

Ideas

o f r e f e r e n c e

MPS member leads Center of Excellence

By Eric Brown, MD

A co-sponsor of the 5th Annual Psychiatry Update at the University of Minnesota this September was the University of Minnesota's Center of Excellence in Women's Health. Many of our members may not be aware that the Director of the Center is psychiatrist and MPS member Nancy Raymond, MD, of the University of Minnesota Department of Psychiatry.

Designation as a Center of Excellence in Women's Health (CoE) is awarded by the Office on Women's Health of the United States Department of Health and Human Services in a competitive process. Dr. Raymond, along with Anne Taylor, MD of the Department of Medicine/Cardiology at the University, spearheaded the effort to have the University designated a Center of Excellence in Women's Health in 2003. The University of Minnesota received the designation based on the recognition that it has the resources to provide excellent, comprehensive health care for women, advance research into women's health, reach out to communities in need to promote women's health, educate local health care professionals about women's health issues, and provide effective mentorship for women in health care leadership. The Office on Women's Health will support the Center financially for four years in the amount of \$150,000 per year. The University's Academic Health Center and its schools (including the Medical School, School of Public Health, School of Nursing and College of Pharmacy) provide matching funds to more than double this amount. The University of Minnesota is one of 21 sites around the country who have been designated a Center of Excellence in Women's Health – some of the others include Harvard University, the University of Michigan, the University of Wisconsin, Brown University, Boston University, UCLA,

and UC-San Francisco. The following description of the national CoEs is provided by the national Office on Women's Health:

"The National Centers of Excellence in Women's Health (CoEs) are meant to serve as demonstration models for the Nation to provide innovative, comprehensive, multidisciplinary, and integrated health care systems for women. The CoEs provide for the special needs of women, including the underserved and minorities, by integrating:

- 1 state-of-the-art comprehensive and integrated health care services
- 2 multidisciplinary research
- 3 public and professional education, training, and materials
- 4 community linkages for health services and programs
- 5 leadership positions for women in academic medicine"

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MPS Women Psychiatrists Committee offers forum

The MPS Women Psychiatrists Committee, under the able leadership of its chair, Kasia Litak, MD, is providing opportunities for women psychiatrists to get together periodically to learn from each other and from experts.

In September, the Women Psychiatrists Committee hosted a talk at the Science Museum. Along with the family friendly venue, the program offered child care and a relaxed Saturday morning agenda. In an atmosphere of friendly networking, participants joined colleagues for a scientific discussion and presentation on cardiac outcomes and women's mental health. The event was supported by a grant from GlaxoSmithKline.

If you are interested in joining the Women Psychiatrists Committee, please contact the office at 651-407-1873 or email Linda Vukelich at <l.vukelich@comcast.net>.



Fall 2004

Volume XXXVIII

Ideas of Reference
is the newsletter of
the Minnesota
Psychiatric Society, a
district branch of the
American Psychiatric
Association.

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Ideas of Reference

The newsletter of the Minnesota Psychiatric Society is published quarterly: January, April, July and October for members of MPS and others on request. Signed articles express the opinion of the author and do not necessarily reflect policies of MPS. Articles submitted are subject to review by the editor.

Ideas of Reference accepts advertising. Rates follow:

Display ad	1 Issue	2 Issues	4 Issues
Full Page	\$450	\$350	\$300
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Classified Rates: 25 words or less for \$40 with each additional word at \$0.25

All advertising copy must be in black and white and is subject to approval by the Editor/Newsletter Committee.

Meetings and events may be listed on the Calendar of Events free of charge.

Ideas of Reference has a quarterly circulation of 500. Deadlines are the 15th of the month prior to publication.

Ideas of Reference

Minnesota Psychiatric Society
4707 Highway 61, #232
St. Paul, MN 55110-3227
Phone: (651) 407-1873, fax (651) 407-1754
www.mnpsychsoc.org

Editors

Eric Brown, MD
Ronald Groat, MD

Managing Editor

Linda Vukelich

Executive Council Officers

Will Dikel, MD
President

Eric Larson, MD
President-elect

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Legislative Affairs

Dominic Sposeto

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Involvement and Opportunities

I was standing at Gate 9 of John F. Kennedy International Airport in New York City last May, returning from this year's annual APA meeting, when I bumped into Benita Dieperink, the (now former) co-editor of this newsletter. "I was going to email you," she said, which was my first indication that an interesting opportunity was about to be sent my way. She has been co-editor of this newsletter for the past 3 years, but has found the other demands on her time to be more than enough lately. I was persuaded to give the job a try.

I only recently completed my residency training, and as many of you probably recall, residency training can often be a very insular world. Especially in the initial years of training, most of one's attention is occupied simply by learning the craft of psychiatry while also keeping up with the extensive workload. An unfortunate side effect of this arrangement is often a too-narrow focus on one's smaller world made up of fellow residents, faculty supervisors, and the occasional administrator within the walls of our own training institutions. The problems with this narrowed view show up in the later years of residency, when residents are deciding "what we want to be when we grow up". Having learned psychiatry in a fairly self-contained setting, many residents struggle with understanding the terrain of psychiatric practice outside of teaching hospitals, and what the various career options available to us are.

I have been fortunate to find over the past few years that participation in MPS can be a good antidote to this insularity. My own involvement has given me a better perspective on the larger psychiatric community and the practice climate in Minnesota compared to what I would have had otherwise. It is no coincidence that one of the most popular events that MPS has created and run in the past two years has been the annual "Life After Residency" dinner. This event has featured psychiatrists from a wide variety of practice settings, speaking to an audience of residents about their own practices. This event has also included other professionals providing important information about the financial and legal aspects of psychiatric practice that can be so mysterious to MITs and recent graduates. The dinner has been universally and highly praised by all residents I have spoken to, because for them it has filled what has otherwise essentially been a void in their professional educations. I believe that active participation in MPS can be even more effective at filling this void for trainees. If any current residents are reading this, I would ask you to consider the following questions: How much more

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Activities and the MPS Mission



by Will Dikel, MD
MPS President

Greetings! Here's an update of MPS activities on a variety of fronts, addressing our missions of improving patient care

and the psychiatric treatment environment. For example:

Medical Necessity Task Force

The Medical Necessity Task Force has completed its task of reviewing the medical necessity criteria used by BHP, Preferred One, Blue Cross and UBH. Minnesota Statutes require that health plan criteria must reflect the standards of care of providers in the field, and that inpatient criteria must be consistent with APA and AACAP criteria. The task force discovered a wide variability in health plan criteria, and found all of the plans' criteria to be more restrictive than Minnesota statutes mandate. Floyd Anderson has written letters to the health plans, with cc's to the Attorney General and the Departments of Health, Commerce and Human Services, requesting immediate expansion of these criteria. Great job Floyd!

