



Newsletter Fall 2013



Letter from Your President ~ Bonnie M. Carroll, LCSW

Greetings NCAMHP members,

I hope you are all enjoying the beautiful colors and sounds of Fall this year.

The NCAMHP Board of Directors has recently experienced the loss of two Board members and a third will be resigning at the end of 2013. Lesley Manson accepted a faculty position at her old alma mater, Arizona State University in their Doctorate of Behavioral Health Program. She relocated to the Phoenix area this past August. Caren Wise has decided to take a break from her private practice on the Coast. She lives in the Hoopa area and will continue to see clients in that area. Since she is no longer maintaining her private practice on the Coast, she has decided to resign from the Board as well. Additionally, Jennifer Blair has decided to make a few changes in her life. She works full time at County Mental Health and has a beautiful 1-year-old daughter; so after almost four years on the Board and Newsletter Committee, she has decided to step down to prioritize her family and her own self-care. In addition to these three resignations, a fourth Board member, Paula Nedelcoff is taking a three-month leave of absence to work for NATO in the Netherlands, which is a wonderful opportunity and life experience for her. We are thankful to all of these amazing women for their hard work and dedication to the Board and NCAMHP in general and wish them well in their adventures!

This exodus has also left us with two vacant positions on the Newsletter committee. The Newsletter is a great service and resource for our Membership. This Committee requires a quarterly commitment of time for its publication in the Fall, Winter, Spring, and Summer.

Lastly, our Redbook/Membership Committee is down to one member and it is that time of year again to orchestrate the publication of the Redbook. This committee requires more of an annual commitment rather than an ongoing or quarterly one. So if you want to volunteer for a time limited project, this would be a great spot for you.

The Board and Committees are full of fabulous and passionate practitioners who are excited about the prospect of working with new members like you! So if you've ever thought about joining the Board or a Committee and volunteering your time to our organization, Carpe Diem!! And contact myself or another Board member to discuss your interest. We look forward to hearing from you!

Thank you,

Bonnie M. Carroll, LCSW
NCAMHP Board President 2013
bonnyrose@arcatanet.com



NCAMHP Interviews

Non-profit Agencies in Humboldt County serve many different people. The NCAMHP Newsletter Committee has connected with one local non-profit to learn more about this important area of service in the community. Humboldt Family Service Center Director, Paula Nedelcoff, MFT answers our questions!

*NCAMHP Newsletter Committee (N.C.):
How did Humboldt Family Service Center (HFSC) come to be?*

Humboldt Family Service Center was created in 1972 to help support the low income and working poor to receive mental health at affordable rates. The Board recognized that the very low income population did have some access with Medi-Cal but the middle and low middle were caught without services. As most non profits it began with a group of dedicated volunteers who fund raised wrote grants and created awareness along of course with many service hours.

What populations does HFSC serve?

HFSC works with all demographics/populations: adults, teens, children, elders, families, couples, short term, long term, and court referred. We take pride in the openness to anyone who seeks service.

Who staffs HFSC?

HFSC is staffed by licensed clinicians as well as interns, MFTinterns, and ASWs. We also provide practicum for graduate students. Staff positions are both paid and unpaid, clinical supervision and liability insurance and non cost consultation is provided for all staff providing services, in some programs para professionals are

also used specifically in our substance abuse education (although certification is necessary) and our batterers treatment (formal training and supervision is necessary).

What distinguishes a non-profit from other government or for profit agencies?

I think we are different because we provide such a variety of services to a wide variety of clients; we receive no funding except for our fees. Some of these fees are paid for by the county and or federal government, and or private business but they are strictly fee for service based

Please share anything else that you would like the NCAMHP membership to know about HFSC.

We are proud of the fact that we provide a free walk in clinic weekly that is used with our own agency funds and some small fund raising monies. There is only one support staff (office) person who does not bill for services. The agency runs much like a small business providing excellent training and supervision in exchange for hours for the staff and low cost excellent service for the clients. In most cases all phone calls are returned in the same day and a live person answers the phone. HFSC takes pride in being small enough to be easily accessible and if we cannot provide the service make sure we are able to give the client a current resource to meet their need.



