Goodbye, But Not Farewell
by Edward Gordon, M.D.

This is my last message to you as President of the New York State Psychiatric Association. It is my pleasure and honor to serve you rewarding and exciting as I have had the opportunity to meet many distinguished psychiatrists, politicians and advocates. I have tried to have an impact here and at the APA on behalf of our members and as an advocate for our patients. My major interests since I first came to the Area Council have been in the economic and professional areas and to assure that psychiatrists are correctly paid for providing necessary care. While working in the New York Medicaid Committee, I discovered that Medicaid was underpaying where Medicare was primary to a lawsuit which resulted in a settlement over $1,000,000 paid to our members. Fifteen years later, I called attention to similar irregularities which led to the Crossover suit, returning $67 million of denied reimbursements to physicians and additional millions to hospitals and clinics. Now, with Managed Care coming into its weak underbelly, I am proud to have led the fight to oppose and expose managed profiteering and managed fraud. This fight will continue, and we will win. I continue as a member of the APA Managed Care Committee and as NYSPA representative to the Medicare Carrier Advisory Committee, which reviews Medicare professional policy in New York. I am proud that we have brought and won an important suit establishing the principle that discrimination against those with psychiatric disabilities violates the ADA, and have begun another challenging discrimination

INSIDE THIS ISSUE:
Editor’s Note ......................... 2
Letters to the Editor .................. 2
Area II Trustee’s Report .............. 3
NYSPA News ................................. 3
Physicians Suffering from Psychiatric Illness .................. 4
Sexually Violent Predator Legislation .................................. 4
NYSP-AC ................................ 5
MUR Group Representation ........ 6
NY & the Public Sector: Public Psychiatry Fellowship .... 7
MIT Corner ................................. 7
The Future of Psychotherapy in Psychiatry ........ 8
Neal Cohen, MD Appointed ....... 8
The Crisis in Inpatient Child Psychiatry .................. 9
Classified Ads ............................... 9
AG Meeting .............................. 10

 Incoming President’s Message
by Jim Nininger, M.D.

I am honored and eager to serve as your new president of NYSPA. On the national, state and district branch levels, we are faced with great challenges, the outcome of which will determine our viability as a profession and whether or not our patients receive comprehensive, effective and humane care. We fight through legislative and other means so that psychiatrists and patients might be treated fairly in managed care environments and allowed to cultivate a proper therapeutic relationship. We are forging ahead in a coalition of over 70 organizations (the MEND Campaign) to improve health insurance coverage for the treatment of mental illnesses.

My involvement with NYSPA began as a Representative to the Assembly from the New York County District Branch where under the direction of Rosalie Landy, I served on the Public Affairs Committee, chaired the first Task Force on Psychiatry in Nursing Homes, and chaired the Committee on Aging. I trained at Mount Sinai and since my residency have been affiliated with Cornell where as Payne Whitney, I had various roles including Unit Chief, Director of the Third Year medical student clerkship in psychiatry, and Assistant Director of Training. I am now primarily in private practice, with a sub-specialty in geriatrics, and work two days a week at the Pleasantville Cottage School, a residential school for troubled adolescents, mostly from the “inner city.”

Edward Gordon, M.D. has worked tirelessly and aggressively, particularly in helping psychiatrists to be fairly paid for what they do, and helping them to learn to navigate the maze of CPT codes and regulations. He has been instrumental in pursuing the “Medicaid/Medicare Crossover Suit” where physicians were being denied Medicaid co-payments rightfully due them, saving psychia- trists many multiples of their total yearly dues. Seth Stein, Esq. has served as our Legal Counsel for 20 years and as Executive Director for 10 years. His guidance and expertise are invaluable. His yearly “Medicare Update” is the only such document provided to psychiatrists within the APA. Our Legislative Committee, chaired by Barry Perlman, M.D., with assistance by our lobbyist in Albany, Richard Gallo, has taken an important role in pursuing (and helping to write) managed care and parity legislation for our State. You have all heard from Michael Blumenfeld, M. D., Chair of the Public Affairs Committee, about the NYSPA Searchable Database (printed in this issue) which allows our members to be profiled on our website. Our Area II Trustee, Herbert

 Picnic for Parity: Setting the Table Right
by Molly Finnerty, M.D.

Dr. Finnerty has been active in the Picnics for Parity since its inception and is President of Picnics for Parity, Inc., a not-for-profit corporation that has served as an organizing force for these activities throughout New York State. Dr. Finnerty is also a NYCoDB representative to the APA Assembly. —Ed.

In 1995, the Picnic for Parity pitched its tent for the first time in Central Park. Under a bright sun in the East Meadow, over 500 consumers, family members, advocates, and professionals gathered for very specific reasons: to challenge the stigmatization of public view of mental illness, to denounce the disparity in insurance reimbursement faced by those seeking care for treatment of mental illnesses; to advocate for improved access to mental health services and treatment; and to fight for fair employment and housing opportunities for people with mental illness.

Dr. Luis Marcos, then the Commissioner of the NYC Department of Mental Health, Mental Retardation and Alcoholism Services (DMH) welcomed the crowd to the first annual Picnic for Parity. Quincy Boykin, a consumer advocate, spoke to the assembled crowd saying, “this is a fine event, we should do it again.”

And doing it again — for the fourth consecutive year — is what is what May 17, 1998 was all about — not only in Bryant Park in New York City, but in seven other parks around the state. We have grown from a small gathering of 300 in Central Park, to over 6,000 participants statewide with over 250 participating organizations this year. And we will only continue to grow, as we reach out to our colleagues, families, consumers, advocates, professional and citizens groups. And do it again we will — until insurance and managed care discrimination against people with mental illnesses is stopped.

