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President's Message

Sheldon Miller, MD

I would like to begin my year as president of the Illinois Psychiatric Society by thanking a few of the people who have recently laid the foundation for our continued success in the future. These include the two most recent past presidents, Dr. Daniel Yohanna and



Sheldon Miller, MD

Dr. Dan Anzia. In addition we owe a great deal to our executive director, Meryl Sosa, who continues to advance the programs of the society. Many others also are due thanks but it would be impossible to name them all.

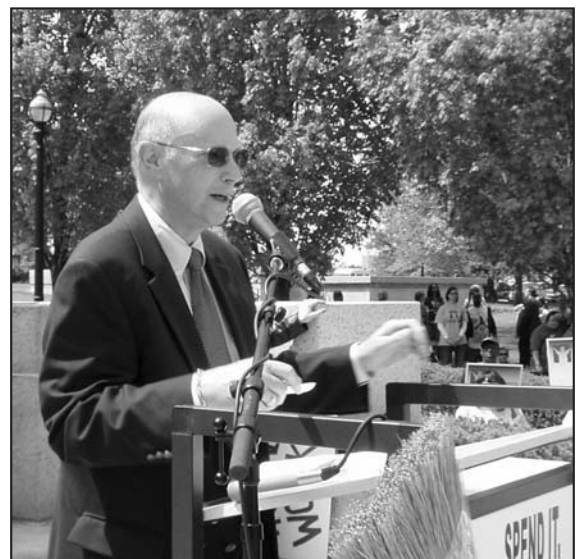
The Society has done much over the years and much remains to be done. I hope that in the coming year we can continue to make progress on projects started as well as new ones yet to come. Perhaps one of the most important tasks is the continuing need to encourage psychiatrists throughout the State to join in the efforts of the IPS. Those people reading this will most likely be members, but I hope that you will help our efforts by speaking with colleagues who are not members and encouraging them to join. We face many challenges including diminishing support for services to our patients in both the public and the private sectors. In order to educate and influence those that make decisions about health care delivery and coverage, we need to show a strong base of support for psychiatry evidenced by a passionate and powerful membership. We need to make sure that when health is discussed in Springfield that mental health is part of the discussion, not relegated to only discussions involving social service or corrections.

We are planning to have a reception and an IPS Council meeting in Springfield this year and hope that both members and potential

members will join their state wide colleagues for a dinner and discussion of some of the issues we face and potential strategies moving forward that will benefit our patients and our members.

Let me now just mention some of the things that IPS will be doing this year in addition to bringing the IPS Council to Springfield for a meeting. As some of you know this is the first year that the IPS has not been housed with the Illinois State Medical Society. With this move we felt as if this was the time to do something we have not done in a while; strategic planning for the future. The Council has had one long session already and plan to have another after the summer season when most of the members will be available. This is an important function and we will let everyone know what the outcome is. We are early in the process and would like input from any and all that would like to contribute. Please email to Meryl Sosa at msosa@ilpsych.org with any ideas. I should also add that I would love to see more members involved in the committee

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Dr. Miller speaking at Mental Health Rally. More photos on page 10.

A NOTE FROM THE EDITOR

Time to Unite

*J. Srinivasaraghavan, MD (Ashok Van),
Editor*

In 1955 there were 558,239 public (state and county) psychiatric beds available for mentally ill individuals in the United States for a population of 164.3 million. The availability of public psychiatric beds was thus 340 beds for 100,000 persons. In 2005 there were 52,539 public (state and county) psychiatric beds available for mentally ill individuals. The population of the United States was 269.4 million. The availability of public psychiatric beds was thus 17 beds per 100,000 people. By now, our population has crossed over 300 million and in all likelihood the number of psychiatric beds has further decreased. In Illinois there were 404.7 beds per 100,000 persons in 1955 and by 2005 we had 14.3 beds for 100,000 persons.



J. Srinivasaraghavan,
MD, (Ashok Van)

Considering a need of at least 50 beds per 100,000 persons, we need to increase the public psychiatric beds more than three times.

In the State of Illinois, nearly half the public psychiatric beds are occupied by forensic patients. In the past decade, an individual not meeting criteria for involuntary hospitalization, often was not accepted. Public Act 95-0602 was enacted recently with the sole purpose of lowering the standard for involuntary hospitalization. We are all sensitive to the needs of our patients and we can certainly empathize with the family members of psychiatric patients and their anguish when their loved ones refuse psychiatric care and yet not meeting the criteria for involuntary hospitalization when there was a stricter standard. It is a major success from the point of view of NAMI that the standard for involuntary hospitalization has been reduced. IPS neither supported nor opposed this legislation, not wishing to oppose the wishes of family members of psychiatric patients and yet cognizant of the realities of mental health funding.

This law poses major problems for both referring facilities as well as

receiving hospitals. How do we deal with the number of patients who meet the criteria for hospitalization, when that number exceeds the number of available beds? A professional at an outpatient clinic determines that one of his patients meets the criteria for involuntary hospitalization and has written the needed petition and certificate, only to find that there are no available beds. Where can the patient be housed? Who bears the liability when an untoward outcome results from non-hospitalization?

We have nationally a shortage of psychiatrists in general and a severe shortage of child and adolescent psychiatrists. Our public hospitals have significant difficulties in recruiting and retaining psychiatrists especially in the rural areas. Further, well qualified mental health professionals are also in short supply in some of the public psychiatric hospitals. This law is also likely to add to the volume of patients seen in the mental health court system, increasing the workload of judges, state's attorneys and defense attorneys. This law will most certainly test the stress on not only mental health but the available legal resources.

IPS has been a member of Mental Health Summit where all different stakeholders interested in the welfare of psychiatric patients join hands in advocacy. There are professional organizations that have differing opinions and a varied point of view on different issues. However, all the mental health professional organizations and consumer associations can agree about the magnitude of the shortage of public psychiatric beds. Of course, it has been documented that widespread use of Program of Assertive Community Treatment (PACT) and Assisted Outpatient Treatment (AOT) can help in reducing the need for inpatient hospitalization. The need for appropriate mental health funding by legislators is imperative and it is time to unite for advocating and achieving needed mental health care for our patients. ■

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President's Message

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activities of the IPS but it is not always possible to know who is interested in what issues. If anyone would like to join the committee process please let me know what your interest is and I will try to help you find the best spot based on your interests. I can be reached at amjaddicted@aol.com. I should add that these committees often meet by conference call so that there is no need to be in Chicago to be involved. We have a number of people from all over the State who participate and the more the better. In particular, we have just created a Telepsychiatry Committee and would welcome input from members in rural areas of the State to join this Committee.

