President’s Message: APA Revenue Sharing

Jim Ninninger, M.D., President, New York State Psychiatric Association

The APA Board of Trustees has approved a revenue sharing proposal to provide revenue sharing to district branches and state associations from APA net dues revenue. Current estimates are that about $700,000 will be available for distribution this year. Non-dues revenue includes revenue from various activities including the APA annual meeting and advertising income. APA leadership has recognized that the district branches and state associations rely primarily on membership dues to support their local organizations and do not have access to outside revenue sources. For most district branches and state associations, membership dues make up over 90% of their annual income, while membership dues are only 19% of the APA's annual income. A special APA Task Force charged with developing procedures for implementing the revenue sharing proposal met last spring and considered various allocation methodologies that would guarantee a minimum payment to each state regardless of the number of members and how funds would be allocated in states with multiple district branches and a state association. Both issues raise critical questions for New York State. While we support the principle that the smallest states should receive a minimum payment, the allocation methodology should not unfairly penalize states such as New York with thousands of members. Also, we want to make sure that there is adequate input from New York regarding any APA requirements regarding allocation of revenue sharing among the state district branches and the state association. To that end, the NYSQA Executive Committee [See President's Message on page 2]

HCFA Publishes Draft E/M Guidelines For Comment

Because of the wide condemnation of the 1995 and 1997 E/M Documentation guidelines, HCFA has been working on a revised version, which will "simplify the guidelines, reduce the burden on physicians, and foster consistent and fair medical review." A Town Hall meeting was held on June 22, 2000 to discuss the new draft guidelines and elicit comment. Eugene Cassell, of the APA Division of Governmental Relations. attended. APA will be issuing a memorandum on this development soon. HCFA is interested in widely disseminating the new Draft Guidelines and obtaining as much comment as possible before publishing them as a final regulation. There will be field testing across the nation as well as in individual physicians' offices. The new draft guidelines represent a return to the documentation requirements before the 1995 version, and may lead to further simplification. It is not anticipated that they will be published for final comment before 2002. In the meantime, the 1995 and 1997 guidelines remain in effect.

Recent Court Decisions Break New Legal Ground

HMO May Be Sued For Unauthorized Disclosure of Confidential Information

By Seth P. Stein, Esq., NYSQA Executive Director

In a decision that will likely be reviewed by the New York Court of Appeals, the Appellate Division, 3rd Department, on May 11, 2000, ruled that a patient-ensrolled in an HMO (Community Health Plan - Kaiser Corporation) could proceed with her lawsuit alleging that a medical records clerk employed by the HMO improperly disclosed information about the patient’s treatment received from a psychiatric social worker employed by the HMO. The lawsuit alleged that the clerk disclosed confidential information about the patient to friends. The appellate court held that the statutory duty of confidentiality imposed upon HMOs considered together with the long established legal principle that health care providers are held liable for breaches of confidentiality gives rise to a cause of action against an HMO for the unauthorized disclosure by a clerk.

New York City Must Provide Discharge Planning for Jail Inmates with Mental Illness

In a decision published this July, New York Supreme Court Justice Richard F. Braun granted a preliminary injunction directing the City of New York to provide discharge planning for all NYC jail inmates with serious mental illness. Details of this decision and its ramifications can be found in Dr. Owens' article on page 7, but the gist is the trial court in its decision described current City discharge procedure as follows: "Upon release from Rikers Island, generally inmates are not provided any mental health services, government benefits assistance, housing referrals, or other services, or planning therefore. Rather, all that is done for inmates released from Rikers Island is that they are taken by bus to the Queens Plaza subway station between 2:00 and 6:00 a.m. and given $1.50 plus two subway tokens."
A

s I write this, the summer of 2000 is coming to a close. We will be starting the new "school year" with a brand new editorial board. Joining veteran Howard Telson, M.D., and Ann Sullivan, M.D., will be Howard Telson, M.D. of New York City, Thomas Gift, M.D. of Rochester, and Jeffery Smith, M.D. of Scarsdale. I am especially pleased that Upstate New York will be represented on the board and we can look forward to news and perspectives from there. These editorial board members-volunteers have agreed to write solicit articles, proof read, and seek out advertising. If you have any ideas, suggestions or contributions, feel free to contact them or myself. A good starting point would be to e-mail me at citrome@nki.rfmh.org, or call me at 845-398-5595.