This year we are closer than ever, with a parity bill passed in the Assembly and an antidiscrimination bill in committee in the Senate: to help forward parity for New Yorkers call your Senator today — general switchboard number: (518) 455-2500. And to find out about how to have a Picnic for Parity in your city call our general information number and ask for a brochure: Executive Secretary, Ken Steele, at (212) 757-1550 (info@picnicsforparity.com); President, Molly Finnerty, M.D., at (917) 796-3523 (finnerty@picnicforparity.com)
LETTERS TO THE EDITOR

Barry Perlman, M.D., Bruce Schwartz, M.D.,
donna@ptofview.com

Point of View Productions

Seth Stein, Esq.,

Socarides also made the paradoxical claim that “Freedom of thought and intellectual inquiry on this issue are

From the Editor...

T

thank you to all of our readers who
gave their feedback on the new Bulletin’s
format and content. Your comments, whether favorable or unfavorable, are always valuable and we want to make sure we
remain responsive and give you what you want.

This issue contains advertisements for
pharmaceutical industry. This helps support the printing and distribution costs of the newsletter, and allowed us to increase the number of pages to twelve. Another possibility is return-
ing to a bimonthly schedule in 1999. Let us know your preference.

Syed Abdullah, M.D.
Michael Blumenfeld, M.D.
James Chou, M.D.
David Harwitz, M.D.
Craig Katz, M.D.
Brian Ladds, M.D.
Howard Ower, M.D.
Andrew Sullivan, M.D.
Seeth Vivek, M.D.

New York State Psychiatric Association
100 Quentin Roosevelt Blvd.
Garden City, NY 11530
Tel. (516) 542-0077
Fax: (516) 542-0094
http://www.nyspsych.org

Executive Committee 1997-98
Edward Gordon, M.D., President
James Nunner, M.D., Vice President
Barry Perelman, M.D., Secretary
Bruce Schwartz, M.D., Treasurer
Herbert Feyser, M.D., Area II Trustee
Seth Stein, Esq., Executive Director

Information for Subscribers

The Bulletin welcomes articles and letters that NSA 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 e-mail to the editor. All authors are encour-
gaged to also provide a photograph of themselves which will be printed alongside their article.

Information for Advertisers

The Bulletin welcomes advertise-
ments from both NSA 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 advertisement and display advertisements are available. Please contact the managing editor for current rates and media requirements. NSA members receive a discount of 50% of basic classified ad rate.

The opinions expressed in the articles or letters are the sole responsibility of the individual authors, and may not necessarily represent the views of NSA, its members, or its officers.

Graphic Design & Production
Donna Sanclemente
Point of View Productions

New York State Psychiatric Association • THE BULLETIN Summer 1998

Page 2

LETTER TO THE EDITOR

Letters to the Editor are welcome but are limited to 750 words. The full text of all letters will be available on The Bulletin web site at <http://www.nyspsych.org/bulletin>.

Reparative Therapy

In his reply to my article, “What NeedsChanging? Some Questions Raised by Reparative Therapy Prac-
tices,” Dr. Charles Socarides says my "sole aim seems to be to bury the homosexual movement" (Letter to the Editor, 25 September 1998). Obvi-
ously, he misunderstood my position. I was not faulting his claimed treat-
ment successes, but his acknowledged treatment failures. Dr. Socarides’ quotes studies showing a person’s homosexual orientation can be changed. He includes the work of Bieber et al. (27%) converted,
Socarides (35%), and Macintosh (23%). Serious students of this literature know that numerous methodological criticisms and epistemological questions exist regarding the permanence and meaning of these "cures." But even if one were to accept them at face value, these studies still do not substantively address the untoward effects on the gay men and women who don’t change in these "reparative therapies." This seems to me, a rather glaring omission. If the majority of these patients do not change. What happens to them? As theoretically helpful as these procedures may be to some, they can do significant harm to others. My own clinical experience with gay men who failed to convert to heterosexuality, he noted, while undergoing reparation therapy is that they suffered damage to their self-esteem, suffered either anxiety, depression, or both, and, often became deeply mistrustful of mental health professionals. Feelings of mistrust and shame may explain why there are no good follow-up studies.

Because Dr. Socarides believes homosexuality is a merely a malignancy, he would be none too pleased to hear the 65-77% of the patients who don’t change and who may later decide to embrace a gay identity. It only makes that he be a pathological liar (or is it saved?) by reparation therapy. He obviously believes that the lives of heterosexual individuals are more valuable than that of gay men. However, it should be an APA concern if its unique computerized online database. Patients and colleagues will be able to locate psychiatrists by geographic area and check if he/she is a member of a particular health plan or if he/she is open to the following referrals. Instructions, with instructions, are located on pages 7 and 8.

The Bulletin also welcomes new mem-
bers on its editorial board: James Chou, MD, and Brian Ladds, MD. In this issue, Dr. Chou writes about the role of Minor/morality-repre-

Vincent J. Falbo, M.D.

Dr. Socarides claims my essay is “filled with defamatory statements, inaccuracies, false assertions and conclusions.” Hyperbole aside, my arguments were presented apologistically. There are certainly a need to study this matter further.

Dr. Socarides quibble with my “personal clarification. He is a master of anti-
gay amendement, later overturned by the US Supreme Court. In fact, it is a matter of public record that the American Psychosocial Association threatened to take legal action against him if he ever again misrepresented their position on homosexuality. He did in that affidavit. Dr. Socarides’ letter also did not address his affidavit in support of Tennessee’s Sodom Law. Certainly the APA has a right to know why Dr. Socarides has moved away from the traditions of the psychiatric and psycoanalytic mainstream by endoring a state’s attempt to criminalize consensual, adult sexuality. Instead of answering my questions in a forthright manner, Dr. Socarides tried to undermine my professional credibility. For the record, I am Secretary of the NYC District Branch as well as a member of its Committee on Ethics, although my remarks reflect my own opinions and are not an official position of the APA. No Dr. Socarides called me a "prominent member of the national central committee of gay lobbyists." Were the charge not so profoundly unpleasant, it would be slanderous. This ficitive group only exists in Dr. Socarides’ vivid imagina-
tion, but it does evoke the image of a global intent on subverting us. Dr. Socarides also made the paradoxical claim that “Freedom of thought and intellectual inquiry on this issue are uncomfortable 11” by 17” size of The Bulletin’s web site at <http://www.nyspsych.org/bulletin>.

