

Ideas

o f r e f e r e n c e



Spring 2004

Volume XXXVIII

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



Eric Larson, MD

Riding the third rail

By Eric Larson, MD
President-Elect, Minnesota Psychiatric Society

Our family recently spent Spring break at a family reunion in Boston, welcoming a new nephew. My 12-year-old son, who normally concerns himself with the trumpet, soccer, and video games, was completely enchanted by his 14-month-old cousin, adopted from India. My 14-year-old daughter enjoyed her role in the family as oldest cousin, telling stories to the younger ones and serving as ring leader. As we took the subway from the Alewife station to the connecting train to Faneuil Hall, I saw it—the third rail.

Many of the issues facing Minnesota psychiatrists today have to do with our own political third rail—money. Much of my year as President-elect will be spent in discussions about how we can deal with this highly charged topic, in a way that is healthy and good for our patients as well as ourselves. Malcolm Forbes was reported to have said that the answer to 9 out of 10 questions is money, and an unknown wise man said that money makes a good servant but a poor master. I will use the latter statement as a compass as we consider the questions below. The other compass I'll use is a motto of the institution at which I trained: "The needs of the patient come first."

By way of further introduction, I am currently in private practice, doing inpatient work at Fairview University Medical Center, and with an office in the west metro area. I am an Assistant Clinical Professor at the University of Minnesota Department of Psychiatry, and am co-chair of the "Correcting Financial Dysfunction" Subgroup of the Mental Health Action Group. These efforts have been sponsored by the Citizens' League of Minnesota, and have had a high degree of visibility with state government, payers, mental health professionals, and consumer advocates.

I trained and worked at Mayo Clinic for a total of 15 years, and worked at Park Nicollet Clinic for 9 years.

Here are some questions to start us off:

- How can Minnesotans pay for the mental health care needs of the poor in our state? Or of psychiatric patients in correctional institutions? How about the working poor with inadequate mental health coverage?
- How can we attract bright students to psychiatry when they can earn 3 times as much in other specialties? How does our financial situation compare to other medical specialists?
- How can we innovate and find more cost-effective

Continued on Page 13

MPS wins national awards

APA has singled out MPS for acclaim in three categories. Once again, the newsletter editors have been acknowledged for this outstanding publication and for the second year in a row, an MPS writer has won acclaim for excellence in editorial writing. This year the APA has a new award, the District Branch Best Practice Award. MPS won the award for the collaborative project resulting in the recent publication entitled, *The Minnesota Mental Health System: Demand Capacity and Cost*. A more detailed description of each award follows.

Continuing Excellence in the Newsletter of the Year Category

The Newsletter of the Year Award recognizes publications and their editors for communicating effectively with members and external audiences on matters of importance to psychiatry and the District Branch or State Association. Judging criteria include: how the entry addresses the publication's editorial goals; quality of writing and headlines; readability; originality; general layout and design; and overall

Continued on Page 13

Inside

President's letter	3
MPS news	4
Members on the go!	4
The bigger picture	7
Feature	8
Legislative report	10
APA news	11



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
1/2 page	300	250	200
1/4 page	200	150	125
1/8 page	100	85	75

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

Benita Dieperink, MD
Ronald Groat, MD

Managing Editor

Linda Vukelich

Executive Council Officers

Karen Dickson, MD
President

Will Dikel, MD
President-elect

M. Kevin O'Connor MD
Past President

William Clapp, MD
Secretary / Treasurer

Judith Kashtan, MD
APA Representative

Michael Koch, MD
APA Dep. Representative

Councilors

Floyd Anderson, MD
Jeff Hardwig, MD
David Opsahl, MD
George Realmuto, MD

Executive Director

Linda Vukelich

Legislative Affairs

Dominic Sposeto

Constitutional Committees

Maurice Dysken, MD
Constitution/Bylaws

James Jordan, MD
Ethics

David Cline, MD
Nancy Raymond, MD
Membership/Fellowship

M. Kevin O'Connor, MD
Nominating

Tracy Tomac, MD
Program

Standing Committees

Michael Koch, MD
Legislative

William Clapp, MD
Greater Minnesota

Kasia Litak, MD
Women Psychiatrists

Judith Kashtan, MD
Public Affairs

Floyd Anderson, MD
Private Practice

Maurice Dysken, MD
Awards/Research

Maria Lapid, MD
Early Career Psychiatrists

Maria Lapid, MD
William Orr, MD
Geriatric Caucus

A second childhood

Years ago I financed a great deal of college and medical school through singing and playing in a rock and roll band (Well, truth be told, my Dad helped a great deal, also) The point is I'm making music again, and it feels good.

It got me reflecting on a similar pattern of regression in my other professional career, psychiatry. I returned to the exclusive practice of our profession (relatively speaking), about four years ago. I found I still like it. Really like it. Better than I did ten or fifteen years ago. I like the patients (as a rule) who come to see me. They're interesting and I can help most of them with the tools available to us today. I enjoy my colleagues (as a rule); a motivated, well meaning and diverse collection of professionals. We interact with schools, police, courts, politics, business, academics, the military, religion, news agencies, and just about every nook and cranny of society. I can explore and apply neuroscience, chemistry, social science, medicine, psychology, common sense, and a variety of other information and opinions. My activities during the professional day can vary from diagnosing, to prescribing, to supporting, to giving advice, to challenging growth through therapy, to doing business, educating, comforting, advocating, to thinking, pondering and worrying. I'm challenged to stay clear of mind, patient and kind.

I'm just practicing psychiatry again, and it feels good. It's like a second chance, a second childhood.

(By the way—To the leadership and active members of the MPS. I don't remember a time when there were so many initiatives with so many connections to our community, locally and beyond. I hope *Ideas of Reference* captures the issues and the energy. This is our intention.)

Ron Groat, MD

Minnesota Psychiatric Society
Annual Recognition Dinner
Friday, May 21, 2004
Featuring awards presentations and guests:
APA Medical Director Jay Skully, MD

M.P.S.
SPRING SCIENTIFIC MEETING
Saturday, May 22, 2004
Minneapolis Marriott Airport

All good things must end...



by Karen Dickson, MD
MPS President

All good things must end...wonder who said that? I have enjoyed the privilege and pleasure of serving this past year as MPS President. It is a

privilege because MPS members trusted me and elected me, and because I learned so much in such a short time. It has been a pleasure because I love this organization and its members, and have enjoyed promoting our values, mission and goals.

In this activist year, MPS has defined for the first time a mission statement, and has articulated its priorities, goals and objectives. And we set out to accomplish them with determination and focus. The mission statement and goals served as a very useful road map throughout this busy year. Access to mental health services and reimbursement were a major focus for MPS this year.

