and was better than what they had in the long-term state hospital. They needed food, clothing, housing, medical support, psychiatric attention, socialization, rehabilitation programs and a continuing care team. To meet these needs, we in the public sector set up an independent, nonprofit corporation called Vin Fen. This mental health corporation contracted with local, state and federal agencies and nonprofit organizations to provide a variety of community services. It was apparent to us that housing was essential. So, with leadership from the public sector, we developed a variety of housing options including group homes, co-op and supported apartment living, and independent apartment living, as well as a few foster care placements. Much of the funding came from contracts with the federal Housing and Urban Development (HUD). Others came from commitments by local and state housing and authorities and supplements (Section 8s) to reduce rent.

This program was recognized by the Robert Wood Johnson Foundation. We became the project officers for the RWJ Program for the Chronically Mentally Ill. In 1986-1987 Columbus, Ohio, was one of the nine grant recipients cited by Meg Kissinger in the *Milwaukee Journal*. They used both RWJ and HUD money to construct a wonderful community housing program for the mentally ill as well as support programs. All nine recipients had to have a major housing component.

Milwaukee did not receive a grant. There were at least two major reasons Milwaukee did not get in on this type of program 20 years ago. First, Milwaukee lacked a Central Authority to plan and coordinate such a community program: everything in Milwaukee was fragmented. There was not good continuity of care. Second, there was not a private nonprofit corporation whose primary responsibility was developing a broad-based continuing care program and no corporation willing or able to take on the housing. Milwaukee has never been able to really think through how to provide continuity of care in the community – one system of care.

In my opinion, housing for the mentally ill will not be solved in Milwaukee unless the Behavioral Health Division first takes on the leader role in a truly centralized function. Second, it must build a single community system that replicates in the community the functions served by the state hospital, including a housing component. The rights of patients to live community life in accord with their highest level of functioning must supersede the legal right simply to a least restrictive environment. Third, each deinstitutionalized patient must receive a **total treatment and rehabilitation plan coordinated by a single agency** that includes housing. Each component piece must be accountable to a coordinating central authority.

Jon E. Gudeman, MD
Former Medical Director and Administrator
Milwaukee County Mental Health Complex

A Psychiatric Perspective Addressing the Roots of Violence in Milwaukee

Senseless Acts of Violence Point to Need for Prioritizing Mental Health, and Promoting Professional and Community Interventions in Small and Large Ways

by Michael Bell, MD, and Fannie LaFlore, MS, LPC, CADC-D

The headline of a September 1, 2006, article in the Milwaukee Journal-Sentinel had a common refrain. It pointed to the senseless violence that continues to end innocent lives in Milwaukee: "'Shots came out of nowhere' as promising student sat on porch, her friend says."

With the frequency of violence that rips through our community, each new incident brings about the same responses after the initial shock wears off: outrage, then resignation. For some, there is also a feeling of helplessness. For others, it becomes despair. Most victims, families and perpetrators directly affected by this "street" violence live in or around the central city, near addresses that become increasingly familiar: 26th and Vliet, 6th and Hadley or 45th and Locust, for example. In the aftermath, a predictable sequence of events unfolds. "Did you hear? Sharon's son was shot last night. Two men drove by and shot him in the leg and chest. I think they pronounced him dead at the scene."

The most recent example took place around 11 p.m. on Wednesday, August 30. It involved Candace Moss, a teenager shot in the chest by errant bullets, according to police, as she stood in front of her neighbor's house in the 5300 block of N. 39th St. The newspaper article quoted a friend, Amber Cotton, 20, as saying that 'out of nowhere' as many as 15 to 20 shots were fired. This past June, the victim had received "Good Citizen" and "Outstanding Math Student" awards from John Muir Middle School, where she would have started eighth grade when school resumed September 5.

In the aftermath of such senseless violence, our deepest fears of living in an unsafe community are magnified. The next day, individuals designated as leaders protest. Someone like Alderman Michael McGee is willing to stand up and speak out, while so many other public servants go about their business. McGee always tells youth to "stop the violence." Some listen, while others cannot hear. As old-time people sometimes used to say: "They hear, but deaf."