The charge of anti gay propaganda and the lies of the highly monied, omnipresent, gay activist lobby.” Here the charge can be the right’s stereotype of privileged gay men intent on acquiring power beyond their actual numbers. In essence, Dr. Socarides seems to believe that there is a secretly powerful and wealthy political entity comprised of both gay radicals and monied classes. Dr. Socarides’ response confirms what I called out in my my original Bulletin article: reparative therapists’ rhetoric has not only begun to increasingly resemble that of religious fundamentalists, but of right-wing extremists as well.

Unfortunately, the twentieth century has seen numerous examples of intolerant ideologies using con-
spiracy theories to justify attacks against vulnerable minorities. I am well aware that the APA’s demonizing language might be due to either ignorance of or indifference to the true scientific implications of using minorities, sexual or otherwise, as political scapegoats. But if his argu-
ments are not based upon indifference or ignorance, I would argue that Dr. Socarides’ letter is indeed further evidence that he is playing a very calculated and dangerous political game.

Jack Drescher, M.D.
New York, NY

New York State Psychiatric Association
140 Old Orangeburg Road
Orangeburg, NY 10962
Tel. (914) 398-5508
Fax: (914) 398-5508
http://www.nyspsych.org

350x1019 to 446x1138
Making APA User Friendly

by Herb Peyer, M.D.

A new approach to improving APA is under way, with the goal of making it more user friendly. To achieve this, the APA is conducting a comprehensive review of its operations and looking for ways to streamline processes, reduce costs, and increase efficiency. The process involves the participation of APA leaders, staff, and members in a series of meetings and discussions. The aim is to identify areas where changes can be made to improve the organization's ability to serve its members. To ensure that the members have a voice in the process, the APA has established a series of stakeholder meetings and a web-based platform for members to provide input and feedback. The APA is also taking steps to improve its communication with members, including providing regular updates on the progress of the project and opportunities for members to ask questions and offer suggestions. The APA is committed to making the organization more responsive to the needs of its members and to creating a more supportive and engaging environment for all who are involved with the APA.
Advocacy and Help for Physicians Suffering from Psychiatric Illness

by Susan Eisner, M.P.H., C.A.S.A.C.
CPH Outreach Education Coordinator

The OPMC (Office of Professional Medical Conduct - the Medical Board of the State of New York) of the Department of Health has a website at https://www.health.state.ny.us/docs/omp/index.html that the public can view listing the names of physicians who received disciplinary actions ranging from probation to license revocation, as well as details as to why these actions were taken. I was shocked to see some names I recognized, including my former psychiatric colleagues with whom I’ve worked. What happened? What interventions are available for a colleague in trouble? What can be done before their personal and professional lives are reduced to shambles?

The Committee for Physician’s Health of the Medical Society of the State of New York runs a program to provide clinical guidance and advocacy for physicians suffering from psychiatric illness. Although OPMC has an impaired physicians program for physicians who have shown work impairment (and participate after their license is reinstated), CPH is a diversionary program in that they can enroll physicians suffering from psychiatric illness without the knowledge of OPMC or any other agency. Their goal is to enroll physicians who suffer from psychiatric illness before they are impaired in their work.

Ms. Eisner, joined by a physician who utilized the services of the Committee for Physician’s Health, were the speakers at a recent Grand Rounds held at the Rockland Psychiatric Center.

The attendees were treated with a frank discussion about physician impairment and ways to help our troubled colleagues. A summary of their presentation follows. —Ed.

I

n the long-standing tradition of medicine, physicians have helped colleagues with their health problems. It is in this tradition that the Committee for Physicians’ Health (CPH) was established by the Medical Society of the State of New York (MSSNY). CPH helps those affected by Substance Use Disorders and other psychiatric illnesses. CPH serves licensed and unlicensed physicians (MD’s and DO’s), residents, medical students, and physician assistants. Services are provided at no charge and without regard to medical society membership status.

The philosophy of CPH is that Substance Use Disorders and other psychiatric illnesses are diseases which can be successfully treated. Our mission is to identify individuals in need of assistance to refer to appropriate treatment programs, to monitor progress in recovery, and to advocate for continuation of or return to active medical practice. Especially important is CPH’s advocacy role regarding employment, medical liability, and other insurance, becoming part of managed care panels, and other related issues.

Who makes referrals to CPH?

Anyone concerned enough to help. Seventy percent of the referrals are either self referrals or referrals from colleagues. Other sources of referrals are family, treating physicians, nurses, hospitals, patients and pharmacies. All calls to CPH are completely confidential. The identity of the referral source is never revealed, unless the caller wishes to be known. In most cases, according to New York State law, persons who refer in good faith, as well as the volunteers who work with CPH, are immune from legal challenge. In addition the identities of those enrolled in CPH are protected by law and are not revealed without consent.

While making a referral is vital, it can sometimes feel uncomfortable. People may think they don’t have enough information, that they may be wrong, or that they might ruin a career. While these feelings are natural, it is important to take a different view. Any physician who refers to an appropriate treatment program, to monitor progress in recovery, and to advocate for continuation of or return to active employment, is helping to save a life and a career.

In the past 12 years, Dr. Mansky has been a member of the Executive Committee of the Capital District Branch. He is presently immediate past president and deputy representative to the Assembly.

NYSPA Members Heads CPH

Peter A. Mansky, M.D.

Dr. Mansky, a NYSPA member, has been the Medical Director for the Committee For Physicians’ Health (Physicians’ Health Program) of the Medical Society of the State of New York for the past six years. He is a member of the Board of Directors of the American Academy of Addiction Psychiatry. He is active in his County Medical Society and in the American Psychiatric Association. For the past 12 years Dr. Mansky has been a member of the Executive Committee of the Capital District Branch. He is presently immediate past president and deputy representative to the Assembly.

Sexually Violent Predator Legislation: Another Misuse Of Psychiatry

by Howard Owens, M.D.