Finally, let me just mention some other activities that IPS is involved in or will be. We have been very active helping a variety of state legislators to introduce and pass legislation that will be beneficial to the patient care we deliver. One example has been our successful efforts to get eating disorders to be a mandated diagnosis for insurance coverage. We have also been working with the legislature to make sure that psychiatric patients released from prison or jail has immediate access to Medicaid. More persons with mental illness are located in prisons and jails than are currently located in psychiatric hospitals. Thus, it is important to support measures that will help prevent recidivism upon discharge from prison or jail. Currently, ex-offenders leave prison without any medication or access to mental health professionals. Thus, persons who may have received mental health treatment for the first time in their lives and who may be very functional at the time of discharge decompensate quickly in the absence of treatment and return to their old habits. It is also critical for

all to know that we are carefully watching for any legislation that would attempt to change the scope of practice allowing non-medically trained people to prescribe medications.

We are also looking forward to having Chicago host the APA's mid year meeting, the Institute for Psychiatric Services. We have been working with the APA on this event. Due to IPS' close relationship with Congressman Danny K. Davis, he will be featured as the Keynote Speaker at the Institute. He is a staunch supporter of mental health and he is a great storyteller and we know you will enjoy hearing him. We will also be hosting a reception on October 2, 2008 for our members at Buddy Guy's Legends near the Palmer House. We hope that many of you will come by and enjoy some food, beverages, live music and great company! We will have a membership booth, so feel free to stop by and

say hello and maybe sign up to participate in a committee.

We will be having the IPS Annual Women Psychiatrist's Brunch on November 23, 2008, so please put this date on your calendar! Our speakers this year are APA President Nada Stotland, MD and Representative Deborah Graham. Representative Graham is an excellent speaker and we are pleased that Dr. Stotland will be participating in this event given her busy APA schedule this year!

Many other activities are ongoing and many new ones will emerge. I would love to hear your ideas. Please get involved, help us expand membership and help improve the psychiatric care for all patients in Illinois. I look forward to an exciting and productive year. ■

AMA, APA and other societies coordinate a multispecialty survey of U.S. physician practices

Have you been selected to participate in the Physician Practice Information survey?

The AMA and more than 70 other organizations are conducting a comprehensive multispecialty survey of America's physician practices. The results will be used to positively influence national decision-makers to ensure accurate and fair representation for all physicians and patients, and to articulate the challenges of running a practice that provides expert patient care, while operating a business that is sustainable. Of particular importance is the section of the study pertaining to practice expenses and the amounts that are attributable to you. The Centers for Medicare & Medicaid Services has indicated it will use the results of this study to help determine physician payment. The survey firm, dmrkynetec, will contact randomly selected physicians and practice managers to collect responses. All responses will remain confidential.

Please alert your staff regarding your willingness to participate in this survey and the importance of accepting incoming calls, faxes or e-mails from dmrkynetec, the firm administering the survey.

If you have been selected to participate in this important effort and have any questions about this survey, please call toll-free at 1-877-816-8940 and ask to speak with one of dmrkynetec's executive interviewers about the 2008 Physician Information and Practice Expense Survey. ■

Deep Brain Stimulation and a Brief History of Neurosurgical Interventions in Psychiatry

Anthony M. D'Agostino, M.D.
Alexian Brothers Behavioral Health
Hospital, Hoffman Estates, Illinois

The history of neurosurgical interventions in psychiatry is reviewed in scholarly fashion by Cosgrove and Rauch.¹ The following historical overview borrows liberally from this article.

Historical Overview

They remind the reader that the modern age began with Egas Moniz in 1936. He described the performance of prefrontal leucotomies performed by injecting pure alcohol with the aid of a neurosurgeon, Almeda Lima, in prefrontal areas. He reported a "worthwhile improvement" rate in 14 out of 20 in these very severely ill patients. He coined the term "psychosurgery" and it has been with us ever since. Moniz was certainly not cavalier in what he was attempting to do and won the 1949 Nobel Prize in Medicine for his work. While a generation of psychiatrists under whom this writer was trained attempted to discredit his work because of the way it was applied (especially in the United States), a respectable Nobel Committee obviously found scientific merit in his work. His paper appeared in the United States in the *American Journal of Psychiatry* in 1937.²

It is also well known that in United States Dr. Walter Freeman (a neuropsychiatrist) and Dr. James Watts (a neurosurgeon) began doing prefrontal lobotomies, the purpose of which was to interrupt white matter tracts in the frontal lobes based on Moniz's work. Despite complications

including frontal lobe syndrome, seizures, disinhibited behavior, and other signs of cognitive and personality deterioration, in the absence of anything better they felt they were fairly successful in performing this procedure in several thousand cases. The sheer numbers of procedures was facilitated by their use of a "lobotomy bus" which they used to travel from place to place doing these relatively brief procedures which were in many cases preceded by the use of unmodified ECT as anesthesia. Access to the brain initially began with bilateral burr holes but shortly thereafter they developed the "transorbital" approach by which an instrument was thrust through the relatively thin bony layers at the top of the orbit which allowed rather quick access to large areas of the frontal lobe which, in the absence of stereotactic precision, obviously resulted in damage to more than simply white matter tracts. What initially was touted as something of a medical miracle quickly resulted in a professional and popular reaction to prefrontal lobotomy and it all but stopped in the United States, no doubt hastened by the success of the introduction of new antipsychotic medications like Thorazine.

But the issue of mental illness as an aberration of brain function did not go away and interest continued in trying to understand the brain better and help the unhelpable. Nevertheless, to many psychiatrists and the public at large the juxtaposition of mental illness and

brain based treatments could not avoid ongoing references to Mary Shelley's Dr. Frankenstein.