News From The Education Committee

The NCAMHP Education Committee met this Summer and the focus of the meeting on was on the following topics:

- Reviewing evaluations from the DSM V workshop
 - Evaluations for the DSM V workshop were very positive, with the only suggestion for improvement being that we have a larger space when workshops are full. It was also suggested that we include lunch, even when the workshop ends at 2:00.
- The need to explore other locations for future workshops
- Possible topics for the Spring workshop
 - Three topics were suggested for the Spring workshop:
 - The relationship between trauma and dissociations and disease
 - Treatment of severe depression

- Neuroplasticity and somatoform disorders
- Dave Berman will help to create a membership survey available by email blast that will guide the committee in choosing a topic. Please complete the email survey if you want to participate in choosing a topic and presenter...
- How to make the website more user friendly



Psychotherapy may fix serotonin receptors better than antidepressant drugs

29 September 2013 [Journal of Psychotherapy and Psychosomatics](#)

A paper published in the current issue of *Psychotherapy and Psychosomatics* provides new findings on the role of psychotherapy in regulating serotonin receptors.

This study was part of a larger project comparing psychotherapy and selective serotonin reuptake inhibitor (SSRI) drug treatment in major depressive disorder (MDD).

Patients with MDD were randomized to receive either fluoxetine 20-40 mg/day or brief psychodynamic psychotherapy for 4 months. Brain serotonin 5-HT_{1A} receptors were measured before and after treatment with positron emission tomography and the radioligand [carbonyl-¹¹C] WAY-100635.

Of all the patients in the study, 23 participated in the positron emission tomography part of the study: 8 from the psychotherapy group and 15 from the fluoxetine group. Clinical evaluations included (in addition to the main outcome measures HAM-D and Beck Depression Inventory) Social and Occupational Functioning Assessment Scale (SOFAS) and Social Adjustment Scale-Self-Report (SAS-SR) and Brief Symptom Inventory.

In both groups, the SOFAS scores increased in a similar way. In the whole group, increase in 5-HT_{1A} receptor BPND was positively correlated with increase in SOFAS scores after treatment in the orbitofrontal cortex, suggesting that those who had the highest improvements in social and occupational functioning had the largest increases in 5-HT_{1A} receptor BPND.

Further analyses indicated that this association was driven by patients receiving psychotherapy. In this group, increase in 5-HT_{1A} receptor BPND was positively correlated with an increase in SOFAS scores after treatment in the orbitofrontal cortex, ventral anterior cingulate cortex, medial prefrontal cortex, and parietal cortex and lateral temporal cortex. Such correlations were not seen in the fluoxetine group.

This is the first study to show that the increase in the density of the 5-HT1A receptors after psychotherapy is strongly associated with the increase in social and occupational functioning. Thus, among depressed subjects, 5-HT1A may be a marker of social functioning, not of the severity of depression symptoms.

While both treatments improved SOFAS, only psychotherapy was associated with increase in 5-HT1A density. The reason for this may be that the serotonergic neurotransmission is enhanced by SSRI treatment in a different way than by psychotherapy.

Our findings suggest that SSRI medication, although leading to decreased symptoms and increased functioning in the short run, nevertheless is associated with an incomplete recovery of the serotonin system after treatment. This could be related to higher relapse risk.

<http://www.karger.com/pps>

- **Full citation:** Karlsson H., Hirvonen J., Salminen J., Hietala J. Increased Serotonin Receptor 1A Binding in Major Depressive Disorder after Psychotherapy, but Not after SSRI Pharmacotherapy, Is Related to Improved Social Functioning Capacity . *Psychother Psychosom* 2013;82:260-261



Understanding The Nocebo Effect

By Dave Berman

The Scientist Magazine recently published an article called “Worried Sick” that looks at research into the neuroscience of the nocebo effect. The word “nocebo” comes from the Latin “I shall harm” and superficially appears to be the flip side of the coin to the more familiar placebo effect (from the Latin “I shall please”). Both refer to ways we are influenced by information or substances, one to our detriment and the other to our benefit.

