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**President's Message**

*Danesh Alam, MD*



Danesh Alam, MD

After almost 20 years of efforts, the Joint Committee on Administrative Rules (JCAR) approved the rules for psychologists to prescribe medication on September 12, 2017. The Illinois Psychiatric Society (IPS) made significant last-minute efforts with JCAR despite a rule-making process that sometimes seemed like an exercise in futility. The Chair of the JCAR rulemaking body, Senator Don Harmon, was the original Sponsor of the bill for the psychologists. Under his leadership, politics carried the day at JCAR much like everything else in state government. None of our concerns in the final rules were heard at the JCAR meeting. The hearing ended with the President of the Illinois Psychological Association, Beth Rom-Rymer, taking pictures with Senator Don Harmon, considered the legislative champion by the Illinois Psychological Association.

Although imperfect, IPS made every

effort to ensure patient safety remained central in the psychology prescribing legislation. Many in the field believe that this law is a model for legislation around the country. Illinois has now joined New Mexico and Louisiana in allowing appropriately trained clinical psychologists limited prescriptive authority for psychopharmacological medications.

However, not all psychologists can or will prescribe medication. In order to obtain a license as a prescribing psychologist, one must have a basic science foundation at the undergraduate level (physiology, microbiology, anatomy, etc.), complete a doctorate degree in clinical or counseling psychology (5-7+ years), and obtain 60 additional credit hours of post-doctoral Master of Science coursework in clinical psychopharmacology. After meeting these conditions, psychologists must then complete a 14-month supervised clinical training course, complete a research project, and pass a national certification exam. Upon completion, psychologists in Illinois anticipate working in close collaboration with the patient's primary care provider.

At this time, it is anticipated that about 5 psychologists will apply for a license in Illinois as soon as an application is available. These are individuals who have probably completed online courses and have completed their clinical rotations by shadowing physicians in areas such as Family Practice or OB-GYN. There are about 20 psychologists who are ready to begin clinical rotations and about 150 who are in training to become prescribing psychologists. Various schools are gearing up to provide training in this area.

What does this mean for our field and our work here in Illinois?

**Save the Dates:**

**IPS Annual Meeting/Holiday Party and Awards Night**

*January 27, 2018*

Please RSVP and watch for more information in the IPS e-blasts!

*(Continued on page 8)*

## The Living Room and Beyond . . .


Angela Adkins, NAMI DuPage, Executive Director

One of the biggest obstacles to recovery from mental illness is the repeated cycle of crises and relapse. Typically someone who is in a crisis goes to the local ER where they are stabilized and sent home. Often there is no effective follow-up to ensure that the patient is doing what he or she must in order to avoid another crisis. The NAMI DuPage Living Room breaks this cycle by not only stabilizing the immediate crisis but providing ongoing responsive support. It is an alternative to the ER for non-emergent mental health crises but it is also so much more. Only the NAMI Living Room offers access to aftercare peer support services through peer specialists who aid in recovery, reduce hospital recidivism and decrease dependence on emergency services. Peer Specialists train for 16 weeks and learn role playing, conflict resolution, empathic listening and other essential skills. This extensive training, along with their lived experience with mental illness, makes them uniquely qualified to work with individuals and families providing NAMI wrap-around services that include education and support, Social/Recreation and Job Readiness Programs. Peer Specialists provide support and encourage Living Room guests to access these services on a regular basis. Continuous support is important to decrease recidivism and prevent further mental health crises. In less than two years of operation, The Living Room has served 186 guests, with a recidivism rate of under 20%. Housed at the DuPage County Community Center in the heart of Wheaton, the Living Room is open from 3:00 PM to 9:00 PM, seven days a week and is free for everyone. In fact all NAMI DuPage programs are offered free of charge to individuals and families.

The Living Room guests are encouraged to follow up regularly with a peer specialist after their visit. An important part of follow-up peer support is goal setting. Clients are encouraged to set goals including an agreed upon outcome for the next visit. The peer specialist discusses the ability, tools and resources available to achieve each goal and to overcome obstacles. Clients are encouraged to establish both short and long term goals. This kind of after care for both

individuals and families has a proven track record of setting guests toward lifelong wellness.

Going beyond crisis stabilization, this program provides an opportunity to develop close bonds between the peer specialists and their clients. We are seeing multiple instances where the peer specialists are able to notice small changes and nuances in their clients because of the ongoing, open ended, nonjudgmental nature of their meetings, helping them resolve symptoms before they balloon into crises. Most peer specialists say that they notice a pattern – people who came to them clearly struggling and blaming many external factors progress to taking ownership and responsibility for not just their own recovery but also other problems in their life. This is true, for example, in Steven's story.


Steven is a retired software designer suffering from depression and uncontrolled dyskinesia (a side effect of long term anti-psychotic medications causing uncontrollable stiffness, jerky movements of face and body). In July 2016, he first came to the Living Room in a crisis, after being already hospitalized 5 times in the year. He was seen by a peer specialist; he told the specialist that after one year, in July 2017, he had made a plan to end his own life. The Living Room peer resolved his immediate crisis and paired him with a peer specialist with whom he meets weekly now. He says this about his experience *“being able to relate to someone who has had the same experience as me is very valuable. I wish I had access to someone like this when I was first diagnosed”* He further goes on to add *“As soon as I entered the Living Room, I got immediate attention, I felt more comfortable and more respected. Beyond the Living Room, my meetings with the peer specialist helped me develop a course of action and most importantly stick to it.”* In the last month he voluntarily entered a partial hospitalization program (PHP) on the urging of his peer specialist when he had some troubling symptoms. His willingness to work with the peer to enter the PHP and not let his condition go into a crisis is his biggest progress. The availability of someone who is more accessible than a doctor or a therapist, is in the community and most importantly, someone who has weathered the same challenges, finally gave him the impetus to actively work on his recovery. The effectiveness of this program cannot be better illustrated. 

## IPS Does Ravinia in Style

*Hossam Mahmoud, MD MPH*

**O**n August 6, 2017, IPS arranged its annual Concert at Ravinia for IPS members and their families. This year the event featured the Chicago Symphony Orchestra. The program included memorable pieces, such as Overture to a Pops Concert, “Moon River” from Breakfast at Tiffany’s, the theme from The Pink Panther, the March from The Great Waldo Pepper, and “Le Jazz Hot” from Victor/Victoria. IPS President Dr. Danesh Alam, and many IPS members and their families were in attendance, including residents, early career psychiatrists and seasoned members.