In 1937 Papez proposed that there was a circuit that involved the interrelationship of cortical and subcortical nuclei and tracts and that these were very likely playing some role in human and mammalian emotional life. The concept of the "limbic system" was developed and expanded. It seemed a good bet that this "circuit" had something to do with affective states and affective disorders but just how they operated together has been something of a mystery until relatively recently.

Over time a number of procedures were developed with the expressed intent of becoming more precise in the creation of lesions and in attempting to limit the degree of collateral damage and subsequent side effects. Subcaudate Tractotomy was reported in 1964 as an attempt to minimize the size of surgical lesions specifically

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aimed at interrupting white matter tracts between cortex and subcortical structures. Indications included not only depression but OCD and various anxiety states. It soon became apparent through this and other work that schizophrenia was not going to be a very good indication for surgical intervention and this certainly remains the dominant feeling as of this writing. The incidence of complications was much smaller with this procedure but still not insignificant.

Anterior Cingulotomy was introduced after reports that stereotactic cingulotomy for intractable pain seemed to help concurrent anxiety and depressive states. H.D. Ballentine at Mass General Hospital eventually demonstrated the safety and effectiveness of cingulotomy in a fairly large number of patients. It had become the procedure of choice in North America in the last few decades and complication rates have been relatively low. Cosgrove and Rauch reported that in over 800 cingulotomies done at MGH since 1962 there have been no deaths, no infections, and remarkably few surgical complications. Moreover, they reported that patients who underwent cingulotomy showed no significant behavioral, intellectual, or neurologic deterioration as a result of the cingulate lesions themselves. They actually demonstrated some reasonably significant increases in IQ scores.

Another procedure was developed sometime later called Limbic Leucotomy. This was a combination of subcaudate tractotomy with anterior cingulotomy and was designed to address the unique symptoms of OCD. Like the other more recent procedures, these were done stereotactically and with a good deal of precision resulting in far fewer side effects and complications.

Anterior Capsulotomy is another procedure which has been practiced for several decades. In this procedure a lesion is created in the anterior 1/3 of the anterior limb of the internal

capsule. Lesions are created fairly precisely either by thermal coagulation or, more recently, using the Gamma Knife. Although capsulotomy has been used to treat both depression and OCD, it seems to be more commonly used for OCD. However, at least one device company may be about to enter clinical trials with the anterior horn of the internal capsule as a target for the treatment of depression using deep brain stimulation. Cosgrove and Rauch report that the complication rates for capsulotomy are higher than those seen in cingulotomy.

According to Cosgrove and Rauch, cingulotomy is judged to be the safest of all the procedures performed although, in terms of superiority of clinical outcome, no procedure appears to be convincingly better than another. However, they do report that at least 45% of patients receiving anterior cingulotomy require a repeat procedure with good response expected in about 50% of these. In these repeat procedures the usual strategy is to enlarge the lesioned area, usually by going lateral to the previous lesion and expanding the overall volume of ablated tissue.

Deep Brain Stimulation

What the last 70 years of surgical intervention has taught us is that the interruption of "traffic" between limbic/paralimbic areas and areas of cortex does result in measurable improvement in affective and some anxiety disorders but little or no improvement in schizophrenia. The downside has been deterioration in personality, executive function, other cognitive functions, memory, and disinhibition of social behaviors in some of these techniques.

The relationship between brain functions and the extent of, at times, indiscriminate destruction of both discrete tracts and functioning brain cells in critical frontal/prefrontal areas brought an abrupt end to the prefrontal lobotomy as a viable treatment of any psychiatric disorder. The

later procedures, especially anterior cingulotomy, now done under MRI guided stereotactic technique has made possible precision targeting to minimize "collateral damage" and undesirable residual deficits. But up until recently all of these procedures have involved destructive lesioning of otherwise healthy brain tissue. More recently, the ability to do precision targeting coupled with the capacity to "stimulate" without destroying discrete areas in the brain has found application primarily in movement disorders with increasing interest in depression and OCD as these circuits have become more identifiable. These techniques and technologies are now referred to as Deep Brain Stimulation or DBS.

Moreover, recent advances in brain science have allowed greater understanding of the functional relationship between cortical and subcortical structures. The advent of functional neuroimaging has allowed for the first time the correlating of brain activity in real time associated with various emotional conditions, both before and after various treatment interventions.

In a series of experiments going back to the early and mid 90's, Helen Mayberg and colleagues^{2,3,4,5,6} have attempted to develop a working functional model of depression. Through the study of regional glucose metabolism in depressed patients and normal volunteers the critical role of interactions between limbic, frontal, striatal, and paralimbic sites has become somewhat better elucidated.

Her model has three main components²:

A dorsal compartment involved with attention and cognitive features of depression, i.e., apathy, psychomotor slowing, impaired attention and executive function involving dorso-lateral prefrontal cortex, dorsal anterior cingulate, inferior parietal cortex and striatum.

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Deep Brain Stimulation

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A ventral compartment mediating vegetative and somatic aspects of depression, i.e., sleep, appetite, sex, and endocrine disturbances involving the hypothalamic-pituitary-adrenal axis, insula, subgenual cingulate (Area 25) and brainstem.

Components of both dorsal and ventral compartments are grouped together based on known reciprocal connections with one another.

A rostral cingulate component different from dorsal and ventral areas but with regional connections to both. PET findings have indicated that metabolism in this (rostral cingulate) region can predict antidepressant response in acutely depressed patients and may serve an important regulatory function between the dorsal and ventral compartments.

Studying acutely depressed patients treated with fluoxetine she found pretreatment hypoactivity of the dorsal compartment and normal to slightly elevated activity of the ventral compartment. Responders to fluoxetine showed increased (normal-

ized) activity of the dorsal compartment with decreases (below normal) in the ventral compartment. Non-responders showed increased (above normal) activity in the ventral areas without increases (normalization) in the dorsal areas.

The hypothesis here predicts that both normal sadness and depressive illness are associated with decreases in dorsal limbic activity and relative increases in ventral paralimbic areas. Illness remission, whether by psychotherapy, medication, ECT, or surgery requires suppression of activity in ventral areas with a resulting disinhibition of dorsal areas.