Integrated Care Task Force

Roger Kathol's Integrated Care Task Force has concluded its first round of planning meetings- Inpatient and outpatient sites are being identified for initiation of primary care/psychiatric coordinated care projects, and meetings have been held with the health plans to discuss expansion of reimbursement options to cover psychiatric consultation and other integrated activities. On September 27, Roger presented his findings to the Governor's Health Care Cabinet. He presented research that proved that "carving out" mental health services provides the illusion of saving money, but actually increases health plan expenses. The Cabinet endorsed this project, and committed to providing support for group meetings with the health plans that will focus on shifting the fragmented health/mental health care non-system to an effective, integrated model of services.

Mental Health Authority Bill

In Minnesota, the Department of Human Services is

considered the State overseer of mental health services. However, most mental health treatment in Minnesota is provided by primary care physicians, and these activities are not under the auspices of DHS. MPS, with the backing of MMA, is strongly supporting a shift in Minnesota's approach to mental health issues, moving from a social services model to a public health model. The rationale for this is outlined in an article that I wrote, "Mental Health and Public Health", available on line at: <www.ramseymed.org/pdf/Mental-Health-Public-Health.pdf>.

The Mental Health Authority Bill moves the bulk of oversight of mental health disorders to the Department of Health, and has a public health focus on epidemiology, early intervention, screening, physician training, outcome measures and accountability of State monitoring activities.

At the least, MPS is hoping for the creation of a psychiatric epidemiologist position within the Department of Health, whose role would be to gather, analyse and distribute information to Minnesota's physicians about psychiatric disorders, as is now done in the Health Department's newsletter about infectious diseases. The newsletter would also be expanded to include information about effective screening, diagnosis and treatment, and thresholds for referral to psychiatry for consultation and/or treatment.

Diane Mandernach, Minnesota's Commissioner of Health, has expressed support for these efforts. We expect some resistance to the paradigm shift from a variety of fronts, and MPS members can be helpful in political advocacy on this issue.

Mental Health Action Groups

Our members have remained active with the Action Groups, and Doctor's Dickson and Goering are on the Steering Committee. MPS has communicated our priorities to the Committee, including:

- Do not raid the Health Care Access fund,
- Provide payment for team meetings and coordinating care for complicated patients,
- 50% increase for child and adolescent psychiatrists,



Council highlights

Highlights and Actions from the September 2004 Council Meeting

**September 11, 2004, 7:00 AM
Fairview Riverside, Minneapolis, MN**

President's Report—Dr. Dikel reviewed the MPS mission and workplan. He reviewed the invitation to join the lawsuit and, following discussion, a motion to join the lawsuit as a complainant was passed. **ACTION:** MPS will join the class action lawsuit against DHS complaining that co-pays deny care as stipulated in the Medicaid Act. A discussion followed regarding medical necessity. Dr. Dikel reviewed the law, reminding everyone that Minnesota requires that providers determine medical necessity criteria. The Private Practice Committee has completed its work on the issue and will communicate with health plans.

Executive Director's Report – Linda Vukelich reported that a Rochester area residents' meeting is planned for November 16. She also reminded everyone about the joint meeting with the Minnesota Psychological Association planned for January 28, 2005 about suicide risk and violence. The Primary Care Prescribing Educational Project is underway and the curriculum planning committee will meet shortly to create a standard program on depression to be presented around the state. Will Dikel encouraged everyone to think about new initiatives for next year. Ms. Vukelich is representing MPS at the Mental Health Legislative Network. She also reported that the MPS bylaws amendment had passed, resulting in new Council positions. She would forward our current bylaws to the APA for review. The Mental Health Action Groups are continuing to meet, and MPS members are participating, but MPS has requested additional representation and will communicate endorsement of the following:

- 50% increase in child and adolescent Psychiatry reimbursement rates
- Payment for more than one service per day

Members on the go!

New MIT: Cynthia Belt, MD; Steven Miller, MD; Arlene Nunez, MD; Ranji Varghese, MD

Upgrade to GM: John Glass, MD (U of M); Steven Harker, MD (UWM); Simon Kung, MD (Mayo); Christine Stanson, MD (H-R)

Transfer In: Mary Beth Lardizabal DO (GM from ME); Eric Nelson, MD (GM from PA); Joel Oberstar, MD (MT from MA)

Transfer Out: Ted Matzen, MD (GM to IL)

- Payment for consultation with primary care
 - Payment for services provided by mental health clinic nurses
- Use the health care access fund only for current, mandated purposes

System Interagency Communication Plan – Jeff Hardwig described the chain of events that happen under a newly created structure of required contacts in Northern Minnesota. He suggested that MPS advocate for the Mental Health Authority legislation and quality standards using this model. He will check into a document showing before and after data and it will be titled "Patient Centered Coordination of Care Standards."

Legislative Committee Report – John Uecker, MD reported that the Legislative Committee would begin holding monthly strategy meetings in October. It will solicit input from the membership via email before discussing priorities.

Secretary Treasurer's Report – Bill Clapp, MD reviewed the July and August Financial reports and reported that he and Ms. Vukelich meet regularly to discuss the budget and managing MPS funds. They will begin to work on the proposed budget for 2005 soon. He added that the Council has noted that Ms. Vukelich's time is currently stretched and that hiring a consultant to provide support will be included, so she will have sufficient time for administrative leadership.

PAC Update – Karen Dickson, MD presented the PAC Board Minutes and reviewed PAC. She noted that the PAC Board is interested in developing a core group to meet and develop a grassroots presence.

MMA Report – Karen Dickson, MD reported that the MMA continues to meet with the Council of Health Plans and she suggested that psychiatry should be on every agenda as a way to implement the workgroup recommendations. **ACTION:** MPS will write a letter to MMA officially requesting to be on the quarterly agenda at their meetings with the Council of Health Plans.

