THE BULLETIN

NEW YORK STATE PSYCHIATRIC ASSOCIATION

Spring 1998, Vol. 40, #1 • Bringing New York State Psychiatrists Together

The New Bulletin is Born

by Edward Gordon, M.D.

Ed Gordon, M.D.

With this edition, The Bulletin starts a new era. I congratulate Leslie Citrome, M.D., M.P.H., the new Bulletin Editor and the members of the new editorial board: Syed Abdullah, M.D., Michael Blumenfield, M.D., David Harwitz, M.D., Craig Katz, M.D., Howard Owens, M.D., Ann Sullivan, M.D., and Seeth Vivek, M.D. With its new format and appearance, the Bulletin is ready to meet the challenges of the next century.

Dr. Citrome brings a new enthusiasm to this important job as well as substantial editorial experience. Dr. Citrome is a Research Psychiatrist at the Nathan S. Kline Institute for Psychiatric Research and will be the Director of its new Clinical Research and Evaluation Facility when it opens later this year. Dr. Citrome has been responsible for the West Hudson Psychiatric Society's web page and has served as editor of the DB's on–line version of its newsletter. He has also served as guest editor of two issues of *Psychiatric Annals*.

The new Bulletin editorial board has been drawn directly from the NYSPA components and will include representation from the major NYSPA committees and members in training, early career psychiatrists and minority/underrepresented members. The Bulletin editorial board will reflect the diversity of interests and activities of our organization, its committee and its membership. Michael Blumenfield, M.D., Chair of the NYSPA Committee on Public Affairs and editor of the NYSPA Website (http://www.nyspsych.org) is a member of the Bulletin editorial board and will work closely with Dr. Citrome to integrate our two key communication links to our members.

After appointment of a new editorial board, the next task was refocusing and clarifying the Bulletin's mandate and mission. The Bulletin editorial board has been given the following charge:

- The Bulletin should be published on a timely basis and on a regular schedule throughout the year. Once the new publication schedule is established, our members should receive each and every issue on time and as scheduled.
- The Bulletin, its editor and the members of the editorial board, must function as a vital element in our organization and must participate fully in our meetings and activities together with the other NYSPA committees and components.
- The Bulletin should represent and reflect NYSPA's organization, its

[See **President's Message** on page 2]

Welcoming Editorial

by Leslie Citrome, M.D., M.P.H.

Leslie Citrome, M.D., M.P.H.

Welcome to the first issue of the new Bulletin, your New York State Psychiatric Association newsletter. The editorial board and I hope you will like the new format and that you will find the content relevant, timely, and compelling.

As with any new product, we welcome your comments, good or bad, and your suggestions for improvement. Consider this a "test issue;" your feedback will mold this newsletter to your needs.

For now we will publish on a quarterly schedule. In 1999, bimonthly publication will be considered. We invite all the district branches in New York State to send in their news, announcements, and any material they would like to share with the rest of the NYSPA membership. Many district branches already have newsletters, the highlights of which can be synopsized in the Bulletin.

Our 5,000 NYSPA members work in diverse settings. The Bulletin will reflect that by soliciting contributions from the private, public, academic, and research settings, and from organizations closely allied with ours. The editorial board will be responsible for presenting information about the NYSPA committees and components they are working with, and about their own professional areas of practice. They will also be asking many of you to write about your work and experiences. In this issue we have a column from the Alliance for the Mentally Ill of the State of New York, some important announcements regarding Medicare reimbursement and also on the new prompt payment law, as well as a piece on "Network Therapy," and an article about "transinstitutionalization." A regular feature will be the report from the Area II trustee, updating us on matters relevant to our organization's role within the APA. We will hear regularly from Members–in–Training.

We can no longer ignore the advances made regarding the dissemination of information via the internet. You'll be able to obtain issues of the Bulletin on-line, and read them on your computer screen in the same format as it appears on paper. Patients will find referrals through NYSPA's searchable database. You'll find details of this project inside this issue of the Bulletin, as well as a tutorial on getting hooked up with e-mail and the internet. E-mail will be the preferred means of submitting material for the Bulletin. All the members of the editorial board use it (some more reluctantly than others) and this is how Bulletin material is reviewed, edited, and sent for layout. Feel free to

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INSIDE THIS ISSUE:

NEWS FROM THE NYSPA OFFICE

NYSPA–Backed Lawsuit Settled: A Victory for Parity

The New York State Psychiatric Association, the professional medical specialty organization representing over 5,000 psychiatrists practicing in New York, announced the settlement of a lawsuit supported by the New York State Psychiatric Association and the American Psychiatric Association, challenging discrimination against mental illness in long term disability insurance.

The lawsuit was brought against Israel Discount Bank of New York on behalf of Leonard F., an employee of Israel Discount Bank of New York who became disabled because of severe depression. Under the terms of the company's long term disability policy, Leonard was entitled to only two years of benefits because his disability was due to mental illness. No similar limitation was imposed on any other illness or condition and benefits were provided for all others until age 65.

Under the terms of the settlement, the company will adopt a "parity" long term disability policy for its employees that will provide the same benefits for mental illnesses as provided for all other illnesses and conditions. Although the company did not admit liability, Leonard F.'s claims for damages and other relief were also included in the settlement agreement.

Edward Gordon, M.D., President of the New York State Psychiatric Association, stated:

> "With the settlement of this case, our organization and the APA continue our fight to eliminate all forms of discrimination against persons with mental illness in our society. Insurance discrimination against mental illness is one of the most pernicious elements of the stigma against mental illness. Without equal insurance coverage, persons with mental illness are denied access to the financial and health care benefits to which they are entitled. NYSPA will continue its efforts to advocate for laws guaranteeing parity for the treatment of mental illness. We will support litigation challenging discrimination against persons with mental illness."

Seth P. Stein, Esq., NYSPA General Counsel and partner in the firm of Stein & Schonfeld, counsel for Leonard F., stated:

> "As has been reported in the media recently in sports world, the Americans with Disabilities Act represents a powerful weapon for persons with disabilities. In the settlement of this case, we have successfully challenged and overturned a long–standing discrimination against persons with mental illness in disability insurance. The settlement of this lawsuit demonstrates how the law can work to achieve parity and fairness for persons with disabilities because of mental illness. The support of the New York State Psychiatric Association and the American Psychiatric Association played a critical role in bringing this important case to court." ■

See Page 3 for more NYSPA News!

THE BULLETIN

of the

NEW YORK STATE PSYCHIATRIC ASSOCIATION

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Information for Contributors
The Bulletin welcomes articles and letters that NYSPA members will find timely, relevant, and compelling. Articles should be between 750 and 1500 words (three to five double–spaced manuscript pages) and letters no more than 750 words. All submissions must be made electronically, preferably by email to citrome@rfmh.org, or by diskette and mailed to Leslie Citrome, MD, MPH, Nathan Kline Institute for Psychiatric Research, 140 Old Orangeburg, NY 10962. All authors are encouraged to also provide a photograph of themselves which will be printed alongside their article.

Information for Advertisers
The Bulletin welcomes advertisements from both NYSPA members and commercial enterprises. Total circulation averages 6,000 copies per issue. The Bulletin is received by all 5400 members of the American Psychiatric Association who belong to a district branch in New York State. The Bulletin is also sent to the leadership of other district branches across the United States and to New York State legislators, medical libraries, and science writers. Four issues are planned for 1998, and six for 1999. Both classified advertisements and display advertisements are available, as well as the capacity to distribute full color inserts. Please contact the managing editor for current rates and media requirements. NYSPA members get a discount of 50% of the classified advertising rate.

