August • 2003

# In Touch

with the South Carolina Psychiatric Association

## SCPA President's Letter *Margaret Shugart, M.D*

I hope everyone who attended the APA Annual meeting in San Francisco enjoyed the variety of educational events as well as the sight-seeing. This year's Annual APA Meeting and SCPA meeting were both a success. Lorraine Dustan did a wonderful job organizing the SCPA meeting. The variety and quality of speakers was superb. I hope the upcoming SCPA Annual Meeting will also be a success. As I begin to plan for this event, let me know about your interests, topics, and preferred speakers and location. This is <u>your</u> meeting!

Certainly part of the success of the APA Annual Meeting was due to the new Medical Director, Jay Scully. While we miss him in South Carolina, we are pleased that he can make positive changes on the national level.

This time of year brings to mind changes and transitions. Graduations, new residents and medical students, beginning careers and the season changing. As a residency training director, it is rewarding to see physicians grow and change and the enthusiasm of new trainees. This is the same excitement we all feel when learning new information in our field and listening to inspiring speakers. It is the same enthusiasm and pride we feel when educating our patients and their families and watching our patients grow and change. While we are practicing in a time of many challenges with budget cuts, managed care, and lack of mental health parity, there continue to be many rewards in the practice of psychiatry. Hopefully, we can maintain our enthusiasm as we face the challenges ahead together. We already have an active Committee on Public Relations, formed at this year's SCPA Annual Meeting. We always need interested members to serve on Committees and the Executive Council. Please let me know if you are interested. Remember, the SCPA is <u>your</u> organization!

## APA President's Message *Marcia Goin, M.D.*

In February 2002, the policy-issuing carrier for the APA-endorsed Psychiatrists' Professional Liability Insurance Program at that time, Legion Insurance Company, was downgraded by A.M. Best from A- (superior) to B (fair). A few months later, the Commissioner of the Pennsylvania Insurance Department, who regulates Philadelphia-based Legion, petitioned the Commonwealth Court of Pennsylvania to place Legion in rehabilitation. Since the time that motion was granted, Legion has operated under the control of the department, which oversees its finances and maintains its day-to-day operations. As long as it remains in rehabilitation, Legion is responsible for claims brought against psychiatrists who are insured under policies it issued.

In late August 2002, however, the rehabilitator petitioned the court for an order of liquidation, and on June 26, 2003, Judge Mary H. Leavitt issued a ruling providing for issuance of such an order of liquidation. Although Legion currently remains in rehabilitation, it is anticipated that this will occur sometime after July 14, 2003. The order also granted the motion of Psychiatrists' Purchasing Group (PPG) to give psychiatrist policyholders direct access to the reinsurance purchased from Transatlantic Reinsurance Company for the Professional Liability Insurance Program. If this provision survives possible appeals, this would be very good news for many policyholders, particularly those who may now have access to the reinsurance funds to cover claims that might not otherwise be covered by state guarantee funds because of fund limits or exclusions. PPG is the sponsor of the Psychiatrists' Professional Liability Program and has provided educational and liaison services to insureds.

While it is possible that the decision of the court will be appealed and not immediately implemented, APA is in the process of reviewing the court's lengthy opinion to fully understand all aspects of the ruling. It is also working with its consultants and program personnel, particularly principals of PPG and PRMS, the administrator of the APA-endorsed program, to determine how the decision is likely to affect psychiatrists insured through the program who have malpractice claims against them and what steps they may need to take under the order.

As soon as we have additional information about any of these matters or whether an appeal has been filed, we will pass it along to you.

If you have specific questions about your policy or coverage, please contact PRMS by phone at (800) 245-3333 or by e-mail at update@prms.com. As we learn more, we will use the pages of *Psychiatric News* and other means as appropriate to keep you updated. Also, PRMS is likely to post updates on its Web site at www.psychprogram.com.

# APA Unveils Blueprint to Save America's Crumbling Mental Health System

Reprinted from *Psychiatric News*, May 16, 2003

## *Vision Report Offers 12 Guiding Principles to Reform, Rebuild System*

Arlington, VA - The American Psychiatric Association has unveiled a far reaching blueprint to reform and rebuild our crumbling mental health system—A Vision for the Mental Health System—amidst the deepening funding crisis in state and local mental health services. The report was prepared by a blue-ribbon task force of psychiatrists from the public and private system.

APA Past President Paul S. Appelbaum, M.D., in a stinging assessment of our nation's mental health system, noted that deeper cuts in mental health services, particularly in state Medicaid programs, are leading to a "wholesale collapse of our mental health system."

Dr. Appelbaum emphasized that APA's Vision report "lays out a set of principles to rebuild and reform our mental health system, and provide a system of care for our most vulnerable citizens."