In 1997 the New York State Psychiatric Association endorsed the opposition to the proposed amendment to the Criminal Procedure Law, which would have transferred sexually violent predators from the prison system into state mental hospitals for indefinite treatment.

Although this legislation was stopped at that time, we should remember that Hyde and many heads: the New York State Legislature is once again considering such legislation, and some version of it now appears likely to be passed. The New York State Medical Society in January that Governor Pataki would press a law to allow the state to commit sexual offenders in mental hospitals even after they had served their sentences.

In addition to having a potentially popular issue in an election year, the proponents of this legislation have taken powerful support from the U.S. Supreme Court’s decision in the 1997 case of Hendricks v. Kansas. In that case, the court upheld the Kansas Sexually Violent Predator Act, approving the civil commitment of persons labeled as sexually violent predators. The similar New York bill was aimed at retaining in the hospital a diverse group of offenders, those who have been convicted and sentenced for sex crimes, and who have completed their sentences, those who have never been sentenced because they have been found to be incompetent to stand trial, and those who have been found to be guilty. Guilt is a defense of insanity and are about to be released from the hospital (presumably because they are no longer mentally ill and danger).

One of the serious flaws in this legislative approach is that it treats sex offenders as if they were a homogeneous group. In fact, sex offenders are a heterogeneous group with various types of psychopathology. The 1997 bill’s most curious provision, which was obviously designed to circumvent ordinary civil commitment law was, its definition of a “sexually violent predator,” as an individual who does not have a “mental disease or defect” but who does have a “mental abnormality or personality disorder.” Such offenders would be committed to a secure facility operated by the NYS Office of Mental Health until such time as the person’s mental abnormality is “cured” and they are no longer a danger to others. In an amazing exercise of candor, the bill even acknowledged that the treatment prognosis for some sexually violent predators is extremely poor. The legislation concludes, “that this type of statute would mandate the indefinite retention of untreatable offenders in the secure state mental hospitals.” NYSPA pointed out in its 1997 Memorandum in opposition to this law, New York State now has only three secure mental health facilities: Meanwhile there are estimated to be 5,000 individuals in New York who are required under the Sex Offender Registration Act of 1995. Over 1,000 of these offenders would probably be eligible for the New York State commitment program under the criteria in the bill. NYSPA pointed out that it costs the state $130,000 a year to maintain a patient in a secure mental health facility, considerably more than the cost of keeping the same person in prison.

NYSPA’s memorandum concluded that the enactment of this legislation would result in an ever-increasing number of civilly incarcerated offenders. “Since the bill permits release only upon a showing, in effect a guarantee, that there will be no repetition of the act, then there is little likelihood of release. The number of sexually violent predators who are in civil incarceration will inevitably grow with time.” This result creates a direct conflict with the state’s responsibility to provide treatment to the mentally ill. NYSPA pointed out that the New York State Constitution (Art 17.3) makes the state responsible for the care of the mentally ill. The state psychiatric system operated by NYS-OHMH cannot carry out this responsibility if its limited facilities are flooded with civilly incarcerated sexual offenders, who would displace patients with serious Axis I disorders (e.g., depression and anxiety disorders). “The psychiatrists know are most in need of hospital treatment.”

The legislation would have the further ominous effect of forcing psychiatrists to serve as the gatekeepers, who would be called upon to diagnose the “mental abnormality or personality disorder” which is required for a civil commitment. Psychiatrists recognize that the release of sex offenders into the community represents a direct threat to the public safety problem. What NYSPA opposes is the misuse of long-term civil commitment as the “solution” to the problem. Unfortunately the current political climate suggests that some civil commitment law for sex offenders will pass the legislature. Because there have been serious problems that such legislation could be bad for psychiatrists, NYSPA is working very actively to prevent its passage. NYSPA is working against the SVP program in the final form that any such law takes. The Codes and Mental Health Committee of the New York State Assembly, and the New York Psychiatric Center (the latter being under the jurisdiction of the NYS Department of Correctional Services) faculty generally operate at full capacity and have no excess supply of empty beds.

—Ed.
Sexually Violent Predator Legislation

Continued from page 4

that are involved in implementation of such a law. To provide a framework, a special work group was formed, comprised of NYSPA's Executive Committee, working in conjunction with Executive Director Seth Stein, with NYSPA's legislative representative, Richard Gallo, and with Dr. Richard Caccamise, Chairman of the APA Council on Psychiatry and Law, and Dr. Richard Rosner, Chair of NYSPA's Council on Psychiatry and Law, and with Executive Director Seth Stein, working in conjunction with Executive Director Seth Stein, comprising of NYSPA's Executive Committee, working in conjunction with Executive Director Seth Stein, and members of the mental health providers, medical societies and patient advocate organizations to secure passage of landmark legislation. Because parity faces stiff opposition from the insurance industry and business lobbies, the PAC needs your help in getting our message across to the legislators. Contributions to the NYSP-PAC are vital if we are to have an impact in Albany.

In addition, the PAC will continue its efforts to strengthen provisions of NYS managed care laws to protect physicians and patients in their struggle with managed care to secure access to medically necessary treatment. We will of course continue to be vigilant to insure full support and adequate state funding for programs and services for persons with mental illness, and assure that the public is protected by opposing broadened scope of practice for psychologists.

In this critical year, it is important that we ask you to join with us. If you contributed in the past, please continue this year and increase your contribution if possible. If you did not contribute last year, please join us now. The NYSP-PAC is the only political action committee representing the interests of psychiatrists in New York. Without the support of psychiatrists, our voice will not be heard in Albany.

Please call the NYSP-PAC at (516) 542-0088 to receive information about how you can help.
What is a MUR Group?

MUR groups are groups that have been identified as either being underrepresented (in psychiatric services) within the U.S. population or underserved (in psychiatric services) within the U.S. population or underrepresented within APA. These groups are: Women, International Medical Graduates, Gay/Lesbian/Bisexual, Black, Asian, Hispanic, and American Indian/Alaska Native/Native Hawaiian.