I say they appear superficially related because recent research suggests these two phenomena have very different biochemical mechanisms. According to the article, nocebo first appeared in scientific literature in 1961. Since then it has only been studied a tiny fraction as much as placebo because it is controversial among bioethicists and ethics committees don’t easily approve research in this area.

Nonetheless, The Scientist quotes Ted Kaptchuk, director of Harvard’s Program in Placebo Studies at Beth Israel Deaconess Medical Center in Boston: “Nocebo is at

least as important as the placebo effect and may be more widespread...In places like primary care, people are swimming in placebo and nocebo effects.” That means what doctors and nurses are telling people about their conditions, treatments and medications are having both positive and negative effects.

The Scientist points out “fear and distress before an operation has been associated with slow postoperative recovery and delayed wound healing.” Interestingly, decades of research show hypnosis can be used to speed post-op recovery and wound healing, reduce the need for medications and even anesthesia during surgery, and in the most basic of ways help people relax and calm fears or distress.

In addition to Kaptchuk, another important figure in this field is Fabrizio Benedetti, an Italian neurophysiologist. In 1997, Benedetti became the first to demonstrate the biochemistry of the nocebo effect, as well as showing how to block it. Once again, the power of suggestion in hypnosis has long been used to turn on and off physiological processes.

Despite the disproportionate amount of effort put into placebo research, since Benedetti’s 1997 discovery there’s been an uptick in the funding and time devoted to investigating the mechanisms behind nocebo, with impressive results. “Without a doubt, there’s been a level of research and a sophistication of research that has made a quantum jump in the last decade or so,” says [chair of family medicine and director of the Institute for the Medical Humanities at the University of Texas Medical Branch in Galveston, Howard] Brody.

In 2007, for example, Benedetti discovered that the hypothalamic-pituitary-adrenal axis in the brain, an important part of the body’s “stress system,” is activated during a nocebo response, as detected by an increase in the secretion of the hormones ACTH, from the pituitary gland, and cortisol, from the adrenal gland, both markers of anxiety.⁸

Then, in 2008, Kaptchuk and colleagues at Harvard performed the first brain-imaging study of the nocebo effect. After conditioning healthy volunteers to expect pain on their right forearm, they watched as the hippocampus lit up when people experienced pain from a sham acupuncture device.

Through Benedetti’s and Kaptchuk’s work, it is now clear that a person’s expectation of pain can induce anticipatory anxiety, triggering the activation of cholecystokinin, the hormone that Benedetti blocked with proglumide. Cholecystokinin-mediated pathways in turn facilitate pain transmission, which occurs in specific areas of the brain. The finding does not coincide with what is know [sic] about the biochemistry of the placebo effect—which seems to be at least partly regulated by opioid release—suggesting the two phenomena have distinct mechanisms.

8: F. Benedetti et al., “The biochemical and neuroendocrine bases of the hyperalgesic nocebo effect,” [Journal of Neuroscience](#), 26:12014-22, 2006.

This expectation of pain plays a big role in childbirth. I recently completed Teresa Van-Zeller’s training “Birthing As Nature Intended,” and this fall will begin offering birthing education classes. The point of the program is teaching pregnant women how to relax and use self-hypnosis for drug-free, pain-free deliveries of their babies. In other words, natural childbirth!

The biggest reason this isn’t more common is the prevailing childbirth education and indoctrination women currently receive. They are told to expect lots of pain. No wonder their experiences often match such predictions.

The tragedy of this lack of investigation, researchers assert, is that controlled trials about the nocebo effect are needed to further understand and prevent nocebo's insidious effects on medicine and research. "In clinical drug trials, the placebo effect—and now we know the nocebo effect—can be really, really large," says Manfred Schedlowski, a clinical researcher at the University Hospital Essen in Germany. "This hinders the development of new drugs."