The event was a wonderful opportunity to socialize in a relaxed atmosphere and experience the captivating music performed by the Chicago Symphony Orchestra. The Concert at Ravinia event is one of my favorite IPS activities, as it is a great opportunity to reconnect with colleagues and make new friends.

Special thanks go to our Executive Director, Meryl Sosa, and our Administrative Coordinator, Kristen Malloy, for bringing us together. 



From left: Meryl Sosa; Joshua Nathan, MD; Elie Crystal, MD; Diego Marin, MD; Smitha Aailaboyina, MD; Patricia Calimlim, MD; Hossam Mahmoud, MD



Member, Dr. Toulios (far left) with friends.



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The image depicted contains models and is being used for illustrative purposes only.

wants to thank you all for the incredibly important work you do each day.

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## The Network Adequacy and Transparency Act: A Big Step Forward for Patients and Physicians

*Hossam Mahmoud, MD, MPH*

Access to healthcare services in general and to psychiatric services in particular continues to be a major challenge that many patients encounter in Illinois, especially in rural and remote parts of the state. Access to care includes not only being able to receive services but also being able to access services that are affordable, comprehensive and commensurate with a patient's needs, without undue burden and without interruption. On September 15, 2017, Illinois took a major step in the right direction, as Governor Bruce Rauner signed the Network Adequacy and Transparency (NAT) Act into law, after the bill passed unanimously in both the House and Senate.

The NAT Act is the outcome of two years of dedicated work by the Illinois State Medical Society (ISMS), with strong support from the Illinois Psychiatric Society (IPS) and other professional bodies and associations in Illinois. The NAT Act ensures that Illinois patients have better access to healthcare, by making insurance plans more transparent and by addressing the so-called "narrowing of physician networks" in Illinois. The NAT Act provides new protections for Illinois patients insured under private health plans that are state-regulated. It does so by enhancing patient access, ensuring insurance plan transparency, and safeguarding continuity of care.

### Enhancing Access

According to the NAT Act, insurance companies must provide health plans that ensure that patients enrolled within their network have adequate access to healthcare facilities and to physicians, including psychiatrists and other specialists, who are geographically accessible from where the patients reside. If the network does not provide adequate access to services due to distance or lack of sufficient providers or sufficient specialties, the patient would be able to access such services out of network, without incurring higher costs than if the provider were within network, unless the patient is in an HMO.

### Improving Transparency

Insurance companies must keep updated directories

of the physicians and healthcare facilities within the network. In addition, insurance companies must notify patients when changes to the network occur, including when a physician or healthcare facility leaves the network. This protects patients from unexpected out-of-network charges. Accordingly, insurers must provide information on the geographic area covered by the plan, the contact information and specialties of the providers within that plan, the anticipated number of insured individuals within the network, an internet website and toll-free number to access up-to-date and accurate information on providers and the network, as well as a description of the degree of accessibility to healthcare services, including the possible availability of telehealth services.

### Continuity of Care

A network plan is obligated to provide at least a sixty-day notice in case of termination or nonrenewal of a provider, notifying both the provider and patients served by that provider. Furthermore, primary care providers are responsible for notifying their active patients who would be affected by termination or nonrenewal from the network plan. While a patient's physician might opt out or be dropped from the network, patients can still see the provider, as long as s/he remains within the plan's service area, for a transitional period of 90 days. The provider will have to agree to be paid the amount of reimbursement under either the terminated plan or if the patient is transitioning to a new health plan, the provider must accept the reimbursement rate of the patient's new healthcare plan.

### Implications for Psychiatrists in Illinois

Under the NAT Act, psychiatrists and other providers have a role in ensuring patient access and network transparency. Physicians, including psychiatrists, are required to maintain updated information with the network plans in which they participate.

The NAT Act specifically includes "Behavioral Health" in the list of specialties that the Department of Public Health will consider when examining ratios of physicians to patients within a particular network, to monitor adequate access.

Finally, for psychiatrists practicing telepsychiatry, The NAT Act identifies telemedicine as an option that plans can use to address shortcomings of certain networks and to ensure adequate access.

While the NAT Act is a major step in enhancing access to care and network policy transparency, it will require ongoing monitoring to ensure implementation and ongoing compliance. Furthermore, it will require collaboration between providers and insurance companies to maintain accurate and updated provider databases for patients to access. IPS has strongly supported the work of ISMS to ensure the NAT Act becomes law, and we will continue to work closely with other professional societies and associations to advocate for patient access to comprehensive high-quality services, and to ensure that psychiatric care is an integral part of these services.

Below is the link for The Network Adequacy and Transparency Act:  
<http://www.ilga.gov/legislation/publicacts/100/PDF/100-0502.pdf>

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**Doctors for America**

**D**octors for America (DFA) is a national organization that played a large role in advocating for and writing the Affordable Care Act. It is made up of mostly physicians and medical students around the country. DFA organized a white coat fly-in in DC on Thursday 6/22/17 in protest of the proposed AHCA which would cause 23 million more Americans to be uninsured. The bill would save \$3 billion in social security due to premature death.

The local DFA chapter co-hosted a rally with the group Indivisible on the same day at Federal Plaza in Chicago. Several IPS members attended.