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LETTERS TO THE EDITOR

Letters to the editor are limited to 750 words, consequently the contents of the following have been edited to conform with this requirement. The full text will be available on the Bulletin web site at http://www.nyspsych.org/bulletin

It is a matter of professional responsibility to comment on an article appearing in the New York State Psychiatric Association Bulletin, APA, Area 2, Volume 39, Number 4, pp. 8-10 by Jack Drescher, M.D. in your Special Fall issue, 1997, entitled "What Needs Changing? Some Questions Raised by Reparative Therapy Practices." This essay is so filled with defamatory statements, inaccuracies, false assertions and conclusions, as well as misinterpretations, that it would take a full–length feature essay to correct them all. Dr. Drescher, a prominent member of the national central committee of gay lobbyists, has egregiously utilized his position as associate editor of the Bulletin to tar and feather those who practice psychoanalytically informed psychotherapy (reparative psychotherapy) with homosexual patients. Let me crystal clear: "reparative therapy" is simply psychotherapy aimed at repairing the damage done in early childhood which has led to the development of a prehomosexual child, and later a homosexual adult. Obligatory homosexuality is a developmental disorder — contrary to Drescher's political bias — and those who desire to correct the problem should have the right to do so by pursuing this course of treatment. This is our "moral imperative." Dr. Drescher's sole aim seems to be to bury the homosexual therapeutically, but we cannot afford to turn a blind eye and a deaf ear to our patients and their entreaties.

Deriding even the normality of heterosexuality, Dr. Drescher dismisses any scientific reports on successful treatment as misguided, ineffective, and even "cruel." Nowhere does he cite the successes found in the following reports: (1) Edward Glover's report (1960 Portman Clinic Survey, London), (2) a fact–gathering committee report of the American Psychoanalytic Association (1956), (3) The Bieber, et al. report (1962), (4) the MacIntosh report in 1994 published in the *Journal of the American Psychoanalytic Association* (1995). The National Association of Research and Therapy of Homosexuality (NARTH) report of 1997 confirmed the MacIntosh study.

As a gay psychiatrist Dr. Drescher has the freedom to hold to his own beliefs, but political rhetoric should not be the way. For he seriously misinforms our psychiatric colleagues and does an injustice to psychiatrists and psychoanalysts worldwide.

In truth, this scientific hoax instigated by gay activism within the American Psychiatric Association led to a revolutionary change in our sexual mores and customs. This change, more revolutionary than all other changes in recent social history, was ushered in by a single act of considerable consequence: the removal, through social–political activism, of homosexuality from the category of aberrancy by the American Psychiatric Association. This act was naively perceived by many psychiatrists as the "simple" elimination of a scientific diagnosis in order to correct political injustices. In reality, it created further injustices for the homosexual and his family as it belied the truth and prevented the homosexual from seeking and receiving help.

Dr. Drescher complains of the "rhetoric" of NARTH, a rhetoric which hardly exists. We have been essentially silenced by the peremptory rejection of our scientific papers at national and local APA meetings; advertisements for our public forums have been cancelled, and we have been branded as "bigots," "homophobes," or "prejudiced." Freedom of thought and intellectual inquiry on this issue are overwhelmed by the deluge of gay propaganda and the lies of the highly monied, omnipresent, gay activist lobby. Dr. Drescher asks "What needs changing?" In my view, Dr. Drescher does for maligning individuals as well as discriminating against homosexuals who seek help. For where can they turn if they can not turn to psychiatry and psychoanalysis?

Finally, it should be recalled that in 1972, against the rising power of the gay political psychiatric machine and its confusing impact on the media, the New York County District Branch of the American Psychiatric Association, to its credit, under the leadership of Dr. Bernard Diamond, established a Task Force on Homosexuality as an official committee of our organization. Its purpose was to shed light on the nature, meaning, and content of homosexuality to psychiatry and an increasingly bewildered public. After two years of deliberations and sixteen meetings, the task force, composed of a dozen experts affiliated with our district branch and the major medical centers of New York City, attempted to submit its report on homosexuality to the Executive Council of the New York City District Branch headed by Dr. Robert Campbell. This report unanimously documented the fact that obligatory homosexuality was a disorder of psychosexual development, and it simultaneously asked for civil rights for those suffering from the disorder. The report was deemed "not acceptable" to the new members (Dr. Bernard Diamond had died during the interim), and some old members of this executive committee.

The committee was then dissolved. Its members eventually published it as a "study group" report in the late spring of 1974 (New York City District Branch, APA Task Force Report, C.W. Socarides and Bieber, I., cochairmen) Published in the *International Journal of Psychiatry*, 2(4) 460-479, (1973) (a copy of this report may be obtained by writing to the author of this letter).

Charles W. Socarides, M.D.
New York, NY

President's Message

Continued from page 1

actions, positions, goals, committees and components. The Bulletin should keep our members informed of NYSPA activities and should promote and advance our efforts on behalf of psychiatrists in this state.

- The Bulletin should actively pursue advertising revenue from the same advertisers placing ads in other APA publications in order to help defray the cost of publication.

I remind all members that the Bulletin is the only publication representing the professional practice of psychiatry in New York State. Its success and its future will depend ultimately on your interest and participation as an informed readership. Please write letters, express your opinion and submit news items from your district branch. The Bulletin has a long tradition of service to our members. With its new editorial board, this tradition will be revitalized and carried forward. ■

Editor's Welcome

Continued from page 1

send me your comments at citrome@rfmh.org.

We will be actively seeking advertising to help defray the costs of publication. As such, you will be seeing advertisements from pharmaceutical companies, with perhaps an occasional insert. All advertisements will be screened for appropriateness of content. Classified ads will also be welcome; NYSPA members will enjoy a 50% discount on the first three lines. We hope to be a source of information for job opportunities for fellowships and staff positions, private practice opportunities, office space, and professional services.

For those who don't know me, my daily work puts me in contact with both the public and the private sector, and with researchers, clinicians, and mental health administrators. As Dr. Gordon mentioned, I am employed full–time at the Nathan Kline Institute operated by the New York State Office of Mental Health. My research interests lie in the areas of schizophrenia, clinical psychopharmacology, aggression, and in the study of medication utilization and outcome. Since completing my residency at New York University in 1987, my career has been rooted in public psychiatry and I have worked for federal, state and county agencies, in capacities ranging from attending psychiatrist to clinical director of a state hospital. I also have a part–time private practice and I am on the medical staff of my local community hospital. I have been involved with my district branch since 1992 as education coordinator and now as president–elect. I look to the Bulletin as a new challenge and an opportunity to learn and grow.

Before you read on, I want to acknowledge my predecessor, Robert J. Campbell, M.D., truly one of the giants of American psychiatry. Editor-in-Chief of the Bulletin for 15 years, and an associate editor for 18 years before that, Dr. Campbell has been an articulate spokesman for our profession at the national, state, and local levels. He has shaped the education of several generations of psychiatric residents with his *Psychiatric Dictionary* and has kept us informed on a weekly basis as Editor–in–Chief of *Psychiatric News*. We all owe him a debt of gratitude. ■

AREA II TRUSTEE'S REPORT

BoT Wraps Up '97


Herb Peyser, M.D.

At the December meeting, the Board of Trustees:

• Approved the change in the Fellowship category. All board certified members will become Fellows almost automatically after five years or so of membership. Those who are Fellows now and had previously gone through the more exhaustive process of review for Fellowship at the DB and national levels will be raised to Distinguished Fellows, and in the future the new Fellows will have to go through that same process to be elevated from Fellow to Distinguished Fellow. The Early Career Psychiatrists had wanted this and the Assembly had supported the idea. It does tend to bring us in line with the other specialty societies.

• Approved central office control of membership upgrades and transfers from one DB to another. Some DB's who had no trouble with transfers in the past (others have had trouble) would have preferred to keep more autonomy and more control of the situation; but the Board sided with the Membership Committee to try it out this way and see.

• Did not approve the Area II and N Y County DB sponsored initiative (passed for a second time by the Assembly) to extend the moratorium on an APA dues increase for 1998 to 1999. They did not vote to increase it but decided to wait for the Budget Committee's deliberations and recommendations before acting. Although there was a good surplus of revenue over expenses this year the Board is deeply concerned about the future, what with full dues paying members decreasing year after year and the probability of good economic times not lasting forever. In addition there are pressing public affairs issues arising now (see below) that may cost significant amounts of money. (I voted for the moratorium anyway and am on both the Budget Committee and the Joint Task for the prioritizing of the budget and expenditures, so I can carry the ball there for a moratorium and perhaps push for the dues decrease that many members are requesting.)