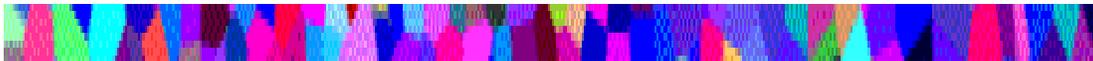
Beyond acknowledging the scope of the nocebo effect, this quote is telling about how doctors are thinking about “nocebo’s insidious effects,” – in terms of drug development. Consider the possibility that the important ethical debates and research into nocebo’s mechanisms may ultimately have less practical value than thinking in terms of mitigation via new communication strategies, including techniques explored in the book “Hope Is Realistic,” by medical hypnotists Michael Ellner and Kelley T. Woods, which I reviewed last year (<http://bit.ly/hhhirrev>).

“Most doctors don’t know what nocebo means,” agrees Y. M. Barilan, a practicing physician and associate professor of medical education at Tel Aviv University in Israel. That’s not to say that they don’t recognize the phenomenon. “They all know that the way you talk to a patient has enormous influence on side effects, mood, and state of mind,” Barilan notes—but without guidelines on how to deal with the problem or even to recognize it, the nocebo effect remains a specter of illness haunting our health-care system.

As medical hypnotists, all we have is the way we talk to our clients. We don’t get to prescribe drugs or run brain scans on sophisticated equipment. As research on nocebo becomes more widely reported, I hope doctors will allow a place for us in that discussion. I am particularly interested in exploring the link between nocebo and somatoform disorders, which are being reclassified as “somatic symptoms and related disorders” in the controversial new DSM-5. More on this in a future article...

* * *

Dave Berman, C.Ht. practices Clinical and Medical Hypnosis, Neuro-Linguistic Programming (NLP) and Life Coaching. He is certified by the International Medical and Dental Hypnotherapy Association and an affiliate member of the North Coast Association of Mental Health Professionals. Dave can be reached at (707) 845-3749 or through his website: www.HumboldtHypnosis.com.



Trainings

Fall General Meeting, Thursday, Nov. 14th, 2013; 5:30pm to 8:00pm at Humboldt Area Foundation – Presentation: “Body, Mind and Spirit: Holistic Exercises for Mental Health Professionals and Their Clients,” presented by: Margaret Emerson



Announcements

At the NCAMHP Fall General Membership meeting held on November 14th, 2013 at 5:30pm at Humboldt Area Foundation the NCAMHP Board will present the nominations for the 2014 elected Board positions for the General memberships' approval.

The Education Committee is prepared to schedule one of the following three workshops for Spring 2014 and requests your vote to decide which one. At the bottom of this message you will see the link for the survey. Please go to the survey page to cast your vote by October 21 at 8pm.

Robert Scaer, MD - "8 Keys to Brain-Body Balance." The bodily experience of emotions, the impact of emotional trauma on the body, and how to incorporate the body in healing emotional distress. More info: <http://www.traumasoma.com>

Michael Ellner, CHT, MSH and Dr. Richard Nongard, MFT - "Conversational Hypnosis and Neuroplasticity Training in Working with Chronic Pain and Somatoform Disorders." Help people living with chronic pain and/or somatoform disorders change their minds, emotional states and physiology as they learn how to re-wire their brains for health and healing. More info: <http://subliminalscience.com/conversational-hypnosis-and-neuroplasticity-training-in-working-with-chronic-pain-and-somatoform-disorders.html#12>

Jacqueline B. Persons Ph.D - "Working with Treatment-Resistant Depression: Combining Cognitive-Behavioral Therapy with Individualized Case Formulations." Workshop to include information on current treatments available for depression, co-morbidity, progress monitoring, and clinical decision-making when treatment is not working. More info: <http://www.sfbacct.com/our-psychologists/50-jacqueline-b-persons-phd-director>

Vote now at:

<http://www.surveymonkey.com/s/V3N3CTP>

Thanks,

NCAMHP Education Committee



October is Domestic Violence Awareness month. While searching the internet for relevant statistics of the prevalence of domestic violence in the U.S., it became apparent that current accurate data is not readily available. The following web search revealed important themes and landmark cases. Citations include writers when listed, and web links for further information.

