Newsletter Summer 2013

Letter from Your President ~ Bonnie M. Carroll, LCSW

Greetings NCAMHP members,

I hope you are all able to enjoy the sun and festive spirit of summer this year.

We had a great General Membership meeting on May 2nd where many of our members engaged in a lively discussion around the proposed changes to our bylaws. I thought the discussion was good and that members felt comfortable sharing their thoughts and different viewpoints. After the discussion, the membership voted on whether to accept or reject the proposed bylaw changes. After all the votes were counted the proposed bylaw changes were accepted. The final vote vas 39 to accept, 8 to reject, and 4 abstained. You can view the most recent revised version of our bylaws after you log onto the NCAMHP website.

While you're on the website, please take a few minutes to look through the postings on our message board. The message board can be a useful way to communicate with each other and post any announcements that you want to share with your peers.

Our Education Coordinator Judy Judge is making sure that the "Calendar of Events" section of the website is updated with the upcoming NCAMHP trainings, so you can get a head start on blocking off the days that NCAMHP will be offering educational and membership events.

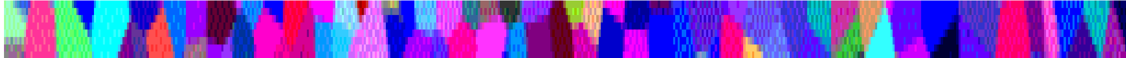
And speaking of the website, I am excited that Scott Sherman and Dave Berman have joined our Website Committee and are volunteering their time to explore ways that the website can be improved for the NCAMHP members and consumers. Scott and Dave will be working with our Webmaster, Justin Loch to enhance some of our website functions and accessibility.

I recommend that you all spend some time exploring our website and looking through the information and resources that are provided there. For example, under "Website

Resources" we have a good list of useful professional and educational website links. So happy surfing the web this summer. ☺

Best Regards,

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



On June 1st, Dr. Steven Frankel completed a Law and Ethics training through NCAMHP. Here are some helpful highlights and further resources:

A helpful link to California laws:

www.findlaw.com

California Psychologist, 46(3), 21-22

Suicide: Risk Management Considerations

A. Steven Frankel, Ph.D., J.D. & Adam Alban, Ph.D., J.D.

Abstract

Managing risks associated with suicidal patients/clients (P/Cs) suggests the use of a well-articulated suicide assessment protocol. Popular techniques such as "safety contracts" should be used under limited circumstances and never as primary intervention. In the event of an attempt or a success, clinicians should be mindful of requirements for post-event contacts with P/Cs and/or their families, be familiar with "the apology statute," and be aware of Sheriff's/Coroner's subpoenas.

Introduction:

The assessment and management of risk for suicide is one of the most important areas of knowledge for all clinicians. A cursory search of the psycINFO® or of internet search engines such as "Google Scholar" will result in an overwhelming number of publications concerning suicide and a broad variety of populations, sub-populations and risk groups. In this brief article, we address four of the more popular legal risk management issues that arise over the course of care with suicidal patients/clients("P/Cs").

The risks of "no-harm contracts" or "contracts for safety":

Our review of the literature on the use of safety or "no-harm" contracts with suicidal P/Cs is best summed up in an abstract from one of the articles we reviewed (Garvey, *et al*,

2009): “The contract for safety is a procedure used in the management of suicidal patients and has significant patient care, risk management, and medico legal implications. We conducted a literature review to assess empirical support for this procedure and reviewed legal cases in which this practice was employed, to examine its effect on outcome. Studies obtained from a PubMed search were reviewed and consisted mainly of opinion-based surveys of clinicians and patients and retrospective reviews.