• Supported the Medical Director's plan to introduce zero–based budgeting this year, starting from scratch, to winnow down and eliminate some of the accretions to the budget that have developed over the years., including some people's sacred cows. This will be based in part on functional analyses of the different departments, a process we introduced last year at the same time we moved toward developing a more understandable functional budget in addition to the rather dense line–by–line budget usually presented.

• Gave notice of termination of collaboration with the American Psychological Association on an electronic journal ("Treatment"). A Task Force had reviewed the matter and we recommended termination (three to one), noting that no business plan had been made for it, no preparation for it to pay for itself, no APA governance (I was on the "Treatment" Oversight Committee and can report on the truth of that), no provision for it not competing with other APA and APPI journals publications for ads, papers and subscribers, and no protection for it possibly being used by the psychologists in their political activities toward gaining prescribing privileges. The Medical Director, Dr. Steven Mirin, will report at the next meeting on his review of what APA and APPI are doing in print and on the net, what our plans are and what is feasible. Although I had been an early supporter of Treatment, as the Task Force's investigations unfolded I moved strongly toward withdrawal. But we had really ought to have an e-journal, this time most probably our own, with quick publication, interactivity and a chat room with experts. It is feasible and it is the future.

• Noted the American Psychological Association's increasing push for prescribing privileges that we feel will seriously menace good patient care, they being not at all or at best very inadequately trained in these areas. They are introducing legislation this year in eight states, more than ever, and APA is gearing up to deal with the issue. California and Louisiana are among their point states, New York not so much so yet. It will take money, a Task Force has been set up, and we will work out a plan of action and budget funds for it. These are really state issues which national can help with and finance. The members have said they want more of national's money turned back to the DB's and state organizations for these and other such activities anyway.

• Decided that they must closely review the salaries and benefits of the top ten staff members. The readers of the Bulletin can find out more about the Medical Director's pay package by checking the Bulletin web site at: http://www.nyspsych.org/bulletin. This information has already appeared in other publications. After all, we are a 501c3 non–profit corporation and the salaries of the top five staff members are open to all as a matter of law as well as a matter of membership rights.

• Continued President Herb Sacks' initiative of bringing five or so DB Presidents to each Board meeting, to tell us about their DB issues and to hear what the central APA does. This increase in communication with the DB's has been very useful and will go on.

• Approved provision for a new staff person, half to handle Members-in-Training and half to handle Early Career Psychiatrists affairs. This had been sought by both groups, and the latter, the ECP's, are moving toward representation on the Board, perhaps by taking over one of the Trustee-at-Large positions. The former group (MIT's) already have a voting Trustee and a non–voting Trustee–Elect on the Board.

• Approved the new Panic Disorder Practice Guidelines after working out an accommodation between the more psychopharmacologically oriented and cognitive behavioral people on the one hand and the psychodynamic people on the other, between the stricter research evidence-based and those more clinically oriented consensus based.

• Heard Dr. Dale Walker's report on the progress of his Strategic Planning Initiative Committee, and approved the statement of the mission and goals of the organization. The Committee is looking at a revision of governance, prioritizing mechanisms, and membership issues involving dues, dues processing, communications, MIT, ECP and minority/underrepresented issues, and recruitment and retention matters.

• Heard from the Search Committee for Editor of *Psychiatric News*. We have reviewed 35 applicants, winnowed the number down to nine, will review the material and submit the names of three to the Board in February for interviewing and selection. There was much discussion in our Committee and at the Board meeting itself of the mission statement, whether it is a house organ or not, how much autonomy and independence it should have, what its editor's job description should be, etc.

• Heard from Public Affairs about the DOCs Initiative where psychiatrists are linked up with their local media people and trained and given information to help them with their media work. I'm linked up and would be happy to connect anyone with our Public Affairs people if they are interested. It could be helpful regarding the prescribing privileges matter, for many people in the legislatures and in the public do not fully understand the differences between psychiatrists and psychologists and must be informed.

• Supported psychiatrists who are running for office in AMA in an effort to add to the influence there of our delegates (two and two alternates) and our Section.

• I've been to the Mid-Hudson, N Y County and Capital District DB's so far this year, and am scheduled for Genesee. I would like to attend all the others over the next year, hear what they have to say and try to answer their questions, particularly where it concerns the various Board subcommittees I serve on.

I have been busy working with the New York County DB leadership on a meeting downstate with the APA President Dr. Herb Sacks, and the Medical Director. Dr. Steve Mirin,. NYSPA, the local DB's, and any others who can come. This grows out of the New York County Town Hall meeting we had earlier this year and offers the DB and NYSPA members and leadership the opportunity to express their concerns, hear the answers, and meet both Herb Sacks and Steve Mirin.

Please contact me about both these matters as soon as you can. Thanks. ■

NYSPA NEWS

New Prompt Payment Law Takes Effect

Effective January 22, 1998, HMOs and health insurance companies doing business in New York will for the first time be required to pay interest at the rate of 12% per annum on late payments. Under the provisions of the new state law, HMOs and insurance companies must pay all "clean" claims within 45 days of submission or pay the interest penalty. A "clean" claim is one that the HMO or insurance company does not contest. If there is a dispute regarding a claim, the HMO or insurer must pay the portion that is not in dispute and, within 30 days, notify the doctor or patient why it disputes the claim or request additional information to determine its liability. Psychiatrists who encounter problems with prompt payment can contact the NYS Insurance Department at (800) 342-3736 or NYSPA at (516) 542-0077.

Please let us know how prompt payment is working for you.

Major Changes For Medicare Program For 1998

In January, 1998, NYSPA sent out its tenth annual Medicare memorandum describing the significant changes for this year:

- CPT has replaced the psychotherapy codes (90842, 90843, 90844, 90855) with 24 new CPT code numbers (90804 through 90829). Medicare has dropped the G codes and replaced them with the new CPT psychotherapy codes effective as of January 1, 1998. However, psychiatrists can continue to bill Medicare with the G codes for the first three months of 1998. Thereafter, psychiatrists must use the new CPT codes for Medicare billing.
- Psychiatric fees will receive an 8.4% increase in 1998.
- The Balanced Budget Act of 1997 permits a physician to "opt out" of the Medicare program and make "private contracts" with patients for a period of two years. The Medicare limiting charge rules do not apply to services provided under a private contract. By agreeing to a private contract with a physician, patients give up the right to receive any reimbursement from Medicare for services they receive from the physician.
- HCFA has agreed to delay enforcement of the new Evaluation & Management documentation guidelines for an additional six months until July 1, 1998. The E&M documentation requirements for psychiatrists performing E&M services were sent to every physician enrolled in Medicare and are available on the NYSPA Website (http://www.nyspsych.org).

The memorandum prepared by Seth P. Stein, Esq., NYSPA Executive Director and General Counsel, and sent to every NYSPA member addresses in depth the changes in the 1998 Medicare Fee Schedule (MFS), the new CPT codes for psychiatry and the new Medicare law on private contracting. In addition to the 8 page memorandum, members received Medicare fee schedules for their locality and sample documents for private contracting.

NYSPA is the only medical organization in the country that has prepared sample documents on private contracting for its members. Private contracting by opting out of the Medicare program is a very serious step and should be considered carefully by members before taking any action. The Medicare memorandum outlines key issues of concern regarding private contracting and should be studied by any psychiatrist considering opting out of Medicare.

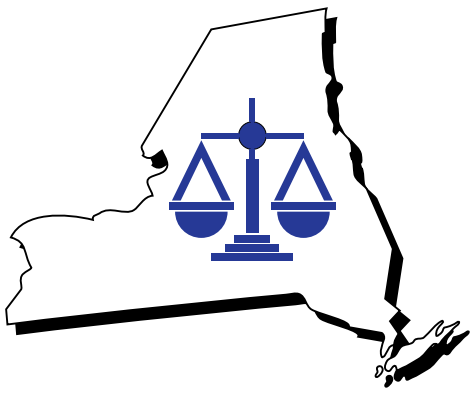
Edward Gordon, M.D., NYSPA President, in his letter to the membership accompanying the Medicare mailing, noted that members are concerned about the cost and value of APA membership at all levels and stated "I believe that the information and fee schedules included in the annual Medicare update alone are worth the cost of NYSPA membership. NYSPA provides value to our members and the annual Medicare updates are the best evidence of our value."