By mid-August of 2005, when Milwaukee's homicide toll reached 88, the community was especially alarmed by this widespread and senseless loss of life, particularly when placed in the context that this number was equal to the count for all of 2004. America remains the most violent country in the world. African-American families continue to bear the heaviest burden of consequences associated with "street" violence. It is well-documented that a black male is 40 times more likely to be a victim of a gun shot wound than his white counterpart, and more likely to go to jail than college.

What often gets under-reported are the long-lasting consequences to families when someone is murdered or goes to jail. People are forever changed by exposure to senseless deaths, imprisonment and other burdens beyond what newspaper headlines reveal. The tears are countless for families of those who are killed and those who kill. The loss of fathers, sons, mothers and daughters can affect relatives for years. Children are scarred in many ways, and their innocence shattered when they are exposed to significant violence at early ages.

The family inevitably suffers in other countless ways. Women are left to raise children alone. A child doesn't see his or her father for years, if at all, due to expenses that can become overwhelming. To visit a loved one in jail or the cemetery at an early age is an experience that, unfortunately, many people of darker hues have had to find ways to bear.

African-American women have had the special task of being the primary teachers of our youth. It's amazing how most manage to do the job well despite many obstacles based on the current social and cultural environment. When we've been approached to comment on various social problems, the most common question is essentially, "How can we keep our sanity, when all around us people are losing theirs?"

It is our view that senseless violence can be deemed a result of a special kind of insanity. Neuropsychiatric research has suggested that the frontal lobe of the human brain takes almost two decades to fully develop and mature. How does this potentially relate to violence? The frontal lobe has been called the "CEO of the Brain."

In particular, the pre-frontal cortex is associated with executive functioning, meaning that it deals with our ability to appreciate consequences, to plan for future events, to understand and integrate a proper sequence of activities for goal-directed behavior. This part of the brain is very sensitive to injury through alcohol, direct trauma and various psychiatric disorders. When this part of the brain is injured or compromised, people tend to

become more impulsive.

Impulsivity, in our opinion, is a common factor in most violent acts. Imagine this scenario: A 15-year-old male with a history of witnessing violence and perhaps abusing alcohol finds a Raven-25 handgun (a popular model in Wisconsin). Already, we have the breeding ground for violence.

A closer look at the scenario above reveals at least five risk factors for impulsivity and violence. These include an undeveloped prefrontal cortex secondary to the young man's age, and the fact that we know males are typically more aggressive. He has witnessed violence and is abusing alcohol, both of which lead to poor blood flow to the prefrontal cortex, again leading to impulsivity. He also has access to a handgun, one of the most impulse-driven instruments of death known to mankind. It takes fractions of a second to form a thought of hurting someone else or yourself, and then pulling the trigger.

When we talk about people killing other people, we often find ourselves engaged in conversations about policies, legal and socioeconomic issues, cultural and ethical concerns. Surely these factors are valid and have implications.

However, if we look at individuals and violent incidents as a study of human behavior, we find that as you increase the number of factors that relate to impulsivity, you increase violent acts. Although such impulses border on insanity, it does not necessarily equate to someone being deemed not responsible for their actions. On the contrary, promotion of mental health requires that we are held accountable. People always have choices in any given situation. Most consider options other than violence. Most think of potential consequences prior to acting out their impulses of anger and frustration.

Many view violence in our community as simply normal. Most perpetrators are simply labeled "criminal" as if nothing more substantial underlies their destructive feelings, thoughts and behavior. In fact, violence has become so common in some communities that most people do not even recognize it as a symptom of mental health issues.

We suggest that senseless violence is a signal of something underneath the surface that is very wrong, a pathological state when it is not self-defense or carried out during a war, for example.

A fever, for example, is a sign that someone may have anything from a simple cold to an allergic reaction or even possibly cancer. It means that something needs to be addressed in most cases. Violence also is a powerful signal that something needs to be addressed in more depth. It's easy to preach "stop the violence" and other surface comments that do not begin to deal with why individuals are so careless, in feeling, thought and action.

Many areas need to be addressed to reduce violence, including education, economics, politics (poli-tricks) and family life, among others.