Why do MUR Groups exist in APA?

The APA has a strong history of support for all MUR members as demonstrated by its formation of its office of Minority/National Affairs and its creation of the seven designated MUR groups. The mechanism of formal representation of MUR groups within APA governance does not resemble an affirmative action program, but rather incorporates these groups as an essential operational part of the organization. The global objective of MUR activities is maintaining the APA as an organization that is sensitive to MUR issues and hence represents all of its members including those who belong to MUR groups. All of these 7 groups, in addition to being underrepresented in APA, are also underrepresented in APA leadership. The basic idea is that an organization that is sensitive to MUR issues is good for all members. In addition to initiating specific MUR-related activities, MUR representatives also serve a role as watchdogs assuring that APA does not inadvertently promote insensitive positions. These two functions are achieved through a wide range of activities some of which I will highlight below.

How are MUR Groups Represented in APA?

Each MUR group has a Committee (appointed by the APA President-Elect) within the APA Components and a Caucus within the APA Assembly. MUR Committees and Caucuses are independent though they usually work together closely. These groups are in a position to actively contribute to the formation of APA positions and policies. The primary functions of these groups are to advocate for relevant issues, to provide communication between APA leadership and their constituents, and to create a mechanism for networking for their constituents. Each APA member who could be classified as MUR can choose to join their caucus, and in doing so, will become a voting caucus member. Currently, membership in more than one caucus is not permitted, although this policy may be under review (e.g., a woman, lesbian, Hispanic, IMG member would currently have to select only one of the four possible caucuses). Each Caucus elects a president, an Assembly Representative, and a Deputy Representative.

In NYSAPA, there is no formal mechanism for selection of MUR representatives, however, nationally elected MUR representatives who are NYSAPA members serve as MUR representatives within NYSAPA and have voting privileges.

What do the MUR Groups Do?

MUR groups directly participate in virtually all APA activities, but I will attempt to highlight some key areas. One key area is the scientific program. MUR groups always present a series of presentations relevant to MUR members within the scientific program at the Annual Meeting, often in the workshop format. In addition, MUR groups actively promote adequate representation of women and minorities in the scientific program in general. Recently, a specific focus has been placed on the highly popular industry sponsored symposia which have not been successful in including a representative number of women and minorities among their expert presenters. Another goal is to assure that the topics covered in the scientific program are relevant to MUR members.

MUR groups also actively participate in the creation of APA documents including the DSM and APA practice guidelines. All APA documents are widely distributed within the organization before being finalized providing sufficient time for input from all groups. In particular, MUR input has been critical in the development of the DSM-IV section on cultural formulation and culture bound syndromes, as well as in including cultural psychiatry training as essential components of training curricula.

Membership issues are another important area of MUR activity. It is essential to maintain the APA as an organization which maintains its appeal to women and minorities. Many activities also directly focus on recruiting minority students into the field as well as recruiting minority psychiatrists to become APA members. One highly visible activity is the series of MUR awards which are selected by the MUR Committees and awarded at the Annual Meeting. There are also efforts underway to enhance the number of MUR psychiatrists in academics and on medical school faculties.

APA has consistently demonstrated that adequate psychiatric services to women and minority populations is a high priority. This has become such an institutionalized aspect of APA policy that it hardly requires any input from MUR groups. Nonetheless, MUR groups have voting privileges.
within the last 10 years or more, there have been many changes in healthcare, one of which has been substantial blurring of the formerly fairly distinct boundary between the public sector and the private sector. Patients on public support are now included in many managed care organizations and are treated in private practice settings. Federally-funded researchers have begun to apply these concepts at an agency and seek reimbursement of their efforts at the local level.

The Fellowship is a one-year, full-time program for psychiatrists who have completed accredited psychiatric residency training and who plan to devote their careers to working with high risk populations in the public sector. It is usually large for a psychiatric fellowship, training 10 fellows per year. Fellows spend two days per week in seminars at a psychiatric institute, learning the major principles and practices of psychiatry. They spend three days each week in the field, applying these concepts at an agency providing mental health services in the public sector.

Didactic Seminars provide a systematic framework of knowledge to support the field work. The Academic Seminar is a year long comprehensive overview of major topics in public psychiatry, taught by medical directors of the core faculty. In an Applied Seminar. Fellows use this academic foundation to organize a series of clinical, management and fiscal presentations of their field placement experiences. In addition, each fellow is expected to design and present a project consisting of a literature review and an examination of that project with the majority of their placement site.

These Applied Seminars are a crucial aspect of the Fellowship year, offering Fellows the opportunity to organize, present and evaluate their efforts at implementing the concepts they have learned during the year.

In recent years the Fellowship has attained national prominence. It is generally regarded as one of the best public psychiatry programs in the country. Fellows have been invited to contact the district branch office at (212) 421-4732. Projects which have begun development this year include: a series of workshops on mental health at area elementary schools; the designing of a residents committee website; an electronic residency and fellowship manual; and a statewide directory. The committee also actively participates in the recruitment and selection of the annual “Picnic for Parity.” Held in St. Louis in October, this event is dedicated to promoting awareness of, and support for, the efforts of the mental health community, especially pertaining to the need for parity in the financial coverage of service delivery.

As ever, there are continuing efforts to increase representation among area residency programs on the committee, as well as improving communication among district branches statewide, as well as helping to find and mentor annual residents’ cruise, currently scheduled for June.

The NYCoDB Residents’ Committee, consistent with the committee’s role in the mental health community, promotes the educational, professional and personal growth of psychiatrists of similar backgrounds.

How Can You Participate?

These activities, broad as they are, require much energy, and there is always room for more participants. The first step is to get involved with your District Branch. Although there is no formal MUR representation mechanism at the District Branch level, start by getting involved with local activities and address the Board of Directors on any relevant issues. Within NYSPA, there are currently four MUR representatives (or deputy representatives) in NYSPA whom you can contact with any questions that you might have. Their names are Drs. Ramsawamy Viswanthan, Sylvia Olarte, Nalini Juthani, and myself.