Seth Stein, Esq.

Albany Report

Barry B. Perlman, M.D.,
Chair, NYSPA Legislation Committee

Richard J. Gallo,
NYSPA Government Relations Advocate



A regular feature will be a report from the State capital. We'll hear from the chair of our legislation committee and from our lobbyist. Parity and coalition building continue to be at the forefront of our Albany activities. We all await successful passage of the Senate bill. Letters to your State Senators are very important — please help. Feel free to ask questions or provide feedback. —Ed.

Real Progress on the Road to Parity in New York — State Assembly Passes Parity Bill: 148-0

On February 9, the New York State Assembly unanimously passed A.8315—B (by Assemblymember James Brennan, et al.). The bill requires all managed health care and indemnity insurance plans that cover mental illness to do so on the same basis, terms and conditions as they do any other illness in such plans. The bill does not require plans to initiate benefits where they do not already provide coverage for mental illness, nor does it address alcoholism or substance abuse — parity for those conditions will be the subject of separate legislation.

Coalition Building

NYSPA played a central role during the past twelve months in focusing attention on parity both within and outside of the Legislature. However, we are by no means alone in deserving credit for the intense advocacy leading to the Assembly's overwhelming passage of A.8315—B.

Following last summer's passage of the chiropractic insurance mandate, NYSPA teamed with the State Medical Society (MSSNY) to convene a meeting of mental health consumer and provider groups that were interested in the parity issue. The meeting resulted in the formation of a broad-based coalition, now known as Mental Health Equality Not Discrimination (MEND). The MEND campaign currently has over sixty member groups supporting parity legislation. A core group of MEND members and subcommittees meet weekly to plan and execute strategies.

The MEND campaign has undertaken several projects promoting the enactment of parity legislation during the current legislative session. The activities include:

- press conferences;
- newspaper editorial board meetings;
- Picnics for Parity in key legislative districts (based on the successful New York City Model);
- New York State specific actuarial data;
- media advertising;
- public opinion polling and petition drive;
- business support; and
- grassroots lobbying.

The focus of the MEND campaign now shifts to New York State Senate where Senators Thomas Libous and Nicholas Spano have legislation (S.5484) pending that prohibits "disparity" in coverage for mental illness within managed care group plans.

S.5484 would require HMOs and other managed benefit plans to cover mental illness without limits on inpatient or outpatient services, unless such limits also are imposed on other covered services in the plan. While narrower in scope than the Brennan bill (A.8315—B), the Libous bill would displace the prevailing practice of managed care entities to limit mental health benefits to thirty days of inpatient care or twenty outpatient visits. The premise being if the expertise exists to appropriately manage a condition through utilization review, then capping the number of days or visits allowed for such conditions is needless. The bill also requires co-payments and deductibles for mental illness consistent with those applied to other conditions in the plan.

It is important to recognize that the overwhelming and bipartisan support for parity in the Assembly is not necessarily a harbinger of what to expect in the Senate. Traditionally, the Senate Majority has been far more resistant to insurance mandates than the Assembly Majority. Senate Republicans, who lead the upper house, tend to align ideologically with business interests that abhor such mandates. Therefore, it is essential to bolster the efforts of our Senate Republican champions (Senators Libous and Spano) by communicating with their Senate colleagues in whose District you reside or work.

A sample letter is included here for your convenience. You can write your Senator at:

The Honorable John Doe
New York State Senate
Legislative Office Building
Albany, New York, 12247

E-mail addresses for State Senators and Assembly Members, as well as texts of bills, etc., can be found through links provided in the legislation page of the NYSPA web site (http://www.nyspsych.org).

The cornerstone of NYSPA's Government Relations Program is a vigilant presence in the State Capitol strengthened by a ready network of District Branch members willing to communicate with legislators. Seldom is it necessary on routine matters — issues of interest to psychiatrists with which the Legislature is well acquainted through our efforts — for NYSPA to activate the DB legislative networks to achieve favorable results. However, just the opposite is true when NYSPA confronts new issues raised by others or embarks proactively to bring about new law. NYSPA's current campaign to achieve insurance parity for mental illness this year is one of those activities that will require advocacy from the grassroots to be successful.

Use this template to write to your State Senator today!

[Sample letter]

Dear Senator_____

As you know, Republicans and Democrats in the New York State Assembly unanimously passed A.8315—B (Brennan). Importantly, this bill would prohibit insurers and HMOs, that include mental health benefits in their group policies or contracts, from:

- imposing arbitrary limitations upon the number of inpatient days and outpatient visits covered for the treatment of mental illness (currently most managed benefit plans limit such coverage thirty days inpatient care and twenty outpatient visits);
- imposing higher co-payment, deductibles and co-insurance requirements for mental health services than are applied for access to treatment for physical health conditions in the same group policy or benefit plan;
- imposing annual or lifetime dollar limitations on mental illness that are not applied to coverage for other conditions in a given policy or contract.

Removal of these arbitrary and discriminatory limitations is required to assure that persons with mental illness can access necessary health care.

Senator Thomas Libous has sponsored a similar measure, S.5484 in the Senate. I greatly appreciate and support his efforts in this regard. I respectfully request that you and your Senate colleagues seriously examine the merits of each of these proposals this year with an eye toward agreement between the houses and the Governor.

Child Health Insurance Program in NYS to Include More Mental Illness Benefits

Late last year, Governor George Pataki announced the impending receipt from the federal government of $255 million dollars for expanding New York State's Child Health Insurance Program (CHIP). During his State-of-the-State Address in January, the Governor revealed plans to use the new federal CHIP's money to increase the number of children eligible to participate in the program but not the benefit package. Because CHIP barely covers mental illness (no inpatient benefits and only twenty outpatient visits) NYSPA seized the opportunity of the new federal funds to petition the Governor and the Legislature to broaden the CHIP benefit package for mentally ill children.

The State Assembly was first to publicly respond by indicating their intention to negotiate for additional mental health benefits in CHIP as part of the budget process. Shortly thereafter, the Governor announced, he would ask the Legislature to add to CHIP an inpatient benefit of thirty days for mental illness.

The Governor's announcement did not include mention of CHIP outpatient benefits, currently capped at sixty visits total for mental illness, alcoholism, and drug abuse, only twenty of which may be used for mental illness. Presently, both the Administration and the Legislature are considering the implications of allowing the sixty visits for these conditions to be blended so more visits can be available for any one condition when clinically indicated.

The Governor expects CHIP coverage to be available to 425,000 children by 1999. He is also optimistic about physicians participating in the program because reimbursement rates are more like conventional insurance rates than Medicaid rates.

NYSPA will continue to push for parity coverage for mental illness in the CHIP program, as budget negotiations proceed. Right now, we are appreciative of the readiness of the Governor and the Legislature to take this important first step.

Assembly Acts on Managed Care Bills

The State Assembly has passed four bills aimed at improving the plight of consumers and providers dealing with managed health care entities.

A.1816—A (by Gottfried) would assure that HMOs and insurers are held accountable to their enrollees for injuries the enrollee sustains as a result of decisions made by the HMO or insurer;

A.6585—A (by Gottfried) would require the Commissioner of Health to establish a structure external to an HMO for resolutions of disputes involving utilization review decisions;

A.7730 (by Kaufman) would allow a patient to continue to see his or her physician for a period of up to one year beyond the point at which either the patient or the physician disassociated from the health insurance plan;

A.8921 (by Grannis) would ensure enhanced disclosure by HMOs and insurers, including more detailed disclosure of the methodologies used to reimburse providers, and would prohibit financial arrangements with providers that force providers to assume undue risks, reduce or limit medically necessary care, or penalize providers according to case mix.