The BROADEN STUDY, currently being conducted in the USA at Alexian Brothers in Elk Grove/Hoffman Estates Illinois, Columbia University in New York, and the University of Texas, Southwest Medical Center, Dallas, is an attempt at a double blind placebo controlled surgical study of the Mayberg model for depression in treatment resistant patients. The preliminary report by Mayberg and Lozano in *Neuron*, March 2005, described six patients with refractory depression implanted bilaterally with

a deep brain stimulating device in the subgenual cingulate (Brodmann Area 25) white matter. This resulted in a "striking and sustained remission of depression in four of six patients." Using PET technology, the remissions were associated with "a reduction in local cerebral blood flow along with changes in downstream limbic and cortical sites..." These results are interpreted as suggesting that disruption of "traffic" in these areas via deep brain stimulation of area 25 can reverse symptoms of depression in these heretofore treatment resistant patients.

This was an open study as were other similar implants done at a few other locations around the world. The BROADEN STUDY is double blind in that one of every three patients will not have the device activated until six months post implant, when all patients will be activated. Neither the patients nor the study psychiatrists will know whether the individual patients are on or off until the study is over some 12 to 18 months later. The DBS device is so constructed that not only can the current be varied patient to patient according to the degree of improvement or lack thereof, but the source of stimulation can also be varied. Each of the two electrodes has four possible stimulation sources depending on the final position of the placed electrodes. Only the programmer knows for sure.

We are cautiously hopeful. ■

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IPS Legislative Report

Kenneth Busch, MD
Jagannathan Srinivasarghavan,
(Ashok Van) MD

Knowing the key issues and special interests of legislators are important parts of the political process. Time is valuable for legislators and they need to know what their constituents are thinking. Forming ongoing relationships with legislators is a crucial component of this process. It also involves understanding the political climate that motivates legislators to use policy information for their platforms. Political dimensions and competition frequently divide legislators from reaching consensus on major positions. This has been a significant factor in the 95th Illinois General Assembly that recently adjourned until November. IPS leadership has strived to develop new initiatives to increase advocacy efforts on behalf of our patients. Our goals have involved ways to better understand the complex issues and political dynamics in Springfield, and how this translates into decision making by legislators and votes on key bills affecting our patients. IPS officers and the Governmental Affairs Committee have worked long hours to plan and develop legislative strategies in conjunction with our Lobbyist, Mr. John Potts, and IPS Executive Director, Meryl Sosa JD. We thank IPS Immediate Past President, Dr Daniel Anzia, for his exceptional leadership during his term in office. Here are some of the highlights:

Illinois General Assembly

It has been high priority by IPS to strengthen mental health parity legislation in Illinois. As such, IPS has worked closely with Representative Fred Crespo (D-44), Senator John Cullerton (D-6), and the Illinois Eating Disorders Parity Coalition to add eating disorders to the current Parity Law. We are pleased to report that HB 1432 has passed both chambers to



From left: Surinder Nand, MD; Linda Gruenberg, DO; Daniel Anzia, MD; Representative Fred Crespo; Kenneth Busch, MD; Sheldon Miller, MD; Daniel Yohanna, MD

expand parity coverage. This bill changes the definition of serious mental illness to include anorexia nervosa and bulimia nervosa and will mandate coverage under state-regulated health plans for these illnesses. IPS was instrumental and the key player in the success of this legislation. IPS President, Dr Sheldon Miller, provided critical testimony to a key Senate Committee. IPS Executive Director, Meryl Sosa JD worked tirelessly with the Coalition to maintain support and advocacy in Springfield. We thank Ms. Sosa and Dr Miller for their outstanding efforts moving the bill forward on behalf of our patients. The bill will now be on its way to the Governor and IPS will be working hard once again to ensure that the Governor signs the bill into law.

IPS was instrumental in proposing legislation to expand Medicaid benefits for medical assistance to inmates of penal institutions. We have been working on the Prison Medicaid Bill with Senator Kwame Raoul (D-13) and Representative Constance Howard (D-34). The language of SB 2303 was drafted by IPS with the Legislative Reference Bureau (LRB) in Springfield. Currently, offenders who have Medicaid benefits when they enter a penal institution in Illinois have these benefits terminated upon entry and must reapply for Medicaid upon discharge from the correctional facility. This process, by law, can take up to three months. Until Medicaid benefits are reestablished, the ex-

offender is without his medication and cannot see a psychiatrist. This legislation would suspend Medicaid benefits during an offender's period of incarceration and the benefits would be immediately reinstated upon discharge. SB 2303 passed the Senate by 56-0 and was referred to the House Rules Committee. The Companion Bill, HB 4714, passed the House 66 to 49, and was referred to the Senate Rules Committee. In spite of this progress, these bills appear to be stalled in Rules as a result of political gridlock in Springfield. IPS will continue to monitor the status of the Prison Medicaid Bill when the Illinois General Assembly reconvenes later this year for the veto session.

HB 4745 is another priority for IPS and we have been working closely with Representative Sara Feigenholtz (D-12) to move the bill forward. This bill would amend the Illinois Controlled Substances Act. It provides that a prescription for Schedule II controlled substances must be filled by a mail-order pharmacy within 14 days (rather than 7) after issuance. It also provides that an emergency prescription for a Schedule II controlled substance that is filled by a mail-order pharmacy must be verified by a written prescription within 14 days (rather than 7). HB 4745 also deletes the provisions of the Illinois Controlled Substances Act relating to the filling of oral prescriptions. It provides that any written prescription for

continued



From the left: Daniel Anzia, MD; Representative Michael Tryon; Sheldon Miller, MD; Linda Gruenberg, DO; Senator Christine Radagno



From the left: Kenneth Busch, MD; Linda Gruenberg, DO; Susan Scherer, MD; Senator Mattie Hunter; Sheldon Miller, MD; Lisa Rone, MD; Meryl Camin Sosa, JD

IPS Legislative Report

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a Schedule II controlled substance (not just mail-order prescriptions) may be filled within 90 days (rather than 7 days) after issuance. We are pleased to report that HB 4745 passed the House by a vote of 115–0. However, the bill is now stalled in the Senate and referred to Rules. This may be the result of the political stalemate in an election year rather than the intent and content of the bill.