It is easy to determine, for example, the direct consequences of years of untreated high blood pressure. A stroke might be among the severest outcomes. Few may be surprised when one considers an individual's medical history, years of high-salt diets, no exercise, smoking and obesity as contributing factors.

What, in comparison, are the equivalent consequences of years of depression, anxiety, isolation, substance abuse and trauma? How can we as a community play a role in removing the threat of impulsive violent acts from our community? An understanding of risk factors for violence, and the ability to respond with both preventive tools and resources for intervention in a timely manner, can give us the power to help save lives in the community.

Violence is but one symptom, and a consequence of years of mental unrest. Addressing impulsivity is a start, and there are various other means. We all can help the people we serve in removing risk factors.

If we know guns increase the risk of impulsive violent acts, let's remove the guns. We applaud the efforts of local civic leaders in the recent "buy back the guns" program that was launched in recent summers. Since alcohol impairs the ability to ponder and consider one's actions, let's help our patients recover from substance abuse and dependence.

Health care professionals and support staff, faith- and community-based organizations providing treatment and support services, and other public health officials can become part of a first-line of defense if we notice details that might indicate that something is wrong in the life of a child, youth or adult.

Physicians who provide yearly physicals can share information about their career as a way to encourage a positive self-concept in youth. Something as simple as sharing our professional training background might spur someone to consider health care work as a future option. Front-desk staff might find something to compliment a child about if they notice someone who looks sad or withdrawn. Other staff might engage a youth in brief conversation by asking questions of interest when they're at the clinic while waiting for a parent during an appointment.

It's often easy to dismiss a kid or youth who appears to be unruly or disrespectful in their interactions with siblings or adults, or to belittle their potential based on stereotypes that suggest some youth only have interest in basketball or rap. But what if we took a closer look at the many opportunities, some fleeting and some longer in duration, when we have moments to enforce positive self-concepts in young people who may rarely get positive reinforcement?

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Milwaukee *continued from page 13*

Health care, if looked at from a lifespan and quality-of-life perspective, should involve both consideration of physical and mental health needs, as well as take into consideration the socioeconomic and environmental factors that can affect the functioning, well-being and self-concept of a child or adolescent. Given the recent increases in violence and other forms of dysfunction noted among many young people we serve in our communities, it's important not to overlook the variety of factors that can impact their daily lives and the small ways we might be able to have some impact on their choices and future potential.

Behavioral Health or Behavioral Science is the study of how human beings behave as individuals and within groups and cultures; what influences the way people think, feel and act; what roles people play when they are members of a group; why groups value certain ideas, customs and traditions; what factors determine how individuals develop their identity, values and character and how we deal with those who are different, in addition to other broad issues of importance in society.

Certainly, professionals in primary and behavioral health care cannot be everywhere, but by including general questions about academic interests and self-concept perceptions related to overall well-being when we examine or evaluate youth during an appointment, we can get better clarity about an individual's mental state at a given time. We can offer support, make referrals and do follow-up with clients. We can make greater attempts to communicate with their parents, teachers and youth workers who influence the lives of clients we serve.

In addition to preaching "stop the violence," we have to provide adequate resources and support to promote healing after violence and prevention before it takes place. The bottom line is that, no matter the underlying cause of violence, the consequence is always the same: psychological pain.

Symptoms of this psychological pain are manifest through feelings, thoughts and behavior, and the routine way that news media cover such incidents of senseless violence cannot fully describe how deep the wounding goes. When a reporter interviews the mother of a victim, we witness the immediate aftermath of a painful experience, with tears rolling down her face. The mother, along with her extended family, may have been sitting on a porch during the interview. When media leaves, she goes back into her house, still in shock and disbelief. Friends offer to cook, clean and solicit funds to help with expenses for burial and other immediate family needs. Nourishment of the spirit is often an afterthought. The protection of the mind is considered a luxury. It all comes at the expense of mental health.

Violence is in many ways predictable and treatable, if we all take seriously the symptoms people show in our families and communities before the last and final sequence of events erupt that lead to violence. This does not mean attempting to become Good Samaritans in ways that put ourselves or our own families and neighbors at risk of harm. But we can act to intervene in meaningful ways beyond what has become routine in attempts to comfort.