New York State Budget for 1998-99

Ordinarily, even with good news to report, State Budget matters headline our Albany Report at this time of the year. However, this year's Budget Request from the Governor to the Legislature is not ordinary. The nightmare budgets of yesteryear are thankfully no where to be found. Gone are the massive proposed cuts to Medicaid spending for psychiatric services, and the devastating reductions to State and community mental health programs sought in past years. Even the perennially under–funded housing programs for mentally ill adults are reasonably well funded in the 1998-99 Budget. However, one area for concern in this year's budget is mental health services for children which, beyond the changes proposed for the CHIP program as reported above, is poorly funded and lacking in direction.

Scope of Practice Issues

The usual array of "scope of practice" bills are again before the Legislature — all of which are holdovers from last year. Some of these bills will probably pass the Assembly as they have in the past. The Senate has traditionally been our ally on scope of practice matters and there is no reason presently to suspect their attitude has changed. ■

Transinstitutionalization: The Shifting of Two Systems

by John M. Oldham, M.D.

Dr. Oldham is the Chief Medical Officer for the New York State Office of Mental Health (OMH), providing leadership and oversight for the largest state hospital system in the United States. Dr. Oldham is also the Director of the New York State Psychiatric Institute, the main locus of activity for Columbia University's Department of Psychiatry. In this column, which will be a regular feature of the new Bulletin, NYSPA members will be updated as to what is going on in public psychiatry in New York State. The first article in this series is about forensics and the public sector. We will hear about a new concept: transinstitutionalization.

Although OMH employs scores of psychiatrists, not all have elected to join the APA. Financial considerations may be a factor, but another possibility is the feeling that the APA is not a relevant organization for them. APA, NYSPA, and the district branches all need to reach out to these potential members. The Bulletin hopes to hear from psychiatrists who have chosen careers in public psychiatry, and to hear what they would like the APA to do for them. We can ask Dr. Oldham and his staff to respond. Let's take advantage of this opportunity to dialogue. —Ed.

It was a pleasure to be asked by the new Editor of the NYSPA Bulletin, Les Citrome, to contribute a column on issues relevant to psychiatrists in the public sector. As I thought about what might be of interest, I thought about some of the changes that have occurred in the state system during the 10 years that I have served as Chief Medical Officer for the New York State Office of Mental Health. Of course, the first change that comes to mind is the reduction in the inpatient census, from approximately 24,000 beds in 1988 to about 7,000 beds at the present time. This process can be referred to as "downsizing," implying basically a fiscally–driven plan, or as a reflection of a shift in emphasis from institution–based care to community–based care. In truth, there are elements of both.

Reinvestment Legislation Key

Unlike, however, the deinstitutionalization of the 1960s, with all of its problems, the recent version has generally been a more reasonable process, protected in New York State by hard–won but key reinvestment legislation. Recovered resources made possible some real alternatives to institutional care, along with much needed (though still not enough) supported housing. Concomitant development of new medications, such as clozapine and the newer atypical antipsychotics, mood stabilizers, and antidepressants, made it possible for many patients to do well in the community for the first time. Intensive psychiatric rehabilitation, peer support programs, comprehensive psychiatric emergency programs, assertive community treatment teams, intensive case managers, and other innovative programs all added to the array of increasingly flexible treatment choices.

State of the State

Besides being smaller, how has the state system changed? Treatment of the patients remaining in the state hospitals is more challenging. I was invited to give a special lecture at the Psychiatric Services meeting in Washington, DC last fall, and I chose "Criminalization of the Mentally Ill in the Public Sector" as my title. I suggested that in addition to the successful return to the community of many patients, others were still being "transinstitutionalized" from the mental health to the criminal justice system. Prisons are, unfortunately, a growth industry in our state and in many others throughout the country. Increasing numbers of our patients remaining in the hospital are "multi–problem" patients, with major mental illness, severe personality disorders, substance abuse, and in some cases, criminal histories and histories of violence.

In my presentation, I also suggested that there is a growing trend of "reverse transinstitutionalization," with patients coming to the state system from the prison system. The recent Supreme Court decision (*Hendricks vs. Kansas*) has led to similar legislation in many states, and a bill is currently in progress in New York that will bring a new population of patients to the state mental health system, i.e. individuals who have completed prison sentences for sexual crimes and are judged to need institution–based continued treatment.

Working Within the System

How do these trends affect the professional lives of psychiatrists working in the state system? There are many challenges and frustrations, of course, and caring for the most complicated and seriously ill patients is hard work. But it is not dull! With the excellent help of Bill Tucker, Director of OMH's Bureau of Psychiatric Services, and his staff, we schedule all kinds of CME programs, bringing truly the best experts available in psychopharmacology, specialized treatment, and other relevant areas, to make educational presentations. Recent programs, for example, by John Bradford and Robert Hare have been absolutely first–rate opportunities to learn assessment and treatment approaches for these difficult patient populations.

Challenges Remain

Personally, I have had unparalleled educational experiences in the public sector, and the recent forensic focus has enabled me to learn about clinical situations that I would not have had access to otherwise. Many challenges remain, of course, since the need to learn more and better methods of prevention and treatment for our "toughest customers" is quite real. ■

MIT CORNER

Mind Matters

by Craig Katz, M.D.

In addition to reporting on resident related activities, the Bulletin has made a commitment to serve as a forum for new ideas and opinions for this very special group of members. Recruitment and retention of new members is a critical issue for the future of the APA. We need to be able to entice all residents to join, as well as to remain in the APA when they graduate from their residency programs. The Bulletin strongly encourages submissions from psychiatric residents throughout New York State. Dr. Katz is one of two MITs that serve on the Bulletin's new editorial board. In this article he presents his viewpoint about a recent story that appeared in the New York Times.—Ed..

The January 22,1998 edition of the *New York Times* headlined a front page article entitled, "Study Challenges Idea of PMS as Emotional Disorder." The accompanying article described how a recent NIMH study, published in the New England Journal of that same day, detected effects of ovarian hormone suppression and replacement on the symptoms of premenstrual syndrome (PMS) in woman who suffer from this disorder.

The newspaper article heralded these findings as suggesting that PMS is "biological" and not an "emotional disorder." In fact, neither the primary article in the NEJM, nor an accompanying editorial, advanced such a claim. Instead, the authors sought to unravel the pathophysiology of PMS and appeared to have made some significant steps in this direction. I believe that we should reflect on this discrepancy not as being a journalistic error but instead as bespeaking a commonplace but erroneous assumption about what constitutes mental illness.

The assumption runs as follows: some mental illness is biological, i.e. real, and some is psychological, i.e. not so real (maybe even made up, as the *New York Times* article suggests). In psychiatry, we tend to accept this dichotomy when we break down psychiatric diagnosis into Axis I and Axis II disorders, with the former being the more biological problems and the latter being more of a matter of personality. In therapeutics, this translates into psychopharmacologic versus psychotherapeutic treatments — one is frequently thought to pertain to the brain and the other to the intangible mind. Despite a strong personal bent to the contrary, I occasionally lapse into the belief that my psychopharmacology patients have more profound, even believable, problems than my psychotherapy patients. Nor do I believe that such a politically incorrect outlook is uncommon among psychiatrists, let alone the lay public.

A major thrust of academic psychiatry, in this "Decade of the Brain," is to uncover brain correlates of psychiatric illness, most recently through a proliferation of imaging and functional imaging studies. This well-placed energy should not be taken to mean that, in the absence of such biological correlation, a psychiatric disturbance is "just an emotional disorder" until proven otherwise. Such was the assumption of the *New York Times* in my opening example. At bottom, the PMS study was not asking if there is a pathophysiology of PMS but rather what it might be. Should the investigators have instead found no effect of sex steroid depletion or repletion on PMS, they of course could not then infer that PMS has no neurobiological basis. Neurobiological research does not conclude that mind inheres in brain but instead takes this as its starting premise. There must be a pathophysiology to abnormal mental experiences, just as much as there must be a physiology to normal states.