IPS Advocacy Day

On March 4th, IPS traveled to Springfield for a series of meetings with key legislators. Drs. Daniel Anzia, Sheldon Miller, Lisa Rone, Linda Gruenberg, Ken Busch, Peter Alahi, Susan Scherer, and Arden Barnett, and IPS Executive Director, Meryl Sosa JD met with leadership in the House and Senate on Tuesday afternoon and Wednesday morning. This included a very productive meeting with House Majority Leader, Representative Barbara Flynn Currie (D-25), to inform her about IPS priorities. She was pleased to hear about our initiatives to expand parity to eating disorders and our work with the Prison Medicaid Bill. IPS thanks Rep. Currie for crucial support with our initiatives. This was critical during the debate later on parity expansion when



From the left: Sheldon Miller, MD; Kenneth Busch, MD; Senator Edward Maloney; Susan Scherer, MD; Lisa Rone, MD; Linda Gruenberg, DO; Meryl Camin Sosa, JD

the Eating Disorder Bill passed the full House by a vote count of 66 to 42.

On Tuesday evening, IPS hosted a reception and dinner for legislators at the Sangamo Club in Springfield. We were delighted to host Senator Christine Radogno (R-41), Senator Dale Righter (R-55), Representative Patricia Bellock (R-47), Representative Sara Feigenholtz (D-12), Representative Carolyn Kraus (R-66) and Representative Michael Tryon (R-64). Everyone appeared to enjoy the occasion in an informal atmosphere.

More meetings were held on the morning of March 5th to advance our priorities. This included meetings with Senator Kwame Raoul (D-13), Senator Don Harmon (D-39), Senator Mattie Hunter (D-3), Representative Karen Yarbrough (D-7), and Representative



From the left: Lisa Rone, MD; Linda Gruenberg, DO; and Senator Dale Righter

Sara Feigenholtz (D-12). The highlight of the day was a special tour of the Senate Floor conducted by Senator Edward Maloney (D-18). It was a great privilege to observe this area and much gratitude is extended to Senator Maloney for the wonderful tour and warm hospitality.

IPS thanks our lobbyist, Mr. John Potts, and Executive Director, Meryl Sosa JD, for making this event so successful. It was conducted under difficult circumstances with a snowstorm in Springfield. In spite of the weather, IPS made it though the snow and learned a lot in the process.

Congressional Level

On February 10th through 13th, Drs. Ken Busch, Sid Weissman and Louis Kraus along with Meryl Sosa JD represented IPS on Capitol Hill at APA Advocacy Day in Washington, DC. We heard from political analyst Charles Cook about the general election outlook and James Peake MD, Secretary of Veterans Affairs, about PTSD and TBI programs for war veterans returning from Afghanistan and Iraq. Another highlight was a roundtable discussion on the needs of military personnel, veterans and their families with Congressional Staff, Mental Health America, VA officials, and the National Military Families Association.

Drs. Busch, Weissman, Kraus and Ms. Sosa made visits to the following Congressional offices during Advocacy Day: Representatives Danny K. Davis (D-7th) Rahm Emanuel (D-5th), Janice Schakowsky (D-9th), John M. Shimkus (R-19th), Jerry Costello (D-12th), Mark Kirk (R-10th), Peter Roskam (R-6th) and Bobby Rush (D-1st) as well as Senators Barack Obama (D) and Richard Durbin (D). Key issues discussed at these meetings included mental health parity legislation, health information technology, and expansion of PTSD and TBI programs for returning soldiers and their families.

The Illinois Psychiatric Society continues to have a strong relationship with Congressman Danny K. Davis. The Mental Health Advisory



From the left: Kenneth Busch, MD; Daniel Anzia, MD; Nada Stotland, MD (APA President); Congressman Danny K. Davis; Shastri Swaminathan, MD; and Sidney Weissman, MD.



From the right, Kenneth Busch, MD, Congresswoman Jan Schakowsky, Professor Sheila Hollins (fourth from right), President of the Royal College of Psychiatrists and Members of the Royal College of Psychiatrists.

Committee was established by IPS last year and has met monthly to advise the Congressman on mental health issues. IPS applauds Congressman Davis on the passage of The Second Chance Act, H.R. 1593. This bill was signed into law by President Bush on April 9th. It will provide grants to help re-train ex-offenders and provide greater services for treatment of mental health and substance abuse. We also want to take this opportunity to thank Congressman Davis for having dinner with us and British colleagues on Capitol Hill during the APA Annual Meeting.

IPS has worked closely with Congressman Bobby Rush and his Staff. The Congressman is congratulated for his wonderful efforts on Sponsoring H.R. 20, the Melanie Blocker Stokes Post Partum Depression and Care Act. This legisla-

tion will provide greater resources, funding and grants for treatment of post partum depression. The Bill passed the U.S. House of Representatives last year and is now moving forward in the U.S. Senate.

IPS recently had the good fortune of having breakfast with Congresswoman Jan Schakowsky. The Congresswoman kindly offered to assist IPS and APA to promote our initiatives in her leadership position as Chair of the Bipartisan Women's Congressional Caucus. IPS thanks Congresswoman Schakowsky for her interest and is in the process of planning other events with her.

IPS has formed a close relationship with key staff from Senator Richard J. Durbin's office. As a result, IPS was asked to provide input on the first draft of legislation to expand mental

continued

IPS Legislative Report

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health services to students on college campuses. Since this bill is of critical importance, IPS has requested that APA be also involved with the initiative. We thank Senator Durbin for drafting this legislation and it is a privilege and honor for IPS to provide feedback.

IPS PAC

The IPS PAC is a separate, voluntary, non-partisan, not-for-profit committee comprised of psychiatrists who support candidates who share the views of our medical specialty.

A strong PAC is absolutely essential in order to have access to legislators in the Illinois General Assembly and educate them about mental illness, our patients, and our profession. PAC contributions are approved by the IPS PAC Board to legislators who have policy goals and objectives in common with us.