The Bulletin will also be looking for an Associate Editor in the year 2001, and ready to take the reins when my term in up on August 1, 2002. Serving on the Editorial Board would be a good start, and there is still some room for expansion beyond the current editorial board and we can look forward to news and perspectives from there. These editorial board members-volunteers have agreed to write solicit articles, proof read, and seek out advertising. If you have any ideas, suggestions or contributions, feel free to contact them or myself. A good starting point would be to e-mail me at citrome@nki.rfmh.org, or call me at 845-398-5595.

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an array of other antipsychotics, new and much better than it had been but it is still not fully in place. The improvement was due in large part to the staff, as a result of Board actions, consulting much more with the DBs/SSs and the members, but the contact must be further increased to insure efficiency and prevent duplication and expense. For example, staff devised some good member recruitment-retention initiatives involving volunteers and discounts for purchasing APA publications, but when the question of central staff calling members delinquent in their dues came up it was necessary to point out to them that this is already being done locally, by many DB/SS Execs and officers, people closer to the members than the central staff. Many DBs/SSs would be less than happy if not involved. Some of us have been pushing for increased Board and governance contact with staff projects. Lack of such led, for one example, to the problem almost two years ago when APA staff launched a central referral service with Lilly support. Some of us got governance involved and got management then to go to the DBs/SSs where they were told that would not be feasible and would involve in many cases conflict with similar DB/SS activities, and where many members expressed concerns about Lilly’s involvement (this was shortly after the AMA Sunbeam incident). The project was dropped, but management could have done that before launching it.

APA is a membership organization and differs not only from for-profits but also non-membership non-profits. The Boards are different. Theirs are composed of people chosen for their financial and corporate expertise and to bring in money. Ours is elected by and accountable to the members. It is for that reason that it should be in close contact with staff projects so as to answer members’ questions and guard their interests.

A few of us developed a small Work Group of members expert from the components to work closely with the Information Service, et al. items coming to the Board and give information to the Board on such matters as our database,

OBITUARY

Thioridazine

Thioridazine succumbed after a long illness on July 7, 2000, joining serendipite in the QTC graveyard. As announced in a “Dear Doctor or Pharmacist” letter from Novartis Pharmaceuticals Corporation, a boxed warning has been added about the danger of arrhythmias and sudden death.

Thioridazine is now indicated only for schizophrenic patients who fail to show an acceptable response to adequate courses of treatment with other antipsychotic drugs. Thioridazine is now contraindicated with certain other drugs, including fluoxetine, propranolol, pindolol, any tricyclic antidepressant (PSS) 2D6, and other agents known to prolong QTc. Baseline ECG and serum potassium is now recommended.

Patients currently receiving thioridazine need to be informed of these risks, and switching to another antipsychotic ought to be considered.

Recently, thioridazine, also known as Mellaril, enjoyed a reputation of being a low potency antipsychotic. Although not available by injection, it was popular as both a pill and a liquid, for a diverse group of patients. Both adults and children were recipients.

Reports of retinitis pigmentosa capped the maximum dose at 800 mg./day in an era of high-dose neuroleptic treatment. Recently there had been more talk about the atypical properties of thioridazine, making it more attractive.

Thioridazine is survived by an array of other antipsychotics, new and old.
Project for Psychiatric Outreach to the Homeless

An Interview with Katherine Falk, M.D.

By Martha Crowner, M.D.

Q: How and when did the Project for Psychiatric Outreach to the Homeless start?