Mental disorders causing distress and dysfunction affect nearly 1 in 5 adult Americans in any given year. Nearly 3% of American adults are severely and persistently mentally ill and the majority of these patients depend upon Medicaid and state mental health services for their care.

Today, Medicaid provides care for more than 60 percent of people with schizophrenia. Task Force Chair, Steven S. Sharfstein, M.D., said that "2003 is a watershed year for mental health because for the first time 25 years, a Presidential Commission is focusing on this crisis, and the U.S. Congress is seriously considering a law to equalize insurance coverage for mental illness and other medical conditions."

Dr. Sharfstein noted that APA's mental health blueprint was prepared in anticipation of the Final Report of the President's New Freedom Commission on Mental Health due in late April to President Bush, which "we hope will include many of the 12 critical principles for our mental health system" outlined in the Vision for Our Nation's Mental Health System.

Members of the task force include: Steven S. Sharfstein, M.D.; Chair, Paul S. Appelbaum, M.D.; Norman A. Clemen, M.D.; Anita S. Everette, M.D.; David Fassler, M.D.; Susan L. Padrino, M.D.; Roger Peele, M.D.; Darrel A. Regier, M.D.; and Michelle B. Riba, M.D.

## *The Twelve Principles for a Vision for Our Nation's Mental Health System:*

1. Every American with psychiatric symptoms has the right to a comprehensive evaluation and accurate diagnosis which leads to an appropriate, individualized plan of treatment.

2. Mental health care should be patient and family centered, community based, culturally sensitive, and easily accessible without discriminatory administrative or financial barriers or obstacles.

3. Mental health care should be readily available for patients of all ages, with particular attention to the specialized needs of children, adolescents, and the elderly. Unmet needs of ethnic and racial minorities require urgent attention.

4. Access to mental health care should be provided across numerous settings, including the workplace, schools, and correctional facilities. An emphasis should also be placed on the early recognition and treatment of mental illness.

5. Patients deserve to be treated with dignity and respect. When they are clinically able they are entitled to choose their physician or community based agency and to make decisions regarding their care.

6. Patients deserve to receive care in the least restrictive setting possible that encourages maximum independence access to a full continuum of clinical services, including emergency/crisis, acute inpatient, outpatient intermediate level, and long-term residential programs.

7. Since mental illness and substance abuse occur together so frequently, mental health care should be fully integrated with the treatment of substance abuse disorders and with primary care and other general medical services.

8. Support must expand for research into the etiology and prevention of mental illness and into the ongoing development of safe and effective treatment interventions.

9. Efforts must be intensified to combat and overcome the stigma historically associated with mental illness through enhanced public understanding and awareness.

10. Health Benefits, access to effective services, and utilization management must be the same for people with mental illness as for other medical illnesses, preferably funded by integrated financing systems. Although states are the ultimate locus of responsibility for the public safety net, the federal government and the private sector employers must also support an increased investment in the mental health of Americans.

11. Funding for care should be commensurate with the level of disability caused by a psychiatric illness. Disability occurs both in the severely and persistently mentally illness and in patients with other unforeseen psychiatric conditions who suffer despite having previously been productive and functional.

12. More resources should be devoted to treatment and to training an adequate supply of psychiatrists, especially child psychiatrists, to meet the current and future needs of the population.

# Fiscal Fallout: Patients in the Criminal Justice System

*Marcia Goin, M.D., APA President*

APA's far-reaching white paper titled "A Vision for a Mental Heath System" loudly rings the alarm bell, warning that our mental health system is crumbling (*Psychiatric News*, May 16). This is further echoed in the message from the President's New Freedom Commission that the "mental health system is in shambles." As a consequence of this, an increasing social and financial toll is exacted, with more and more of the seriously mentally ill entering into the criminal justice system. These developments are largely due to the lack of treatment resources in the community. When mental health dollars disappear, the shift of patients from necessary and appropriate care and from hospital beds to prison beds is not a new phenomenon. Penrose described this dynamic in 1939 in his comparative study of European statistics of mental disease and crime, published in the *British Journal of Medical Psychology* (volume XVIII, pages 1-15) in the article "Disease and Crime: Outline of a Comparative Study of European Statistics." Unhappily for our society, fiscal planners have not learned from history.

The move to deinstitutionalization that took place about 40 years ago was powered by federal legislation. A shift from public psychiatric hospitals to the community, with the states and counties providing major resources for overarching social services, vocational rehabilitation, and treatment services, was responsive to concerns that psychiatric patients were being "warehoused" and denied the best available treatment.

The introduction of new antipsychotic medications also drove the deinstitutionalization engine. The states and counties were obligated to put into place community resources to monitor medication treatment, assure rehabilitation, and provide adequate housing for people with impaired autonomy.