Overall, empirically based evidence to support the use of the contract for safety in any population is very limited, particularly in adolescent populations. A legal review revealed that contracting for safety is never enough to protect against legal liability and may lead to adverse consequences for the clinician and the patient. Contracts should be considered for use only in patients who are deemed capable of giving informed consent and, even in these circumstances, should be used with caution. A contract should never replace a thorough assessment of a patient’s suicide risk factors. Further empirical research is needed to determine whether contracting for safety merits consideration as a future component of the suicide risk assessment.” The danger of no-harm contracts can be that, due to their popularity, they are *California Psychologist, 46(3),* 21-22 often used as a primary intervention, rather than as a minor component of a multifaceted approach. Our view is that “contracts for safety” should only be used with P/Cs with whom the clinician has a well-established emotional connection, and should only be used within the context of a more thorough assessment of suicidality.

Assessing suicidality and suicidal risk:
There are many good resources for suicide assessment protocols. Such protocols typically evaluate “static” (unchanging factors in a P/C’s life that may impact suicidality, such as having a close relative commit suicide during the P/C’s childhood, genetic family histories of depressive disorders) along with “dynamic” (recent events that can affect suicidality, such as powerful losses) factors. Risk assessment protocols exist for children/adolescents (see, e.g., Berman, et al, 2006) as well as adults (e.g., Jobes, et al (2009), Packman, et al, (2009), and Sullivan, et al (2009).

Documenting the completion of a suicide assessment is critical and should be placed in the charts of P/Cs. These forms of documentation are important because, despite the best efforts of skilled clinicians, sometimes P/Cs attempt suicide. Yet, our standards of practice do not require perfect outcomes; they do, however, require that we act reasonably. Documenting that care was taken to assess risk factors for suicide is an integral aspect of demonstrated that we acted reasonably.

Post-suicide attempt/completion contacts with P/Cs and family members: don’t forget the “apology statute”:
If contacted by any family members of a deceased P/C resulting from a suicide completion, we are not free to admit or deny knowledge of the P/C, absent a release singed by the P/C’s “personal representative.” Examples of personal representatives include executors/executrixes of estates, trustees, or whomever a judge appoints as a personal representative. That person stands in the shoes of the deceased P/C and is free to release us (or not) to speak with whomever the release covers. With valid permission to speak, we need not remain silent and have (statutory!) permission to act with compassion.

One of the most interesting and helpful statutes in California (and most other states, see www.sorryworks.net) actually arose from empirical research in psychology which strongly supports the finding that, when someone is angry at us in our professional roles, the likelihood of a law suit against us drops statistically significantly when we respond to their anger with empathic statements of the "I feel your pain" variety. "[E]xpressing sympathy or a general sense of benevolence relating to the pain, suffering, or death of a person involved in an accident and made to that person or the family of that person" are statements that are protected under California law. Such statements are inadmissible in civil suits in California (*Evidence Code* § 1160). However, the statute does not protect our words if we admit fault!

Sheriffs'/Coroners' Subpoenas:
In the event of the death of a P/C, you may receive (often by fax) a "Sheriff's/Coroner's Subpoena. Such a subpoena is clearly labeled as such and must be *California Psychologist, 46(3),* 21-22 responded to without any release necessary, as it has the same status of that of a judge's order. Such subpoenas indicate that the death of the P/C is under investigation to determine whether the cause was at the hands of another or was self-inflicted. Clinicians might be asked to produce records that may cast light on possible causes for the P/C's death.

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Steve Frankel, Ph.D., J.D., practices both law and an ABPP Diplomate in clinical/forensic psychology in the San Francisco Bay area. A Clinical Professor of Psychology at USC, he has authored over 50 articles, chapters and books and has provided continuing education in law, ethics, trauma and forensic psychology for over ten years. His website is www.sfrankelgroup.com.

References:
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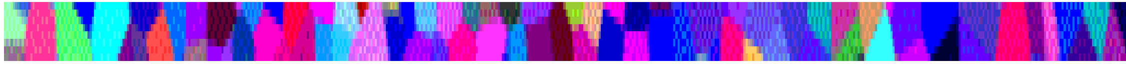

In a response from our membership to obtain further information on Professional Wills, we share this information with permission – This section was prepared by the Professional Wills Committee at the NYU Postdoctoral Program in Psychotherapy and Psychoanalysis. It consists of a note from the committee on the importance of making these wills, a checklist of necessary items before you prepare a professional will, a template for the will itself, and a checklist for the executor of your professional will.