A: I got enraged. In the Fall of 1985, I called the police about two homeless men who obviously needed to be taken to a hospital. The first was sitting on the sidewalk on East 66th Street and Lexington Avenue wearing only an undershirt and The New York Times. When I called the police, saying that there was a half-naked man who was ill and needed to be taken to a hospital, I was asked if he was naked from the waist up or the waist down. PS. The police did nothing. Two weeks later I called them again about a different man who clearly needed help. Again, the police did not take anyone to a psych ER. There was a half-naked man who was ill and needed to be taken to a hospital, and then, within a few days, they too much time spent waiting in the ER, and then, within a few days, they were back on the street in exactly the same condition, on exactly the same corner.

So I made some phone calls. I wanted to know: If the homeless mentally ill were not taken to hospi- tals, where did they go and who took care of them? I learned that there were many community agencies in many neighborhoods that were mandated to work with them. And there were mental health teams. But none were funded to include psychiatrists. The only route to psychiatric care was through ERs or clinics. Astoundingly, social workers were expected to work with seriously ill patients without the benefit of psychiatric intervention.

The homeless situation was visibly much worse in 1985 than it is today. I had already decided I wanted to do something, when it occurred to me that as a psychiatrist I was trained to treat these individuals. I realized I was uniquely qualified to help these people, not just ladle soup in a shelter kitchen and I felt obligated to act.

I initially organized the program through the New York County District Branch in the Fall of 1985. I asked Len Harris, who was then Director of Public Relations for The New York Times, to write the letter asking for psychiatrists to volunteer. This letter was sent to every member of the NYCoDB in the spring of 1986, and the program was up and running by June.

We started with three agencies and seven psychiatrists. Project Reachout did all the outreach to homeless mentally ill adults on the Upper West Side and all of Central Park. The Neighborhood Coalition for Shelter had a permanent residence for formerly homeless, mentally ill adults on East 81st Street, and the Center for Urban Community Services (CUCS) had a drop-in center on West 115th Street. In the early years, it was an all-volunteer effort — psychiatrists gave a few hours each week at an agency where they provided psychiatric services.

Q: Were you working in the public sector?

A: No, at the time I was exclusively in private practice on the Upper East Side of Manhattan.

Q: How has PPOH grown in interven- ing years?

A: In 1991 we incorporated as a not-for-profit organization, separate from the APA. In 1993 we received a grant from the Robin Hood Foundation to train residents. An important part of our program now is the Clinical Elective Program (CEP) through which we offer clinical electives to residents from nine hospital training programs in the city. Each semester we have from 20 to 30 residents with us. We also provide training for a Fellow in Public Psychiatry from the New York State Psychiatric Institute and a Fellow in Psychotherapy from Mount Sinai.

Recently, we have received several large grants which have allowed us to hire psychiatrists who can commit to at least eight to ten hours a week. We annually see more than 1,500 individuals — men, women and children. We have 45 psychiatrists who provide evaluations, diagnosis, and ongoing treatment at 27 sites.

Q: Does PPOH serve people living on the street and in shelters?

A: We see individuals at all levels of homelessness. For those who are still living on the streets or in the parks, we see them in outreach programs, soup kitchens and drop-in centers. We also treat people in shelters and continue to see them after they find homes in permanent supportive housing. We believe that they need life-long treatment and that treat- ment needs to be provided onsite in order to stop the revolving door of homelessness. In addition to pro- grams for adults, we also provide psychiatric services in a variety of specialty programs: a shelter for battered women; family shelters for women and their kids; a drop-in center for runaway teenagers; a drop-in center for gay, lesbian, and transgendered teenagers and young adults; and programs specifically for the elderly.

Q: What services does your project provide?

A: We work with agencies that provide all services on site. We call it “one-stop shopping” — this includes case management, medication manage- ment, and referral to housing as well as medical and psychiatric services. We collaborate with case workers and agency staff because we need each other and none of us can do the job alone.

We've found it makes a huge difference to have a psychiatrist on site. Psychiatrists can run groups, prescribe medication, and also see patients in individual psychotherapy. Follow-up is possible because the clients have developed relationships with their case workers and the agency. We support the agencies in other ways, too. We help coordinate services and think through difficult problems; we often help arrange involuntary transport to a hospital. Additionally, we provide staff education, in-service training, and we support them. When the services are available on site, the client is able to make use of them and the end result is—they get better.