We believe victims of violence and their families deserve more than teddy bears and flowers at crime scenes. Families forced to deal with violence deserve access to mental health treatment, psychological and other practical support from the community, and should not be simply stigmatized as non-human.

Violence will likely always be with us in one form or another, but our reaction to it should evolve from simply watching the news and shaking our heads in dismay, to actually doing something about it through daily actions on both a small and large scale. After the news cameras leave, who will respond to the unmet needs of the victims and families that will suffer consequences for years to come?

It cannot just be African-American women alone. It needs to be all of us in different ways, or the cycle of violence will haunt everyone to some extent, and despair will replace hope for too many, for too long.

Michael Bell, MD, is Director of Behavioral Health at Milwaukee Health Services Inc., a community health center in Milwaukee's central city, and also an Assistant Clinical Professor of Psychiatry and Behavioral Science at the Medical College of Wisconsin. Fannie LeFlore, MS, LPC,CADC-D, is a Licensed Mental Health and Substance Abuse Counselor and Owner/President of LeFlore Communications, LLC, a small business based in Milwaukee that offers expertise and professional services in Corporate Communications Consulting and Special Projects in Business and Human Services.

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Election Update *continued from page 9*

Originally, the committee planned to prepare a report to the legislature by the end of May but formally set a deadline of September 13. On that day, the Senate Organization Committee voted 3-2 along party lines to delay final action until December 5.

Editorial: De Facto Clinical Regulation by FDA

Once again, doctors, it is time to advocate for your patients

By Laurens D. Young, MD

Recent rulings by the US Food and Drug Administration and other governmental bodies remind us that despite all the scientific progress of the past 50 or so years in psychiatry, it is still necessary to remind others that psychiatry really is the practice of medicine. As I am now mainly a geriatric psychiatrist, I read with interest a recent *New England Journal of Medicine* publication derived from the CATIE study which tested three "atypical" antipsychotic agents for psychosis in elderly patients with advanced Alzheimer's disease against placebo. The results, I thought, were encouraging, as they confirmed (with some study imposed limitations) my general experience that these drugs were effective in reducing "psychotic" symptoms in the elderly and had side effects that could often be managed with dose changes or discontinuation. The authors, however, commented that the benefits were statistically "offset" by the adverse effects. Almost no attention was paid to the finding (somewhat limited by the small number of patients—around 400) that there was no difference in serious adverse effects such as falls, deaths and cerebrovascular events between placebo and trialed drugs.

The latter omission is important because earlier this year the FDA issued a "Black Box" Caution on the use of newer antipsychotic agents in dementia because a review of previous trials had revealed an increase in deaths and serious adverse events in this population. The mass media however had plenty to say: concluding that antipsychotics were of little use, were not indicated, and created the impression that any use no matter how carefully considered and monitored was risky It has been alleged that this kind of publicity has brought a stop to drug company interest in testing these issues for fear of law suits. It certainly puts a damper on those who would like to investigate these important clinical problems scientifically and turns them to less cumbersome pursuits.

This is not the first time that the FDA has plunged a "black box" into customs and standards of psychiatric care. Last year the FDA notoriously issued a caution on nine antidepressants (SSRIs and others) noting increased suicides in trials. Collectively such events send a chill through practices and jeopardize pharmacological firm interest in psychiatric issues. Now, having cast a pall over the most effective class of medication for late adult psychosis and the most popular classes for juvenile affective disturbance, does this mean the FDA will start looking for problems with previously acceptable treatments for young and middle-aged adults? Even if further reviews of trials preserve the initial impressions that the newer antidepressant and antipsychotic are generally effective and safe, the seeds of doubt have been planted in the public mind by these actions that amount to retrospective embargoes. The common factor is that the FDA and other regulator agencies took it upon themselves to draw sweeping conclusions based on a small bunch of studies that were designed for much more modest decision making, and the public does not understand what a drug "indication" really means.