New Business – Eric Larson announced that he would be stepping down from his post as Medicare Advisory Committee Representative and that Susan Meland, MD would be taking on the role. ■

Friday, January 28, 2005

Metropolitan State University, St. Paul Campus

**Assessing and Managing Risk for Violence
and Suicide:
Multidisciplinary Perspectives**

MPS Legislative Committee Report

(Bad things happen, when good people do nothing)

By Jonathan Uecker, MD, MPS Legislative Committee Co-chair



Existing Bills

We plan to review and support last year's **Mental Health Authority Bill**. With the other ideas on the list, we are going to contact MMA and NAMI and see if there is any support for these ideas. We have been asked by DHS to **support a Bill allowing PAs and Advanced practices Nurses to Commit Patients**.

Because restrictive managed care networks limit access to psychiatrists and mental health professionals, MPS and MMA two years ago submitted a bill in the Minnesota legislature to **oppose mental/behavioral carve outs in Minnesota insurance products**, i.e., mental health/substance abuse systems separately financed and administered from general health care benefits. **MPS should actively support this bill (our own) in 2004.**

The MPS Legislative Committee will launch an e-mail system to alert members about upcoming bills and legislators they should contact.

Ideas for proposed Bills:

As per the DHS plan, committed patients are going to be treated in community settings and there is a plan to close the RTC's (except AMRTC and St. Peter). So far most of this is occurring out state. A concern has been raised regarding increased liability for private practitioners and community hospitals that will be managing more dangerous and suicidal patients who traditionally in the past were sent to the RTC's. A possible solution is **extending the existing liability/underwriting for state facilities and state psychiatrists to community psychiatrists and hospitals, clinics, etc.** who are working with a patient during the duration of the patient's commitment. In essence, if there was a bad outcome with a committed patient and if a law suite happened, the plaintiff could only sue the state and not psychiatrists personal malpractice or the community hospital's/outpatient clinic's insurance. This coverage would end when the commitment for the patient expires. The hope is that such a bill would ease the concerns of reluctant community providers and facilities to provide care to more difficult patients.

Again as more treatment is becoming community based would it make sense to develop legislation that helps **protect vulnerable adults from unscrupulous landlords**. Currently there is a court case in Anoka County regarding a landlord running a prostitution ring involving mentally ill and developmentally disabled young women (vulnerable adults), and

offering them a discount in their rent for their services. Many communities do not have rental licensing laws that are often designed to help protect the right of renters. Perhaps a state wide "bill of rights for vulnerable adult renters" would be helpful to curb some of the abuses such refusal to make repairs, address problems with disruptive neighbors, and refusal to return security deposits, and high application fees. It would need to be worded in such a way as to not discourage landlords from accepting vulnerable adult renters.

Licensing for Sober Homes - right now this is no licensing or oversight of these facilities. The public often confuses them with licensed half way houses. Some of them are well run (often those that are part of a licensed chemical dependency program) but often they are little more than flop/wet houses and are not good environments for people who are early in their sobriety - see attached letter from Uecker, Dickson, et al.

Minnesota medical assistance payments to psychiatrists are now so low that a private practitioner cannot pay overhead expenses and clinics that hire psychiatrists cannot recoup their costs. MPS needs to **publicize exceptionally low rates for medical assistance and Medicare psychiatric services**. We can demonstrate cost-effectiveness for integrated psychotherapy and pharmacotherapy by psychiatrists and should **advocate pay for telephone consultations and case conferences with other mental health and substance abuse providers**. These legislative initiatives stem from the clinical appropriateness and cost-effectiveness of MPS members and other physicians to engage in direct communication regarding individual patient care cases, with patient consent, when such communication is likely to result in a better care outcome for that patient.

As more treatment is becoming community based several safeguards need to be considered. One is minimal training standards for group home staff and foster care staff. Right now there is a lack of facilities that are willing to take more difficult patients. This will obviously undermine efforts to move treatment into the community, as a poorly trained staff is less likely to be successful with difficult patients. It is predictable frequent re-hospitalizations will be needed. One would think about a basic curriculum for these staff including an over view of the major mental illnesses, medications, psychosocial treatments, and

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MPS Joins Class Action Lawsuit

By Linda Vukelch, MPS Executive Director

MPS was invited to join a class action lawsuit against the Department of Human Services, alleging that Minnesotans who cannot pay co-payments cannot access care as provided in the Medicaid Act.

Since Minnesota receives federal Medicaid dollars, it must comply with the requirements of the Medicaid Act. This suit challenges Minnesota's law, which is broader than the Congress allows. The plain language of the Medicaid Act says that providers cannot deny medical services if a person is unable to pay a co-payment. Minnesota has added language which permits a provider to deny services if a person is unable to pay a co-payment "if it is the routine business practice of a provider to refuse such service to an individual with uncollected debt. . ." Thus, the suit challenges that provision as a violation of the Medicaid Act.

Second, both state and federal law specify notices an eligible Medical Assistance recipient must get. The suit also claims that Minnesota's notices violated state and federal law.

MPS was invited to join because our advocacy efforts in support of access to care provide an institutional interest and that, although our members are not harmed, but since their patients are, MPS has a tangible legal interest.

The purpose of this litigation is to reverse the law and collect damages (return any co-pays collected since it went into effect).

As a complainant, MPS will be named on papers as a matter of public record and will offer information to the media, as well as the court. MPS joins NAMI-MN and several individuals in this lawsuit. ■

MPS members honored

Karen Dickson, MD

MPS Past President Karen Dickson, MD was recognized as one of the *100 Influential Health Care Leaders* by *Minnesota Physician* magazine in its August issue.

Along with her work on behalf of MPS, Dr. Dickson was noted for her work on the board of trustees and executive committee of the Minnesota Medical Association. She is also on the board of the National Alliance of the Mentally Ill-Minnesota.

When asked about challenging issues, Dr. Dickson reported that the biggest issues in mental health are access and funding. Dr. Dickson is a frequent contributor to *Minnesota Physician*, and makes the most of the opportunity to inform and engage medical colleagues.

Congratulations, Dr. Dickson!

John Scanlan, MD

John M. Scanlan, MD was named honorary board member of Neighborhood house, St. Paul's 107-year-old settlement house and community building organization, at the institution's annual awards luncheon on September 29.