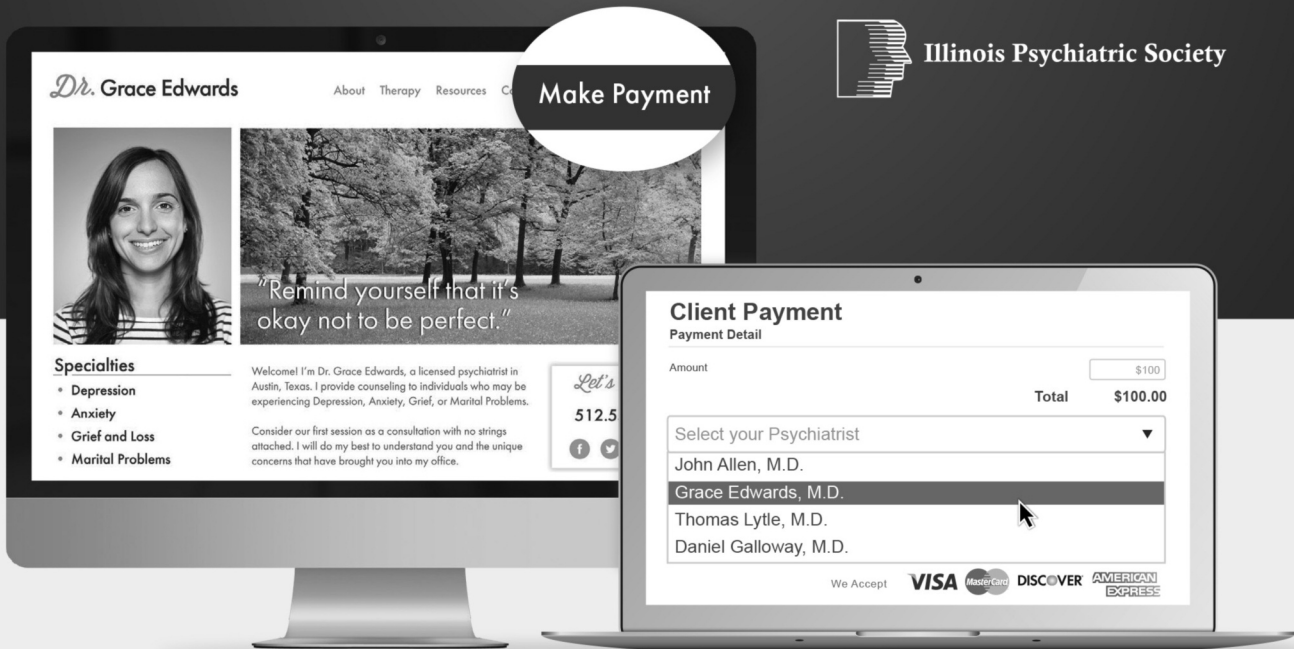
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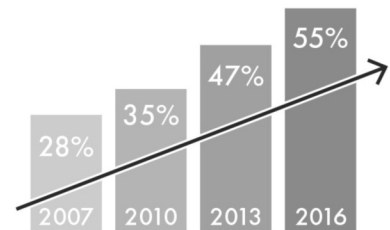
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## The Changing Landscape of Mental Health Treatment – A Three-Part Series on Telepsychiatry

### Part I: The Six Most Commonly Asked Questions by Psychiatrists about Telepsychiatry

*Hossam Mahmoud, MD MPH*

Telehealth has been around for about six decades, yet it is only over the past few years that telepsychiatry has gained large-scale momentum as an effective and convenient method for providing mental health services and enhancing access to much-needed psychiatric care.

As the medical director of an Illinois-based telemental health company, I get the opportunity to regularly interview psychiatrists interested in pursuing careers in telehealth, both in Illinois and across state lines. These conversations often leave me with the impression that telepsychiatry continues to be perceived as a novel approach to many, including psychiatrists and other physicians. Furthermore, significant hesitations and misconceptions regarding telepsychiatry persist among many clinicians, even those considering a career in telepsychiatry. This has motivated me to write a series of articles aimed at introducing telepsychiatry further, dispelling some misperceptions and discussing perceived challenges, in the hopes of alleviating some concerns regarding this method of health-care delivery.

In this first article, I attempt to answer some common questions I am often asked about telepsychiatry, in the hopes that more of my colleagues will consider this approach as a way to enhance access to patient populations who struggle to find a psychiatrist. While most of my answers are based on my personal experience as a telepsychiatry clinician, I include a short list of peer-reviewed articles for further reading.

#### **What is telepsychiatry?**

Telepsychiatry, as a subset of telehealth, refers to the utilization of information technology and other forms of communication, in order to provide psychiatric care remotely through live and interactive videoconferencing. (1,2)

#### **Is telepsychiatry effective?**

We have over six decades of research that has demonstrated that telepsychiatry is a feasible approach and an acceptable method to deliver mental health services; furthermore, the clinical outcomes of services conducted via telepsychiatry have been shown to be similar to in-person treatment. Telepsychiatry has proven effective for a wide array of patient populations, across different ages and a range of different treatment settings. (1,2) In addition, some studies suggest that certain patient populations, such

as patients with PTSD and patients who have autism spectrum disorders, might find telepsychiatry preferable to in-person sessions. (1)

#### **Why consider telepsychiatry?**

Telepsychiatry improves access to psychiatric services by allowing patients to overcome transportation difficulties, restrictions on their mobility, geographic distances, as well as the time and cost burdens entailed in traveling to see a psychiatrist for an in-person session. (1,3)

Furthermore, telehealth can reduce the travel cost and commuting time for psychiatrists, potentially contributing to a healthier work-life balance.

#### **Is telepsychiatry HIPAA compliant?**

It is essential to work with a company that offers a HIPAA-compliant video platform that protects the privacy of patients and the confidentiality of personal health information. Such a system must use end-to-end encryption, securing data in transit and rest. All such systems and policies must be protected by a stringent data security access policy.

With the increasing risks of cyber security threats, ransomware and phishing, it is essential to encrypt the hard drive of the computer being used for videoconferencing and for handling protected health information. It is also imperative to maintain an up-to-date antivirus program regardless of which operating system is being used.

#### **Is telepsychiatry burdensome?**

Telepsychiatry can be performed from the comfort of your clinic or home office. It is recommended to maintain a well-lit professional background with uniform light distribution, that allows patients to have a clear view of the psychiatrist's face and facial expressions. Despite some misconceptions, large monitors and expensive equipment are not required. Nor are exceptionally expensive state-of-the-art computers. It is essential, however, to have an internet connection that allows for both high-speed uploads and downloads for optimal videoconference platform quality.

#### **Which patient populations can benefit from telepsychiatry?**

In my opinion, most patients in need of mental health care can benefit from telepsychiatry. However, some patients and communities that face significant barriers to accessing healthcare services would particularly benefit from these services. At this stage it is important to highlight that while these patients can sometimes live in rural and remote areas of Illinois that are difficult for psychiatrists to reach, many patients in need of urgent psychiatric care also live in suburban and urban areas in Illinois, even in downtown Chicago.