Collaboration with the Minnesota Medical Association was a cornerstone in our efforts, and we succeeded in being heard by the major health plans about our concerns with reimbursement and access to mental health services. The Workgroup on Access to Mental Health Services delineated principles and recommendations that I hope will serve as an articulate working template for carrying our efforts forward.

I know that President-elect Will Dikel, MD and our next President-elect Rick Larson, MD, who both shared in the workgroup's efforts and experiences, will continue our focus and initiatives on access and reimbursement. MPS is promoting a legislative solution to access as well, the creation of a statewide Mental Health Authority to restore medical leadership and apply a public health model of early identification and early intervention and best practices.

Paul Goering, MD and I serve on the Citizen's League and DHS Mental Health Action Group's Steering Committee. This is a pivotal venue for implementing the principles and recommendations that we delineated in our own workgroup on access. I am cautiously optimistic that the political will, determination, and leadership exist within this Steering Committee on Access to bring the light of day and the fresh air of reform to a crippled mental health system badly in need of reform.

We published a well respected landmark report on the mental health system in Minnesota in collaboration with other mental health advocacy groups and state agencies, which in turn provided a forum for other useful collaborations in our efforts to reform the mental health system. Linda Vukelich's dedicated, tireless efforts were phenomenal in breathing life into this very useful project and report.

MPS membership increased to within five members of our goal of 450 which will earn us an additional APA Assembly Representative. It is likely we will attain that goal later this year. MPS succeeded in prompting APA to offer amnesty on back dues, and to reconsider possibly reversing this policy permanently. Payment of back dues is a definite obstacle to lapsed members rejoining MPS, and also impedes the growth of both APA and MPS by discouraging returning members.

Geriatric and correctional psychiatry have been enlivened, and early career psychiatrists were actively recruited through two dinner events with featured keynote speakers through the dedicated efforts of Judy Kashtan, MD and Floyd Anderson, MD.

Pivotal and critical alliances with Minnesota Medical Association, the Minnesota Society of Child and Adolescent Psychiatrists, NAMI-MN, SAVE, the Mental Health Association and Minnesota Psychological Association all were promoted and strengthened by regular meetings with representatives of these groups.

We formed a Political Action Committee, still in its fledgling stage. I am pleased that Deane Manolis, MD is reaching from his retirement to co-chair the new MPS PAC.

The Council defined written job descriptions of our executive director and lobbyist, and conducted performance reviews for the first time. Overall organizational structures were tightened, defined, revitalized, and given new energy and direction.

We have active co-chairs on key committees, the Legislative Committee and Membership Committee. I am confident these committees have the advantage now of both seasoned and fresh leadership.

Our past president Scott Crow, MD, is planning a first time MPS sponsored Board Review course. Our

Continued on page 14



Council highlights

Highlights and Actions from the March 6, 2004 Council Meeting

Administrative Board Room, Fairview Riverside East, Minneapolis, MN

President's Report—Karen Dickson, MD suggested that MPS draft a letter to patients telling them that the provider tax is not going to support better health care and include a web link to a petition. **Action:** MPS will develop a letter and a web link to a petition. She also announced that she and Dr. Deane Manolis would be sharing leadership responsibilities for the PAC since Dr. Kevin O'Connor will move to New Jersey soon. In addition, Drs. Dickson, Dikel and Larson will convene a workgroup to work on a model contract. The Council's structure was discussed. Bylaws amendments to support increased liaison will be offered for consideration. **Action:** Bylaws amendments will be presented for a vote at the May MPS Scientific meeting.

Executive Director's Report—Linda Vukelich reported that the collaborative report was complete and that the news conference announcing its release was well attended. She announced that the Executive Committee had met with an expert to discuss an Independent Provider Organization. Questions remain regarding feasibility and value in the marketplace. **Action:** The Private Practice Committee will take the lead with a task force. Linda has also been meeting with the Minnesota Psychological Association's Program committee to plan a joint meeting which could include interactive TV broadcasts to locations throughout the state and incorporate local mental health fairs for the public. The 2004 MPS award winners were proposed, discussed and approved.

Integrated Care Task Force Report—Roger Kathol, MD described the MPS Task Force on Integrated Care's executive committee as one including psychiatrists, primary care doctors, health risk management

experts, etc. He described the intent of the task force – to set up 8 to 10 outpatient programs and 2 to 3 inpatient programs and the task force will help them to improve their model. The goal of the task force is to provide good models and an opportunity for health plans to change the way they pay in response.

Private Practice Committee Report—Floyd Anderson, MD announced that the committee has obtained Medical Necessity Criteria and will review it. He also described the recent Residents' Dinner featuring talks from private practitioners.

Legislative Committee Report—The Council heard from Dr. Joe Wilson, a member opposed to the smoking ban. Following discussion, the Council agreed to support the MPS Legislative Committee's recommendation to continue to support the ban. In addition, the Council approved the committee's recommendations to take a position against for-profit HMOs, support reimbursement for telephone consultations in specific situations and clarify that psychiatrists providing services to community mental health centers are exempt from the provider tax on payments made to them. MPS will support legislation requiring health plans to pay provider taxes that are itemized on patient billings and support a request from HCMC for state bonding support for its acute psychiatric service. MPS supports legislation sponsored by NAMI-MN that would require mental health screening for children who are suspended from school for more than 10 days in any school year. MPS supports changing the name of the Board of Behavioral Health and Therapy to the Board of Professional Counseling.

PAC Report—George Realmuto, MD reported that the PAC had 18 members and funds of \$4,100. ■

Members on the go!

New MITs: Negar Beheshti, MD (Henn-Regions); Heidi Iwanski, MD (Henn-Regions); Mohammad Rafiq, MD (Henn-Regions); Emily Rae-Stuart, MD (Mayo)

New GM: Kathryn Selmo, MD

Upgrade to GM: Deborah Coen, MD (U of M)

Reinstated GM: Susan Czapiewski, MD

Transfer Out: Lyle Christopherson, MD (to SD); John J. Witek, MD (to AZ)

Transfer In: Inder Raj K. Grewel, MD (from OH)

New Distinguished Fellows: Suzanne Albrecht, MD; Paul Goering, MD; Eric Larson, MD; Douglas Nemecek, MD

New Fellow: Sushila Mohan, MD

New Distinguished Life Fellow: Thomas R. Stapelton, MD

New Life Fellows: Arlene Boutin, MD; Terry Lehman, MD; John Rauenhorst, MD

MPS program development initiative

By Roger Kathol, MD, Integrated Care Task Force Chair

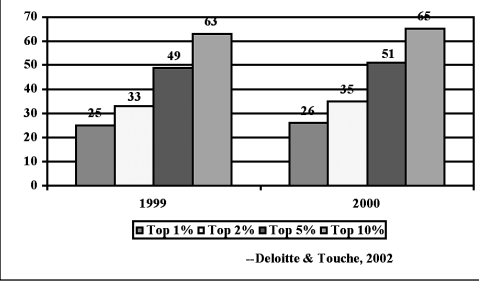


The vast majority of health care costs are incurred by relatively few individuals (Figure 1).