John Scanlan served on the Neighborhood House board of directors from 1991-1999 and provided leadership as board president in 1994-1995. He has continued to work closely with board and staff in developing new programs, improving accountability in both finance and programs, and initiating strategic planning. He is currently co-chairing the Neighborhood House Capital Campaign Committee charged with raising \$7.5 million to fund our new home, the Paul and Sheila Wellstone Center for Community Building. Throughout his association with Neighborhood House, John's personal support has been much appreciated by staff and board members alike.

John has gifted the community with his leadership in many ways. He is medical director of behavioral health at Blue Cross/Blue Shield of Minnesota. He holds an appointment as clinical associate professor in psychiatry at the University of Minnesota. He has published nationally and internationally in the area of

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SAVE THE DATE!

The Minnesota Psychiatric Society and the Minnesota Psychological Association present

Assessing and Managing Risk for Violence and Suicide: Multidisciplinary Perspectives

Friday, January 28, 2005
Metropolitan State University, St. Paul Campus

Mental Health in Minnesota:

The Bigger Picture” from the perspective of the Minnesota Mental Health Legislative Network

By Sandra L. Meicher, Executive Director, Mental Health Association of Minnesota



I would like to thank the Minnesota Psychiatric Society for inviting the Mental Health Legislative Network (the Network) to share our perspective on “the Bigger Picture” regarding mental health issues in Minnesota.

The Network is a coalition created in 1990 and consisting of organizations, providers, consumers and family members who work together to create a unified voice on mental health issues in the Minnesota legislature. The Network’s goal is to create a strong mental health system that provides comprehensive mental health services, easy access to care, a full array of community-based services, and stabilization and recovery for persons with mental illness. The Network lobbies for new legislation and its members’ work together to build public and professional awareness of issues, trends and the needs of people with mental illness in Minnesota. The Network has successfully fostered passage of major legislation, such as the Mental Health Act of 2001, an Act that could have added \$87 million dollars worth of new services in Minnesota, but the huge state deficit at the end of 2001 prevented its full implementation. The Network is co-chaired by the Mental Health Association of Minnesota and the National Alliance for the Mentally Ill/Minnesota (NAMI/MN). These two agencies take turns serving two-year rotations as Chair of the Network.

The Network members prepare for the upcoming legislative session by developing their legislative agenda. This process could include: 1) writing new proposed bills that the Network authors and its members support, 2) a review of policies and proposed bills introduced by other organizations that the Network reviews and may decide to support, and 3) bills and/or issues that it opposes. Individual Network members may request the review and support of a piece of legislation their organization is proposing. By the time the session begins, the Network has usually identified the key issues that it will support and oppose, although there are always surprises and new issues emerging. The Network also organizes an annual Mental Health Day on the Hill, where people from throughout Minnesota come to meet with their state legislators.

The 2005 Network agenda will probably include a number of items that the Network supported in 2004 but did not successfully get passed. Key

proposals for 2005 are likely to include:

- Elimination of co-pays on medications and office visits. Co-pays create financial barriers for adults with mental illness, forcing people living on low incomes to choose between food and medical treatment.
- Extended Employment Projects for people with Serious Mental Illness (EE-SMI). These projects are effective but received large cuts.
- Bridges Housing and other subsidized housing for people with SPMI, and new funding to assist people with secure, safe and affordable housing, which is key to stabilizing a person’s situation, aiding their recovery and avoiding homelessness.
- The \$20 million dollar bonding bill proposed by the Governor as his initiative to end long term homelessness. At least one-third of homeless people have a mental illness.
- Elimination of the \$5,000 cap on the benefits set under MinnesotaCare. People with mental illness reach the cap quickly due to the high cost of medications. The program should also pay for mental health services provided by other providers, in addition to physicians.
- Reinstatement of MFIP grants (Minnesota Family Investment Project/welfare) — elimination of the \$125 reduction of family grants. This cut is an extreme hardship for these families.
- Payment for consultations, including non-face-to-face, between primary care providers and psychiatrists, which would address the shortage of child psychiatrists in Minnesota.
- Elimination of the \$500 limit on dental care, which prevents people from getting their teeth cleaned as often as needed. Many medications for mental illness create a “dry mouth” resulting in a need for frequent cleanings to avoid cavities.
- Legislation to address use of seclusion and restraints
- Adequate funding to cover the costs of sex offender treatment, without redirecting funding used in the current mental health system.

There are some exciting new developments in Minnesota, such as the work of the Minnesota Mental Health Action Group (MMHAG). MMHAG will propose policies and procedures that strengthen the



Focus on Women's Health Issues

By Benita Dieperink, MD

Four recent events highlight the growth of interest in women's health, including women's mental health, amongst the healthcare community in the state of Minnesota.

The award of the **Center of Excellence in Women's Health (CoE)** to the University of Minnesota is a major victory for our community and is an opportunity for healthcare professionals to coalesce and streamline our efforts in this area and to disseminate information for the improvement of health in the state (see Eric Brown's article detailing the CoE on page one).

The **5th Annual Psychiatry Review, "Women's Mental Health Across the Lifespan"**, was held on the 27th and 28th of September, 2004. This event was sponsored by the Department of Psychiatry at the University of Minnesota (U of MN) Medical School, the National Center of Excellence (CoE) in Women's Health at the U of MN and the Hennepin Women's Mental Health Program (HWMHP) at Hennepin County Medical Center. The keynote speaker was Peter J. Schmidt, MD, Chief of the Unit on Reproductive Endocrinology, Behavioral Endocrinology Branch, at the National Institutes of Mental Health/ National Institute of Health. He spoke about reproductive aging and depression, including a review of studies which have looked at the effect of gonadal steroids on

peri- and postmenopausal physical and mental symptoms. He highlighted the resultant findings and controversies. Other presenters discussed depression in teenage girls, eating disorders, mood disorders during pregnancy and the postpartum, domestic violence, premenstrual syndrome, gender differences in neurodevelopment, low sexual desire in women, infertility, promotion of healthy youth development, borderline personality disorder and chemical dependency in women. The conference was very well attended, with over 300 health care providers present.