Domestic violence consists of acts committed in the context of an adult intimate relationship. It is a continuance of aggressive and controlling behaviors, including physical, sexual, and psychological attacks, that one adult intimate does to another. Domestic violence is purposeful and instrumental behavior directed at achieving compliance from, or control over, the abused party. While it is difficult to obtain current accurate statistics, domestic violence is one of the most under-reported crimes in the United States. The Department of Justice in 1998 estimated that there were between 960,000 and four million domestic incidents each year. In 1994, the Bureau of Justice Statistics estimated that about 92 percent of domestic violence cases involved female victims.

Legal definitions of domestic violence are usually delineated by the relationship between the parties and by the nature of the perpetrator's abusive behaviors. For example, the relationship may be a current spouse, a former spouse, a family member, a child, parents of a child in common, unmarried persons of different genders living as spouses, intimate partners of the same gender, dating relationships, and persons offering refuge. Such definitions recognize that victims may not be exclusively women, and domestic assaults may not just occur between heterosexual couples. The types of behavior frequently encountered in domestic violence are physical attacks, sexual attacks, psychological abuse, and the destruction of property or pets.

See more at: <http://findlaw.com>

It's only been in the past few years that the battered male syndrome has gotten serious attention. The latest percentage of battered men was placed at approximately 36% or roughly 835,000 of the 2.3 million abuse cases reported yearly. Researchers believe that those figures are far from accurate for the obvious reason that most men are very reluctant to admit they have been victims of abuse.

See more at: <http://wikipedia.com>

Domestic Violence: History of Police Responses and Landmark Cases

Police responses to domestic violence have historically been clouded by notions, for example, the idea that a wife is the "property" of a husband and he has the right to carry out whatever behavior is necessary to "keep her in line." This idea and others like it reflect attitudes held by the greater society. Further aggravating the situation was the perception that domestic violence is not "real police work," and such disputes are private matters that should be kept within the household. Prior to 1980, when domestic situations were brought to the attention of police, calls were often diverted by dispatchers, given a lower priority, or officers responded to the

scene and departed again as quickly as possible without achieving any type of meaningful intervention.

Beginning in the late 1980s, there were many attempts to change the way police departments intervened in domestic violence situations. Inspired by Sherman's Minneapolis experiment, many police agencies adopted preferred or mandatory arrest policies. Arrest both acknowledges that society views domestic violence as a criminal offense and also provides immediate safety for the victim. Accompanying these new arrest policies were civil proceedings (discussed below).

– See more at: <http://ask.com/domestic violence>

Prior to the 1980s, the practice of police agencies was to use mediation in domestic incidents. But ironically, much of this so-called mediation was done only when only one spouse was present. Several prominent court cases helped change legislation. In 1972, Ruth Bunnell was killed as a result of police non-intervention. The case of wrongful death against the City of San Jose was dismissed in the California Court of Appeals but received much publicity. In 1985, a jury verdict awarded \$2.3 million in favor of plaintiff Tracy Thurman who sued the Torrington, CT, police department after they repeatedly failed to arrest her abusive husband (*Thurman v. City of Torrington*, 1985). Her husband eventually caused her serious bodily injury.

Another landmark case began in the California courts system. In 1996, Maria Macias was killed by her estranged husband after an order of protection was not enforced by the Sonoma County Sheriff's Department. The victim had requested help from the department on 22 occasions. The lower courts held that women have a constitutional right to safety and equal protection, and the Sonoma County Sheriff's Department provided inadequate police protection based on the victim's status as a woman and a victim of domestic violence. The case was dismissed by lower courts but in April, 2002 was heard by the Appeals Court of California (99-15662).