Many of the patients who fall into this high cost category are those who use behavioral health services (Figure 2). Importantly, nearly 80% of the total cost for these behavioral health patients are for general medical and pharmacy, not behavioral health claims expenditures, yet the communication and coordination of clinical services between general medical and behavioral health providers is minimal. In fact, the current system encourages service and cost shifting from the psychiatric to the medical sector and vice versa as independent medical and behavioral health business entities try to limit total dollars spent from their own respective budgets.

In an attempt to improve clinical outcomes and, ultimately, the costs associated with persistent behavioral health needs over time, members of the Minnesota Psychiatric Society have set up a Task Force charged with creating 8 to 10 outpatient and 2 to 3 inpatient clinical environments designed to provide integrated general medical and behavioral health service. To accomplish this objective, a group of Minnesota physician and non-physician leaders from industry, health plans, medical organizations, health care administration, government, and patient advocacy is seeking to identify hospitals and clinics (and

Figure 1: Percent of Claims Costs for Complex Patients



the providers therein) interested in participating in a collaborative effort to link medical and psychiatric care using the core outcome changing components from models of general medical and behavioral health care integration which have undergone longitudinal investigation.

How Is This Initiative Different? Why

Participate?

The MPS Task Force initiative is unique in the nation.

It combines several important factors which could create clinical and economic environments which reverse adverse outcomes in some of the most difficult and expensive patients treated in Minnesota.

Since participant clinics will create state of the art integrated care programs and health plans will collaborate by supporting “out of the box” reimbursement approaches which fairly compensate for and encourage coordinated general medical and behavioral health care, model integrated programs participating in this initiative could inform future improvements in care throughout Minnesota during coming years.

Participant program organizations and providers would experience:

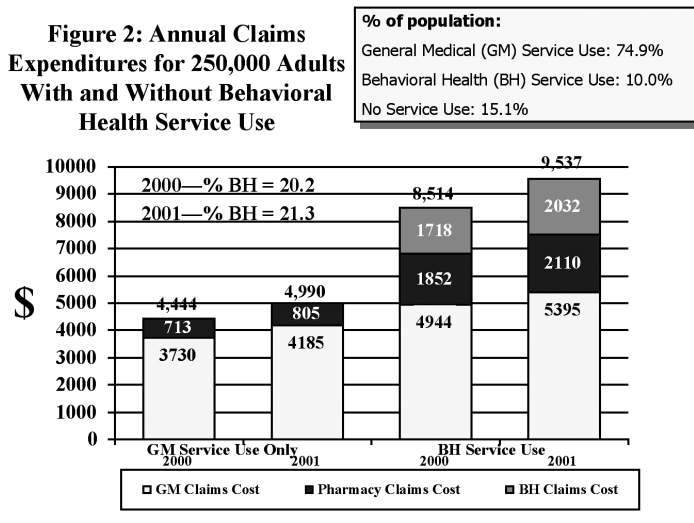
- Task Force support for creating their own version (model) of integrated care delivery designed to work in their system as long as core features

known to be effective in published reports and required for Task Force program participation are included.

- The development of a reimbursement environment for general medical and behavioral health specialists and participant general medical hospitals and clinics conducive to coordinated assessment and treatment of medical and psychiatric health care concerns or illness in the non-psychiatric setting. This will be done through collaboration between providers, care delivery organizations, government agencies, health plans, and employers. Each support system will be based on the model of integration established in

Continued on page 14

Figure 2: Annual Claims Expenditures for 250,000 Adults With and Without Behavioral Health Service Use





2003 Gloria Segal Awards

Senior medical students Kelsey Carignan and Sandra Joan Rackley are the 2004 Gloria Segal Award winners. This award is in memory of the late Gloria Segal, a Minnesota legislator who championed treatment excellence for the mentally ill and authored much of Minnesota's current mental health legislation.

The award, which includes a \$1,000 honorarium, is given to senior students at the University of Minnesota and Mayo Medical Schools, for excellence in pre-clinical and clinical psychiatric rotations, patient care, and research, as well as community involvement on behalf of the mentally ill, and enthusiasm for the profession of psychiatry.



Kelsey Carignan

Kelsey Carignan has been working with persons with mental illness for many years. She recently returned to the University of Minnesota to take prerequisites for medical school after receiving her BA from Oberlin College with a psychology major.

In college she was recognized for her excellent academic achievements through membership in Phi Beta Kappa and the Sigma Xi Scientific Research Society. In 1990, while studying in Portland at Reed College, Ms. Carignan was the Nominee for the Harry Truman Public Service Scholarship.

Ms. Carignan has a long list of research experiences. She worked with MPS members to produce a research paper entitled, "Pharmacotherapy of Borderline Personality Disorder", a retrospective study of the medication and psychosocial treatment of 91 patients with borderline personality disorder at Anoka Metro Regional Treatment Center. She also designed and implemented her senior honors thesis at Oberlin College, entitled, "Effects of Failure, Success, and Neutral Feedback on the Mood and Eating of Restrained and Unrestrained Eaters". She also assisted in development and implementation of a study designed to measure the impact of community support services on the success and satisfaction of clients with mental illnesses living independently entitled, "Service Outcome Study".

As a trainer/consultant at Supportive Living Services, Ms. Carignan provided consultation and training to mental health staff working with clients with a diagnosis of borderline personality disorder. She taught the skills modules of Dialectical Behavior Therapy and also provided individualized services to a caseload of 17-20 persons with serious and persistent mental illnesses as a psychiatric rehabilitation practi-

Continued on page 13



Sandra Joan Rackley

Sandra Joan Rackley plans on finishing her medical degree at the Mayo Medical School this June. She has been recognized with the Dean's Award full tuition scholarship 2000-2004, named the Edward Crosland Stuart Scholar,

1998-2000, and won a merit scholarship and funding for summer service demonstrating Christian commitment, leadership potential, academic achievement, and vigorous outlook. Along with several honor societies, Ms. Rackley was also the 1999 winner of the Daniel Blain Woods Award. It recognized her for exhibiting qualities required of a good doctor: wisdom, compassion, desire to serve, ability to analyze problems, integrity, and academic excellence.