If you wish to be appointed to a national committee, we have a current chair of the committee as well as the APAC President–Elect. Ask the committee of your branch for the name of the committee and the chair. If you wish to participate in a caucus, inform the APA Office of Minority/National Affairs, or the APA President–Elect at the Annual Meeting or contact the caucus president. This information can be obtained through the APA Office of Minority/National Affairs. If you have specific issues you wish brought up in the Assembly, please don’t hesitate to contact me directly.

Phd from the University of Cape Town. He is a member of the Bulletin Editorial Board and reports in this issue about some of the activities of the residents’ committee of the NYCoDB. The Bulletin looks forward to publishing news from MURs from across the entire State of New York. —Ed.
APA and NY Academy of Medicine Presentation: The Future of Psychotherapy in Psychiatry

by Brian Ladds, M.D.

Should psychiatrists provide psychotherapy?

This question, rather absurd, is however very real in the minds of non-payers, as well as of third party payors, and very well-attended, presentation on the future of psychotherapy in psychiatry held in New York City.

Dr. Cohen is a member of the Bulletin Editorial Board and is the Director of Residency Training at St. Vincent’s Hospital in Manhattan.

T

he New York County District Branch of the APA, and the New York State Psychiatric Association, in cooperation with the New York Academy of Medicine, teamed up on April 29, 1998, to co-sponsor a presentation on the future of psychotherapy in American psychiatry. The idea for this symposium originated with Dr. Norman Straker, Secretary of the section, who recognized that many psychiatrists are very concerned with the constraints that managed care has imposed on them when providing psychotherapy to their patients. Third party payors, and others, have increasingly asked whether the scope of practice of psychiatry should be re-defined, possibly leaving other mental health professionals as the preferred provider of mental health services. In the case of residency training to become the psychiatrists of the future be taught less about psychotherapy than psychiatrists have been in the past?

Under the leadership of Dr. Herb Fox and Dr. Hillel Swiller, Chair and past Chair of the Department of Psychiatry, and Dr. Bill Tuckler, President of the APA district branch, Dr. Straker and I organized a presentation by Dr. Jerald Kay, chairman of the department with several residency training directors. Dr. Kay, Chair of Psychiatry at Wright State University, in Ohio, addressed these issues for the audience of approximately 70 psychiatrists, bringing with a survey of several different proposals that have been made to redefine the field of psychiatry. These include, for example, proposals that psychiatry become a subspecialty within the field of medical re-integrate with neurology. These proposals would call for substantial less emphasis on psychotherapy training for psychiatrists. Dr. Kay rejected such proposals and forcefully argued that residency training should remain distinct from medical care. Dr. Kay has the experience of doing long-term psychotherapy. There is no substitute for learning about the subtleties of the doctor-patient relationship.

The panel of training directors, including Dr. Ronald Rieder (Columbia), Dr. Amy Hopkinson, respondent, Dr. Betsy Auchincloss (Cornell), Dr. Michael Serby (Mount Sinai), Dr. Carol Bernstein (NYU), endorsed much of the position of Dr. Kay. In short, psychotherapy should remain an integral part of psychiatry residency training. In addition, a panelist pointed out that residents are under increasing pressures to manage large caseloads of patients whose primary treatment modality focuses on medication, and also that the need to teach advances in neuro-science may force some decrease in the curriculum dedicated specifically to classical forms of psychotherapy. Many of the psychiatrists in the audience, including residents in training, emphasized the need to fight vigorously on behalf of preserving the traditional scope of practice. However, one member of the audience urged that many graduates of residency training, especially in academic settings, have not mastered competencies in psychotherapy, and have not demonstrated strong abilities in presenting psycho-dynamic formulations. In short, residency training programs should no longer claim that they do other wise. I suggested that the is this a concern of the specialty that is concerned with the broader community to be having these discussions because the ACCME is concerned with promoting competencies for residency training, and thereby, potentially directly affecting the role of psychotherapy among future psychiatrists.

The next meeting at the Academy will be held on June 17, 1998 and will focus on the Ethics of Psychotherapy. The purpose of this is to begin the process of reviewing NYSAs structure, finances, mechanisms for setting priorities, relation of DIs to each other, to NYSAA and the APA, especially in view of the APA’s Strategic Planning process and its effect on NYSAA, and the costs of New York City APA District Branches. A review is appropriate and necessary. The varied background of the committee members should assure the fair perspective necessary for a successful outcome of the strategic planning process.

Finally, as Past President, I will continue to sit on the Executive Committee and continue to contribute to NYSAA’s work. However, with additional free time available, I was able to arrange a return of my “Med/Column” column, holding help and tips on coding, documentation, scope of psychiatric practice, and other economic aspects of practice, as prompted by member questions and needs.

T
e

he New York City Department of Mental Health, Mental Retardation and Alcohol Services will merge with the New York City Department of Health and Hygiene into a new Department of Public Health, under the leadership of New York City Commissioner Neal Cohen, M.D.

Dr. Neal Cohen has been an outstanding Commissioner of Mental Health since 1996 and has a long tradition of advocacy for the mentally ill and service in the community outside of State psychiatric hospitals. Dr. Cohen knows that Dr. Neal Cohen is a psychiatrist who has been active in both the public and private sector in New York City, and an active member of the New York County District Branch of the APA. Dr. Cohen was responsible for establishing Project Help for the homeless in the 1980’s, and has served as Chair for the New York County Community Services Board. Dr. Cohens appointment speaks to his personal accomplishments, as well as the significant regard for psychiatry in the public health arena.

Dr. Neal Cohen sees this merger as an exciting opportunity to provide improved integration between mental health, substance abuse and general medical services. The newly created department will serve as a vehicle to ensure quality assessment of patients’ needs and delivery of mental health and substance abuse services as all too often being an outsider in public health planning and development, just as it is often overlooked at the level of primary care assessment. He sees his mission as the integration of treatment services, reducing stigma, and treating the entire person in body and mind.