John Searle, the philosopher, has written, "To put it crudely... everything that matters for our mental life, all of our thoughts and feelings, are caused by processes inside the brain." Why take the time to remind ourselves of this? Because, for some reason likely having to do with the seeming incompatibility between our sense of personal will and a biological source of who we are, we too readily forget it. As MIT's beginning a career in psychiatry, such an omission will have adverse consequences on our current and future clinical practice. Our patients generally come to us because they are, in some manner, suffering. Assuming that some of their problems are "just psychological" without any basis in the stuff of their brains is to belittle their difficulties, whether in our words, actions, or attitudes. To take the brain out of the person is to take the person out of people. No stance could be more contrary to a field which seeks to understand what makes people who they are. Our patients can rightfully expect otherwise from us.

Moreover, I believe that the untenable division of psychiatric problems into the biological and the psychological subtly underpins managed care's emphasis on brief, psychopharmacological treatments and provides the unspoken conceptual basis for what often seem to be primarily financial, and not clinically sound, reimbursement decisions for mental illness. Why pay for the psychotherapy, or even the hospital treatment, of something that is not real?

Perhaps we need to come to see, and to help others to see, that referring to peoples' problems as either biological or psychological may have far more to do with our available treatments for a given problem rather than with the problem itself. At the very least, whether or not I am correct in observing that many psychiatrists among us maintain a distinction between biological and "emotional" disorders, the *New York Times* article exemplifies how the general public does. As psychiatrists, we must vigorously correct this assumption, which is as wrong as it is pervasive. If we do not, arguments for mental illness "parity," either in popular opinion or in insurance reimbursements, will proceed nowhere. ■

Network Therapy: Using Family and Friends' Support to Treat the Substance Abuser

by Marc Galanter, M.D.

Dr. Galanter is Director, Division of Alcoholism and Drug Abuse, and Professor of Psychiatry, at New York University Medical Center. He has been the champion of a technique called "Network Therapy," which provides us with a framework for dealing with substance abusing patients. We frequently encounter substance abuse, often together with Axis I and Axis II pathology, as it complicates treatment planning and makes for a challenge that most of us would rather do without. Here is a brief description of Dr. Galanter's method.—Ed.

If you mention alcohol or drug abuse, most psychiatrists will quickly turn the page. But these problems are among the most common ones that our patients confront, and they are more amenable to treatment than you might think. Here is one approach to engaging these patients in a successful office that we have developed and evaluated at NYU Medical Center over the last ten years. In order to get your substance abusing patients to deal with their problem, consider bringing in support from their family and friends. This can be a valuable tool for improving your clinical effectiveness.

One central issue in treating substance abuse is to encourage the patient to give up the denial and rationalization that so often lends to relapse and early drop-out. In order to do this, family and friends can be engaged in parallel with individual therapy to bolster the treatment. In this approach, a small group of family members and friends, say three or four, are enlisted to provide ongoing support to promote attitude change. These "network" members are part of the therapist's working team, and not subjects for treatment themselves. The goal of this approach is the prompt achievement of abstinence with relapse prevention, and the development of a drug–free adaptation, all with support from the network.

A Clinical Example

Paul was concerned that the woman he hoped to marry was alcoholic, and contacted a consulting psychiatrist. When Paul was getting to know Nancy, she seems to function well. It was only after they moved in together that he found that she would regularly go on drinking binges; sometimes she did not show up the next day at work. Nancy had been in treatment for a few years with a reputable general psychiatrist, who had tried to convince her to stop drinking without success.

At Paul's request, she came to the consultant to review her problem, but said that she was quite comfortable in her "analysis," period. A few months later, she dropped out of treatment. The drinking continued unabated, and Paul was ready to walk out on the relationship, but said he would give her one more chance if she saw the addiction consultant. This time, she acknowledged that it would be reasonable to get some support to help her look at her situation, and the consultant asked her to bring Paul and a friend of hers to the next session to discuss the issue.

These two network members were certainly more revealing about the extent of Nancy's alcoholism than she had been, and all three together moved Nancy to acknowledge that she had a problem with alcohol. Paul and the friend, later joined by Nancy's sister in network sessions, prevailed on Nancy to accept the idea of abstinence, and developed a regimen to support her recovery, one that included individual sessions as well as meetings with this network.

She had a slip back into drinking while in treatment and was once prepared to give it all up, but her network was behind her continued abstinence. She and network members worked together to understand that certain drinking cues — situations and emotional states — led to the relapse, and then planned together how Nancy could handle these cues when they came up again.

Families and Drinking Cues

In recent years, we have begun to consider the orchestration of family dynamics to move the addicted person toward recovery. The technique of the family-based "intervention," for example, has served as an approach to the reluctant substance abuser, and the multiple family therapy groups for substance abusers have also come into use to create a setting where a diversity of issues are discussed to neutralize individual resentments. In another important development, addicted people are now understood to be vulnerable to relapse whenever they are exposed to cues which have previously been associated with exposure to the drug. In Network Therapy, the emergence of craving precipitated by drinking or drug-taking cues is examined with the patient in both individual and in network sessions, in order to clarify the cues that produce a vulnerability to relapse for that person. Once these cues have been defined, plans to avoid them can also be made at sessions held with network members.

The Network's Role

At the outset of therapy, it is important to see the patient with the group on a weekly basis, for at least the first month. Sessions can be tapered off bi–weekly and then monthly intervals after a time. In these sessions, the network has a straightforward task, to aid the therapist to sustain the patient's abstinence. It must be directed with the same clarity of purpose that a task force is directed in any effective organization. Unlike family members involved in traditional family therapy, network members are not led to expect symptom relief or self–realization for themselves.

The approach presented here can serve as a basis for the clinician expanding his or her repertory of treatment options, and can provide a basis for reading further as well. Each clinician will ultimately adopt a style suitable to them, but the effectiveness of that style can be enhanced by support from a network of family and peers. Think about giving it a try.

Reference

Galanter, M. (1993). *Network therapy for alcohol and drug abuse*. New York: Basic Books. ■

Close Up: The Alliance for the Mentally Ill of New York State

In this article Mr.Liebman describes his organization. Many of us have already participated in events organized or supported by AMI and its local chapters throughout the state. They are a powerful political force, and a vital link in the struggle for parity, destigmatization, and improved access to care for the seriously and persistently mentally ill. Feel free to contact the staff at AMI-NYS at (518) 462-2000 or by e-mail at aminys@crisny.org. Their web page address is http://www.crisny.org/not-for-profit/aminys.—Ed.

There have long been many areas of agreement between the Alliance for the Mentally Ill of New York State (AMI-NYS) and the New York State Psychiatric Association. Now more than ever, this coalition is both timely and influential.

The Alliance for the Mentally Ill of New York State is the state's largest family–based mental health organization. Our mission is threefold:

a) Provide mutual support for other family members;
b) Educate the public about serious mental illness; and
c) Advocate for positive changes in the mental health system.

Advocating for positive changes in New York's complex mental health system has been the area where we seem to have a common agenda with NYSPA on so many issues.

We have long been vocal in our call for coordination of care for people with serious mental illness. All of us agree that the mental health system has been fragmented at virtually every point of entry. As AMI members, we have focused our advocacy on what we perceive as the state's core mental health issues — housing, reinvestment dollars, additional money for research, more funding for atypical medications and additional employment programs.

There are other legislative issues as well. One of the most important priorities for this year's legislative session is around the issue of mental health parity. Over the years, this has been an issue that has been of vital concern to both NYSPA and AMI. There is no one more knowledgeable on this issue than Richard Gallo, the lobbyist for NYSPA. He has helped spearhead the charge for parity. Along with Roy Neville, the insurance chair of our organization, Richard has worked longer and harder on this issue than virtually anyone.

The fruits of the labor of both NYSPA and AMI are paying off. We have recently formed a coalition known as MEND (Mental Illness Equality Not Discrimination). Along with NYSPA and AMI, other members of this broad-based coalition include the Medical Society and the Mental Health Association. Over fifty other organizations have signed on as well.