Along with acquiring knowledge, Ms. Rackley also has considerable experience imparting knowledge to others. In 1998 she taught a summer English immersion course for college students in Kashgar, China by leading seminars and tutoring individuals. Through the Mayo Outreach to Students and Teachers, she led interactive health presentations for local K-12 classes on a variety of topics. She also developed a mental health presentation and learning experiences for middle and high school classes.

In her academic life, Ms. Rackley is a leader. She has served on the Bioethics Curriculum Committee from 2000 to 2004 as student representative responsible for longitudinal bioethics curriculum in the medical school. During the same time she helped establish and maintain the curriculum database used in internal reviews and the LCME accreditation process. She is a full voting member of the Mayo Medical School Admissions Committee which is responsible for making appointments to Mayo Medical School class of 2008, evaluating applicant files

Continued on page 14

MPR focuses on mental illness

by Linda Vukelich



Entitled, A Bad State of Mind: Minnesota's Fractured Mental Health System, Minnesota Public Radio (MPR) aired a week-long series of stories about mental health in Minnesota earlier this year. As this year's Excellence in Media award winner, MPR is being recognized for its continued efforts to inform and enlighten Minnesota listeners about a very complicated system and the people it impacts. The following are excerpts from the stories aired. Our congratulations to each of the reporters for their outstanding work and to MPR for this well-deserved honor.

An "ugly" process

by Tom Scheck

Mr. Scheck's report about the Minnesota mental health system's shortages and long waits captured the impact it has on individuals and their families. He noted that families in crisis may have to wait months for treatment of mental health diseases, while health care organizations are closing mental health treatment facilities even as the rates of mental health disease soar.

A combination of a shortage of services and a confusing system means that the mentally ill often choose the easiest, yet most expensive option, the emergency room.

The report included information from the General Accounting Office that said more than 1,000 children were placed in Minnesota's child welfare system so they could receive mental health services in 2001.

Mr. Scheck interviewed Glenace Edwall, with the state Department of Human Services who said her agency recognizes the problems and plans to propose changes to improve the mental health system.

The report illuminated the need to build capacity statewide.

A needless suffering

by Lorna Benson

Ms. Benson reported on the shortage of psychiatrists who treat children and provided individual stories illustrating the personal price children and their families endure when they cannot get treated. She noted that, based on national estimates of 15 million American kids having a psychiatric disorder, if the current pool of the nation's child and adolescent psychiatrists divided that caseload, each psychiatrist would have almost 2,400 patients.

Every day children with psychiatric disorders are forced to wait for care while kids with colds and earaches get immediate medical attention.

MPS President-elect Eric Larson, MD offered his input. "We see kids who had clear symptoms of depression or anxiety that lead to them failing school

and ruining relationships and feeling like a failure and if they had been seen six months ago, they wouldn't have gotten so disabled that they needed to be hospitalized. That's just almost an every-day event." Dr. Larson calls it "an unnecessary crisis."

The situation won't improve until some basic changes are made in the health care system.

Depression in the elderly is hard to treat

by Erin Galbally

Ms. Galbally interviewed Dr. William Orr who heads the geriatric psychiatry department at the Minneapolis VA. He made the point that the current mental health system is struggling to meet the treatment needs of older adults, predicting the demand for mental health services among the elderly will continue to increase.

The 50% co-pay under the federal Medicare program for patients receiving psychiatric services was also highlighted as a proactive care disincentive.

People who make a difference

by Bob Collins

Mr. Collins provided sketches of five people who make a difference. These are people making a difference at a grass roots level.

Pete Feigel - Pete Feigel was diagnosed with major depression at 13, hospitalized at 15, and spent nearly a quarter of his life in Minnesota's mental health care system. Mr. Feigel has been a subject of this column in the past and won the MPS Advocacy award.

Mary Meyer - Mary Meyer is a Woodbury police officer who specializes in police response to incidents involving the mentally ill and conducts training for other officers.

Louise Brown - Louise Brown is director of Minnesota's Children's Mental Health Partnership, a coalition of parents, educators, human service workers, politicians, and criminal justice system workers.

Joe and Joann Zwack - The Zwacks co-founded the Forensic committee of NAMI-MN (National Alliance

Continued on page 15

The bigger picture



Psychiatric Residents &

by Benita Dieperink, MD

We asked the Residency Training Directors of the three Psychiatry programs in the state to describe

- 1) are there guidelines issued by AADPRT (the American Academy of Directors of Psychiatry Residency Training) and ACGME (Accreditation Council of Graduate Medical Education) regarding the residents' professional interaction with pharmaceutical companies?*
- 2) how are the Training Directors handling the residents' education about how to manage their professional interaction with the pharmaceutical industry (how to handle marketing influences or pharmaceutical grants; how to evaluate independently the accuracy of the pharmaceutical literature, etc.).*

Thomas Mackenzie, MD of the University of Minnesota program, Elizabeth Reeve, MD of the Hennepin-Regions program and Kemuel Philbrick, MD of the Mayo program replied.

The **AMA** (American Medical Association) issued guidelines to all physicians, regarding the influence of the pharmaceutical industry in 1991. These guidelines were an important step and they addressed the need to discontinue acceptance, by physicians, of gifts from the pharmaceutical industry that were extravagant and not related to patient care. They gave specific recommendations regarding the acceptance of educational materials, lunches, etc.

AADPRT has convened a task force, which has surveyed Residency Training Directors and issued recommendations in 2002:

- The committee would like to emphasize to the membership that this is an important topic and one about which it is important as well for residents-in-training to receive formal education and to discuss within their programs with faculty.
- The Committee recommends that program directors and residency programs strongly consider a formal didactic set of presentations to residents on this topic, and that training directors discuss this issue with residents. A copy of a model curriculum was created by Michael Jipson, MD, at the University of Michigan.
- The membership did not uniformly endorse that the AADPRT should support the AMA position regarding gifts from the pharmaceutical industry, but the Task Force recommends that the position of the AMA be distributed to residents-in-training and that it be discussed with informed faculty.

- The Task Force recommends that departments of psychiatry, or their home department, as well as medical schools, establish a clear policy regarding this topic and that the policy be distributed to residents-in-training and to faculty. The Task Force also recommends that existing policies be made available to membership to serve as potential models of such policies.