Professional Wills

Dear Colleagues:

There are few topics that strike more fear in the heart of an analyst than stories about colleagues who've become ill and are forced to take a leave from their practice, even for a time-limited recuperation. Anxieties abound about financial catastrophe, compromise of professional identity and reputation, as well as lost opportunities. Despite our natural wish to avoid this topic, much needs to be said and planned. In particular, we all need to prepare for the possibility for our own deaths, manic defenses notwithstanding. Specifically, we need to delineate plans to care for our patients and our practices in the event of our demise or incapacitation.

An important tool in preparation for such an event is the Practice (or Professional) Will, which differs from a personal will. It is not a legal document, but simply a detailed set of instructions, including specific information regarding location of and access to records and patient information, to an appointed team of trusted colleagues who will serve as professional executors upon the event of our death or incapacitation. This Practice Will represents a way of providing care to our patients and sparing already beleaguered family members in the face of the crisis created by our deaths. In fact, the literature strongly recommends that family members, particularly those who are also mental health professionals, **not** serve as one's professional executor, thereby relieving them of the additional burden of professional executorship, while protecting one's patients from tranferentially complicated situations. The literature also indicates that having a Practice Will is an important component of standard ethical practice.

This is clearly a challenging topic, procedurally, but even more so emotionally. Our

committee has taken on the task of reviewing the content and mechanisms for creating Professional Wills that other institutes and professional associations have put in place, and we've come up with some user-friendly guidelines for our NYU community on preparing such a document. Attached is a Professional Will template that can assist you in drawing up or modifying your own, as well as to-do checklists for yourselves as well as your executors. Please feel free to talk to any of us on the Practice Will Committee for further guidance.

Very truly yours,

Practice Will Committee, NYU Postdoctoral Program in Psychotherapy and Psychoanalysis, New York, NY
Members

Caryn Gordon, Psy.D. (*Committee Chair)*
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Private Practice in New York, NY and Teaneck, NJ
Stephen Mitchell Center for Relational Studies, New York, N

Checklist for Preparing a Professional Will

— Name a Professional Executor and 3 co-Executors

— Make list of patients to be contacted (names, phone numbers and addresses). Update list as often as necessary. Leave specific instructions for some patients (i.e., name of possible referral therapist(s), information useful to contact and handle patient(s), as well as names and phone numbers of collaborating professionals)

— Tell family about existence and location of Professional Will

— Give family names and phone numbers of Professional Executor and co-Executors to contact immediately in case of emergency

— Meet with Professional Executor and co-Executors, show them office and location of specifics that they need access to (i.e., keys, files, answering machine). Discuss concerns, wishes, specific instructions (i.e., how to notify patients) and convey the spirit of your practice (i.e., which approach will work best for your individual practice based on the relationship that you have with your patients)

— Organize appointments books, patients' files, billing and financial records. organize important documents(i.e., license, malpractice insurance, personal will)

— List of colleagues to be personally contacted.

— List insurance companies (names, addresses, phone numbers) that you participate in.

— File instructions for access to answering machine or answering service, as well as access to your professional website

— Leave specific instructions (i.e., how to open front door and security system)

— If you practice in a doorman building leave instructions regarding what you want the doorman to say to patients who haven't been contacted and come to their appointment as usual

— Leave specific instructions regarding patients' attendance to funeral or memorial services

— Make copies of Professional Will and distribute to Professional Executor and co-Executors, attorney, spouse or any significant other

— Review Professional Will regularly (i.e., once a year) and update whenever necessary

— Review HIPPA practice guidelines, consider including note regarding practice will on that form.

PROFESSIONAL WILL

I, ____________________________________, residing at ________________________ ____declare this to be my Professional Will. This supersedes all prior Professional Wills in the event that there are any.