– See more at: <http://ask.com/domestic violence>

On June 18, 2002, in the first ever [*California*] monetary award by law enforcement for their failure to protect a domestic violence victim leading up to her homicide, the Sonoma County Sheriff's Department agreed to pay a million dollar settlement in the landmark federal civil rights lawsuit of "Maria Teresa Macias vs. Sonoma County Sheriff Mark Ihde."

The announcement came mid-trial at the close of dramatic testimony by Sara Rubio Hernandez detailing more than 20 attempts by her daughter, Maria Teresa Macias, to get help with her violent estranged husband, Avelino.

Hernandez outlined her daughter's repeated reports to the Sheriff Dept. of Avelino's multiple felony crimes including his sexual assaults of Teresa and her children, his constant obsessive stalking, repeated threats to kill and restraining order violations. The Sheriff's Department never once arrested or cited Avelino Macias. After deputies ignored more than twenty reports in just the last few months of her life,

Avelino fatally shot Teresa, then shot and seriously wounded her mother, Sara, on April 15, 1996.

This landmark federal civil rights lawsuit, filed in October 1996 claimed that Sonoma County Sheriff's Department violated Teresa's constitutional right to equal protection of the laws. A July 2000 9th Circuit Appellate Court decision in the Macias case established for the first time and in the most unambiguous language to date, women's rights to sue law enforcement when they fail to act.

With the testimony and the historic damages award, Sara Rubio Hernandez said, "I have fulfilled my daughter's wish." Shortly before her death, Teresa told her mother, "If I die I want you to tell the world what happened to me. I don't want other women to suffer as I have suffered. I want them to be listened to."

The settlement sends a resounding message to law enforcement around the country that they can no longer ignore domestic violence victims with impunity. And it sends an equally forceful message to women everywhere, that they have a constitutional right to hold law enforcement accountable when law enforcement refuses to act. Historical documentation compiled by: Marie De Santis, Women's Justice Center, - See more at: <http://justicewomen.com>

Domestic Abuse Costs the Economy \$67 Billion:

According to the National Institute of Justice the annual cost to victims of domestic abuse is about \$8.8 billion. That's because health-related costs of domestic abuse exceed \$5.8 billion annually, \$4.1 billion of which is for direct medical and mental health services. Even after five years after the abuse ended, health care costs for women with a history of domestic abuse remain 20% higher than those for women with no history of abuse. When pain, suffering, and lost quality of life are included, the total is more like \$67 billion. (Source: Lawrence A. Greenfield et al., US Department of Justice, *Violence by Intimates: Analysis of Data on Crimes by Current or Former Spouses, Boyfriends, and Girlfriends*, March 1998).

Why are the costs so high? More than half of American cities cite domestic abuse as the top cause of homelessness. That's because nearly 40% of all domestic abuse victims become homeless at some point. More than a third of police time is spent responding to domestic abuse calls. Even in high-income communities, domestic abuse can be the number one crime. (Source: Allstate Foundation, *The Economics of Abuse*)

Domestic Abuse Costs Businesses \$5 Billion:

Domestic abuse costs U.S. businesses between \$3-\$5 billion annually in lost time, productivity and health care costs paid for by the employer. (Source: Bureau of National Affairs, *Violence and Stress: The Work/Family Connection*, Washington, DC, August 1990. Special Report Number 23). That's because nearly all domestic abuse victims experience difficulty in the workplace, resulting in lost productivity and over 7.9 million paid workdays lost per year. For example, a wrongful death action

against an employer who failed to respond to an employee's risk of domestic abuse on the job cost the employer \$850,000.

– See more at: <http://about.com>



APAPO begins to address issues with health insurance exchange rollout

Early wrinkle surfaces with Connecticut health plan by Communications staff from: **APA Practice Organization** <pracupdate@apa.org>

Nearly 3 million Americans reportedly visited healthcare.gov, the website for federally facilitated health insurance exchanges (HIEs), on Oct. 1 — the first day for HIE enrollment under the Affordable Care Act of 2010. Meanwhile, state HIE sites also had several million visitors.