In summary, telepsychiatry is an effective, HIPAA-compliant, and cost-effective method that has been utilized for decades and that can help overcome significant barriers to accessing mental health care for our patients. I would

*(Continued on back cover)*

## President's Message

*(Continued from page 1)*

I have received a few calls from friends asking if it is time to move to Wisconsin or Indiana.

I understand that the recent JCAR approval has caused disappointment and anxiety for some. I have talked to hospital administrators who have been approached by psychology leadership about training to become prescribing psychologists. They have been promoting themselves as better alternatives to psychiatrists and could be welcomed by primary care physicians, as well as some of our own.

There are some that try to highlight the potential benefit of such an alternative. After all, the current shortage of mental health providers combined with a growing population of people in need of mental health treatment (of which Illinois Medicaid patients are most affected) creates a need for more options. However, psychologists are not able to help with the Medicaid patients at this time.

### **We should be familiar with the highlights of the bill:**

The clinical rotation program must be compliant with the Accreditation Review Commission on Education overseeing the training for Physician Assistants. The following qualifications and limitations are applicable to psychologists seeking to prescribe medications in Illinois:

- The psychologist must have completed a National Certifying Exam.
- The psychologist must have a written collaborative agreement with a physician (a template for the collaborative agreement is included in the rules for the Psychologist Prescribing Act).
- The collaborating physician must file a notice of delegation of prescriptive authority, as well as termination of the delegation authority, with IDFPR.
- The collaborating physician must participate in the joint formulation and joint approval of orders or guidelines with the prescribing psychologist and must periodically review the prescribing psychologist's orders and services to patients.
- The collaborating physician must provide collaboration and consultation once a month in person or via video-conferencing for the review of safety and quality clinical care or treatment.
- The collaborating physician must be available via telecommunications on medical problems, complications, emergencies, or patient referrals.

- The collaborating physician must review the medication orders of the prescribing psychologist, including the review of laboratory orders and other tests, on a monthly basis.
- The psychologist should only prescribe medications for the treatment of mental illness that the collaborating physician generally uses to treat his or her patients in the normal course of his or her clinical practice.
- The psychologist is not permitted to prescribe benzodiazepines, narcotics, and Schedule II medications (e.g. Adderall, OxyContin, Fentanyl, etc.).
- The prescription that a psychologist issues must include the name of the collaborating physician.

### **The psychologist is not allowed to treat the following patients:**

- Patients who are less than 17 years old.
- Patients who are over 65 years old.
- Patients who are pregnant.
- Patients with serious medical conditions such as heart disease, cancer, stroke, or seizures.
- Patients with developmental disabilities or intellectual disabilities.

The efforts that led to shaping this law underline the need for our continued participation in our organization and advocacy for our patients. I would like to thank Dr. Kenneth Busch, Meryl Sosa, Dr. Swaminathan, Dr. Dan Yohanna, Dr. Weisman, Dr. Peter Fore, Dr. Joan Anzia, Dr. Lisa Rone, Dr. Linda Gruenberg, Dr. Jim Mackenzie, and various individuals who gave countless hours to keep patient safety the central focus of this legislation (I am sure I have missed some important contributors, my apologies in advance.) Personally, I see this as an opportunity to expand our services, provide leadership and education, and lead the efforts to shape the change that this bill may cause!

At this time, IPS will continue to closely monitor several bills in the legislature, and we have approached several members of the legislature to look at Medicaid reimbursement rates for psychiatric services.

I would like to thank Dr. Mahmoud for resuming the editorship of this publication as well as Dr. Nakshbandi and Dr. John for supporting his efforts as co-editors.

Please plan to join us for the Annual Holiday Party and Awards night January 27, 2018. Dr. Anita Everett, the President of the American Psychiatric Association, will be the guest and speaker.

Please contact me at [Danesh.Alam@nm.org](mailto:Danesh.Alam@nm.org) or Meryl Sosa at [MSosa@ilpsych.org](mailto:MSosa@ilpsych.org) with questions or feedback. 



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## Residents' Corner

### Transition to Psychiatry: Curiosity about Our Patients

*Eric Cheung, MD, UIC Dept. of Psychiatry*

It's hard to forget the first day of residency. The rush, the excitement, the fear, all experienced at the same time. I remember looking up contraindications to aspirin five times that day prior to ordering it, just to be sure. Medical school was meant to prepare me for this day. Four years of long hours studying, clinical duties, and patient interactions to prepare me to finally see and treat my own patients. For most physicians, the transition from medical school to residency is the most significant and the most memorable. However, I experienced a more profound transition during my residency. That is the transition from medicine to psychiatry.

The six months I spent as an intern on medicine were challenging. I also look back on those days with a sense of accomplishment. I overcame the steep learning curve for interns during that time. I was getting better at navigating the electronic medical records, managing multiple patients, organizing my time, getting notes done, putting orders in properly, etc. The off-service attendings were great at educating me, even when they knew that my specialty was elsewhere. By the end of six months, I would be at the peak of my training in medicine but excited and ready to begin psychiatry, the career I chose.

I had a mix of emotions at that time. I was excited but I also felt I was back at square one. I felt like a nervous, confident, happy, and terrified intern on his first day of residency all over again. However, I had a small advantage. I was familiar with the hospital so the learning curve shouldn't be so steep. I could focus on psychiatry. Everything was going to be okay.

The transition was more significant than I had originally anticipated. It was more than just working with different diagnoses and treatments, learning about new templates, or satisfying meaningful use requirements in different ways. Something felt different when I began psychiatry. It was a different sort of transition than the transition from medical school to residency. It troubled me for quite some time starting off.

I could not put my finger on it until I attended my first lecture on psychiatric interviewing. It was one of my first lectures in psychiatry. And it was a good one. The

attending began asking us to reflect on our patient interactions thus far. Since my fellow classmates also had medicine for the first half of the year, much of our stories came from the perspective of an off-service intern. In our discussion, we talked about the difference between a psychiatric interview and a non-psychiatric interview. The attending shared his personal reflections about his transition from medicine to psychiatry that I'll never forget: "I had to learn how to be curious about the patient again."