This is not a substitute for a personal last will and testament, nor is this a legally binding document. It is a formalized set of detailed instructions intended to give authority and direction to my Professional Executors regarding my professional practice, and in particular to ease the transition for my patients in the event of my incapacitation or death.

FIRST

I am a licensed ____________________, (*state*)____________ License # ____________, and (S*tate*) ____________License#____________ in private practice. My office address is:_______________

____
I also maintain an office at: ____
____

SECOND

In the event of my death or incapacitation, I appoint____
as my Professional Executor, whose phone number is:__________________ and whose office is located at:____
_ . I also appoint the following colleagues to serve as my team of Professional Co-Executors who will assist my Executor in any matter deemed necessary to properly administer this Professional will.
They include:
(N*ame*)____________________________________ Phone number _____________
Office address
____
____

(N*ame*)____________________________________ Phone number ______________
Office address
____
(N*ame*)____________________________________ Phone number ______________
Office address____

____
____

In the event that my primary Executor is unavailable or unable to perform this function, I hereby appoint _____________________________________ from my team of Co-Executors, as a backup Professional Executor. I also authorize my Professional Executor to name any colleagues in my profession, in addition to the Co-Executors already mentioned, to help carry out any tasks related to my practice.

THIRD

(optional)
The attorney for my professional practice is:____________________________________, whose phone number is________________ and whose offices are located at: _________
____
The attorney for my Estate is ___________________________________, whose phone number is _______________________and whose offices are located:_________________________________

FOURTH
The executor of my personal last will and testament is :
____ ,whose phone number is:_________________, and who is located at
____.

FIFTH
*Include specific address and whereabouts
A. My current patient records are located at:
____

B. My past patient records are located at:____

C. Billing and financial records related to my professional practice are located at:________________

D. Some or all of my patient, billing and financial records are on a computer, located at:____________

The password to access my computer is _____________________and the program that houses these records is____

E. My appointment book and patient phone numbers are located at:_____________________________(optional)
F. My professional e-mail address(es)____ and the

password (s) to access my e-mail
accounts____
Instructions for amending my professional
website____
____

G. My office phone number(s) is:_______________________________, and the code(s) to access my voice mail is:
____
____

H. Any necessary keys you will need for access to my office, filing cabinets, storage facilities, etc. are located at: ____
____
____

I. For assistance in locating/ accessing my records you may contact:
_____________________________,
whose phone number is:_________________, and whose address
is:_______________________________
____
____

In addition, the following person(s) may be helpful in locating/accessing my
records:________________
____

SIXTH

My specific instructions for my Professional Executors are:

A. First of all I would like to express my deep appreciation for your willingness to serve as the Professional Executors for this will.

B. There are four copies of this Professional Will. They are located as follows:

1. One is in your possession.
2. One is with my personal will.
3. One is with my professional liability insurance policy.
4. One is in the possession of my attorney (optional).
5. Other ____ ________________

C. A list of current and past patients and their phone numbers who are to be notified about my death and any planned memorial services (as defined in my will) is located with the copy of my Professional Will and relevant documentation of my professional liability insurance policy. This file is located at
____
____
____
____
____

Additionally names and phone numbers of other professionals (if any) who collaborate in providing patient care will be noted in the patient's file.

1) If possible please notify my current and past patients by phone, offering face-to-face meetings with those who wish to do so. My team of Co-Executors and anyone else the Executor appoints may help with these meetings. Please offer referrals to those patients for whom I have not already provided referrals. You may refer patients to yourself.

2) Any patient who cannot be reached by phone should be contacted by mail. Each patient should be informed in the letter that I have become unable to continue my practice and that he/she should contact one of the (above mentioned) Co-Executors for further information and assistance in arranging for alternative treatment.

3) In the event of my death or serious impairment for which recovery is unlikely, patients should be provided with as much information as directly as possible with obvious consideration for tact, timing and discretion particular to the situation. In the event that I am impaired with an indeterminate prognosis, greater care should be exercised in how much information is disclosed with the promise of providing additional details as the situation unfolds and becomes clearer.