Our goal is to insure that we get a mental health parity bill through the legislature this year. The Assembly passed their parity bill in February. We are hoping that the Senate follows suit.

With the strength of the coalition and all our grass roots members, we will be able to make a lot of noise this year.

Everyone realizes that this is a difficult battle, but we feel that we have several weapons on our side:

A) The aforementioned grassroots strength of our organizations;
B) The fact that not providing equal coverage in mental illness with other illnesses is pure and simply a matter of discrimination;
C) The Federal Government and 14 other states already have mental health parity;
D) Study after study indicate that the cost of full coverage for mental health parity is minimal for insurers.

Another issue of concern to us is that of medications. Many of you know first–hand how new atypical antipsychotic medications have helped to dramatically change lives.

A vital piece in patching together the sometimes convoluted mental health system is accessibility to these medications. Individuals with serious mental illness should have access to the best possible medications. As many of you know first–hand, there are often times a series of bureaucratic hoops that have to be jumped through before the right medications can be prescribed. Legislation that gets to the core of this issue is presumptive eligibility for medications for individuals released from an Article 28 hospital. Through the work of Dr. Barry Perlman, this issue has gained currency in recent years. Essentially, this legislation would ensure that an individual would be presumed eligible for medications when they leave a public hospital. As lengths of stays at these hospitals continue to decrease, it is more important than ever to make sure that people have medications that they desperately need when they leave the hospital.

Without this medication in place, you continue to have a revolving door policy for the thousands of people with serious mental illness who enter these hospitals. As soon as an individual is on a medication that might help him or her, they are immediately released back into the community without medications because they are not yet Medicaid eligible.

This bill presumes that an individual will be eligible for Medicaid immediately after leaving the hospital. The reality is that most people who leave the hospital will ultimately get Medicaid anyway. The money will just come back retroactively. Much like parity, presumptive eligibility is an issue that cost taxpayers nothing while providing better services for everyone. It is a win–win for everyone. AMI members will be working closely with

[See **Message from AMI** on page 8]

Signing On: Why Should You Care About the Internet and Email?

by Leslie Citrome, M.D, M.P.H.

All of us have heard about the internet, the so–called "information superhighway," and most of us have at least heard about "e-mail," a method of sending messages electronically from computer to computer. This article is for those psychiatrists who have not yet experienced the internet or the e-mail revolution.

Why should you care about the internet and e-mail?

For one thing, some of your patients are probably using it. They are getting information about treatments, both conventional and alternative, and perhaps getting information about you. Your colleagues are using it, doing journal searches, communicating with each other, and even doing book shopping at prices that are typically discounted 20%. If you have school–aged children, they are using the internet at least at school, if not already at home. In fact, school–aged children are often the best resource for those unfamiliar with computers. If you don't have children, ask a niece or a nephew, or even the kid across the street. They'll tell you all about "America On-Line."

What's e-mail?

Think of it as instant mail delivery without having to lick a stamp or waiting for the letter carrier. The exchange of ideas is achieved electronically, in the comfort of one's office or home. You can appreciate how hard it is to get several psychiatrists together for a meeting, especially if they live all over the state, and you know how cumbersome mailing and faxing is. E-mail is far more convenient — your mail is waiting for you when you connect, or "log-on," to your "internet service provider" (ISP), and you can respond to everyone with one message, without having to dial any phone numbers, or address multiple envelopes. Your e-mail program "remembers" who you correspond with, so you don't have to re–type e-mail addresses. You always have copies of every piece of mail that you receive or send out. No more missing pieces of paper or busy fax lines! The ISP is responsible for assigning you one or more e-mail addresses.

What's a web site?

There are several sources of information ("web sites") on the internet that you would be interested in. You look at them by entering their names in a special computer program called a "browser." Most names start with www (for world wide web), and end with .com (for commercial sites), .org (for non-profit organizations), .edu (for educational institutions), .gov (for government), or .net (for networks). Some are professional in nature such as the NYSPA site (http://www.nyspsych.org), and your district branch site (the West Hudson Psychiatric Society has one at http://www.rfmh.org/whps). Some sites allow you to shop for books (http://www.amazon.com) and software (http://www.necx.com) at a discount, far cheaper than what you can do locally, and far more convenient. The catalogs on-line contain "links" to reviews of products or books, as published in national magazines. The Bulletin will contain more information on new and interesting links in future issues. Readers are encouraged to share their favorites. The on-line version of The Bulletin (http://www.nyspsych.org/bulletin) will contain all these links so that members can experience these first–hand.

Where do I sign up?

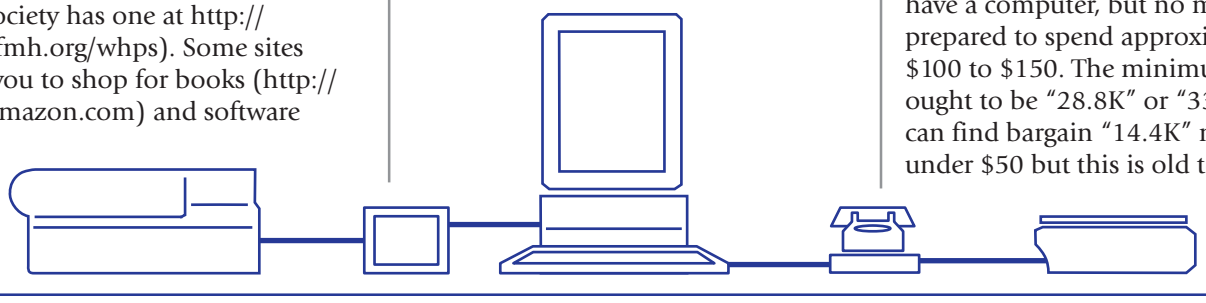
If you have a child in the upper elementary school grades or higher, chances are they have experienced the internet at school, and if you have a home computer with a modem, they will know how to sign up on a service such as "America On-Line." The school may provide access or additional information about other ISPs. If you work in a university–affiliated setting, the university may provide information on accessing the internet and may even be able to provide you with an e-mail address of your own, so you don't have to share one with the kids. Once you have an ISP, there are other (free) services where you can setup additional e-mail addresses, which you access by checking in at special web sites (http://www.mailcity.com).

How much does it cost?

Generally expect to pay approximately $20 a month for unlimited use. You can generally find an ISP with a local phone number (beware of surcharges for a 1-800 number access). If you have only one phone line, you'll be tempted to get another. If your cable TV company offers "Cable Modems," the cost is more like $50 a month, but you'll get much faster access (by several orders of magnitude) and you won't use a phone line. If you don't have a computer, you'll need to buy one or get a WebTV device that sits on top of your television. These gadgets cost about $300 and allow you to surf the internet and do e-mail. You still have to pay $20 a month to a special ISP, and you'll still need to use a phone line to connect. Still, these devices do their job well, and even though they don't run all sorts of software that a personal computer would, they are an adequate choice (vs. no internet access at all).

Need a new computer?

If you have to buy a computer, they are now more powerful, and more affordable, than ever before. You can spend anywhere from $1000 to $3500, depending on speed, memory, storage space, and size of monitor. The $1000 bargain machines are equivalent to the $3500 machines of 2 years ago. Laptops are somewhat more expensive than the equivalent desktop, and are less upgradeable. Minimum speed recommended for a new computer is a "Pentium 166 Mhz" for a desktop, or "120 Mhz" for a laptop. Get at least "16 MB" of memory, and "3 GB" of hard-disk storage space. Monitor size is up to you and your eyes. Before buying your first computer, ask a knowledgeable friend for more advice. Be aware that purchasing a higher–end computer from a computer store is more expensive than ordering a computer over the phone from a manufacturer specializing in mail–order sales (for example, Dell at http://www.dell.com, or Micron at http://www.micron.com).



What about a modem?