Q: Why is there a need for your project? It seems obvious that psychia- trists are needed.

A: Psychiatry had virtually abandoned these individuals. Some psychiatrists I talked to thought the homeless just needed more social workers. They do need social workers, but that's not enough. As psychiatrists, we have a unique contribution to make. Here's a concrete example. There was an elderly woman living on the steps of a settlement house for months, prob- ably for years, winter and summer. She had been a nurse. Of course, the settlement house staff tried to get her to come indoors but without luck. They saw her condition deteriorate over the years, and finally they called us desperate for help. We sent them a psychiatrist. He saw her twice, and she came inside.

Q: What do psychiatrists have that is unique?

A: That's hard to say. Our training as psychiatrists is unique. We learn to form a trusting relationship quickly with patients. And it is the relation- ship that allows everything else to happen.

Q: What has changed in the last 10 years?

A: Patients have more and better services available. Many people can get housed because their mental illness has been stabilized and there has been more permanent housing made available. Unfortunately, much of that permanent housing has been filled. Today we need more units of perma- nent supportive housing with all services available on site.

Q: What else do you need?

A: We need more psychiatrists willing to work with this population and more funding for all kinds of services.

Q: How can readers volunteer?

A: Call Cathy Treber at 212-578-2650. We ask psychiatrists for a minimum commitment of two hours per week. This is very gratifying work. We can tailor the placement to psychiatrist interests in an area of New York that is close to their office or home.
Denial of Service
Continued from page 1

increasingly impatient with Angela’s slow progress. As is the common practice these days, they requested “Doc to Doc” phone conferences with a reviewer employed by the managed care company. After the second such review I received a notice from the unit social worker that the insurance had been denied. As is the usual social worker’s practice, a letter was prepared for me to present to the patient to continue in a shelter. However, demanding that the patient was not ready for discharge, I requested an “expedited” appeal. I was informed that the case would be reviewed by a second physician, also employed by the managed care company and wanted for her to contact me. She never did. Twenty-four hours later, I was told that the second physician had denied care. I even though I was not required to discharge the patient, no further treatment would be authorized. Reviewers were then informed of the denial of care beginning June 20, and the completion of the external appeal application, the patient had been informed of a denial except by the telephone contact with the social worker. However, in the face of a mandated external appeal, a letter was hurriedly put together by the company, backdated to June 20 and faxed to my office and to the state on June 23. The state employee coordinating this appeal was courteous, helpful, and provided a great deal of assistance in putting together the appeal package. An emergency appeal was inappropriate, as the patient was still in hospital, and continued treatment was urgently required.

On June 29 I received a letter by fax informing me of the result of the external appeal. The letter informed me that the case had been reviewed, that the determination was binding on the health plan and enrolled and sent me a copy of their determination which said “Approved health plan denial of coverage overruled, health plan must pay for the proposed treatment.” The reviewer gave reasons supporting his approval of treatment the following: “Given her current diagnosis of depression and suicide (with recent plan and intent), history of trauma, the chaos of her home environment, the lack of adequate social support, and the absence of a consistent therapeutic relationship, she continues to be at high risk for suicide without further treatment,” adding “she is clearly improved to the point where a discharge to an unstable environment (or possibly to a shelter) is addressed.” A two-page opinion was attached, with two references. The reviewer observed “the patient has a history of major depression complicated by her history of childhood physical and sexual abuse. It is likely that the chronicity of her depression, recurrent suicidal behaviors, poor and abusive interpersonal relationships, and medication non-compliance all have roots in these traumatic experiences.” He gave weight to my comments, notes, and my accompanying letter, adding “as her psychiatrist suggests, recent medications need at least to be consolidated before discharge.” Thus, the external reviewer’s statement that the patient “does subject to demonstrate an imminent risk to self” is not consistent with clinical data, psychiatric opinion, and what mainstream psychiatric literature would assess as high suicide risk.”