The Humphrey Institute of Public Affairs, in collaboration with the School of Public Health at the U of MN, organized a conference on October 1, 2004 called, **"After Birth: Policies for Healthy Women, Families and Workplaces."** This conference integrated both the public policy experience around the Family Medical Leave Act with research findings about family adjustments after the entry of a child into the family. There were two keynote speakers: Donna Lenhoff, JD, the lawyer who spearheaded the passage of the Family Medical Leave Act through Congress and Susan Maushart, PhD, who wrote [The Mask of Motherhood: How Becoming a Mother Changes Everything and We Pretend It Doesn't](#).

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MPS member leads Center of Excellence

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Since its designation last year, the University's Center of Excellence has begun working on a number of projects in many different spheres of health care in Minnesota. For example, the CoE is taking steps to become involved in women's mental health, including undertaking a review of education in women's mental health within the University of Minnesota's psychiatry residency program, and supporting the work of the two Minnesota Area Health Education Centers (AHECs), which support rural practitioners and encourage young people to consider careers in health care. The Northeast Minnesota AHEC has a particular focus on mental health care issues.

In addition to the CoEs, the United States Department of Health and Human Services also gives a designation of Community Centers of Excellence in

Women's Health (CCOEs) to non-university based medical clinics, which are meant to partner with CoEs to improve access to underserved women and develop innovative models of comprehensive and preventive health care delivery. Hennepin County Medical Center/Pilot City Health Center has been awarded such a designation, making Minnesota one of only three states in the nation to have both a Center of Excellence and a Community Center of Excellence; the others being Missouri and Arizona.

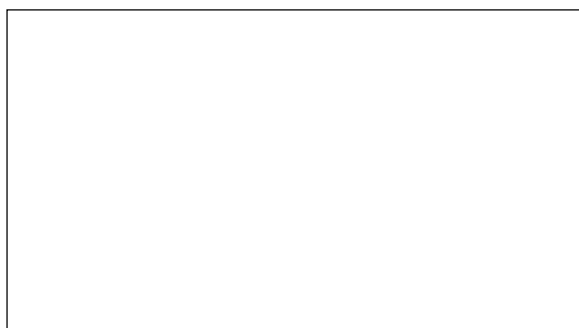
For more information on the University of Minnesota Center of Excellence in Women's Health, see their website at <http://www.womenshealth.umn.edu>, or email wmhealth@umn.edu. For information about the National Centers of Excellence, see their website at <http://4woman.gov/COE>.



The award of the Center of Excellence in Women's Health (CoE) to the University of Minnesota is a major victory for our community.

Lastly, Kasia Litak, MD has been doing an excellent job of organizing speakers for the local meetings of the **Women Psychiatrists** group (part of, but not limited to, members of the Minnesota Psychiatric Society). Topics have included the use of anticonvulsants in pregnancy and cardiac disease in women. These meetings are a nice chance to get together informally to discuss issues related to women's health and the issues particular to women psychiatrists.

This is not a comprehensive report of meetings in the area of women's health, only some good examples of local efforts to address the specific needs of women and their families. ■



Drs. Nancy Raymond and Benita Dieperink convene with Ann Taylor, MD after her presentation at the Science Museum.

Fall Meetings Feature Timely Topics



Dr. J. Michael Bostwick provided emerging research about SSRIs and suicide risk.



Panelist Carrie Borchardt, MD discusses SSRIs and risk for suicide in children with Bob Nesheim, MD.



Dr. Joe Westermeyer discussed cultural aspects of clinical care.



Tiffany Chow, MD updated attendees about frontotemporal dementia.



Benita Dieperink, MD reviews the finer points about post partum depression with presenter Nada Statland, MD and Judy Kashtan, MD.



Panelist Jeff Hardwig, MD offered clinical insights and shared his clinical experience after the recent FDA warnings.



Ad hoc

International Falls

By Jeffrey Hardwig, MD

A system for achieving a patient centered coordination of care standard

A notable casualty of a fragmented system of mental health care has been the communication between the separate elements of the care continuum. Effective communication with and on behalf of our patients is as essential to psychiatry's work as the scalpel is to surgery, and we have essentially dropped our main tool on the floor.

In my corner of Minnesota, the consequences of not communicating were becoming plainly and repeatedly evident. I have an exclusively outpatient practice with the nearest psychiatric unit 118 miles away. There were occasions when my own patients would end up being transferred to out of town placement through our local community hospital emergency room and I would first learn of it when they appeared for their next follow-up appointment, perhaps weeks or even months later. This was both unsettling and unacceptable.

What didn't take place in this non-system of care? I did not have the chance to assist the inpatient providers with diagnostic information. I could not ask questions or request tests or interventions that could only take place in an inpatient setting. The home town team could not be alert to a high risk patient who needed an earlier appointment than that available through routine front desk scheduling. It was a situation full of inefficiency and risk.

What follows is the result of the combined efforts of the various entities involved in hospitalization a psychiatric patient in our area. Let me point out here that there was a reassuring level of cooperation among all those involved.

System Elements:

- Fairview, University Medical – Mesabi; Hibbing Inpatient Providers
- Falls Memorial Hospital Emergency Room; Physician and Nurses
- Koochiching County Social Services; Case Managers
- Northland Counseling Center Therapists (International Falls)
- International Falls Clinic Psychiatrist

Goals Were Defined:

- To speed the diagnostic process
- To increase safety and reduce errors

Owatoona

By Joseph Wilson, MD

We have an inpatient unit at the Owatonna Hospital providing treatment for people suffering the usual psychiatric maladies common to southern Minnesota. We have labored since January 1, 2004 under the burden of the ban on cigarette smoking imposed by our Minnesota state legislature.

Our staff uniformly favors the recommendation of a tobacco-free lifestyle for our patients. However, we are realistic and acutely aware of the folly of the well-intended effort to use the opportunity of a grave crisis in the lives of our patients to coerce what typically amounts to a very brief interruption in tobacco use.

We have seen no apparent reduction in the smoking habits of our patients after discharge. More importantly, we have documented assaults on staff, avoidable use of involuntary hospitalization, and refusals of clearly indicated voluntary admission in cases when patients find the sudden cessation of tobacco use to be intolerable.

We consider this dangerous and unjust policy to be an unintentional form of patient abuse, and call for assistance in our effort to overturn this legislation. ■

Boards Adopt Joint Statement on Pain Management

The Minnesota Boards of Medical Practice, Nursing, and Pharmacy have adopted a joint statement on pain management. The statement is intended to provide health care professionals with guidance to deal with issues of pain relief.