Consumers aren't the only ones interested and engaged in the initial phase of the rollout.

The APA Practice Organization (APAPO) is part of an early advocacy effort to influence the process as qualified health plans (QHPs) gear up to participate in HIEs, with coverage beginning on Jan. 1, 2014. APAPO is collaborating with the Inter Organizational Practice Committee (IOPC), along with the Connecticut Psychological Association (CPA), to address a situation that recently arose in that state.

The IOPC is a coalition of representatives from all the major neuropsychological organizations in the U.S., including the American Academy of Clinical Neuropsychology (AACN/American Board of Clinical Neuropsychology), Div. 40 (Society for Clinical Neuropsychology) of APA, the National Academy of Neuropsychology (NAN) and the American Board of Professional Neuropsychology (ABN), as well as APAPO.

The coalition sent a [Sept. 29 letter](#) (PDF, 515KB) to Connecticut Lieutenant Governor Nancy Wyman, chairperson of the Board of Directors for the state-run health insurance exchange known as Access Health CT. The letter expressed concern with the behavioral health fee schedules published by HealthyCT, one of the QHPs participating in Connecticut's HIE.

Under that plan's reimbursement system, only medical doctors and advanced practice registered nurses (APRNs) are reimbursed for neuropsychological assessment. The fee schedule that includes neuropsychologists — the predominant providers of neuropsychological services — disallows reimbursement for neuropsychological assessment. As the coalition letter emphasizes, "Restricting reimbursement for psychological assessment to practitioners not trained to perform the services (APRNs) or with very few qualified practitioners (MDs) will dramatically limit access to neuropsychological services for Connecticut citizens."

Compounding the problems resulting from the HealthyCT fee schedule, masters and doctoral level behavioral health providers are combined into one reimbursement group and all paid at the same rate for authorized services. The letter noted the total years of training and education for psychologists, along with their unique specialized training and skills. It contrasted the HealthyCT scheme with Medicare and nearly all private insurance fee schedules — which recognize the differences between psychologists and lesser trained behavioral health providers.

Staff for APAPO are unaware of HIEs in other states limiting patient access to neuropsychological and psychological services in this manner.

The Connecticut Psychological Association brought the matter in that state to APAPO's attention and is leading the advocacy charge, having sent the initial organizational letter of concern on behalf of psychology to the Access Health CT chief executive officer and board of directors earlier in September.

APA Executive Director for Professional Practice Katherine C. Nordal, PhD, serves as APAPO's representative to the Inter Organizational Practice Committee. She noted that, given the massive scope of health care reform, professional psychology is certain to experience bumps in the road as HIEs begin to provide insurance coverage.

"With health insurance exchange enrollment under way, there are sure to be challenges and opportunities for us to influence the implementation process," said Nordal. "APAPO will continue advocating to help ensure that licensed psychologists are adequately included and that consumers have access to psychological services they need through health plans that participate in the exchanges. "

Sixteen (16) states including Connecticut are operating a state-level HIE on their own, while other states are partnering with or deferring to the federal government (Department of Health and Human Services) to operate the HIE for that state.

If you know of issues or concerns for practicing psychologists regarding participation or HIEs or QHP payment policies, please contact your state psychological association along with APAPO. Send an [email](#) or call (202) 336-5886 to report an issue to APAPO.

Visit the [APA Practice Organization online](#) to learn more about [health insurance exchanges](#).



\$120 million settlement announced in Ingenix lawsuit against Aetna

APA Practice Organization will guide eligible practitioners on settlement claims submission, likely in 2013

Dec. 19, 2012—On Dec. 7, Aetna agreed to a proposed \$120 million settlement of a class action lawsuit filed by psychologists, other health care professionals and patients in federal court in New Jersey. The APA Practice Organization (APAPO) has collaborated on the lawsuit with the New Jersey Psychological Association (NJPA), a named plaintiff, since 2009.