The report gave a brief summary of the qualifications of the reviewer, who was well qualified for this role. In addition to a small private practice, he is an assistant professor of psychiatry, teaches medical students, residents, and geriatric fellows and conducts research. He described himself as having authored nearly 30 publications and described yet additional qualifications. It was gratifying that such a well-qualified reviewer agreed with my treatment in every regard and that the New York law granted access to a balanced, informed review.

NYS Experience
In New York state a regulation was promulgated on June 18, 1999 providing for external review of adverse determinations of healthcare plans. This provides for an independent review of adverse decisions of insurance companies and funds supporting the patient. Angela agreed that she needed additional care and I instructed the hospital social worker to prepare an expedited appeal. The appeal documents were completed and faxed to the New York State Insurance Department.

As I was aware that the information which would be made available to the independent reviewer by the insurance company was biased and incompleteness, I composed a letter summarizing Angela’s treatment, attaching a copy of the admitting history and physical examination and all medical progress notes for the admission. These were forwarded by New York State to their external appeal agent, “Medical Care Manage- ment Corporation,” a Maryland company.

New York state law requires that patients be informed of care denial within 24 hours. Between June 19 when we were informed of the denial of care beginning June 20, and the completion of the external appeal application, the patient had been informed of a denial except by the telephone contact with the social worker. However, in the face of a mandated external appeal, a letter was hurriedly put together by the company, backdated to June 20 and faxed to my office and to the state on June 23. The state employee coordinating this appeal was courteous, helpful, and provided a great deal of assistance in putting together the appeal package. An emergency appeal was inappropriate, as the patient was still in hospital, and continued treatment was urgently required.

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NYS Experience
On Monday, July 31, 2000 The New York Times devoted a small paragraph to a report of the first year of the external appeals program. Three hundred, thirty-one denials were overturned and treatment decisions the organizations were upheld. The state Insurance Commissioner was quoted as saying, "The external appeals law established a prompt, consistent and fair process with treatment decisions [See Denial of Service on page 8]
The New York State Legislature finished its “Regular Session” on June 14, returned for a special one-day session the following week, then headed for the campaign trail. The Senate and Assembly managed to produce a timely state budget this year, as well as a modest array of headline worthy bills which the Governor has signed into law. These include:

- Comprehensive legislation to combat gun violence;
- Legislation to promote safer and more effective learning environments within New York’s schools;
- Sexual assault reform legislation;
- Zero tolerance for hate crimes legislation.

The Senate and Assembly also passed — during the closing hours of the session — a physician profiling bill that, while still objectionable from the perspective of organized medicine, is a far less onerous measure than what was originally proposed. As of this writing, the Governor has not taken a position on the bill. As for Democrats, the issue was sentiment over the Speaker of the Assembly’s inaccessibility to rank and file Assembly Democrats. This unhappiness escalated into a full scale but unsuccessful coup attempt replete with reprimals that shuffled the Assembly leadership deck just when the Lower House was finishing its work for the year.

Fighting for Psychiatry

NYSPA’s legislative priorities for this year centered on the continuing issues of insurance parity for mental illness, the Executive Budget, and scope of practice legislation for mental health practitioners. In addition, NYSPA:

- worked closely with the State Medical Society and other medical specialty organizations on the physician profiling issue;
- fought to defeat two Senate billscalling psychotropic medication a major cause of school violence and adult crimes;
- worked to secure legislative approval of the Governor’s budget proposal for $125 million in new money for the implementation of "Kendra’s Law" and other initiatives to serve the SPMI population; and,
- expressed support for letting the Mental Health Special Needs Plan law expire on the basis that the objectives of the statute have been realized through other initiatives.

Parity for Mental Illness

The widely supported campaign to end New York State’s longstanding authority to limit or exclude health insurance benefits for mental illness once again failed to pass in the Senate despite being sponsored by twenty-three of thirty-six Senate Republican majority members. As we reported in the Bulletin and elsewhere earlier this year, the State Assembly unanimously passed a broad based mental health insurance parity bill (MHIP) last January — just three weeks into the 2000 Legislative Session. While the Assembly has passed a MHIP three years in a row, the Senate has managed only once (in 1999) to advance a MHIP of their own beyond the Senate Insurance Committee.