Inadequate pain relief is a serious public health issue. Estimates of Americans experiencing pain range from 50-75 million persons annually. According to David Holmstrom, RPh, JD, Executive Director of the Board of Pharmacy, "Health care providers often under-medicate because of the preception that prescribing adequate amounts of controlled substances will result in scrutiny by regulatory agencies."

The intent behind this joint statement is to reassure health care professionals that pain management is a legitimate and necessary aspect of the practices of all three professions, and to provide resources where practitioners can obtain additional information. Go to <www.northstar.state.mn.us> for more information.

MPS PAC Grows

By Galen W. Stahle, M.D.

The MPS PAC met on August 30th to discuss how to maximize the influence of our money. With the help of our lobbyist, Dominc Sposeto, we went through the entire list of 134 candidates for the Minnesota House of Representatives up for election in November. We decided to make donations to about 25 of these candidates for the purpose of making them aware of MPS and to make it easier for Dominic to approach them with important material in the future. We also discussed the possibility of fund-raisers and endorsements and decided to content ourselves with some small donations for starters.

For those interested in who was given money and how much, the details are available to any MPS member for the asking. Please contact Karen Dickson or Galen Stahle re this.

The MPS PAC is without a Mayo representative since Kevin O'Connor left town. If anyone from Mayo is interested or if you know anyone from Mayo who might be a suitable replacement for Kevin, please contact Karen Dickson.

We also have plans to assemble a cadre of MPS members who would be "ambassadors" or "assistant

lobbyists" and take a very active part in political "schmoozing", attend fund-raisers the candidates put on, etc. This would be a commitment of several years so that you could get to know legislators, they would get to know you and this would further increase the effectiveness with which we are able to further the agenda of the MPS.

Anyone interested in this activity should contact Karen Dickson to volunteer.

Thank you to our 2004 members!

Suzanne Albrecht, MD; David Cline, MD
Karen Dickson, MD; Phillip Edwardson, MD; Paul Goering, MD; Jeffrey Hardwig, MD; Judith Kashtan, MD; Mark Koller, MD; Eric Larson, MD; Glenn Lewis, MD; Deane Manolis, MD; Vanita Mishra, MD
Addy Murtaugh in memory of Robert J. Murtaugh, MD; John M. Rauenhorst, MD; Nancy Raymond, MD; Chris Sigurdson, MD; Werner Simon, MD; Ivan Sletten, MD; Galen Stahle, ME; James Swenson, MD; Tracy Tomac, MD; Jonathan Uecker, MD; Robert J. Wasson, MD. ■

Legislative Report *Continued from page 5*

training in behavioral interventions. The cost of such training would be the responsibility of the proprietor of the home - by the way it is rumored that some people are making tons of money providing corporate foster care (one corporate foster care provider in Anoka county was overheard saying they made a half a million last year) - which suggest the money is out there.

Reimbursement codes for MA and PMAP covered clients for 1) payment of team meeting time for all essential providers who are working with committed or high need patients, 2) and for psychiatric consultation to other health care providers who are working with such individuals. It is well known that a small percentage of patients use a very large percentage of health care dollars. This could be reduced by effective coordination of care. Current reimbursement does not cover such work and as a result various providers who are working with such individuals often duplicate services, lack an overall direction, and poorly manage these individuals. Hopefully private insurers would see the benefit of reimbursing these services after it is tried with MA patients.

The current practice of **committing sex offenders** is a terrible waste of money. Other states have effectively (and for millions if not perhaps billions of fewer dollars) treat and managed sex offenders, by provid-

ing, longer prison sentences, treatment before release from prison, and by providing intensive supervision after release. The sex offender population is growing very rapidly, and DHS will have to expand its bed capacity for them. Under the current statutes the likely hood that many of these people will ever be released is very small. It is anticipated that the eventual cost may be as much as \$50 million per year for this program. Keep in mind this is money that is coming out of the DHS budget. The current administration is not in favor of raising taxes - so other programs provided by DHS will need to be dramatically cut.

Development of a reimbursement code for screeners and facilitators who are responsible for **identification of mental health problems of children in schools** (as part of the larger mental health in schools initiative).

To help curb growing health care costs: We propose the creation of a five **person Board of Health Plans and Health Policy**. The public in general elections elects members of this board at large. Terms would be 6 years, and would be staggered so that two seats are up for election every two years. The Board would function more or less like similar boards that oversee power utilities in many states. Members of the board can not have any

Continued on page 11





Scientific smorgasboard

Compiled by Eric Brown, MD

Scientific smorgasboard

We are introducing a new regular feature in the newsletter this quarter. This segment will be devoted to presenting helpful or thought-provoking research related to the practice of psychiatry.

This edition's article illustrates our emerging understanding of how genes interact with social history, and provides another piece of evidence against the fallacious "genes vs. environment" dichotomy.

Influence of Life Stress on Depression: Moderation by a Polymorphism in the 5-HTT Gene

Avshalom Caspi,^{1,2} Karen Sugden,¹ Terrie E. Moffitt,^{1,2*} Alan Taylor,¹ Ian W. Craig,¹ HonaLee Harrington,² Joseph McClay,¹ Jonathan Mill,¹ Judy Martin,³ Antony Braithwaite,⁴ Richie Poulton³

In a prospective-longitudinal study of a representative birth cohort, we tested why stressful experiences lead to depression in some people but not in others. A functional polymorphism in the promoter region of the serotonin transporter (5-HTT) gene was found to moderate the influence of stressful life events on depression. Individuals with one or two copies of the short allele of the 5-HTT promoter polymorphism exhibited more depressive symptoms, diagnosable depression, and suicidality in relation to stressful life events than individuals homozygous for the long allele. This epidemiological study thus provides evidence of a gene-by-environment interaction, in which an individual's response to environmental insults is moderated by his or her genetic makeup.

¹ Medical Research Council Social, Genetic, and Developmental Psychiatry Research Centre, Institute of Psychiatry, King's College London, PO80 De Crespigny Park, London, SE5 8AF, UK. ² Department of Psychol-

ogy, University of Wisconsin, Madison, WI 53706, USA. ³ Dunedin School of Medicine, ⁴ Department of Pathology, University of Otago, Dunedin, New Zealand.