In my first few months of psychiatry training, I found myself with a series of checklists for new admissions. My checklists helped me survive my months in medicine. The checklists included the necessities of suicidal and homicidal ideations, auditory and visual hallucinations, mood, manic episodes, anxiety, past psychiatric history, etc. I remember my experience with one of my first patients. We were consulted for postpartum depression. The patient denied current depression but endorsed having anxiety for many years. I went through the interview with checklist in hand. Fast, efficient, effective. Right? When we spoke about the patient in rounds and within the conversation, I embarrassingly realized that I had forgotten to ask for reasons why the patient felt she was anxious. It wasn't on my checklist. I was distraught and felt like I had failed. What happened? What happened to my natural curiosity for my patient?

Over the next several weeks and after multiple patient interviews, I learned to regain much of my curiosity for my patients. It took me through an interesting journey of self-reflection. As psychiatrists, the illnesses we diagnose, treat, and manage are highly integrated into a patient's sense of "personhood." We are curious not because we necessarily care more than non-psychiatric specialties. We are curious because everything of one's personhood is connected to mental health. With this realization, I remembered why I wanted to become a psychiatrist.

A patient with a UTI may present classically with dysuria, hematuria, increased urinary frequency, etc. After a urinalysis and cultures, the best course of action would be to prescribe the appropriate course of antibi-

otics, provided there are no other complications. Very rarely would the presence of UTI touch upon a deeper part of the patient's way of life or perspective on the world. Very rarely will a UTI fundamentally affect a person's sense of personhood. Good medical care of a patient with a simple UTI rarely needs a discussion how this UTI has affected his or her productivity with work, relationship with friends and family, or sense of self. Good medical care for a UTI, and many other pathologies, is adequately defined as appropriate diagnosis followed by appropriate treatment.

Psychiatry is different. The interview process is special and can even be considered sacred. We're asked to slow the pace of the hospital setting and to make the patient comfortable enough to allow for the most honest and accurate history possible. Even then, patients are often not entirely forthcoming about their situation. On top of that, we're asked to have a heightened awareness of transference and countertransference during the interview. This is to ensure that we are not unconsciously biasing our assessment, interaction, or treatment of the patient. Furthermore, the psychiatric interview can be therapeutic in and of itself. It can often provide an outlet for patients, especially for those suffering from depression and anxiety.


So much more goes into the psychiatric interview due to the nature of psychiatry. It is what made my transition from medicine to psychiatry so significant. Mental illness is interconnected with a person's sense of personhood. Curiosity for that sense of personhood is critical to ultimately understanding the mental illness that plagues it. I see that innate interest well developed among my psychiatric attendings. In light of this realization, one of my many personal goals is to always be deeply curious about my patients. If I am lucky, I can pass along this lesson to future psychiatrists, as it was passed on to me. 

*If you are a resident and would like to submit a column for the next Residents' Corner, please email [kmalloy@ilpsych.org](mailto:kmalloy@ilpsych.org). Whether it's a topic you would like to see get more attention, or an experience you would like to share, this is your forum.*

## Mental Health Roundtable



IPS Executive Director, Meryl Camin Sosa with U.S. Senator, Dick Durbin and others at the Roundtable discussion

On Monday, January 30, 2017, IPS Executive Director Meryl Camin Sosa participated in a roundtable discussion regarding mental health and substance use disorders that was organized by Senator Dick Durbin. Ms. Sosa spoke about her issues with commercial insurance when she had cancer and also regarding her daughter's experience with in-patient hospitalization and at a rehabilitation facility. Ms. Sosa had an insurance policy that had a mental health carve out so that while the insurance policy covered a specific hospital system for medical conditions, the carve out did not cover mental health services at that hospital system. Unfortunately, Ms. Sosa did not find that information out until she brought her daughter to the emergency room at the hospital system and found out that mental health services were not covered at that hospital. Also, the carve out only paid for the daughter's rehabilitation as if it were a day program and Ms. Sosa was required to pay for the room and board. In addition, the insurance only paid for 2 weeks of care at the rehabilitation facility. Thankfully, the facility had some grant funding and so the daughter's care for an additional two weeks was covered by a grant. The roundtable also included Kelly O'Brien from The Kennedy Forum and Mark Ishaug, CEO of Thresholds. Ms. Sosa is very concerned regarding the American Healthcare Act because her cancer would be a pre-existing condition that could prevent her from getting insurance. 

## IPS Resident Rooftop Happy Hour

*Mia Bell, MD, Rush*

On July 13, 2017, American Professional Agency (APA, Inc) sponsored a private rooftop terrace event for residents from all the Illinois psychiatry residency programs. The event took place on a rooftop in downtown Chicago with a spectacular view of the city. Delicious food and drinks were provided. The event had a great turnout, with attendance from psychiatry residents from all of the programs in the Chicago area including Northwestern, University of Chicago, Rush, UIC, Loyola, Lutheran General and Rosalind Franklin. In the relaxed atmosphere, residents had the opportunity to network with each other. Trainees discussed residency life, interests, and career goals. Also in attendance was James MacKenzie, DO

(Assistant Professor in the Departments of Psychiatry & Pediatrics and Director of Pediatric Collaborative Care at Rush University Medical Center). Dr. MacKenzie helps organize the event and acts as a great mentor for psychiatrists in training. This was an amazing event that will hopefully continue for many years to come! 🍷



Event Sponsor Kery Hummel from American Professional Agency (APA, Inc.) addressing the crowd.



From Left: Mia Bell, MD; Dena Oaklander, MD; Maria Tocco, MD; Amrita Mankani, MD; Ian Pearson, MD



From left: Michael Medina, MD; Ash Ehsan, MD; Kathryn Weaver, MD; Chandan Khandai, MD; Ali Weiss, MD



From left: Bowie Han, MD; Anita Rao, MD; Chetan Amar, MD; Karla Garcia, MD; Jacqueline Hirsch, MD; Elizabeth Ryznar, MD; Jeremy Kruger, MD; Zack Schwab, MD; Jeff Abbott, MD



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## The Case for Agreed Outpatient Commitment in Illinois

Matthew R. Davison<sup>1</sup>

For many psychiatrists, Illinois commitment law can largely appear binary: either a court finds, by clear and convincing evidence, that an involuntary respondent (patient) meets the statutory criteria for inpatient commitment<sup>2</sup> or, the petitioner has not met said burden and discharge from the hospital is imminent. It is ostensibly an “all or nothing” pursuit, fraught with delays and unknowns that can leave the respondent, the family, and the facility feeling frustrated and unsatisfied.