While the New York City APA District Branches commended Dr. Cohen’s leadership, and share his vision, they have collectively raised various issues regarding the position and role of mental health and substance abuse services in the newly created department moving into the future. While the mental health community feels that Dr. Cohen’s advocacy will be strong, concerns are raised when the Commissioner of Public Health is not a psychiatrist.

The New York City District Branches recommended to Dr. Cohen that the following priorities be maintained in the establishment of this new Department of Public Health: funding for mental health and substance abuse programs should remain distinct and accountable from any general care funding; the structure of the newly created Department should maintain a separate and powerful Division of Behavioral Health Services, with a Deputy Commissioner reporting directly to the Commissioner of Public Health, in the event that the Commissioner of Mental Health is not a psychiatrist, the Deputy Commissioner should be a psychiatrist, in order to maintain a powerful presence of psychiatric leadership in the Department of Public Health.

Dr. Cohen will be meeting again in the near future with representatives from the New York City District Branches to discuss the structure of the new Department of Public Health in more detail. There will be opportunities for further discussions from the APA and NYSAA, as well as community groups and individuals at public hearings scheduled for April and May before the City Council.

In addition, the District Branches strongly support Dr. Cohen’s suggestion that a formal Planning Advisory Council be established within the new department, that will include all the Deputy Commissioner for Behavioral Health Services. Finally, the Branches noted that the new Department of Public Health would be more effective in its advocacy role for behavioral health services, if these services were included in the department’s title.

Once again, the core of the APAs recommendations will be to maintain the high level of advocacy, financial control, and psychiatric medical leadership in the Division of Behavioral Health Services in the newly created Department of Public Health.

Gordon

Continued from page 1

Thanks also to Leslie Citrome, newly appointed Editor and the rest of the editorial board of the rejuve-

nated Bulletin and to Bob Campbell, distinguished Editor Emeritus, who led it so well and for so long.

I want to thank Seth Stein, whose performance as Executive Director and General Counsel is the envy of all other professional organizations. Seth brings erudition and legal, organiza-

Gordon

tional and management skills to the office. He is enthusiastically productive and very much appreciated, as are his able staff, but especially Nancy Hampton and Barbara Capuano.

NYSAA was organized nearly 30 years ago. The current structure, although effective and well organized, has developed specialized structures without strategic planning over the last ten years. The leadership has worked well together for the last four years.

However, coincident with the change in leadership, there has come a proposal for a “Strategic Planning Process,” emulating well known and successful processes. At this NYSAA meeting, a Work Group on Planning for a Strategic Planning & Evaluation Process was established to define the task of a subsequent

Nininger

Continued from page 1

Peiry, M.D., has made great efforts to travel the state and make himself available to District Branches to improve communications, and to promote a new role for the national APA to its members (begin-

ning well before it was stressed as one of President Herb Sacks’, M.D. initiatives).

As we approach the year 2000, fin-

die situations are inevitable. New one hundred years after Freud’s “Interpretation of Dreams” we are in danger of abandoning psychotherapy as a mainstay of our therapeutic armamentarium. As an examiner for the Boards, I’m often dismayed by candidates’ poor grasp of the patient as an individual, at times forsaking empathy for an inventory of possible symptoms and diagnoses. In this issue of the Bulletin you will find more information on this topic.

I greatly serve the work group examining APAs governance structure as a part of the national APA strategic review. I feel there is a serious effort being undertaken to revitalize the organization more streamlined and efficient, and focused on relevant priorities. As a member of the last issue of the Bulletin, (and in Dr. Gordon’s final President’s Message in this issue) this is a priority for NYSAA as well, as it is for APA. Hopefully, there will be less emphasis on psychotherapy in psychiatry held in New York City.

To see the full version of this article, please visit the APA website at www.psych.org.
The Crisis in Inpatient Child Psychiatry
by Richard Perry, M.D.
Chairperson, Committee for Children and Adolescents of NYSPA

Manhattan Children’s Psychiatric Center closed some years ago and its beds were distributed to Queens Children’s Psychiatric Center and Bronx Children’s Psychiatric Center. Many of those beds were not staffed and are still not staffed, increasing the pressure on acute care units which cannot discharge these patients and then must turn away new patients in need of care. A new installation, Brooklyn Children’s Hospital has never staffed its beds to the number that was promised. Within inpatient units, there is a rapid whittling away at the infrastructure. There are reductions particularly in nursing and social work staff. In three municipal hospitals and one voluntary hospital, social work staff in the child inpatient units has been reduced from two social workers to either one or one and one-half social workers. This leads to further reduction in productivity, further increased length of stay, further criticism of the inpatient staffs and increase for the staffs when dealing with managed care and oversight administrators.

It is all quite frustrating when the staffs of the units are providing the only appropriate and/or available care and protection to these children. We are concerned that if public administrators and managed care have their way, there will be an increase in mortality and morbidity within the child mental health system. Money can not be the only determining factor in what we provide for these children. People should be reminded that years ago citizen organizations and the courts mobilized themselves to offer protection to neglected, abused, and exploited children who could not fend for themselves. Although cost reduction or containment should not and cannot be ignored in planning, the guiding principal in child mental health should remain the necessary care and protection of our children.

Dr. Perry is Unit Chief at Bellevue Hospital’s Child Inpatient Unit, and Clinical Professor of Psychiatry at New York University. He is Chair of NYSPA’s Committee for Children and Adolescents. He is also on a committee of the American Academy of Child and Adolescent Psychiatry — the Workgroup for Healthcare Reform and Finances. In this article Dr. Perry outlines the current crisis situation regarding the psychiatric care of New York City’s children. Readers are encouraged to send their feedback to the Bulletin.