4) Following are specific instructions about what should be communicated to my patients:

____
____
____
____
____
____

D. My professional liability insurance is currently provided by:___________________________________,
whose phone number is:_______________, and whose address is
____
____
____

My policy # is___________________.
Please notify my professional liability carrier in writing of my death as expeditiously as possible and arrange for any additional coverage that may be appropriate. Please also notify the State Licensing Board(s) at ( ) - , ( ) - , and the following professional organizations and listservs of which I am a member:

____
____
____
____
____

Please notify colleagues indicated on my contact list which is located in____
____
____

E. Please arrange for copies of patients' records to go to their new therapists upon receipt of a written request for those records and signed release from the patient.

All the remaining patient records should be maintained according to the relevant federal, state, and local laws and regulations governing record retention. For example in NY, state regulations for Psychologists require that patient records must be maintained for at least 6 years after last contact and records of minor patients must be retained for at least 6 years and until one year after the minor patient reaches the age of 21 years. In NJ, state regulations for Psychologists require that patient records be kept for 7 years after last contact and 3 years after the minor patient reaches the age of 18 years.

1) All of these records are absolutely confidential and are to be read by no one unless compelling legal authorization is provided. In the event of such authorization the records should be copied and sent. In addition to my charts there may be process notes. These notes are not to be considered part of the chart and should not be released to anyone for any reason except in the event of the need to defend myself or my estate against a lawsuit.
2) All records, active and inactive, are to be maintained safely and securely, with properly limited access. They must be able to be retrieved in a timely manner at the discretion of (name executor)
____ or a person he/she designates as custodian of my records. Any such designee must understand and agree to abide by these instructions. It is also suggested that any records of individuals where there has been or is likely to be legal action(s) should be retained indefinitely. This will be indicated on my patient list.

When disposing of outdated records, process notes and personal notebooks please ensure it is done in a manner that destroys all materials that could identify the patient, e.g. burning or shredding.

F. Make appropriate changes to the outgoing message on my telephone answering machine. Dial___________________________to access my answering service. The password(s) to access messages and make changes to the outgoing message is
___________________________________. The mailbox number is (   )   -   .

G. If you need any further information or an update of requirements, you can contact my professional association _________________________ e.g.: the NYSPA number is 800-732-3933, the NJPA number is 973-243-9800, and the APA number is (800) 374-2721.

H. My team of executors and I have agreed upon the following compensatory arrangements for time and other expenses incurred in executing these instructions (indicate if this is a voluntary arrangement or whether the executors are to be paid and if so at what rate):

____
____
____
____

I. Following are some additional thoughts I would like to share (optional)

I declare under the laws of the State of ____________ that the foregoing is true and correct.

Executed at____Location, on _______________Date

____
Signature

WITNESSES:

Printed Name:___________________________________

Signature:______________________________________

Residing at:____

Printed Name:___________________________________

Signature:______________________________________

Residing at:____

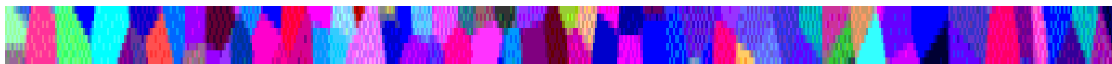
Professional Executor Checklist

1) Meeting with the Professional
   a. Learn the location and instructions for using:
      - ___ keys
      - ___ file
      - ___ answering machine (with number and code or password)
      - ___ appointment book
      - ___ current patient list with contact info
      - ___ past patient list with contact info
      - ___ billing and financial info
      - ___ professional will
      - ___ license
      - ___ malpractice insurance
   b. Learn the spirit of the professional's practice and his/her wishes, in the event of his/her death regarding:
      - ___ what doorman should tell patients

___ what executor and co-executors should tell and offer to patients
___ whether or not patients should be invited to the funeral or memorial services

c. Get names and contact info for:
___ attorney for professional practice (if there is one)
___ family contact person
___ insurance companies