Such experiences can understandably cause an unwillingness or hesitation for facilities (and families) when it comes to whether a contested order of inpatient commitment is ultimately sought. On the other hand, many facilities also have repeat clientele that are voluntary, compliant, and cooperative, but soon after discharge, medication non-compliance prompts re-admission and the all-too-familiar cycle continues.

Practitioners regularly encountering both dilemmas (involuntary inpatient commitment and repeated voluntary admissions) often overlook an opportunity hiding in plain sight: outpatient commitment. Underutilization of outpatient commitment in Illinois is largely due to a widespread lack of familiarity with the process by treatment teams and a lack of adequate infrastructure in the community to address the various ancillary challenges that often accompany mental-health matters (such as housing/homelessness, substance abuse, domestic problems, and other common dilemmas). Both causes of underutilization can be addressed through education, training, and reliable funding that transcends mere platitudes.

There are two common conduits for outpatient commitment: involuntarily or through an agreed care and custody order. Both outpatient methods are examined in turn below and are accompanied by practical insights for those providers considering the viability of outpatient commitment and treatment through agreed care and custody orders.

### Involuntary Outpatient Commitment

Any person 18 years of age or older may execute a petition asserting that another person is subject to involuntary admission on an outpatient basis.<sup>3</sup> Similar to an inpatient petition, an outpatient petition should be accompanied by two certificates of qualified examiners (with at least one of the certificates executed by a psychiatrist). In Illinois, there are two available threshold queries for whether someone meets the criteria for an outpatient commitment, either they are:

(1) A person who would meet the criteria for admission on an inpatient basis as specified in Section 1-119 in the absence of treatment on an outpatient basis and for whom treatment on an outpatient basis can only be reasonably ensured by a court order mandating such treatment; or

(2) A person with a mental illness which, if left untreated, is reasonably expected to result in an increase in the symptoms caused by the illness to the point that the person would meet the criteria for commitment under Section 1-119, and whose mental illness has, on more than one occasion in the past, caused that person to refuse needed and appropriate mental health services in the community.

405 ILCS 5/1-119.1. Thus, by definition, the standard afforded to outpatient commitment is a lower threshold than the criteria applied for an inpatient commitment. Put another way, a treatment team may be more confident in pursuing outpatient by trial under such a threshold, if the circumstances warrant such action.

Outpatient commitment can be sought as a standalone remedy for an individual residing in the community already<sup>4</sup> or for someone who is inpatient at a mental health facility (whether voluntary or involuntary). Moreover, if a petition for inpatient commitment is filed, a petition for admission on an outpatient basis “may be combined with or accompanied by a petition for involuntary admission on an inpatient basis.”<sup>5</sup> If an individual is found subject to involuntary admission on an outpatient basis, the court may issue an order: “(i) placing the respondent in the care and custody of a relative or other person willing and able to properly care for him or her; or (ii) committing the respondent to alternative treatment at a community mental health provider.”<sup>6</sup>

A natural apprehension to pursuing involuntary outpatient commitment is whether the time, effort, and coordination are worthwhile investments if the individual is contesting said treatment. After all, if an individual does not comply, it is easy to foresee a situation wherein the respondent of an involuntary outpatient order is readmitted weeks after the trial. Given this, another route for outpatient—by agreement—should be given thoughtful consideration.

### Outpatient by Agreed Order

Under the Mental Health and Development Disabilities Code, “[a]ny time before the conclusion of the hearing and the entry of the court's findings, a

respondent may enter into an agreement to be subject to an order for admission on an outpatient basis.”<sup>7</sup> This provision allows for a respondent and his or her counsel to resolve a pending petition (inpatient or outpatient) with a settlement agreement that contains specific terms of outpatient treatment. Entry of such an agreed order does not require a full, adversarial hearing but instead a very brief, uncontested court date where the Judge reviews conformity with the applicable statute and finds that the order is in the best interest of the respondent and the public. For psychiatrists, this usually means approximately fifteen minutes of time (if that) to attend court as a show of support and to recite that there is a history of noncompliance and that outpatient is the best (and least restrictive) form of available treatment.<sup>8</sup>

There are many benefits to an agreed care and custody order. First, it allows the respondent to review the treatment plan in-depth and have input into the proposed treatment, which may cultivate an “investment” into his or her own treatment. Second, it artfully resolves any

contested trial or adversarial hearing where the psychiatrist would be forced to undergo extensive cross-examination and potential impeachment. Third, it memorializes an extensive care plan that serves as a blueprint (signed by a Judge) for the respondent’s community care so that providers and agencies may easily reference it and rely on it. Finally, the agreed care and custody order, by definition, involves a “custodian” for the respondent. This term (while an unfortunate word choice) simply means that the respondent has a community partner that oversees compliance and serves as the Court’s “eyes and ears” throughout the relevant time period. The custodian can be a family member, neighbor, or an unrelated entity that is willing to stand in and serve in the role. It does not create a legal “agency” relationship.<sup>9</sup>

For those psychiatrists concerned that outpatient has no “teeth”, agreed care and custody orders in Illinois routinely have provisions allowing “the authority to

*(Continued on page 16)*

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## Agreed Outpatient Commitment

(Continued from page 15)

admit a respondent to a hospital if the respondent fails to comply with the conditions of the agreed order.”<sup>10</sup>

What’s more, “if necessary in order to obtain the hospitalization of the respondent, the custodian may apply to the court for an order authorizing an officer of the peace to take the respondent into custody and transport the respondent to the hospital specified in the agreed order.”<sup>11</sup>

Often, individuals who have repeated hospitalizations or even those respondents who have already been court ordered to take medications are receptive to an agreed care and custody order as it can be a care plan that not only addresses the serious mental illness, but provides a comprehensive roadmap for: housing, therapy, substance abuse, and medication management. Meaning, a large incentive for respondents to consider an agreed care and custody order are the “ancillary wrap services” that can often be creatively incorporated into the order. Similarly, some families strongly insist an agreed care and custody order be discussed prior to an individual returning home.