To whom correspondence should be addressed. E-mail: <t.moffitt@iop.kcl.ac.uk>. ■

This is a brief note to highlight the transition of co-editorship of this newsletter to Eric Brown, MD, who has already distinguished himself by his energetic commitment to MPS and will certainly do a wonderful job in this new role. I want to especially thank Linda Vukelich, who (as anyone who has worked with her knows) is an incredible resource to MPS and a gracious person. Also Ron Groat, MD has brought his experience to bear and offered many ideas for topics and new directions for the newsletter—especially around the perspective of the consumers of mental health care. I want to also thank Deane Manolis, MD for asking me to be co-editor, as I have learned a lot in many ways.

I will be devoting more attention to clinical work again, as a psychiatric consultant to the high-risk obstetrics clinic at Hennepin County Medical Center (HCMC). I also work in our Hennepin Women's Mental Health Program (HWMHP), where we specialize in the treatment of psychiatric disorders related to pregnancy and the treatment of menstrual cycle-related psychiatric disorders (the only program in the state to do so).

Benita Dieperink, MD

SAVE THE DATE!

The Minnesota Psychiatric Society and
the Minnesota Psychological Association
present

Assessing and Managing Risk for Violence and Suicide: Multidisciplinary Perspectives

Friday, January 28, 2005
Metropolitan State University, St. Paul Campus



The bigger picture *Continued from page 7*

mental health system's capacity to serve people with mental illness. There is bipartisan awareness and sensitivity regarding the need for change. Mental health services and support must be available, spanning the range from prevention and early intervention to accessing of inpatient psychiatric care, as it is needed. The Minnesota Psychiatric Society can lend its support, as a member of the Network, to ensuring that a mutually agreed upon legislative agenda is passed by sharing your support of the Network's combined stand on policies. Thank you for being part of a statewide effort to improve services and the lives of people with mental illness.

Current members of the Network include:

- Children's Mental Health Partnership (MCN)
- Family & Children's Services
- International Association of Psychosocial Rehabilitation Services (IAPRS)
- League of Women Voters
- Mental Health Association of Minnesota
- Mental Health Consumer/Survivor Network
- Minnesota Association for Children's Mental Health
- Minnesota Association of Mental Health Programs
- Minnesota Association of Mental Health Residential Facilities (MAMHRF)
- Minnesota Council of Child Caring Agencies
- Minnesota Disability Law Center
- Minnesota Nurses Association
- Minnesota Psychiatric Society
- Minnesota Psychological Association
- National Alliance for the Mentally Ill/Minnesota (NAMI/MN)
- National Association of Social Workers
- Office of Ombudsman for Mental Health and Mental Retardation
- People, Inc.
- Suicide Awareness/Voices of Education - SAVE
- State Advisory Council on Mental Health (State of Minnesota)
- Tasks Unlimited

Legislative Report *Continued from page 11*

financial ties to any health plan in the United States nor work for a health plan or have a family member who works for a health plan. The overall purpose of this board would be to balance consumer interests for access to quality health care against the growing costs of providing such care.

Specific areas of oversight might include:

- Approve any premium increases proposed by the major health plans operating in Minnesota
- Guide the direction of health care in Minnesota
- Promote best clinical practices

- Make recommendations to reduce administrative and overhead waste in Minnesota Health Plans
- To serve as the final arbitrator for denials of care by a Minnesota Health plan
- Review and approve treatments, services, and medication formularies covered/provided by Minnesota Health Plans

To help address **mental health provider shortages** and access: higher MA/ PMAP reimbursements for child psychiatrists, services provided by a clinic psychiatric nurses (decanoate shots, evaluations, therapy - which are currently not reimbursable) and, higher reimbursement for psychiatric Physician Assistants (current payment by MA is so low clinics loose money hiring PA's).

Minimum competencies for all providers of psychotherapy to provide diagnosis-specific therapies for major mental illnesses, which are frequently associated with costly involuntary commitment (major depression, bipolar disorder, schizophrenia, borderline personality disorder and eating disorders). Treatments provided for these patients must be ones recognized as being effective by the practice guidelines of the American Psychiatric Association and by similar guidelines developed by the American Psychological Association.

Legislation preventing the **provider tax** from being used for purposes other than health care.

Since there is an increasing number of mentally ill people ending up in the criminal justice system, and there is a growing problem with public defenders being able to manage their caseloads, a **2% tax on all practicing attorneys** (excluding attorney who work for state, county or federal governmental agencies) could help offset this growing need and help ensure better representation of the mentally ill, and hopefully these efforts would also steer courts towards treatment rather than incarceration.

To help address mental health provider shortages and access: legislation allowing **any willing qualified licensed mental health provider**, who is in good standing with their professional board to be able to collect reimbursement from all the major insurers in Minnesota. It is believed some insurers are still greatly restricting access to providers especially psychotherapists, are demanding a very labor intensive credentialing process, as well have requirements that go beyond what is needed for licensure. ■

Go to
mnpsychsoc.org
for updated news and information.

Continued ...



Editor *Continued from page 2*

competent might you feel about career planning if you knew more psychiatrists who actually practiced in the community? How much more could you learn about the current practice climate in Minnesota if you attended one of the open council meetings of MPS every other month? How much more professional expertise might you build if you participated in one of the MPS committees? I believe that this can be a crucial role for MPS – to expand the knowledge and awareness of our members-in-training about what the “real world” practice of psychiatry is like, and to help smooth the transition to the post-residency world. MITs – keep in mind that, in addition to contributing to the larger psychiatric community, you can also use your participation in MPS to your own benefit, helping yourself to learn more about the world of psychiatry before plunging in headfirst (and blind-folded?) after graduation.

I am very pleased to have the opportunity to work with Dr. Groat and with Linda Vukelich to try to maintain the historically high quality of this newsletter. I welcome your input and feedback about what you would like to see in these pages. If anyone wants to drop me a note, my email address is <brown134@umn.edu>. ■

Eric Brown, MD

John Scanlan, MD

Continued from page 6

abuse of children with handicaps.

John’s other volunteer activities have included chairing the National Association of the Deaf Committee on Mental Health and Deafness and serving on the Lake Qwasso Children’s Home Advisory Committee and the board of directors of Family Services, Inc. He is currently trustee of the F. R. Bigelow Foundation and a member of the Management Improvement Fund of the Saint Paul Foundation and the Development Committee of Wilderness Inquiry.