Those who follow the issue in New York know the Senate and Assembly have different MHIP proposals. Both the Senate and Assembly bills would ban the practice of limiting benefits for mental illness where such limitations are not applied to other illnesses in a given plan. Neither bill compels a health plan to continue or initiate coverage for mental illness. Both bills apply only to group policies and plans. Neither the Senate nor the Assembly bill affects ERISA exempt, Worker’s Compensation, or individual-direct-pay plans.

The Assembly bill affects indemnity plans, “blanket” plans, (like those purchased by colleges for their students), and HMO plans. The Senate bill, on the other hand, applies only to managed care plans — HMOs and managed mental health carveouts in HMOs or indemnity plans. There are other differences of a technical nature between the two bills that we expect will be reconciled in future bill prints.

Given the feedback from legislators and others about how far the parity campaign had progressed in 1999, it was reckoned 2000 would be the year the Legislature sent a MHIP bill to the Governor. But it wasn’t to be. And while we will analyze and speculate about the outcome and what we might do differently next year, the fact remains, that for all the strength in the arguments and tactics promoting a parity legislation in the New York State Senate, the stakeholders on the opposite side of the issue continue to prevail.

Scope of Practice Legislation

If you substitute the phrase “scope of practice” for the word “parity” in the preceding sentence and include the State Assembly in the mix you might well be reading a proponent’s perspective on the outcome of the mental health professions bill this year. Psychiatry, for its part, did prevail again on the licensing issue.

As with the parity issue, the year began with optimism about reaching an accord on a mental health professions bill, one responsive to concerns of psychiatry. Some progress was made with the yet-to-be-licensed mental health practitioners. These groups agreed to the concept (but not the bill language) proposed by NYSPA, that certain prevailing conditions would trigger a required consultation between the non-physician therapist and a physician. However, the concept of requiring a consultation with a physician, under any circumstances, was totally unacceptable to the psychologists and the social workers.

Other important but less fundamental concerns raised by NYSPA this year were met with mixed responses from the proponent groups. The psychologists, for example, objected to all but cosmetic changes to their section of the bill. They argued that psychiatry’s issues were either irrelevant or should be handled in separate legislation. The social workers expressed roughly the same sentiments. On the other hand, the marriage and family therapists, as well as the other as yet unlicensed professions named in the bill, continued to pursue a compromise reflective of NYSPA’s concerns.

For those who might be new to this issue, we want to acknowledge and stress the importance of the partnership between NYSPA and the Medical Society of the State of New York (MSSNY) on this subject. We have been joined at the hip throughout this long and arduous affair. In addition, we gratefully acknowledge the generous financial support of the APA that enabled us to continue the invaluable services of our special advisors Philip Pinsky, Esq. and Andrew Roffe, Esq. Also, there are other organizations voicing strong opposition to the bill as written. The National Association of Black Social Workers has vigorously opposed those sections of the bill dealing with the licensing of social workers, especially the creation of a subspecialty license in “clinical social work.” The Hospital Association of the State of New York has written in opposition to the bill, as well.

At the end of the Legislative Session this year, both the Senate and Assembly determined the bill needed more work and it was held in committee in both Houses. We anticipate a continued struggle on this issue in the upcoming 2001 Session.

Guns and Medicine

The tragedy at Columbine High School and the rash of similar incidents in other parts of the nation spurred New York lawmakers this year to act on legislation combating gun violence and promoting school safety. Legislation on the issues emerged from every quarter of the lawmaking process. The Governor had a package of bills, as did the legislative bodies in the Senate and Assembly.

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(All of NY State except NYC and Long Island)

(Studies, Research Grants for Abstracts, Manuscripts, etc)
Continuity of Care for the Mentally Ill in Jail

By Howard Owens, M.D.