The agreed order can last for up to six months with the possibility of extension.<sup>12</sup> In this six-month window, the respondent is still represented by counsel and the attorney may be asked by the Court to report in on the success of the outpatient treatment as well as alert the Court to any substantive noncompliance. During this time, it would be prudent for the attorney to review and discuss an advanced directive with the client such as a declaration for mental health treatment.<sup>13</sup>

Agreed care and custody orders may also include psychotropic medications, provided that the Court “determines, based on the documented history of the respondent’s treatment and illness, that the respondent is unlikely to continue to receive needed psychotropic medication in the absence of such an order.”<sup>14</sup> In practice, such orders almost-always contain medication. Once in the community, pursuant to the order, the respondent and the community provider can continue to discuss dosages and agreed upon modifications.

### Conclusion

The number of Illinois agreed outpatient orders are few and far between. This is changing. Due to federal grants, ongoing awareness among providers (and insurance companies), and an overall growing frustration with a redundant inpatient legal system, more and more facilities are dusting off outpatient statutes and asking more

questions about agreed orders. Further, such earnest endeavors by treatment teams often have the ancillary effect of developing genuine trust with respondents as the process necessarily involves the individual and gives them a voice and input into his or her community care. This is most apparent on the actual court date, where it looks and feels nothing like a trial and instead more like a collaborative chorus, with everyone on the same “side” and aiming for the same goal, together.

### For your interest:

1. The author is a Chicago-based lawyer with a private practice focused on mental-health law and fiduciary litigation. He is currently contract counsel for Legal Advocacy Service, a division of the Illinois Guardianship and Advocacy Commission. Pursuant to an Assisted Outpatient Treatment grant, he represents respondents throughout the Assisted Outpatient Treatment (AOT) process. He may be reached via email at [Matthew.Davison@illinois.gov](mailto:Matthew.Davison@illinois.gov) and by phone at (847) 272-8481.
2. See 405 ILCS 5/1-119.
3. 405 ILCS 5/3-751(a).
4. The respondent may remain at his residence pending the hearing. If, however, the court finds it necessary, it may order a peace officer or another person to have the respondent before the court at the time and place set for hearing. 405 ILCS 5/3-756
5. 405 ILCS 5/3-751(c).
6. 405 ILCS 5/3-812.
7. 405 ILCS 5/3-801.5
8. The treating psychiatrist should also furnish a “written report” to the parties prior to the court’s entry of the agreed order. The written report is essentially a one-page summation of the respondent’s relevant history, diagnosis, proposed custodian, and any medications. See 405 ILCS 5/3-810.
9. 405 ILCS 5/3-801.5(e)
10. 405 ILCS 5/3-801.5.
11. Id.
12. 405 ILCS 5/3-801.5(g)
13. See, e.g., 755 ILCS 43/75.
14. 405 ILCS 5/3-801.5





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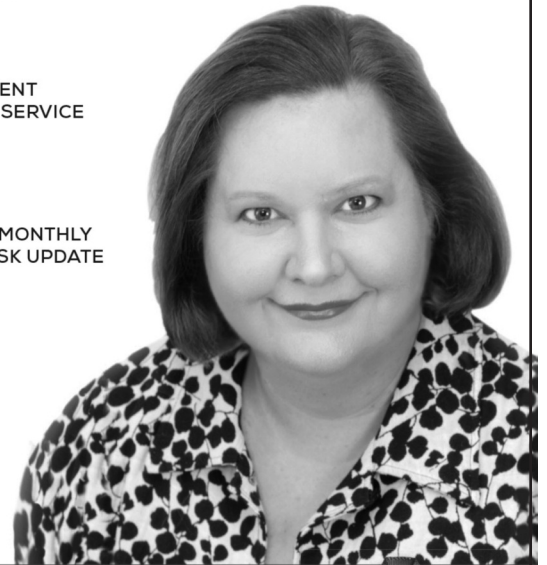
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## Legislative Update

*Betsy D. Mitchell, MPA, IPS Legislative Consultant*

### Prescribing Psychologists Rules

On Tuesday, September 12, 2017, the Joint Committee on Administrative Rules met in Chicago. JCAR did not object to the IDFPR's proposed rules which were promulgated to implement the prescribing psychologists legislation passed three years ago. The final rules will be published soon for the public. IPS will make these rules available to all IPS members.

### In-District Legislative Visits

Please plan to meet with your legislators in their district office this Fall. Recently, IPS developed Talking Points to guide you in your discussions with legislators. Simply call your legislator's district office for an appointment or invite your legislators to your clinic/office. For more information on contacting your legislators or the talking points, contact IPS. Also watch for the announcement of the IPS Spring Advocacy Day in Springfield and plan to attend.

### Task Force on Opioid Abuse Created

On September 7, 2017 Governor Rauner created the Opioid Overdose Prevention and Intervention Task Force to combat opioid abuse in the state. The task force will be co-chaired by Lt. Gov. Evelyn Sanguinetti and Dr. Nirav D. Shah, director of the Illinois Department of Public Health. The mission of the task force is to develop strategies to prevent expansion of the opioid crisis, treat and promote the recovery of individuals with opioid-use disorder, and reduce the number of opioid overdose deaths. IPS will follow the decisions of this Task Force.

### Legislative Highlights\*:

- **HB 68/Lang -- Mental Health Parity** -- The bill makes vital revisions to the parity section of the Heroin Crisis Act (HB1) enacted two years ago. A hearing was held on HB68 and the bill passed out of the House Mental Health Committee, but failed to receive any further action. Discussions on this issue are expected to continue when this bill is reintroduced in 2018.
- **HB313/Feigenholtz - Martinez -- APNs** -- Late in the session, ISMS' final offer to the APNs was accepted to allow for independent practice with a significant increase in post graduate educational and training requirements. The agreement includes several

other vital requirements. After the amendment was adopted, IPS took a neutral position on this legislation which is now under consideration by the Governor.

- **HB311/Greg Harris - Holmes -- Network Adequacy/Transparency** -- Introduced at the suggestion of ISMS, IPS supported this important legislation which passed both chambers and Governor Rauner has signed this bill.

- **House Bill 649/Turner** -- For defendants found unfit to stand trial and found not guilty by reason of insanity, that if within 20 days of the transmittal of the placement order, DHS fails to notify the sheriff of the identity of the facility, the sheriff is to contact DHS to inquire about when a placement will become available. Furthermore, if DHS fails to notify the sheriff of the facility's identity then the sheriff's office must notify DHS of its intent to transfer the defendant to the nearest secure mental health facility operated by DHS. Additional requirements of the sheriff and DHS are included in the bill signed into law by the Governor on August 4, 2017.