The **ACGME** has issued specific and thoughtful guidelines:

- Ethics curricula; full and appropriate disclosure of sponsorship and financial interests is required at all program and institution-sponsored events; programs and sponsoring institutions must determine through policy, which contacts, if any, between residents and industry representatives may be suitable, and exclude occasions on which involvement by industry representatives or promotion of industry products is inappropriate.
- Practice-based Learning and Improvement and Medical Knowledge—residents must understand the purpose, development, and application of drug formularies and clinical guidelines. Discussion should include such issues as branding, generic drugs, off-label use, and use of free samples.
- Systems-based Practice includes behaviors that demonstrate an awareness of and responsiveness to the larger context of health care and the ability to engage system resources to provide care that is of optimal value—these policies must clarify the differences between education and promotion;

THE PHARMACEUTICAL INDUSTRY



teaching institutions must ensure that programs have sufficient funds from appropriate sources to conduct their educational activities; resident curricula should include how to apply appropriate considerations of cost-benefit analysis as a component of prescribing practice; advocacy for patient rights within health care systems should include attention to pharmaceutical costs.

- **Interpersonal and Communication Skills**—resident curricula should include discussion and reflection on managing encounters with industry representatives. Illustrative cases of how to handle patient requests for medication, particularly with regard to direct-to-consumer advertising of drugs, should be included in communication skills curricula.
- **Conclusion:** The principles outlined in the previous paragraphs cannot guarantee individual or institutional professional behavior. Evidence exists, however, that policies relating to sources of educational support appear to affect what physicians believe and how they behave. The value of these principles, therefore, lies in their ability to inform policy and to represent to the public the integrity and objectivity of the professional relationships expected by residency programs and their sponsoring institutions. The ultimate goal of these relationships is to foster effective Patient Care, the general competency that underlies the mission of medical education.

Inappropriate promotional activities by industry seriously compromise the professional relationships maintained by residents, faculty, and patients that form the substance of medicine. These inappropriate activities must not be allowed to continue where they exist. The interests of the patient must be paramount and not contaminated by the profit-driven interests of industry for their shareholders.

PhRMA is a consortium of the major pharmaceutical companies in this country. They have joined to advance a “code” to manage their own behavior

toward physicians:

It explicitly spells out that all interactions should be focused on informing healthcare professionals about products, providing scientific and educational information, and supporting medical research and education.

This code is a good-will policy and there are no specific consequences outlined for failure to comply.

Dr. Mackenzie states, “this is a complex issue. We address it during orientation and residents are provided with the AMA guidelines and materials in the Federal Registry during the PGY3 year. It is a topic I frequently discuss with the chief resident since the interface is often with the resident noon conferences - part of their self directed learning experience....The outpatient director and I meet with the PGY3s weekly and frequently address physician-industry interactions. It seems to have worked best not to impose rules on the residents and they seem to respond by being quite thoughtful” He reports that policies vary and in some cases do not exist yet for the various sites where the University of Minnesota residents train.

Dr. Reeve makes formal education about interaction with pharmaceutical companies part of the outpatient didactic curriculum. This course focuses on compliance with HIPPA guidelines in interaction with pharmaceutical representatives, what training the pharmaceutical representative receives, and how to read the pharmaceutical literature, in addition to other topics. She allows some group sign-ups for educational materials but does not allow the pharmaceutical companies to give any money directly to any resident. For training program functions, she does accept funds but she controls planning the function.

Dr. Philbrick says, “although this issue is formally addressed with the residents and they are aware of both institutional and AMA policies, the day-to-day challenge is to infuse the residents with an attitude of thoughtful reflection on the multiple (and complicated!) questions that are woven into this question. We have tried to accomplish this both in structured ways such as holding a panel-debate on the pros and

Continued on page 12



Budget impasse lengthens session

by Dominic Sposeto, MPS Lobbyist

When the state legislature convened in early February, most legislators predicted a fairly quick session that would likely end in mid April. Now, a dispute over the supplement budget to address the state's \$160 million dollar shortfall threatens to keep the state legislature in session until the deadline established by our constitution, May 17th. The House, controlled by Republicans, and the Senate, controlled by Democrats, have dramatically different approaches to the budget shortfall. Compromise will be very difficult to achieve.

Last year, the state legislature established the state's biennial state budget. They faced a \$4.2 billion budget shortfall and voted to make some difficult cuts

in state spending. Most of these cuts fell on state health and human service programs. With just a \$160 million budget shortfall compared to last year's \$4.2 billion budget deficit, it seemed a quick fix would be possible, especially given the fact that the state maintains a \$600 million "rainy day fund". Apparently not.

The Governor submitted a recommended supplemental budget to the state legislature that called for an additional \$40 million of cuts in health and human services spending and did not draw on the rainy day fund. He also proposed reductions in other areas of government and the transfer of \$70 million from the health care access fund to the state's general revenues.

Shortly thereafter, the House Republicans announced their proposed supplemental budget bill. The House rejected the governor's health and human service budget cuts and opted for raising additional state funds through a state sponsored casino. The House did however go along with the governor on this raid of \$70 million from the health care access fund.

The Senate was the last to the dance and, not unexpectedly, proposed a very different solution to the budget deficit. The Senate not only rejects cuts in health and human services, they use some of their increased funding to restore the budget reductions made last year like co-payments on prescription drugs and limitations on psychotherapy services. The key to the Senate's proposal is the elimination of most assistant and deputy commissioners in state agencies. These administrative positions are appointed by the

governor and not considered civil service positions. Another feature of the Senate proposal is the closing of state tax loopholes which is projected to raise \$50 million. Most Republicans view this as a tax increase and will likely oppose it.

Both the House and Senate budget bills contain recommendations for controlling health care expenditures. They encourage disease management protocols and best practices by physicians. Exactly who would establish best practices and how they would be

managed are not entirely clear. However, the Senate would withhold payments to physicians who do not employ best practices under

The House, controlled by Republicans, and the Senate, controlled by Democrats, have dramatically different approaches to the budget shortfall.

state health programs. The Senate also proposes requiring that the state employ "evidence based medicine" for state health care programs. This concept is commonly referred to as the "Oregon model" that lists health diagnosis/treatment pairs based on their efficacy and cost benefit. Every two years, the state would determine the treatments on the list that the state can afford. Opponents of this approach call it health care rationing.

While both the governor and the House propose using \$70 million from the health care access fund to plug the budget gap, the Senate would merely take out a loan. Under the Senate budget bill, just before the end of the biennium the state would draw \$40 million from the access fund and put in the state's general revenue fund. This would cover an expected \$40 million shortfall and in essence balance the state budget. Then five days later, into the next biennium, the state would pay this money back to the access fund. Voila, a balanced budget for the current biennium, of course, this is just transferring the problem to the next legislature.