The lawsuit alleges that Aetna used a faulty database and underpaid claims for services delivered by out-of-network (OON) providers. According to the lawsuit, the Ingenix database that Aetna licensed to determine payment for OON services consistently understated “usual, customary and reasonable” (UCR) rates that are used as the basis for OON payment amounts – for example, 80 percent of UCR. The UCR is supposed to represent the “going rate” that health care professionals charge for their services in a particular geographic area of the country.

Aetna, United HealthCare, which owns Ingenix, and other insurers agreed in 2009 to stop using the Ingenix database pursuant to settlements with the New York Attorney General.

Under the settlement, clinicians simply need to attest that they were paid as OON providers for Aetna in any year(s) from 2003 to the present in order to claim monies from a “general” settlement fund. Eligible providers who opt to provide more detailed, claims-specific information will be entitled to receive payment from a “prove-up” fund also established as part of the settlement. In addition to health care

professionals, Aetna subscribers are considered “class members” who also will be eligible to receive payments, pending final settlement approval.

The settlement must receive preliminary and final approvals from the court. After the final approval, the judge will likely set the deadline for submitting claims to the settlement fund – we expect that the deadline will be well into 2013 at the earliest. As we have done in past class action lawsuit settlements involving payments to practicing psychologists, the APA Practice Organization will provide detailed guidance for members on how and when to submit claims as soon as relevant information becomes available.

In 2009, [United HealthCare agreed to a \\$350 million settlement](#) with subscribers and providers, including psychologists, over the use of its Ingenix database. Additional class action suits against other companies that used this database are still pending. They include a case with California Psychological Association against the WellPoint/Anthem companies, and other cases with NJPA against CIGNA and Horizon Blue Cross Blue Shield of New Jersey. APAPO is providing extensive legal, policy, communications and other support to the state psychological associations involved with these lawsuits.

“We hope that cases like these will result in fairer reimbursement practices by the insurance companies and ultimately create greater access to mental and behavioral health services for patients,” said Katherine C. Nordal, PhD, executive director of the American Psychological Association Practice Organization.

On a related historical note, this settlement in New Jersey brings organized psychology’s string of lawsuits against managed care organizations full circle insofar as NJPA filed the first case in 1996. That case against MCC, which successfully settled in 2000, challenged “no-cause” terminations that were allegedly based on the company finding psychologists to be “not managed care compatible.”



Advertisements

The following advertisements are not endorsed by NCAMHP.

There are no advertisements for this newsletter. Remember, as a member you advertise for free!

Job Announcements:

P/T or F/T Clinician to work in state certified Sex Offender Treatment Program. Licensed therapist preferred, but will consider Pre-Licensed DOE. Some training provided. Call Gail Narum at 707 441-8626 ext 1.

Humboldt Open Door Community Health Centers Behavioral Health Team has openings at Arcata and Del Norte Clinics for Full Time, Part Time, or Contracted LCSW or Psychologist. Must be licensed and willing to work in fully integrated position in medical setting providing brief interventions, referrals, and time limited individual and group treatments.

If you are interested, please apply online at <http://www.opendoorhealth.com/opendoor/> or email Dr. Lesley Manson at lmanson@opendoorhealth.com for further details.

Your Voice is Important!

Contributions are always welcome; anything from a paragraph to a couple of pages would fit well in the newsletter. The deadline for Winter submissions is December 15, 2013. Send your ideas to the newsletter committee: newsletter@ncamhp.org,
Or Diane Warde, LCSW at wardediane@yahoo.com

Members may advertise and post announcements for office rentals free of charge via the web at any time:

- Step 1: Go to www.ncamhp.org
- Step 2: Click on Member Login and Login
- Step 3: Click on Member Discussion Board
- Step 4: Choose "Office Rental"

Please give us feedback: newsletter@ncamhp.org.



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839-1244
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999-8484
Diane Warde, LCSW
498-3263
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