The collective response of leadership of our representative organizations to these assaults on our profession (and by extension on our patients by depriving us of important tools) has been embarrassingly passive. Staying silent is as good as saying "Oh, just take in all the negative propaganda you can and try to explain the very sophisticated and convoluted statistical reasoning required to make a decision about risks and benefits of treatment in your next 15 to 20 minute session." And then what? Prescribe valium, thyroid, stimulants or antihistamines as was practiced 50 years ago? It would seem to me that we owe a little more concerted cognitive activity to our patients and to ourselves. The governmental urge to regulate industry rather than protect patients ought to be pointed out and challenged along with the diffidence and unwillingness of the drug industry to work positively on major psychiatric problems. I cannot imagine these approaches to groups of internists or surgeons. Change is unlikely to come about without strong advocacy on the part of psychiatrists.

I am not certain what mechanisms the APA may have for moving on these issues, but it should be brought to their attention in a forceful and timely manner. Left alone, the stripping of psychiatry of its ability to intervene effectively will not get better and probably will get a great deal worse. Have your residents and students ever asked you about an identity crisis? Tell them to stay tuned; organized psychiatry appears to be having one.

Formulary Mess *continued from page 10*

I have thought of one avenue that psychiatrists may want to pursue: Legislation, at the state level, that would attempt to mandate insurance companies to accept the following:

A new enrollee's psychoactive medications are to be treated as "preferred" if they have been on the medications for over 6 months.

Any enrollee that has been stabilized during inpatient psychiatric treatment would have their discharge medications treated as "preferred."

What do other WPA members think? Are there other thoughts on how to approach this problem which impacts so many of our patients?

WPA Spring Conference March 30-31, 2007 Assessment and Treatment of Aggressive Behavior

By Kenneth Casimir, MD, Program Chair

Most psychiatrists and other mental health professionals will encounter violence and aggressive behavior in their patients, either directly or indirectly. This may include inpatient management of a patient who exhibits aggressive behavior, assessment of dangerousness in a clinical or forensic context, or outpatient treatment of patients with symptoms that may contribute to violent behavior. In the interest of confronting this topic in an informative and relevant manner, the scientific program at the WPA Annual Conference in 2007 will focus on the assessment and treatment of aggressive behavior. Faculty for the program will include clinician researchers with national and international reputations, as well as distinguished experts from within our own state who are charged with treating the most violent psychiatric patients in Wisconsin.

The program this year will be held in a new venue, the Osthoff Resort on Elkhart Lake. Activities will begin on Friday morning with a continental breakfast and opening of the display area. WPA President Edward Krall, MD, will launch the scientific program with opening remarks at 8 a.m. The keynote speaker for this year's conference will be Hans Steiner, MD. Dr. Steiner is a Professor of Psychiatry and Behavioral Sciences, Child Psychiatry and Child Development at the Stanford University School of Medicine. Dr. Steiner is considered an international expert in three areas: 1. Aggression and its relationship to psychopathology, 2. Psychopathologies associated with trauma and victimization, and 3. Pediatric and psychiatric comorbidity. He has authored over 450 published articles, abstracts, reviews, books and book chapters.

The scientific program will be divided topically into three main portions: Friday morning, Friday afternoon and Saturday morning. Each topic area will begin with presentations by individual speakers, followed by panel discussions with encouragement of audience participation. Friday morning's principal speaker will be Dr. Steiner, who is expected to focus primarily on the Psychobiology of Aggression and Theoretical Models of Aggressive Behavior.

Friday afternoon will focus on the treatment of aggressive and violent behavior in two of the most secure psychiatric treatment facilities in Wisconsin: Mendota Juvenile Treatment Center (MJTC), and the adult Forensic Program at Mendota Mental Health Institute. Presenting first will be Gregory Van Rybroek, PhD, JD, and Michael Caldwell, PhD.

Drs. Van Rybroek and Caldwell will discuss the assessment and treatment of severe conduct disorder and comorbid psychiatric illness in a correctional/clinical environment.

Data from a number of funded studies at MJTC has shown remarkable success in reducing antisocial behavior and psychiatric recidivism in the juvenile population.

The second portion of the afternoon will consist of a presentation by Brad Smith, MD, on the pharmacologic management of violent behavior. Dr. Smith is the Clinical Director of the Forensic Program at Mendota Mental Health Institute, and as such is responsible for the clinical care of some of the most violent, psychiatrically ill patients in Wisconsin. His course on the management of aggressive behavior at APA Psychiatric Services is traditionally sold out, and a very popular offering within the APA curriculum.