The next month of legislative debate will be devoted to the state budget impasse. No matter how it turns out, you can be assured that legislators of both parties will be touting their solution and criticizing the other party's solution during the upcoming fall election. ■

FDA advisory was dangerous

by Jeff Hardwig, MD, MPS Councilor,
International Falls



A number of my patients have called in a state of alarm following the FDA's public health advisory on Monday, March 22, 2004, regarding the newer generation of antidepressants developed since Prozac became available in 1988. I hope that those who read that advisory will also read the American Psychiatric Association's President's response to it. This letter represents my personal reaction to this for my patients and for anyone else who is concerned.

We rely on the FDA to regulate prescription medications to help keep us safe. We expect them to base their decisions on scientific data and to be well thought out. I believe in this case the advisory was neither.

The most apparent impetus behind the advisory stems from the discovery by the British equivalent of our FDA that the makers of Paxil had decided not to publish two studies on depressed adolescents which failed to show benefits of Paxil over placebo. Also, these studies showed an increase in suicidal thinking in the group on Paxil. In contrast, they did publish a positive study which showed Paxil to be better than placebo with no such increase in suicidal thinking in the medicated subjects. The British response was to issue a warning not only that Paxil was not allowed (contraindicated) for depressed adolescents but that all members of the SSRI family were contraindicated. The exception was Prozac which was believed to be sufficiently proven as safe and effective. The FDA initially made a less sweeping advisory directed against Paxil. Only later, in response to pressure from the bereaved parents, whose children had committed suicide after starting an SSRI, the FDA issued a much more global advisory which included all antidepressants developed since 1988 for not only adolescents but adults as well.

I can certainly understand the pressure one feels in the presence of horribly grieving parents and the overwhelming need to do something to help ease their psychic pain. Unfortunately in trying to help them the FDA has reached far beyond what the data would justify and there are very likely to be unintended consequences, even suicides, if people are frightened into stopping their medication.

People need to know that there is no evidence to indict the entire class of newer generation antidepressants as promoters of suicide in depressed children and adults. There is however a need for more

research on depression and its treatment in children and adolescents and there should be strong inducements for even negative studies by the pharmaceutical industry to be published. Our National Institute of Mental Health should be well funded. This is probably an area where our government can do a better job.

We rely on the FDA to regulate prescription medications to help keep us safe. We expect them to base their decisions on scientific data and to be well thought out. I believe in this case the advisory was neither.

I sincerely hope that there is a silver lining in the FDA's advisory. Hopefully it will elevate public awareness of the tragedy of suicide. In the 2001 Minnesota Student Survey of children in the 6th, 9th and 12th grades, students admitted to thoughts of killing themselves in the past year at a rate of 13%, 23%, and 17% respectively. Suicide is the second leading cause of death in 15 to 29 year olds and the third leading cause in both 10 to 14 year olds and 30 to 34 year olds. An average of 447 Minnesotans committed suicide each year for the past 5 years. Prior to the development of any antidepressants the natural history of Major Depression included the eventual suicide of 15 out of every 100 people affected.

Those of us who stand on the front lines fighting suicide need the best that science has to offer. We also are responsible for doing a better job of informing the public with accurate information. The FDA advisory made no mention of the older class of antidepressants, as if they were somehow safer choices. None of the older antidepressants was ever proven to be effective against childhood depression. I would never go back to those drugs as our first choices. One month supply of the older antidepressants is very likely lethal in overdose in contrast to the SSRI family of antidepressants which is more likely to be survived (overdose is never safe). Intentional poisoning was the leading cause of hospitalized injury for females ages 10 to 44 in 2001. How much worse would the outcome have been if all we had were the older antidepressants?

Continued on page 12



Texas offers action paper

Recently, an Action Paper was filed for the upcoming Assembly Meeting and endorsed by the Executive Committee of the Texas Society of Psychiatric Physicians entitled The Emperor Has No Clothes.

Subject: The Emperor Has No Clothes

Intent: Increase membership, decrease unnecessary expenses and have costs correlate with function.

Problem: The APA needs to attract and keep members and cut costs. APA membership across the country is not increasing on any sustained basis - despite increasing numbers of psychiatrists - and in most places, is declining. The most commonly-cited reason for drops is financial. We cannot afford superfluous or unnecessary expenses.

The Assembly of District Branches has no governance authority; this resides with the Board of Trustees. As an example, a recent legal opinion notes that, while the APA Bylaws state that District Branches shall be established, continued or dissociated according to the Procedural Code of the Assembly of District Branches, the Board of Trustees may unilaterally create or dissociate a District Branch, thus even defining the membership of the Assembly. We cannot afford \$780,000 each year of our members dues for meetings of a large body which is only advisory.

Alternatives:

1. Continue the status quo, expecting ever-increasing costs, increasing dues and declining membership.

2. Change the APA Bylaws to abolish the Assembly of District Branches.

3. Change the APA Bylaws to make the Assembly the governing body.

Recommendation: Not Option #1.

Implementation: To the Board of Trustees and membership.

Estimated Cost:

1. \$780,000/year and increasing

2. \$780,000/year savings

3. \$780,000/year and increasing

Submitted by: Priscilla Ray, M.D., A. David Axelrad, M.D. J. Clay Sawyer, M.D., Representatives, Texas Society of Psychiatric Physicians

Endorsed by: Executive Committee, Texas Society of Psychiatric Physicians, March 8, 2004

Psychiatric Residents & the Pharmaceutical Industry

Continued from page 9

cons of industry involvement with trainees and in less formal ways such as watching our own choices and behaviors as faculty. We have chosen to allow some educationally-focused gifts (e.g., textbooks are provided to the Chief Resident who then awards a book each month to the resident who had the busiest ER on-call) but have declined others (e.g., the residency program opted to fund the monthly evening meal to accompany the residents' Psych Cinema club rather than accept an offer from a pharmaceutical company). Our experience is that the incoming residents of the past couple years have been more sensitive to these issues and this may reflect that this topic is earning more attention in medical schools.