On July 12, Manhattan Supreme Court Justice Richard F. Braun issued a temporary injunction that requires the City of New York to provide discharge planning for all jail inmates who receive significant mental health care while incarcerated in City jails. Current practice has been that the City does not provide any discharge plans or continuity of care for most of the mentally ill inmates released from the jails. This court decision has immediate significance for general psychiatrists practicing in the New York City area, because many of the released jail inmates are in fact the same people who at other times show up in emergency rooms, outpatient clinics, drug treatment programs, and inpatient services in general hospitals.

Because of the movement in recent years to close down state psychiatric inpatient wards, the jails have increasingly become the asylums of last resort for the seriously and persistently mentally ill. In the past psychiatrists and mental health advocates were concerned about the "revolving door" between the mental hospital and the community. Ironically, we now face a new "revolving door," with seriously mentally ill people going from jail back to the community and then to jail again with episodes of treatment in the jail but with no arrangement for follow-up care outside. Patients who may have limited insight or motivation then face an insurmountable task in arranging for the resumption of their outpatient treatment. Patients who have been treated for weeks with antipsychotic medication are routinely released from jail with no supply of medication and face a forty-five day waiting period to have Medicaid benefits reinstated. Even a patient who is motivated to get back into treatment may decompensate before he or she ever gets medication. While continuity of care is supposed to be the watchword of modern psychiatry, the gap between the jail and community treatment is a glaring exception to this principle.

In issuing his injunction, Justice Braun concluded that there was a potential for immediate harm to inmates if the City did not begin to provide discharge planning. He also found that the New York State Legislature intended in its Mental Hygiene Law to protect the mental health of all the people of the state, including mentally ill inmates. He further suggested that discharge planning could begin as soon as any significant treatment begins and would not have to wait until the inmate's criminal case is concluded. (The court defined "significant treatment" as anything more than one or two sessions of treatment.)

This is not the end of the story, because the City of New York is apparently considering an appeal of the injunction, and the court has not yet (as of this writing) issued an order that specifies the exact services that must be provided to released mentally ill inmates. If Justice Braun's decision does survive an appeal, however, it will have significant implications for continuity of care for one of the most under-served populations of the mentally ill in New York.

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leaders of both political parties in both Houses.

Among the items to surface as part of the Senate Majority’s gun violence and school safety initiatives, were two bills introduced by Senator Owen Johnson (R- Nassau). One bill called for the establishment of an advisory council to study the effects of psychotropic medications on children and adolescents, with an emphasis on revealing the relationship between using such medications and tendencies toward committing violence or suicide. The other bill would have required the police to report to a central criminal justice registry any crime or suicide committed by a person taking psychotropic medication.

Rarely have we seen legislation with such an anti-psychiatric bias. The advisory committee bill was written in such a way as to drive the study results in a single direction unfavorable to using psychotropic medications to treat children.

Working closely with the Greater Long Island Psychiatric Society (GLIPS), and with informational assistance from APA’s Division of Government Relations, NYSPA was able to suppress the advisory council bill in the Senate but not the reporting requirement bill. The latter bill reached the Senate floor and was passed there on the last night of the Legislative Session. We are pleased to note that our usual champions within the Senate Majority voted against the bill in that House. There was no interest in the bill in the Assembly and it died in committee there.

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being made because they are smart medical choices and not simply sound financial decisions.”

My experience in this case would substantiate the commissioner’s conclusions.

I would urge all of you to appeal all denials of care on behalf of patients who require care which exceeds the insurance companies “standards” but which are required by good clinical judgment.

Information regarding the appeals process can be obtained on the NYSPA web site, www.nyspsych.org. A memorandum on external appeals written by Nancy A. Hampton, Esq., of the NYSPA central office summarizes the law and the process for appeal and gives the phone number (1-800-332-2729) of the New York State Insurance Department. This memorandum is available from the NYSPA central office for those who do not have access to the web site. Ms. Hampton would be happy to assist members in understanding the appeals process and completing the appeal.

One additional caveat: the entire process is dependent on the patient’s requesting the appeal. Therefore, where a patient’s care is managed by a carve out company, it would be wise to obtain a signed request for an appeal from a patient at the beginning of treatment in order to facilitate the appeal, especially since non-emergent appeals may be instituted well after a patient is discharged (and possibly lost to contact).