And many of my colleagues in child psychiatry, are alarmed at recent attempts to either eliminate city and state inpatient beds, or reduce staffing on inpatient units to the point of undermining care. Particularly alarming is the fact that there are many more children being referred for hospitalization than there are beds. The dual forces of managed care, and state and city budget cuts, has all inpatient psychiatry under siege. Child units are not exempt. We look upon psychiatric hospitalization as part of the safety net for children and are convinced that while efforts are currently being made to reduce hospital beds, there are no existing alternative, less restrictive, programs for these children. The prototypical child admitted to an acute care hospital exhibits such dangerous and/or disorganized behavior that treatment in the community is not appropriate. Many of the children have failed outpatient treatment. Many come from foster care. Once admitted to the hospitals, many of these children require disposition to foster care, therapeutic foster care, state hospital or residential treatment centers and facilities. There are far too few beds available in these programs so that the children may languish on the acute care units even after stabilization. Managed care often judges that these children no longer need acute care and carves out periods of hospitalization. These decisions fail to recognize that beds are not available in lower levels of care and that to discharge the child to the community would be unduly risky. The child may also be placed on “alternate level of care” (ALOC) with the result that the hospital receives a much reduced reimbursement. Carve outs and ALOC reduce the revenues generated by the inpatient units, thereby giving more ammunition to those who would close down beds. In this way, inpatient units can be “choked” out of existence.

There is, in addition, concern that just as adult patients were discharged from state hospitals decades ago with the rationale that they could and will be treated in the community, that child hospital beds will be closed without appropriate alternative programs in place. Then, as now, the bottom line is money. What is different now is that we should have learned something from the experience of adult state hospital patients and that we are now dealing with children. Nonetheless, managed care and NY State and NY City budget cuts are moving at reckless speed to reduce costs and the most expensive service, hospitalization, is the number one target.

Rates for classified ads are $60 (minimum) for the first three lines, $10 per line thereafter. NYSPA members receive a 50% discount on the minimum rate classified ad placement. All ads must be prepaid. Send your ad copy along with your check made payable to “NYSPA” to:

Point of View, Asst: Bulletin
P.O. Box 285 • Howell, NJ 07731

If you have any questions regarding classified advertising, please contact Donna Sanclemente (732) 901-4920 or by e-mail donna@pointofview.com.


PSYCHIATRIST Fee-For-Service: Seeking Psychiatrists to provide clinical evaluations, mental status exams & medication to clients in substance abuse programs & in an OMH licensed program. Send resume, with salary reqs to:
Human Resources Dept; The Educational Alliance; 80 Fifth Ave., Suite 402; NY, NY 10011; Fax: (212) 226-1178

CLASSIFIED ADVERTISEMENTS
On April 20, 1998, NYSPA representatives including Edward Gordon, M.D., Herbert Peyser, M.D., Barry Perlman, M.D., and Seth P. Stein met with Jeffrey S. Gold, Bureau Chief of the Health Care Bureau and Katherine Brooks, Assistant Attorney General, to discuss the newly created Health Care Bureau in the Office of the New York State Attorney General.

The Health Care Bureau was created to assist patients and physicians in dealing with managed care and to facilitate access to medical care and treatment under health insurance plans. The Bureau is focusing on assuring that managed care companies comply with the requirements of the new managed care law.

The Bureau is prepared to become directly involved on behalf of patients and physicians in disputes, including contacting managed care companies and health plans to advocate for patients’ rights. The Bureau recently conducted a survey of 35 HMOs operating in New York and found that 18 HMOs failed to comply with the requirements of the managed care law regarding providing information to patients on their rights.

At the meeting, NYSPA raised several issues of concern regarding the operation of several managed care companies in the state. Questions were raised regarding referral practices under the Empire Mental Health Plan for state and local government employees administered by Value Behavioral Health (VBH). VBH is supposed to provide patients with three referrals when they call VBH. Instead, patients receive the name of a VBH clinical group, the name of a provider in the VBH clinical group and a third independent provider. Patients are not aware that two of the three referrals are essentially the same. This practice circumvents the plan requirements that patients get three referral names.

Seth Stein reviewed the practice of sale by pharmacies to drug prescription plans of the names of patients and the medications prescribed for them by physicians. Prescription plans use this information to solicit psychiatrists to change patient medication to drugs sold by the pharmaceutical firm that owns the prescription plan. Some prescription plans have gone so far as to prepare a printed prescription form with the doctor’s name and ID number, the patient’s name and the drug that the company wants the doctor to prescribe.

Dr. Perlman brought up the issue of patient confidentiality in the light of the recent spate of corporate takeovers, mergers and acquisitions in the behavioral managed care arena. When these corporate takeovers occur, enormous databases containing confidential patient information about treatment for mental illness are sold, transferred and exchanged. Dr. Perlman questioned what safeguards are in place to protect patient confidentiality.

Other issues discussed included failure of managed care companies to provide reasons for denials, plan benefits and lists of participating physicians as required by state law, and the failure of DOH to promulgate regulations implementing the managed care law.

Mr. Gold described a successful intervention regarding coverage for treatment of substance abuse. Previously, a carrier in central NY had told providers that it would review claims for substance abuse treatment based upon nationally accepted standards. In 1996, the carrier told the providers that it would now implement a retrospective review procedure before paying claims. The carrier did not tell providers that it also intended to apply different standards in reviewing treatment. Shortly thereafter, the carrier began denying claims on a wholesale basis. When complaints were received, the Bureau investigated and determined that the new review standards were so restrictive that the treatment could ever meet the standard. The Bureau then served a notice of intention to file a complaint based upon improper notification of change of intention to file a complaint.

Perlman questioned what safeguards are in place to protect patient confidentiality.

Perlman noted that this is precisely the type of activist government intervention that patients and physicians need to be able to grapple with managed care. The Bureau’s approach is to intervene immediately to see if a rapid resolution can be achieved.

The Bureau’s complaint hotline number is (888) 692-4422. If complaints are forwarded to NYSPA and the Bureau, NYSPA will also follow up to make sure that complaints receive appropriate attention.

NYS Attorney General Opens New Health Care Bureau

by Seth P. Stein, Esq.

Read the Bulletin on line at http://www.nyspsych.org/bulletin