Neighborhood House has been building doorways of opportunity for vibrant, diverse communities since 1897. Neighborhood House works in partnership with individuals, families and organizations to meet essential human needs, facilitate active participation in community life, and provide access to additional community resources and programs. ■

Psychiatrist Needed at Hammer Residences

Dr. Michael Koch, recently retired HCMC Psychiatrist, has followed 18 MR/MI clients at Hammer Residences Main Office in Wayzata for the past 14 years. Dr. Koch provided monitoring of these clients’ psychotropic medications.

We need a Psychiatrist willing to spend two to two and + hours quarterly in Wayzata to continue this psychiatric med monitoring. Phone contact follow-up with emergencies as they arise will also be needed.

Mary Hoban Rutkowski, RN, CDDN will be present for all these appointments, and will do all scheduling as well as providing an efficient flow of clients. Direct Care Specialists will also attend all appointments with all current behavioral data and psychiatric referrals. Hammer Finance staff will also provide if needed any billing assistance of these MA clients.

Hammer Residences has been serving the MR/MI clients in the group home setting since 1927. We definitely are an excellent organization dedicated to providing quality care to the clients we serve. And we hope to continue on site psychiatric appointments to minimize client stress, yet provide the Psychiatrist with all the support to utilize this time most efficiently.

If you are interested in providing this service, please contact Mary Hoban Rutkowski, RN, CDDN at Hammer Residences at 952-277-2430 or email at <Mary@hammer.org>.

advertisement

Psychiatry Positions

The University of Minnesota and the Minneapolis VA Medical Center seek Part-time /Full-time experienced and mid-career psychiatrists.

Opportunities in addiction psychiatry, geropsychiatry, inpatient/day program, PTSD and rural psychiatry. Active teaching programs in addiction and geriatric academics. Opportunities and Academic rank proportionate to experience. Contact: Joe Westermeyer, MD, PhD, at 612-725-2037 or email: <weste010@umn.edu.> VA Medical Center, One Veterans Drive - 05, Minneapolis, MN 55417.

Equal Opportunity Employer

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International Falls *Continued from page 10*

· To improve patient continuity of care
Written Procedures were Developed:

- When patients were transported from the local community hospital ER to the nearest inpatient unit, the ER staff agreed to notify the outpatient treatment provider of the hospitalization.
- The outpatient treatment providers agreed to contact the inpatient provider in a timely fashion by phone followed by treatment records in order to assist the diagnostic process
- The inpatient provider agreed to contact the outpatient provider prior to discharge in order to communicate changes in diagnosis and treatment and to verify the availability of timely follow-up
- The outpatient provider agreed to arrange for follow-up for the previously established patients within one week of discharge and ASAP for new patients with a goal of within two weeks.

This system is in place and has greatly improved the continuity of care and I am certain has prevented errors. We are confident that we are doing a better job.

However, it is unrealistic and naïve to expect that changes like this will take place on a widespread scale without financial compensation for the time and effort this requires.

Unfortunately, there are considerable barriers to overcome in order to reintegrate our mental health care system and return to a patient centered coordination of care standard. Inequitable reimbursement for mental health care has created forces which pressure us into high volume practices and create disincentives for clinic administrators to hire more psychiatrists.

Even though I am not inclined to take on a high volume practice, I feel the pressure of need in my community to provide psychiatric care. There simply are not enough psychiatrists especially in rural Minnesota and there is precious little time to talk to patients much less other members of the treatment team.

The inpatient units that have survived the onslaught of cuts have been left with fewer beds and must also deal with high volume and rapid turnover of patients. In order to take the time to coordinate care on one's patient's behalf, another patient must wait.

Those of use who treat the mentally ill are eager to provide the kind of care our patients deserve. We need more resources in order to create or reintegrate our mental health care system. The pendulum can finally start swinging in this direction when psychiatrists are paid for communication on behalf of their hospitalized patients. We must get involved and make a difference wherever and however we can. ■

From the President *Continued from page 3*

- Allow reimbursement for more than one service per day,
- Pay for psychiatric consultation to primary care,
- Pay for services provided by mental health clinic nurses.

We will continue to advocate for these and other issues pertinent to MPS, during our meetings with the commissioners of Health and Human Services.

Please contact MPS with any feedback and suggestions for our activities. We can use your help. And don't forget, MPS now has a PAC. Pull out those check books! ■



You have just been subpoenaed. *Do you know how to respond?*



If you have your malpractice insurance through The Psychiatrists' Program you can rest assured. With a simple toll-free call, a risk manager can assist you with the immediate steps you need to take to protect your practice.

As a Program participant, you can call the **Risk Management Consultation Service (RMCS)** to obtain advice and guidance on risk management issues encountered in psychiatric practice. Staffed by experienced professionals with both legal and clinical backgrounds, the RMCS can help prevent potential professional liability incidents and lawsuits.

If you are not currently insured with The Program, we invite you to learn more about the many psychiatric-specific benefits of participation. **Call today to receive more information and a complimentary copy of "Six Things You Can Do Now to Avoid Being Successfully Sued Later"**

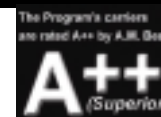
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Continued ...



Calendar

November 12-13

Vibrant Verisimilitudes from Venerable Virtuosi, Psychiatric Update/Fall 2004 - Monon Terrace and Convention Center, Madison, WI. for more information, contact Lynn Tobias at 608-827-2462 or go to <www.miminc.org/cmeconferences.html>.

November 16

Life After Residency, Different Perspectives 5:00 PM, Mayo Psychiatry and Psychology Treatment Center, Sister Helen Hayes Lecture Hall, Genrose Building, Rochester, MN. For more information call 651-407-1873 or go to <www.mnpsychsoc.org>.

January 28

Assessing and Managing Risk for Violence and Suicide: Multidisciplinary Perspectives Minnesota Psychiatric Society joint meeting with the Minnesota Psychological Association. Metropolitan State University Grand Ball Room, St. Paul, MN. For more information call 651-407-1873 or go to <www.mnpsychsoc.org>.

MINNESOTA PSYCHIATRIC SOCIETY

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