- **House Bill 1332/Fine - Morrison** -- Insurance coverage for eating disorders which were not previously covered under the Illinois Parity Law. IPS supported this important legislation which was signed into law on August 24, 2017.

- **House Bill 3502/Conroy - Bush** -- The House amendment to create the Advisory Council on Early Identification and Treatment of Mental Health within the Illinois Department of Human Services. IPS supported this bill. The bill was signed into law on August 18, 2017. IPS proposed certain members to serve on this important Advisory Council.

- **HB 3904/Stratton - Bush** -- IPS supported this important bill to create a women's correctional services division within IDOC. The bill passed the House but was amended in the Senate, so it had to return to the House for concurrence, where it remains. The bill passed both houses this summer with a super majority. It awaits action by the Governor.

- **HB 2959/Fine - Biss** -- Prevents health insurance companies from denying health insurance based on pre-existing conditions, especially if the ACA is repealed. This bill was signed into law by the Governor.


- **HB2907/Bellock - McGuire** -- Amends the Public

Aid Code pertaining to telepsychiatry to not allow HFS to require that a physician or other health care professional be present in the same room as the patient for the entire time during the session. This legislation passed both houses and was signed into law by the Governor on August 25, 2017.

- **House Bill 3161/Manley** -- Creates a special website to be maintained to educate the public on heroin and prescription opioid abuse. Also encourages state agencies to work together on this issue. The Governor signed this bill into law on September 8, 2017.

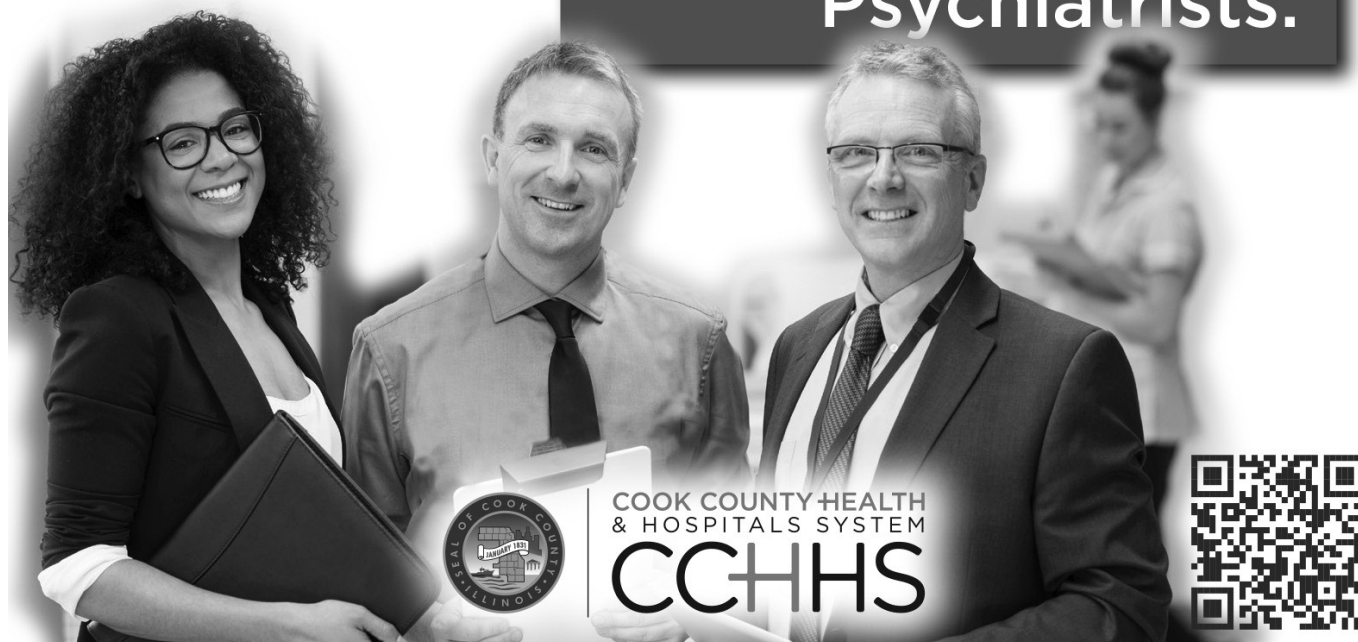
- **Senate Bill 1348/Martinez** -- Medical Practice Act -- On August 25, 2017, the Governor signed into law the Medical Practice Act which will expire on December 31, 2019.

- **SB1391/Harmon -- Creates the Psychology Interjurisdictional Compact Act** -- At the suggestion of IPS and ISMS, the sponsor accepted an amendment to the bill so that the Compact could only apply to clinical psychologists and not psychologists holding a prescribing license in any state. Following a committee hearing where IPS Past President, Dr. Arden Barnett attended and was prepared to testify, the bill was held on Third Reading in the Senate by the sponsor. IDFPR asked for additional time to review the impact this compact would have on the Department. We expect this issue to be reintroduced in 2018.

\*For a complete list of all of the bill IPS followed this past session, contact IPS for additional information. 

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## ips mind matters

### Landscape of Mental Health

(Continued from page 7)

strongly urge my colleagues to consider incorporating telepsychiatry into their work settings. It is a channel of healthcare delivery that has the potential to change the landscape of healthcare in Illinois and across the United States.

Upcoming articles related to The Changing Landscape of Mental Health:

- Part II: Common Misconceptions Related to Telepsychiatry
- Part III: Overcoming Perceived Barriers

IN MEMORIUM:  
*F. Moises Gaviria MD*

For further reading:

1. Telepsychiatry: Videoconferencing in the Delivery of Psychiatric Care. *The American Journal of Psychiatry*. (2013; 170:256–262)  
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2. Usefulness of telepsychiatry: A critical evaluation of videoconferencing-based approaches. *World Journal of Psychiatry* (2015 September 22; 5(3): 286-304)  
<http://www.wjgnet.com/2220-3206/full/v5/i3/286.htm>
3. Telepsychiatry in the 21st Century: Transforming Healthcare with Technology. *Perspectives in Health Information Management*. 2013 Summer; 10(Summer): 1f.  
<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3709879/pdf/phim0010-0001f.pdf>

Disclaimer: Dr Hossam Mahmoud is Medical Director at Regroup Therapy, a Chicago-based telemental health company. 