This is an election year and many candidates will be sharing their platforms with individual constituents and interest groups. Attending fundraisers and awarding PAC contri-

butions are essential components of the political process. Other organizations and corporations know this well. IPS PAC must be at the table in order to be successful with our initiatives.

Psychologists are expected to be back next year with prescribing legislation. IPS will be faced with the challenge once again of defeating the bill in Springfield. The stage is set now. We must be part of this process.

That said, IPS PAC needs your support. Please consider making a contribution and contact our IPS Executive Director, Meryl Sosa JD at 312-224-2601 or email: msosa@ilpsych.org. ■



Meryl Sosa JD and Stephen Miller, MD



Representative Deborah Graham



Representative Patricia Bellock



Representative Fred Crespo

Legislative Changes

By Meryl Camin Sosa, JD

Involuntary Commitment

In 2007, the Illinois legislature enacted **Public Act 95-0602** which was designed to lower the standard for involuntary psychiatric hospitalization and commitment. The standard, in effect, prior to enactment of Public Act 95-0602, was:

“Person subject to involuntary admission means:

- (1) A person with mental illness and who because of his or her illness is reasonably expected to inflict serious physical harm upon himself or herself or another in the near future which may include threatening behavior or conduct that places another individual in reasonable expectation of being harmed; or
- (2) A person with mental illness and who because of his or her illness is unable to provide for his or her basic physical needs so as to guard himself or herself from serious harm without the assistance of family or outside help.

In determining whether a person meets the criteria specified in paragraph (1) or (2), the court may consider evidence of the person’s repeated past pattern of specific behavior and actions related to the person’s illness.”

Thus, until the effective date of Public Act 95-0602, proof of some physical harm or possible serious harm was required to be shown in order for a person to be involuntarily hospitalized. This standard complied with the landmark case, *O’Connor v. Donaldson* (U.S.S. Ct. 1979) which established the constitutional standard for commitment which requires mental illness plus dangerousness in order for a person to be involuntarily committed.

The problem with the Illinois standard was that many families could not have their loved ones involuntarily hospitalized until either the patient had either committed a violent act or placed another person "in reasonable expectation of being harmed" or required the family to show that without their assistance that the patient would suffer serious harm.

Public Act 95-0602 now provides:

"Person subject to involuntary admission" means:

- (1) A person with mental illness and who because of his or her illness is reasonably expected to engage in dangerous conduct which may include threatening behavior or conduct that places that person or another individual in reasonable expectation of being harm;
- (2) A person with mental illness and who because of his or her illness is unable to provide for his or her basic physical needs so as to guard himself or herself from serious harm without the assistance of family or outside help; or
- (3) A person with mental illness who, because of the nature of his or her illness, is unable to understand his or her need for treatment and who, if not treated, is reasonably expected to suffer or continue to suffer mental deterioration or emotional deterioration, or both, to the point that the person is reasonably expected to engage in dangerous conduct."

"Dangerous conduct" means threatening behavior or conduct that places another individual in reasonable expectation of being harmed or a person's inability to provide, without the assistance of family or outside help, for his or her basic physical needs so as to guard him or her from serious harm."

The new standard, which became effective June 1, 2008, no longer requires a showing of serious harm under the first prong of the standard. Also, no expectation of physical harm

need be shown and if there is a possibility of harm, no showing of imminence is required. That is, the statute no longer requires an expectation that the harm will be inflicted in the near future. Prong 3 is designed to help commit persons who have Anosognosia or a lack of insight regarding their mental illness.

Also, lowering the standard is expected to have an impact on out-patient commitment. Under the prior statute, the standard for com-

mitment was so high that by the time a person met that standard, it would be inappropriate for the person to remain out of the hospital. However, under the new, lower, standard, out patient commitment might be used as a less restrictive alternative to in-patient hospitalization.

One problem remains. While the standard for involuntary commitment was lowered, the standard for involuntary treatment was not. Thus,

continued



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Legislative Changes

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it is possible, that a person could meet the standard for involuntary commitment but not meet the standard for involuntary treatment. Thus, the person could be involuntarily hospitalized and even committed and be required to stay in the hospital, but not meet the standard for involuntary treatment and, therefore, the person could not be treated while in the in-patient unit. Thus, the next area for change may be changing the standards for involuntary treatment and ECT.

Changes to the Reporting Requirements under the Firearm Owner Identification Act (PA 95-0564)

In 2007, the legislature adopted PA 95-0564 as a response to the Virginia Tech tragedy. During the drafting of the bill, the Attorney General's office wanted to include a definition of mental health facility which was different than the definition already included in the Mental Health and Developmental Disabilities Code. The Attorney General's office wanted to include language which would have been inclusive of patients seen in physician offices as well as public and private hospitals and mental health centers. However, the definition used by the new statute is the same definition that is used in the Mental Health and Developmental Disabilities Code and, therefore, presumably does not include patients seen in physician offices. However, it will remain to be seen how the statute is interpreted.

Here is the language of the new statute:

Section 10. The Mental Health and Developmental Disabilities Confidentiality Act is amended by changing Section 12 as follows: (740 ILCS 11/12)

Section 12

(b) The Department of Human Services (acting as successor to the

DMH & DD) and all public or private hospitals and mental health facilities are required, as hereafter described in this subsection, to furnish the Department of State Police only such information as may be required for the sole purpose of determining whether an individual who may be or may have been a patient is disqualified because of that status from receiving or retaining a Firearm Owner's Identification Card under subsection (e) or (f) of Section 8 of the Firearm Owners Identification Card Act or 18 U.S.C. 922(g) and (n). All public or private hospitals and mental health facilities shall, in the form and manner required by the Department, provide such information as shall be necessary for the Department to comply with the reporting requirements to the Department of State Police. Such information shall be furnished within 7 days after admission to a public or private hospital or mental health facility or the provision of services to a patient described in clause (2) of this subsection (b). Any such information disclosed under this subsection shall remain privileged and confidential, and shall not be redisclosed, except as required by clause (e)(2) of Section 3.1 of the Firearm Owners Identification Card Act, nor utilized for any other purpose. The method of requiring the providing of such information shall guarantee that no information is released beyond what is necessary for this purpose. In addition, the information disclosed shall be provided by the Department within the time period established by Section 24-3 of the Criminal Code of 1961 regarding the delivery of firearms. The method used shall be sufficient to provide the necessary information within the prescribed time period, which may include periodically providing lists to the Department of Human Services or any public or private hospital or mental health facility of Firearm Owner's Identification Card applicants on

which the Department or hospital shall indicate the identities of those individuals who are to its knowledge disqualified from having a Firearm Owner's Identification Card for reasons described herein. The Department may provide for a centralized source of information for the State on this subject under its jurisdiction.