The Saturday morning portion of the scientific program will focus on the treatment of sexually violent predators (SVPs). We are very fortunate to have two of the authorities in this field, with national and international reputations, practicing in Wisconsin. They have agreed to contribute to our program as faculty members. Dr. Dennis Doren, Director of the Sand Ridge Assessment Unit, and author of *Evaluating Sex Offenders: A Manual for Civil Commitments* will begin with a presentation on the assessment of sexually violent predators. Following this, Dr. David Thornton, Clinical Director of the Sand Ridge Secure Treatment Center in Mauston, will discuss the treatment of sexually violent predators. Dr. Thornton, originally from England, enjoys an international reputation in this area, and we are extremely pleased at his participation in our 2007 scientific program. Following the customary panel discussion, the program is scheduled to adjourn by noon on Saturday.

We invite all WPA members, their families and guests, and all other colleagues in psychiatry and related mental health professions to the WPA 2007 Annual Meeting on March 30-31, 2007. Join us for a truly world class scientific program right here in southern Wisconsin at the stylish and relaxing Osthoff Resort on lovely Elkhart Lake.

Additional details will be contained in the final program and registration materials, which will be sent via mail in early 2007, and at the Wisconsin Psychiatric Association Web site: *www.thewpa.org*

See page 17 for the preliminary scheduled topics and speakers for the 2007 Conference.

WPA Annual Meeting: Assessment and Treatment of Aggressive Behavior

(Preliminary Schedule)

Friday, March 30

8 a.m.	Welcome and Introduction
8:15 a.m.	Psychobiology of Aggression *Dr. Hans Steiner*
9:15 a.m.	Theoretical Models of Aggressive Behavior ***Speaker (TBA)***
10:15 a.m.	Break
10:30 a.m.	Aggression and Its Relationship to Psychopathology *Dr. Hans Steiner*
11:30 a.m.	Panel Discussion
Noon – 1:30 p.m.	Lunch
1:30 p.m.	Aggressive Behavior in Adolescents – MJTC *Dr. Michael Caldwell*
2:30 p.m.	Treatment of Aggression in Adolescents: *Dr. Greg Van Rybroek*
3:30 p.m.	Break
3:45 p.m.	Pharmacologic Treatment of Aggression *Dr. Brad Smith*
4:45 p.m.	Panel Discussion

Saturday, March 31

8 a.m.	Welcome and Introduction
8:15 a.m.	Assessment of Sexually Violent Behavior *Dr. Dennis Doren*
9:30 a.m.	Break
9:45 a.m.	Treatment of Sexually Violent Predators *Dr. David Thornton*
11 a.m.	Panel Discussion

PSYCHIATRIST WANTED

Psychiatrist needed to work with chronically mentally ill consumers in La Crosse County Community Support Program (CSP). Hours are 24-40 hours per week depending on physician's preference. No nights or weekends, and no on-call responsibilities. An attractive salary with benefits included at 32 hours per week. Submit cover letter and CV to:

Paul Brown, Clinical Coordinator
Family and Children's Center
1707 Main St.
La Crosse, WI 54601
Phone: 608.785.0001
Fax: 608.785.0002
E-mail: pbrown@fcconline.org
www.fcconline.org.

EOE

2006 Membership Transactions October-November

New MIT

Rebecca Harrison, MD
Medical College of Wisconsin – Milwaukee

R. Christopher Moore, MD
UW School of Medicine and Public Health

Jessica Taylor, MD
Medical College of Wisconsin – Milwaukee

Robert J. Vicrey, MD
UW School of Medicine and Public Health

Reinstate and Upgrade to GM

Vani Ray, MD

New GM

Maria I. Mas, MD

Calendar of Professional & Clinically Oriented Events

December 7-10, 2006
American Academy of Addiction Psychiatry
Don CeSar Beach Resort
St. Petersburg, FL

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

May 19, 2007
American Psychiatric Association
Annual Meeting
San Diego Convention Center
San Diego, CA

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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