N.B. Unfortunately, I did not survey any residents in writing this article. Commentary is welcome. Also, I will be going to the APA meeting in Manhattan next week and will see for myself how the pharmaceutical industry is interacting with psychiatrists on a grand scale! ■

FDA advisory was dangerous

Continued from page 11

Another silver lining of the FDA's warning is that it should alert all who treat depressed adolescents to be vigilant about monitoring for suicide potential especially early in treatment whether that treatment includes medication or not. If depression deepens rather than improves then suicidal thinking can emerge. If medication is used, there may be side effects that add to the person's total psychic pain and in this way add to suicide risk. Remember it can take weeks before medication kicks in but side effects happen right away. Also, if a very melancholic person has been secretly harboring suicidal thinking, once they start to get better but before they are completely recovered they have the energy to act on these suicidal thoughts.

Those who are on established regimens of antidepressants should not simply stop their medications. If you have questions call your doctor

Somewhere around one in five people will someday experience mental illness. My heartfelt wish is that they will not be less likely to seek help. ■

Riding the third rail *Continued from page 1*

ways to deliver mental health care when it is so costly and complex to measure mental health care outcome and quality in a valid manner? What role should our academic institutions play in designing affordable, real-world methods to do that, even in small offices? Is it possible, given current economics? What does that say about current economics? How do we fund high quality psychiatric training and education, and how do we more rapidly put psychiatric research findings into clinical practice?

- How can we determine our professional standards for volume and quality of care, when money has determined at least part of the various decisions we (and essentially every rational human being) make every day in our practices? How do we do that and still take into account individual differences, and differences in settings? How can we talk about money and not be self-serving in a negative way?
- Will we ever develop consistent relationships with our major payers which are based on trust and aimed at success for patients, payers, and clinicians? What is changeable, and what can never change, as we consider that question? How do we negotiate effective contracts, which acknowledge our scarcity and ability? How do we demonstrate that ability? What questions are others asking about psychiatrists right now, which we do not know about?

The questions are intended to challenge the citizens of Minnesota, the state government, the payers, and ourselves as psychiatrists. I hope they will lead us to more questions, then answers. I will use the coming year to talk with as many of you as I can, to learn how I can most effectively represent and advocate for our patients and you in the complex biopsychosocio-economic arena of 21st century mental health care. ■

MPS national awards *Continued from page 1*

impression. The newsletters are judged by the Newsletter of the Year Corresponding Committee.

The Continuing Excellence designation is recommended for a publication that has consistently excelled year after year, or that has made special journalistic contributions to its DB/SA.

Best Editorial

MPS Past President, Dr. M. Kevin O'Connor won the APA's Award for Best Editorial with his president's letter entitled, *What does it mean to be in a crisis?* published in this newsletter last year.

This award is presented to the author of an original high quality original editorial concerning a current issue in psychiatry. Editorial entries are judged for eloquence, writing quality and style, timeliness, significance of the issue and its relevance to members.

MPS Wins APA Best Practice Award

Nada L. Stotland, MD, MPH, Chair, Assembly Awards Committee announced that MPS won the 2004 Assembly Best Practices Award for the collaborative publication project which incorporated stakeholder meetings and produced a publication entitled, *The Minnesota Mental Health System: Demand, Capacity and Cost*. The award will be presented at the Assembly's spring meeting on May 1.

Dr. Stotland acknowledging the excellence of all the District Branch Best Practice Award submissions when she made the announcement. MPS won the award "in recognition of their groundbreaking project to publish a data-driven, comprehensive document on MN's mental health system, with input from all relevant state agencies and private systems, and to distribute the publication to state legislators, state and county officials, and the general public, providing a crucial empirical base for public policy and advocacy." ■

Kelsey Carignan *Continued from Page 6*

tioner, including medication and symptom monitoring, supportive counseling, and housing assistance. In addition, Ms. Carignan has worked with adults with developmental disabilities and behavioral disorders, supervising and providing direct patient care. She has also worked with the Hispanic migrant community as a bilingual financial worker, helping clients with financial assessments and distributions, as well as translation services.

Kelsey Carignan has been a peer counselor to U of M medical students since 2000. And she has been a volunteer counselor and intake worker in Portland, Oregon, where she offered supportive counseling to women seeking help through Bradley / Angle House Battered Women's Shelter.

As you can see by her accomplishments and experiences, Ms. Carignan is an excellent Gloria Segal recipient. Congratulations! ■

WILLMAR - Rice Memorial Hospital is actively recruiting for a general adult psychiatrist to be the third psychiatrist for its mental health clinic. The position is approximately 80 % outpatient / 20 % inpatient. The inpatient unit is a 12 bed program within a general hospital setting, providing services for patients ranging from mid-adolescence through geriatric. Call is light.

The position is full time. Salary and full benefits are excellent. Located approximately 1 1/2 hours west of Minneapolis, Willmar is located in an outdoor recreational area with many lakes. Send letter of interest and CV to Mary Kjolsing, Rice Memorial Hospital 301 Becker Ave. SW, Willmar, MN or fax: 320-231-4862 For more information call: 320-231-4394





President's Letter *Continued from page 3*

ties to the Department of Psychiatry at University of Minnesota Medical Center were renewed on the occasion of Dr. Charles Schulz's visit to the MPS Council in September.

MPS is also planning a major joint educational event with the Minnesota Psychological Association for 2005 on the topic of suicide. Psychodynamic, demographic and neurobiologic perspectives will be integrated. I am pleased that we have developed strong ties with our psychology colleagues in a time when it seem there is so much acrimony and disharmony between psychologists and psychiatrists in other parts of our country.

We also were able to make our communication more nimble and responsive to time-sensitive matters. I hope that during their presidencies Will Dikel, MD and Rick Larson, MD will take advantage of continuing the MPS Happenings E-Newsbulletin.

The last year also brought sad news of the premature death of Myron Malecha, MD, and the loss also of Robert Murtaugh, MD, both long term MPS members with outstanding reputations for dedication to patient care and long careers serving psychiatry in Minnesota. Somehow, it seems, in our beleaguered health care environment, that we don't have the giants of medicine that we used to have. Perhaps they don't make them anymore, or we have forgotten how to grow them.

MPS has two ongoing taskforces, the Taskforce on Collaborative Care chaired by Roger Kathol, MD, and the Taskforce on Quality Psychiatric Care chaired by Floyd Anderson, MD. The latter will be reviewing the long sought and long coveted BlueCross BlueShield medical necessity criteria, along with the criteria of other health plans. This is an attempt to ensure that the health plans are defining medical necessity in a way that is consistent with prevailing community standards of care.

The Minnesota Medical Association also has appointed a visionary Taskforce on Health Care Reform chaired by past President and MED PAC Chairwoman, Judith Shank, MD. Psychiatric representation on this taskforce is vital and we were able to achieve that with the appointment of Roger Kathol, MD to the MMA health care reform taskforce.