Any person, institution, or agency, under this Act, participating in good faith in the reporting or disclosure of records and communications otherwise in accordance with this provision or with rules, regulations or guidelines issued by the Department shall have immunity from any liability, civil, criminal or otherwise, that might result by reason of the action. For the purpose of any proceeding, civil or criminal, arising out of a report or disclosure in accordance with this provision, the good faith or any person, institution, or agency so reporting or disclosing shall be presumed. The full extent of the immunity provided in this subsection (b) shall apply to any person, institution or agency that fails to make a report or disclosure in the good faith belief that the report or disclosure would violate federal regulations governing the confidentiality of alcohol and drug abuse patient records implementing 42 U.S.C. 290dd-3 and 290ee-3.

For purposes of this subsection (b) only, the following terms shall have the meaning prescribed:

- (1) "Hospital" means only that type of institution which is providing full-time residential facilities and treatment.
- (2) "Patient" shall include only: (i) a person who is an in-patient or resident of any public or private hospital or mental health facility or (ii) a person who is an out-patient or provided services by a public or private hospital or mental health facility who mental condition is of such a nature that it is manifested by violent, suicidal, threatening, or assaultive

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Legislative Changes

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behavior or reported behavior, for which there is a reasonable belief by a physician, clinical psychologist, or qualified examiner that the condition poses a clear and present or imminent danger to the patient, any other person or the community meaning the patient's condition poses a clear and present danger in accordance with subsection (f) of Section 8 of the Firearm Owners Identification Act. The terms physician, clinical psychologist, and qualified examiner are defined in Sections 1-120-, 1-103, and 1-122 of the Mental Health and Developmental Disabilities Code.

- (3) "Mental health facility" is defined by Section 1-114 of the Mental Health and Developmental Disabilities Code.
- (c) Upon the request of a peace officer who takes a person into custody and transports such person to a mental health or developmental disability facility pursuant to Section 3-606 or 4-404 of the Mental Health and Developmental Disabilities Code or who transports a person from such facility, a facility director shall furnish said peace officer the name, address, age and name of the nearest relative of the person transported to or from the mental health or developmental disability facility. In no case shall the facility director disclose to the peace officer any information relating to the diagnosis, treatment or evaluation of the person's mental or physical health.
- For purposes of this subsection (c), the terms "mental health or developmental disability facility", "peace officer" and "facility director" shall have the meanings ascribed to them in the Mental Health and Developmental Disabilities Code.



PERSPECTIVES

On the Ground at NIU

Tanya R. Anderson, MD

The tragedy at Northern Illinois University (NIU) touched every Illinois citizen in some way. The aftermath will be felt for many months to come. However, through great tragedy the brilliance of the human spirit can shine. When the state of Illinois called for mental health clinicians to volunteer to help support the students, staff and faculty of NIU as they returned to campus on February 24, 2008 you responded mightily. For that I want to say a heartfelt "thank you." But this article is not about a state government official's gratitude, it is the experience of a clinician who was honored to serve along with more than 500 of her colleagues in helping to heal the lives, hearts and university home of the NIU community.

Arrival on the campus was at first solemn but as the number of volunteer "counselors" (as we were called) grew, you could feel an energy building. Even with all the collective training and experience assembled in the auditorium, used for orientation there was anxiety. Few have had the opportunity to respond to this type of crisis and the anxiety showed. What could we say? What could we do? And did they really want 500 hundred counselors roaming around offering to help? Or would they just want to be left alone? This community had just experienced the unimaginable. And we were all here to somehow make it better.

After we received a confidential briefing, we were split into groups and assigned to various sites and facilities around campus where students, staff and faculty would be attending the memorial service in the convention center or watching it in one of the video simulcast spots on campus. Being assigned to the convention center was more than I could

have hoped for. Despite the obvious grief the resiliency was palpable. This community had assembled prepared to stand together to do whatever it took to heal. The service was moving. Being near the families of the injured and deceased students was so humbling. Their strength and grace was pure beauty. We all returned to our various housing assignments to get some rest and prepare for the following day, the first day of classes.

Each classroom was staffed by a counselor who spoke to the students briefly about the impact of trauma, inform them of resources for individual assistance if that were desired, answer any questions, and be as actively engaged as requested. I was assigned to be a departmental resource. A department resource counselor stayed in one of the academic departments to support faculty as they prepared to return to the classroom, address whatever issues arose and help the students begin to reestablish normal routines. We were also prepared to be backup should any faculty enter their classroom and the assigned counselor was not present. As a department resource I had the opportunity to interact with students who came into the offices and hung out in the common areas. I sat with faculty who weren't sure how to explain the unexplainable. I met with students who weren't sure how to feel and some who were already experiencing trauma related symptoms. I talked with faculty about their genuine concerns for specific students and discussed how to support the students about whom they had these concerns. I spent time with the administrative staff who often have significant interaction with students and serve as caretakers as well as administrative support. Over and over students, staff and faculty alike said "thank you for being here."