Modems, the devices that computers use to communicate over phone lines, are an extra but many new computers already include them. The speed of the modem will dictate the maximum speed you can connect to an ISP. It does not always mean you will connect at that speed. Phone lines may be old or far away from telephone company equipment, making connecting at the top speed an elusive goal. The new "56K" modems are not yet a standard and not all ISPs can connect at those speeds. This is all a moot point, since e-mail doesn't take very long to send or receive (you type a lot slower than the speed the computer can transmit), and the most popular web-sites are very busy so that the speed information comes from them is slower than the maximum speed of your modem. If you already have a computer, but no modem, be prepared to spend approximately $100 to $150. The minimum speed ought to be "28.8K" or "33.6K." You can find bargain "14.4K" modems at under $50 but this is old technology. A popular modem for laptops is the kind that fits in a slot on its side. These are about the size of a credit card and are more expensive than a modem that goes inside a desktop computer. A bonus that comes with almost all modems today is fax capability. You can send a document written using your favorite word processor to any fax machine.

You can find additional information in magazines such as *PC Novice*, and in a number of introductory books available in any bookstore. Once you're connected, be sure to send me an e-mail! citrome@rfmh.org . ■

PUBLIC AFFAIRS UPDATE

Coming Soon: The NYSPA Searchable Member Database On-Line

by Michael Blumenfield, M.D.
NYSPA Public Affairs Chair

The New York State Psychiatric Association will feature a searchable data base of its members on the NYSPA WEB Site (http://www.nyspsych.org). Visitors to this site will be able to obtain a list of psychiatrists based on District Branch, various locations within certain District Branches, or within various zones in Manhattan. Other searchable criteria will include areas of interest specified by each psychiatrist, as well as the health care plans or insurers with which the psychiatrist has indicated a participating relationship.

Appropriate explanations and disclaimers will indicate the changing nature of this information and how it may not be up to date; the reader will be directed to make a phone call to the psychiatrist and/or the member's district branch to get the most up-to-date information.

The search will provide the reader a list of the psychiatrists meeting the specified criteria and the location of their offices. Each psychiatrist will have a specific listing that will provide additional information such as address, phone and fax numbers (and e-mail address when available and if desired). There will also be information on Board Certification or Board Eligibility and languages spoken. Information about hospital and university affiliation will also be available.

We expect to have the ability to provide a map, online, from the visitor's location to the office of any psychiatrist listed in the database.

There will be no cost to the public or to individual NYSPA members for this service. This project is supported by the NYSPA Public Affairs budget and two supplementary unrestricted grants.

In order to be listed in the NYSPA database it is necessary that each psychiatrist complete the members database form. You may complete this form online by going to the members only section of the nyspa website. An alternate method would be to complete the members database form, which will be printed in the next issue of the Bulletin and by mailing it or faxing it to the address indicated on the form. NYSPA members will also receive the form through direct mailings and it will appear in some DB newsletters. Each member should complete this form only one time. Duplicate forms could result in inaccurate listings.

The NYSPA Public Affairs Committee plans to publicize the existence of the NYSPA searchable database so it can be widely available to the general public and various referral sources. Any suggestions for this project or any questions about it are welcome. Please contact me by telephone at (914) 472-5035, e-Mail: Ronellan@aol.com. ■

NYSPA Plans for the Millennium

by Ann Sullivan, M.D.

Dr. Sullivan is an APA Assembly representative for the New York County District Branch, and is a member of the Bulletin editorial board. The creation of the Strategic Planning Task Force is an attempt to reexamine the role of NYSPA within a changing APA. We will hear more about this initiative in the next few months.—Ed.

A changing health care environment has caused psychiatrists to pause and think about the future of our profession as we approach the millennium. Our State organization is also faced with the same crises and challenges. As a result the New York State Psychiatric Association is establishing a Strategic Planning Task Force to look at what the organization is, what it does, how it relates to its members. Additional concerns are what NYSPA can do to promote the psychiatric profession and the needs of our patients.

Surveying the Membership

A planning process can only be successful if the individuals the organization serves actively participate. Therefore a major aspect of the planning process will be a series of information gathering efforts which will involve the statewide membership. You will receive mailed questionnaires or telephone calls, requesting your valuable input on issues critical to the organization and its responsiveness to you. Key questions will include: How does NYSPA respond to your needs? Are NYSPA priorities your priorities? Do you think you get enough for the dues you pay?

Membership satisfaction is critical for a professional organization. Satisfaction involves members feeling connected to their organization; having easy accessibility and prompt responsiveness when they need assistance, as well as having a voice in the organization's governance, the priorities it sets and the actions it takes. The Task Force will consider ways to bring the state organization closer to home by having District Branch officers more directly involved in NYSPA activities (including a reexamination of the election process for NYSPA officers), and by providing more direct support of District Branch educational, advocacy and public affairs initiatives, and by having regular polling of District Branches as to NYSPA's successes or failures.

Identifying Dissatisfaction

Non–membership dissatisfaction is also a critical issue for a professional organization. Why are some New York State psychiatrists not members of NYSPA? Possible explanations include: dues are too high (especially for early career psychiatrists); priorities and activities do not support psychiatrists in certain areas of practice or if they are members of some minority groups; or lack of awareness of what the organization can do for them as members. The task force is charged with finding the answers.

Insuring the Future

The planning group will tackle two other key issues: establishing priorities for NYSPA activities and ensuring NYSPA's financial viability as we approach the millennium. NYSPA's priorities over the years have resulted in many accomplishments. To name just a few, NYSPA has long been a strong advocate for our profession and our patients in the state legislature, developing and supporting legislation to deal with the problems with managed care; fighting almost yearly budget cuts; and proposing parity in payment for treating mental illness. NYSPA has provided statewide updates on Medicare changes and filed suit to end discrimination in disability benefits for the mentally ill. We will be asking you what you think NYSPA's priorities should be in the future and how the financial resources of the organization are best spent.

Expenditures Under Review

Clearly, maintaining a strong financial base for the organization is a necessity. However dues should not be increased, and a decrease needs to be carefully considered. But organizations do need money to run, and we will be looking for new and innovative ways to provide for NYSPA's future. As one example, NYSPA is aggressively pursuing advertising for the Bulletin in order to significantly lower operating costs. The task force will also take a hard look at all current expenditures and propose cost reductions and operational efficiencies whenever possible.

Assuring Our Efforts

Most important, however, is your personal input. Write or call NYSPA with your suggestions and please reply to any questionnaire, calls or e-mail you may receive regarding this planning process. The success of this process and NYSPA's future depends on you. ■

Message From AMI

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NYSPA on this issue.

Another important legislative agenda item that we are fighting for is a five–year extension on the reinvestment bill. We have witnessed firsthand how reinvestment has helped individuals in their recovery process. A subtle part of reinvestment that has worked well in many counties is the involvement of family members and recipients of mental health services on the mental health sub–committees of Community Services Boards.

For the first time, stakeholders have actually had a role in where money was going to be spent in the mental health system. Reinvestment has become a core issue that we must continue to focus on in the coming years.

Another issue that has currency for family members is around research. AMI has a very strong research committee that continues to advocate for funding for New York State's two research facilities — The New York Psychiatric Institute and the Nathan Kline Institute. We recognize that these two facilities hold the best hope for our future and we will continue to support these facilities in any way possible.

One of the other missions of our organization is to help educate the public about serious mental illness. Our most recent campaign in this area is known as the AMI 2000 College Education Project. Many individuals have their first episode of schizophrenia during their college years. Our program would create greater public awareness in colleges about serious mental illness. We are beginning this process by doing a needs–assessment at college campus clinics around New York State. Our objective is to ensure early intervention for individuals who are seriously mentally ill on college campuses. The quicker the treatment process begins, the better the chances for recovery.

The AMI 2000 College Education Program is new so any ideas you may have would be greatly appreciated. Anyone who would like to receive a copy of our proposal, please feel free to contact us at (518) 462-2000. The input of NYSPA members would be greatly appreciated.

The thousands of volunteer members of AMI and the APA have long had a solid and productive relationship. Though we don't agree on every item, we do have agreement on many core issues vital to the recovery process. We do share so many mutual goals: mental health insurance equality, additional funding for reinvestment, housing and research and more accessibility to better medications. By continuing to work together, we can help end the fragmentation in the current mental health system. ■

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