Vincent van Gogh said "great things are not done by impulse, but by a series of small things brought together." I hope I have succeeded in small things begun and accomplished this year, and hope they will accrue in time towards improving mental health care for our patients. I view the practice of medicine and care of patients as a sacred trust. As physicians, we are privileged by our fortunate backgrounds and talents, and we are highly educated, a great privilege indeed. Even in these challenging times, physicians still generally are highly regarded and respected, and listened to as leaders. We can indeed change things

for the better through a series of "small things brought together." The collective energy and efforts of each of us can bring about change. Together, we can indeed do "great things." ■

Integrated Care Task Force *Continued from page 5*

each specific program with special attention to generalizability at a later date.

This initiative provides an opportunity for general hospitals and general medical or multispecialty clinics to improve access and coordination of general medical and behavioral health service for patients seen in the primary and specialty care setting. Through collaboration with government agencies and health plans, new ways to reimburse for both general medical and behavioral health services which do not fall within the typical payment parameters defined by independent behavioral health business practices will be agreed upon and initiated in the MPS participant clinics and inpatient programs. Special attention will be given to fee structures and authorization requirements for behavioral health so that the providers who will be working in non-psychiatric settings receive fair compensation for services provided and are not burdened by authorization hassles.

Using this approach, general hospitals, non-psychiatric clinics, and the general medical and behavioral health providers in both of these clinical settings can expect fair compensation for the services provided on par with other hospital and clinic services at the participating institution. Perhaps the most important reason for participating in this initiative, however, is that it should lead to timely psychiatrist and behavioral health team access, designed to complement and support non-psychiatrist physician behavioral health care; improved general medical and behavioral outcomes; and, ultimately, lower the cost of care for affected individuals within the institution served. ■

Sandra Joan Rackley *Continued from Page 6*

and interviewing prospective students. And as student representative of the Psychiatry Medical School Education Committee since 2003, Ms. Rackley evaluates horizontal and vertical integration of psychiatry within the medical school curriculum.

She enjoys a full range of research activities and presentations. Ms. Rackley is also a generous volunteer offering medical and public health support to the poor in Bangladesh and Honduras. She also mentors individual high school students and their programs through People of Hope Youth.

Sandra Joan Rackley is exceptional medical student leader with excellent credentials and a very bright future. We are pleased to recognize her as a recipient of this years Gloria Segal Award. ■

Continued ...

The bigger picture

Continued from page 7

for the Mentally Ill of Minnesota) and have worked to change the Minnesota system and raise awareness of needs the mentally ill in prison. They received a Champions of Health Award from Blue Cross Blue Shield in 2003.

On the front lines

by Lorna Benson

Ms. Benson aired a report that looked at some possible solutions to the crisis in lack of child and adolescent psychiatric care available in Minnesota. She reported, "State officials and health plans say they're aware of the problem and they agree the solution might require a radical change in the way Minnesota doctors care for their patients."

Read Sulik, MD, MPS Councilor and child and adolescent psychiatrist, offered a new model. Instead of relying on the traditional model in St. Cloud, he began by recruiting more mental health specialists, looking for doctors who wanted to learn more about mental health, primarily pediatricians and family doctors.

Today Dr. Sulik works less than 30 feet away from the other doctors making the most of this new model.

Managing the illness

by Tom Scheck

Tom Scheck interviewed consumers managing their illness to share the point of view of the individual. He noted that the system is confusing and that people who have difficulty managing their illness often end up in the hospital, on the streets or in jail. However, many do manage their illnesses successfully.

The report noted that "managing a mental illness is a life-long process." While drugs cannot effectively cure a mental illness, some can control the effects.

His interviews offered insight into successful management, including: strong family support, good genes, sometimes luck and hope. According to one man, "If you don't have hope, hardly anything else matters."

This report offered consumers a voice, an opportunity to talk about their mental illness, helping to reduce stigma by celebrating those successfully living with mental illness in Minnesota. ■



Minnesota Psychiatric Society
Annual Recognition Dinner
Friday, May 21, 2004
SPRING SCIENTIFIC MEETING
Saturday, May 22, 2004
Minneapolis Airport Marriott

BEFORE YOU SIGN...

If you are purchasing insurance for the first time or have a policy with another carrier, you may be surprised to find that not all policies offer the comprehensive protection you need in today's environment. Unlike most professional liability insurance programs, we have only one focus: psychiatry. We tailor our policy and services to meet your needs. Our staff of psychiatric professional liability specialists provides personal service and expertise...you will not have to explain psychiatric terminology to us.

Program features include:

- Claims-made policies
- Risk Management Consultation Service helpline
- Administrative and Governmental Billing Defense Costs Endorsement
- Policies issued require the insured's consent to settle* - no "hammer clause"
- Forensic psychiatric services coverage
- Discounts include: child and adolescent, early career, member-in-training, part time, and risk management education

Call today to receive a complimentary copy of *Before You Sign - An Insurance Purchase Checklist!*

THE PSYCHIATRISTS' PROGRAM

The APA-endorsed Psychiatrists' Professional Liability Insurance Program

Call: 1-800-245-3333, ext. 389 • E-mail: TheProgram@prms.com • Visit: www.psychprogram.com

Continued ...



Calendar

- May 1-6** **APA Annual Meeting**, New York City, NY. Call that APA at 1-888-35PSYCH for more information or go to the APA website at <www.psych.org>.
- May 21** **MPS Recognition Dinner** - Marriott Minneapolis Airport Hotel, Bloomington, MN. Contact Linda Vukelich at (651) 407-1873 or <l.vukelich@comcast.net> or go to the MPS website at <www.mnpsychsoc.org> for more information.
- May 22** **MPS Spring Scientific Meeting** - Marriott Minneapolis Airport Hotel, Bloomington, MN. Contact Linda Vukelich at (651) 407-1873 or <l.vukelich@comcast.net> or go to the MPS website at <www.mnpsychsoc.org> for more information.
- May 22** **MPS Council Meeting** - Marriott Minneapolis Airport Hotel, Bloomington, MN.
- July 15** **MPS Residents' Dinner and Practice Perspective Presentations** - U of M Alumni Center, Ski-U-Mah Room, Minneapolis, MN. Contact Linda Vukelich at (651) 407-1873 or <l.vukelich@comcast.net> or go to the MPS website at <www.mnpsychsoc.org> for more information.

MINNESOTA PSYCHIATRIC SOCIETY

4707 Highway 61, #232
St. Paul, MN 55110-3227

Address Service Requested.

Presorted Standard
U.S. Postage Paid
Permit No. 1435
St. Paul, MN 55101