2) In the event of the professional's death
___ a. review the professional will
___ b. obtain patient lists, appointment book, billing and financial info, license, and malpractice insurance
___ c. contact and inform patients, preferably by phone, according to instructions in the will, offering them face-to-face meetings and referrals, if they wish If the executor and/or the co-executors end up meeting with the professional's patients, request that the patients sign a consent form authorizing me and co-executors to have access to their charts.
___ d. advise other professionals (if any) who may be collaborating in the patient's care.
___ e. inform the professional's liability insurance carrier in writing of his/her death.
___ f. inform the state licensing board and any professional organizations and listservs with which the professional was affiliated.
___ g. personally notify individual colleagues
___ h. make appropriate changes to the professional's answering machine.
___ i. maintain patient records according to relevant federal, state, and local laws and regulations.
___ j. records are to be kept confidential and to be maintained safely and securely, with properly limited access.
___ k. process notes are not to be considered part of the patient's chart and are not to be released to anyone.
___ l. when disposing of outdated records, process notes, and personal notebooks, destroy completely all materials that could identify the patient, e.g. shredding or burning.



Insurance Implications of DSM-5

Press Release from American Psychiatric Publishing; a division of the American Psychiatric Association*

*The upcoming fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5) has been developed to facilitate a seamless transition into immediate use by

clinicians and insurers to maintain continuity of care. The new manual represents a step forward in more precisely identifying and diagnosing mental disorders.
To help ensure ease of use, DSM-5 will continue to use statistical codes contained in the U.S. Clinical Modifications (CM) of the World Health Organization's (WHO's) International Classification of Diseases (ICD). The ICD-9-CM contains the internationally approved statistical codes for all medical diseases or disorders but does not contain detailed descriptions of how to diagnose these conditions. Below are frequently asked questions especially pertinent to insurers and clinicians.

Frequently Asked Questions

When can DSM-5 be used for insurance purposes?
Since DSM-5 is completely compatible with the HIPAA-approved ICD-9-CM coding system now in use by insurance companies, the revised criteria for mental disorders can be used immediately for diagnosing mental disorders when it is released in May 2013. However, the change in format from a multi-axial system in DSM-IV-TR may result in a brief delay while insurance companies update their claim forms and reporting procedures to accommodate DSM-5 changes.

How will the previous multi-axial conditions be coded?
DSM-5 combines the first three DSM-IV-TR axes into one list that contains all mental disorders, including personality disorders and intellectual disability, as well as other medical diagnoses. Although a single axis recording procedure was previously used for Medicare and Medicaid reporting, some insurance companies required clinicians to report on the status of all five DSM-IV-TR axes.

Contributing psychosocial and environmental factors or other reasons for visits are now represented through an expanded selected set of ICD-9-CM V-codes and, from the forthcoming ICD-10-CM, Z-codes. These codes provide ways for clinicians to indicate other conditions or problems that may be a focus of clinical attention or otherwise affect the diagnosis, course, prognosis, or treatment of a mental disorder (such as relationship problems between patients and their intimate partners). These conditions may be coded along with the patient's mental and other medical disorders if they are a focus of the current visit or help to explain the need for a treatment or test. Alternatively, they may be entered into the patient's clinical record as useful information on circumstances that may affect the patient's care.

On October 1, 2014, the United States adopts ICD-10-CM as its standard coding system. How will diagnoses be coded then?
DSM-5 contains both ICD-9-CM codes for immediate use and ICD-10-CM codes in parentheses. The inclusion of ICD-10-CM codes facilitates a cross-walk to the new coding system that will be implemented on October 1, 2014 for all U.S. health care providers and systems, as recommended by the Centers for Disease Control and Prevention's National Center for Health Statistics (CDC-NCHS) and the Centers for Medicare and Medicaid Services (CMS). This feature will eliminate the need for separate training on ICD-10-CM codes for mental disorders that is now being offered for all other diseases/disorders by other medical societies and vendors to prepare for the 2014 implementation.