The expressions of gratitude and appreciation were constant and sincere. NIU was healing itself by opening its heart. The strength, hope and resiliency exhibited by the NIU campus is the stuff of which movies are made. I made new friends and

forged bonds that will last a lifetime. This experience was a validation of the triumph of the human spirit. For the 500+ volunteers it was a recommitment ceremony of sorts. An opportunity for all of us to recommit to the work we do and the people we serve so that this type of tragedy never has to happen again. Being an NIU husky for 3 days was an honor and privilege that touched me deeply. For that community to embrace us counselors so warmly was an overwhelming experience... and for that, I am eternally grateful. ■



Changing Tides...¹

"Nothing is secure but life, transition, the energizing spirit."²

By Theodote K. Pontikes, MD

June has arrived, and summer is teasing its way through with a flurry of activity along Chicago's beloved lakefront, diverse neighborhood festivals and numerous graduation celebrations. As I watch the passersby along the South Shore and listen to the echo of "Sometimes I Dream,"³ I cannot but reflect on all that has transpired over the past year, while I enthusiastically prepare to enter my final year of residency training and finalize my decision regarding what career path to pursue thereafter. As I contemplate some of the daunting tasks that lie ahead, I glance at the skyline and, then, notice the young children dancing in the sand, reminding myself that: "Besides the noble art of getting things done, there is the noble art of

leaving things undone. The wisdom of life consists in the elimination of non-essentials."⁴

July 1st marked the beginning of the new academic year, so let us extend sincere "Congratulations" to all our colleagues who graduated from residency or fellowship programs, and an especially warm "Welcome" to the newly minted physicians who have chosen to specialize in Psychiatry. As you enter this new phase of your professional development and are confronted with choices that may challenge your commitment to the Hippocratic Oath, always remember to remain loyal to the patient-physician relationship. Moreover, never forget that "Learning is ever young..."⁵ and seek guidance, supervision and mentorship from your peers, attending faculty, the APA and the IPS.

It is truly an exciting time for the IPS, with the recent election of new officers and strategic planning underway to improve member services in the upcoming year. I feel honored to have the opportunity to serve as the MIT (Member In-Training), and I invite all residents and fellows of Psychiatry and its subspecialties throughout Illinois to contact me at mit.ips_vision@yahoo.com with specific issues (i.e., regarding education; training; practice; ethics; fellowship; volunteer efforts) you would like the IPS to address. I encourage you to approach me with what matters most to you as an IPS resident/fellow member, and I vow to zealously voice your concerns.

Furthermore, I challenge each of my peers to join me and become actively involved by supporting the IPS initiatives and attending events to network with like-minded individuals, while remaining abreast of mental healthcare issues at regional, national and global levels. Only in this way, can personal and professional growth be fostered in a collaborative, rewarding climate. I also ask you to inspire those who are not yet members to join the APA and the IPS and to invest in our vision of making a difference in the well-being of both

mental healthcare patients and psychiatrist physicians. (Dues for the first membership year are gratis for both organizations.)

Please, extend an invitation to potential members to attend future IPS events, as well, and so be a part of an enriching and moving experience. For example, the APA's 2008 Institute on Psychiatric Services will be held in downtown Chicago from October 2nd to 5th at the Palmer House Hilton. It will be an amazing opportunity to meet expert leaders in all of the subspecialties of psychiatry including Child Psychiatry, Community Psychiatry, and Disaster Psychiatry. Resident research will also be featured, as will a full-day session on the special needs of the homeless mentally ill, a most vulnerable patient population. I sincerely hope to meet many of you there!

Dear Colleagues, I genuinely look forward to hearing from each of you, and I am optimistic about what we can continue to accomplish together as members in-training, for "In union, there is strength."⁶ ■

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- 1 Image: "The Fortress of Antimachia." Location: Kos, Greece (birthplace of Hippocrates). www.travel-to-kos.com/gallery.
- 2 Emerson, Ralph Waldo. "Circles." Essays: First Series, 1841.
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- 5 Aeschylus. Agamemnon. (c. 490 B.C.) Translation by William W. Goodwin. Ginn & Company, 1906.
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If you are attending the Institute for Psychiatric Services, please attend the Illinois Psychiatric Society sponsored workshop entitled, "Telepsychiatry and Public Policy." The panel will include: Kenneth Busch, MD, Jagannathan Srinivasaraghavan, MD, Daniel Yohanna, MD, Mary Dobbins, MD and Meryl Camin Sosa, JD.

Book Review

The Insanity Offense

By E. Fuller Torrey

W.W. Norton & Company, New York
Edition 2008, 265 pages, US \$24.95

The *Insanity Offense* is a well-written book emphasizing how our failure to treat the seriously mentally ill is endangering all of us. The social and political aspects of deinstitutionalization and the criminalization of mental illness are articulated very effectively. It might be an opportune time to make effective changes in psychiatric treatment with the Virginia Tech massacre fresh on the minds of readers.

The Lanterman-Petris-Short Act in California and the Lessard decision in Wisconsin and their social consequences are very informative. It's interesting how California became a model state with the best psychiatric treatment in the country to the one

with the most number of homeless mentally ill people over the span of last 35 years. Herb Mullin's trial highlights the tragedy of this Act making the jury choose the only logical option of sending a patient with schizophrenia to a life term in prison instead of any psychiatric treatment. Kenneth Springer's commentary regarding this case is worth a read. Mike Bower's case and a wake up call to California legislators should have woken up the whole country but sadly it has not.

The 3 cases involving Malcolm Tate, Herb Mullin and Brian Stanley clearly illustrate the reasons for involuntary hospitalizations and commitment and the cost of treating the mentally ill becomes obvious to anyone reading the book. Later in the book, the homelessness and eventual crimes caused by deinstitutionalization is well highlighted. The data highlighting the number of seriously mentally ill in the prison systems in this country is alarming

(32,000 seriously mentally ill just in the state of California)—all in this age of advanced healthcare.

The consequence of unconstrained civil liberties includes violence and homicide and is very well documented throughout the book. As written in Chapter 11 (one of the best in the book) deinstitutionalization, implemented with the best of intentions and the worst of plans has left untreated severely mentally ill to fend for themselves in a hostile world.

It is a book that should be a part and parcel of psychiatric training as there is so much to learn from the historical aspects of psychiatric care including valuable lessons. It should also be ideally read by policy makers as it sheds so much light on the blunders made by past administrations, so as not to repeat the same mistakes in the future.

Reviewed by Ajay Mayor, MD & Jagannathan Srinivasaraghavan, MD ■

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is published by the Illinois Psychiatric Society, a District Branch of the American Psychiatric Association. Views expressed by various authors are not necessarily those of the IPS.

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