What went wrong? A number of things went wrong. Most importantly, the necessary community resources didn't materialize in anywhere near the capacity that was needed. Also, antipsychotic medications, although powerful treatments, don't work in isolation. Patients need a relationship with a psychiatrist, clinic, or other stabilizing force to ensure ongoing adherence. Acutely ill patients often need to spend time in a psychiatric hospital to become stabilized. For some, the disorder is so debilitating that longtime bed availability in a protected treatment center is necessary.

While deinstitutionalization has succeeded in decreasing the number of hospital beds, an unforeseen consequence has been the proportional increase in the number of mentally ill people housed in the criminal justice system. Following deinstitutionalization, the number of state hospital beds decreased from 339 per 100,000 population to fewer than 20 in a little more than 40 years. Meanwhile, the number of mentally ill persons in jail has geometrically increased. Take for example the situation in Los Angeles County. In 2002, there were 38,600 psychiatric evaluations at the inmate reception center of the Twin Towers Jail. Of these, 23,190 (60 percent) were found to be in need of mental health treatment. A reasonable person could not fail to see the correlation among decreased funding for mental health resources, the closure of hospital beds, and homelessness and criminalization. Untreated and without access to long-term care, a large number of mentally ill patients end up with symptoms and behaviors that result in jail time.

With the predicted loss of Medicaid financing for mental health services, you can anticipate an accelerated shift from mental health to criminal justice settings. It is tragic that Medicaid cuts will further reduce already strained services in community mental health centers, drug treatment programs, and private offices that would otherwise significantly reduce the institutionalization and reinstitutionalization of the mentally ill.

This shift in funding not only is a blight on our society, but it also costs money—it costs a lot of money. The cost of corrections staff, mental health staff, medication, amortization of buildings, and time spent by the police and sheriffs in court all amount to very large sums of money compared with the costs incurred to treat patients properly in the community. This doesn't make long-term financial sense, much less humanitarian sense.

State appropriations committees and political decision-makers haven't learned from history, but at APA we intend to press for change. APA is developing a blueprint for our members to help them to advocate for a more rational deployment of resources. APA's Corresponding Committee on Jails and Prisons is currently gathering and analyzing the data that will sharpen our presentations to political decision-makers. Research from studies across the country, including a multisite study looking at the differential costs between prebooking evaluation and the absence of such evaluations, should prove invaluable. If you have more information in this area, please contact Henry Weinstein, M.D., Chair of APA's Corresponding Committee on Jails and Prisons, at henry.weinstein@med.nyu.edu.

In this day and age of budget shortfalls, we cannot present only the moral, medical, and psychiatric rationale for appropriate care. We must simultaneously present the "business case" for reversing the current lack of appropriate funding. This effort by APA and you, its members, will make it happen—replacing misguided criminal justice with social justice.

## Medicare Update *James Bouknight, M.D.*

At the June Medicare Carrier Advisory Committee meeting, we were told that CMS has a goal of reducing payment errors to 5%. They estimate that there is close to $2 billion in Medicare payment errors nationwide and these errors are NOT in our favor. To reduce errors, CMS has contracted with a company called Advancemed to audit a sample of charts. They will examine a sample of 200 paid claims per month for the entire state.

If you get a request for records from Advancemed, remember that this is really a request from CMS and Advancemed has all of the enforcement power of CMS. Also try to offer a complete description of the treatment, which may include the rationale for procedures and records before or after the dates requested. We are asked to "follow the spirit, not the letter" of the request.

## Psychiatric Position Available at Sandhills Center

We have an immediate opening for a staff psychiatrist in adult work — preferably familiar with community psychiatry and the public system — either full time, part time, or on a consulting basis. Salary is negotiable. Any residents soon to leave their training, looking for a full or part-time position, or faculty members looking to supplement income, would be welcome to apply.

Also, we are recruiting child psychiatric time at several of our five-county units for part-time consultant positions. We would also consider a full-time or part-time salaried employee to rotate among individual counties. Again, salary is negotiable.

We have a liberal fringe benefit package that exceeds any within the State. As above, we would be willing to consider full or part-time salaried individuals, either newly coming out of their fellowship, or establishing a practice to work on a consultant basis until their practice matures or faculty members wanting to supplement income.

Sandhills Center is a nationally accredited North Carolina Area Program which is in the process of merging with Randolph County to become a six-county program serving a 350,000 individual catchment area. There is a good working relationship between the medical providers, administration and therapists of other disciplines and psychiatrists, as well as excellent support by consumer and family organizations throughout our area.

For consideration contact John G. Wagnitz, MD, Medical/Clinical Director of Sandhills Center for MH/DD/SA Services at (910) 673-1913, ext. 243, (910) 673-1812, ext. 243 or e-mail johnw@sandhillscenter.org. (EOE)

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