With the removal of the multiaxial system in DSM-5, how will disability and functioning be assessed?
The DSM-5 includes separate measures of symptom severity and disability for individual disorders, rather than the Global Assessment of Functioning (GAF) scale that combined assessment of symptom severity, suicide risk, and social functioning into a single global assessment. This change is consistent with WHO recommendations to move toward a clear conceptual distinction between the disorders contained in the ICD and the disabilities resulting from disorders, which are described in the International Classification of Functioning, Disability, and Health (ICF).

The World Health Organization Disability Assessment Schedule (WHO-DAS 2.0) is provided in Section III of DSM-5 as the best current alternative for measuring disability, and various disorder-specific severity scales are included in Section III and online. The WHO-DAS 2.0 is based on the ICF and is applicable to patients with any health condition, thereby bringing DSM-5 into greater alignment with other medical disciplines. While the WHO-DAS was tested in the DSM-5 field trials and found to be reliable, it is not yet being recommended by APA until more data are available to evaluate its utility in assessing disability status for treatment planning and monitoring purposes.

Sometimes different disorders or subtypes share the same diagnostic code. Is this an error?
No. It is occasionally necessary to use the same code for more than one disorder. Because the DSM-5 diagnostic codes are limited to those contained in the ICD, some disorders must share codes for recording and billing purposes. For a few new disorders, such as Disruptive Mood Dysregulation Disorder (DMDD), the only ICD-9-CM code available for DSM-5 was a ”Not Otherwise Specified” (NOS) code from DSM- IV (Mood Disorder NOS 296.99). For ICD-10-CM the code will be F34.8 which is now Mood Disorder, Other Specified. APA will be working with CDC-NCHS and CMS to include new DSM-5 terms in the ICD-10-CM and will inform clinicians and insurance companies when modifications are made.

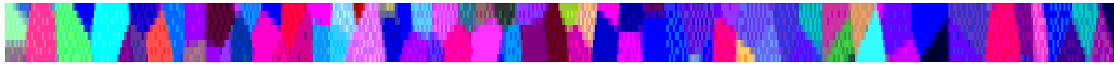
How are DSM-5 and ICD related?
DSM-5 and the ICD should be thought of as companion publications. DSM-5 contains the most up-to-date criteria for diagnosing mental disorders, along with extensive descriptive text, providing a common language for clinicians to communicate about their patients. The ICD contains the code numbers used in DSM-5 and all of medicine, needed for insurance reimbursement and for monitoring of morbidity and mortality statistics by national and international health agencies. The APA works closely with staff from the WHO, CMS, and CDC-NCHS to ensure that the two systems are maximally compatible.

Can clinicians continue to use the DSM-IV-TR diagnostic criteria?
Clinicians may use DSM-5 in their practices starting in May, when the manual is released. However, there may be brief delays while insurance companies update their claim forms and reporting procedures to accommodate DSM-5 changes, and clinicians should use DSM-IV-TR diagnoses and codes when required by a specific company. Transition details are still being developed with CDC-NCHS, CMS, and private insurance agencies. The APA is working with these groups with the expectation that a transition to DSM-5 by the insurance industry can be made by December 31, 2013.

As part of the transition to DSM-5, there will also need to be updates of questions in board certification examinations and quality assessments for medical record reviews. APA will be providing periodic updates of agreements with federal agencies, private insurance companies, and medical examination boards as they become available.

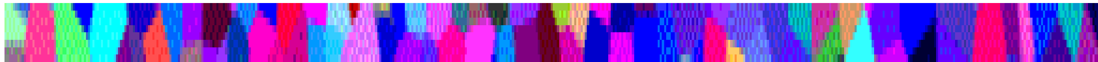
DSM is the manual used by clinicians and researchers to diagnose and classify mental disorders. The American Psychiatric Association (APA) will publish DSM-5 in 2013, culminating a 14-year revision process. For more information, go to www.DSM5.org.

APA is a national medical specialty society whose more than 36,000 physician members specialize in the diagnosis, treatment, prevention and research of mental illnesses, including substance use disorders. Visit the APA at www.psychiatry.org. For more information, please contact Eve Herold at 703-907-8640 or press@psych.org. © 2013 American Psychiatric Association



Biomarker Could Point the Way Past Trial-and-error Inefficiencies – NIH-funded Study

Press Release • June 12, 2013
http://www.nimh.nih.gov/news/science-news/2013/scan-predicts-whether-therapy-or-meds-will-best-lift-depression.shtml?utm_source=govdelivery&utm_medium=email&utm_campaign=govdelivery

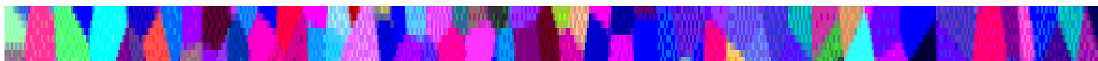


Trainings

August 24th, 2013; from 9:00 am to 1:30pm at Humboldt Area Foundation – "DSM 5 Workshop," presented by: Beth Eckerd, Ph.D. – cost $75, 4 hour CEU's

Fall Workshop: Saturday, Sept. 21st, 2013; 9:00am to 4:30pm at Humboldt Area Foundation - "An Unexpected Journey: The Road to Power and Wisdom in Divorced Co-Parenting," presented by: Alisa Jaffe Holleron, LCSW

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



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Help support Humboldt Family Service Center's

Free Walk In Clinic

It is so easy to support HFSC - come watch North Coast Repertory Theatre performance of *The Allergists Wife* Saturday **July 27, 2013.** Tickets are $15.00 and can be purchased in advance at the agency, feel free to call **443-7358**. If you can't make the play, how about dinner at Applebee's, Wednesday, **August 14, 2013**. Ten percent of all food sold will help keep a paid staff person working the walk in.

Thanks in advance for all your support!

Sand Tray Collection For Sale

- Over two thousand figures representing all cultures, age of people in different walks of life, animals, gem stones, buildings and movie/ mythological figures.
- Large assortment of figures representing the dead in all it's forms.
- Two custom, handmade sand trays with oak frames, water sealed with marine paint.
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Asking $1,700 (shipping extra)
Contact: Claudia Paliaga, MFT
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Job Announcement:

Open Door Community Health Centers
Clinical Psychologist or Licensed Clinical Social Worker full-time or part-time Behavioral Health position open; contact Lesley Manson, Psy.D. at: (707) 672-4866 or email: lmanson@opendoorhealth.com

For your information: Army OneSource is a campaign to provide free online continuing education training.

Four online courses developed by the Center For Deployment Psychology will be offered beginning June 4 through September 30. The courses cover military culture, the impact of combat stress and deployment on children and families and PTSD.

The training is FREE, online and nationally accredited.
http://support.restofthewayhome.com/file_depot/0-10000000/390000-400000/398003/folder/1124313/Email1.html

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ASIST: Applied Suicide Intervention Skills Training

Where: Aquatic Center 921 Waterfront Dr., Eureka
When: September 25 & 26, 2013
Time: 8:30am-4:30pm
14 CEUs, MFTs and LCSWs
Price: $60.00

To Register:
1. Email: DHHS_TES@co.humboldt.ca.us or call 707-441-5520 to reserve a spot.

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 Fall submissions is September 15, 2013. Send your ideas to the newsletter committee: newsletter@ncamhp.org, Diane Warde, LCSW at wardediane@yahoo.com or Jennifer Blair, MFT at jes@humboldt1.com

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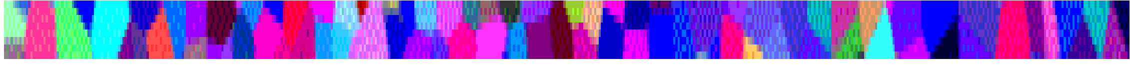
Members may advertise and post announcements for office rentals free of charge via the web at any time:

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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