President's Message

ECT Under Attack - NYSPA Responds

by Jeffery Smith, M.D., Area II PA Committee Chair

Over the past several months, public attention has been drawn to the issue of the administration of electroconvulsive therapy (ECT) to patients in state psychiatric centers and voluntary hospitals. Newspaper articles have reported on a court case involving an application for a court order authorizing ECT to an involuntary patient at Pilgrim Psychiatric Center. Attorneys for Mental Hygiene Legal Services argued to the judge in this case objected to the administration of ECT on grounds that ECT is a dangerous and unproven treatment. The trial court in this case issued a decision authorizing the provision of ECT, but MHLS has filed an appeal that will be heard by the Appellate Division in June.

At the same time that this court case was moving through the legal system, the NYSPA Assembly Standing Committee on Mental Health, Mental Retardation and Developmental Disabilities held hearings on May 18, 2001, on the subject of ECT. The Notice of Public Hearing stated that “there are differing opinions as to the appropriateness of ECT and, historically, ECT has been used as treatment of last resort.” The hearing notice also asserted that “patient advocates are concerned that the legal safeguards for informed consent to be ‘strengthened’ and that MHLS has reported a 73% increase in applications for court ordered ECT between 1999 and 2000. In response to these challenges, NYSPA has taken the following steps:

- Laura Fochtman, M.D., Associate Professor of Psychiatry and Behavioral Science, SUNY Stony Brook University Hospital and Director of the ECT Therapy Program.
- Mark Goldstein, M.D.,心情 and the DB Representative from the Greater Long Island Psychiatric Society

met with Martin Luster, Chair of the Assembly Committee holding the hearings, and his staff, to provide [See President's Message on page 3]

New NYS Medicare Carrier Policy on Mental Health Services

by Seth Stein, Esq.

MEDICARE carriers in New York State have published a new policy for mental health services effective May 30, 2001, that applies to all Medicare carriers. The new policy is available on the NYSPA website and Medicare carrier websites. This policy is the result of an extended process that began when the final draft was released in March, 2000 by Empire Blue Cross Blue Shield acting on behalf of the three New York State Medicare carriers. For the past year NYSPA representatives to the Medicare Carriers Advisory Committee, Edward Gordon, M.D., as Representative, Mark Russakoff, M.D., as Deputy Representative, and Seth P. Stein, Esq., NYSPA Executive Director, have analyzed and commented on successive drafts of the policy to insure that the final policy is consistent with general accepted psychiatric practice. In addition, they arranged a meeting attended by HCFA and representatives of both the carrier and the APA as well as by the NYSPA Medicare team.

The policy establishes new requirements for documentation of the initial diagnostic interview (98081), psychotherapy and pharmacotherapy (90862), new coverage definitions for psychiatric services and new standards of medical necessity that will be applied by all the Medicare carriers in their review of Mental Health claims.

The most important issue raised by NYSPA concerned whether medicalization monitoring is included among the medical evaluation and management services that entitle a psychiatrist providing psychotherapy to bill for psychotherapy and psychological evaluation and management services. Under

[See NYSPA Advocacy on page 8]

The Other Side of Parenting

by Roxanne Lanquetot, MA, MS.

Ms Lanquetot worked at Bellevue's Public School 106, serving the educational needs of the children hospitalized on the in-patient psychiatric units. Two years ago she retired after more than a quarter-century of service in order to devote herself to writing. In conjunction with the Nursing Service, Ms Lanquetot has led support groups for the extended families of the hospitalized children. She understands families of the mentally ill and can identify with them, not only because of her own personal experience, but also because she has become involved in schizophrenia research, where the deficit of the family’s failure to appear in court is paid for by their silence, not only because of the stigma attached to mental illness in the state. The policy establishes new requirements for documentation of the initial diagnostic interview (98081), psychotherapy and pharmacotherapy (90862), new coverage definitions for psychiatric services and new standards of medical necessity that will be applied by all the Medicare carriers in their review of Mental Health claims.

The most important issue raised by NYSPA concerned whether medicalization monitoring is included among the medical evaluation and management services that entitle a psychiatrist providing psychotherapy to bill for psychotherapy and psychological evaluation and management services. Under

[See NYSPA Advocacy on page 8]

New NYS Medicare Carrier Policy on Mental Health Services

by Seth Stein, Esq.

MEDICARE carriers in New York State have published a new policy for mental health services effective May 30, 2001, that applies to all Medicare carriers. The new policy is available on the NYSPA website and Medicare carrier websites. This policy is the result of an extended process that began when the final draft was released in March, 2000 by Empire Blue Cross Blue Shield acting on behalf of the three New York State Medicare carriers. For the past year NYSPA representatives to the Medicare Carriers Advisory Committee, Edward Gordon, M.D., as Representative, Mark Russakoff, M.D., as Deputy Representative, and Seth P. Stein, Esq., NYSPA Executive Director, have analyzed and commented on successive drafts of the policy to insure that the final policy is consistent with general accepted psychiatric practice. In addition, they arranged a meeting attended by HCFA and representatives of both the carrier and the APA as well as by the NYSPA Medicare team.

The policy establishes new requirements for documentation of the initial diagnostic interview (98081), psychotherapy and pharmacotherapy (90862), new coverage definitions for psychiatric services and new standards of medical necessity that will be applied by all the Medicare carriers in their review of Mental Health claims.

The most important issue raised by NYSPA concerned whether medicalization monitoring is included among the medical evaluation and management services that entitle a psychiatrist providing psychotherapy to bill for psychotherapy and psychological evaluation and management services. Under

[See NYSPA Advocacy on page 8]

Why didn't they come to court to offer support for their sons? During the Goldstein trial, it was alleged that Andrew Goldstein's parents were cold and uncaring since they did not attend the trial. Jurors agreed that the failure of the family to appear in court hurt the case since their absence was interpreted as support for his conviction. Nothing was said about the Perez family. Had they given up, or did they not understand English well enough to follow the proceedings? Everyone has been blamed for the violent acts of the mentally ill: patients, the state, the mental health system, providers, and parents for "bad" parenting of the children. It is unfair to hold parents responsible for an illness due to a biological brain disorder, as yet another completely understandable phenomenon. They are as apprently by these violent acts as the general public, but they do not necessarily reject the children because of their illnesses. As the mother of a schizophrenic son, I know from personal experience that the feelings and emotions of parents of schizophrenics are almost as complex as the diagnosis, treatment, and origins of the illness itself. The fact that Andrew Goldstein's parents did

[See PARENTING on page 8]
From the Editor's Desk...

Shall We "Deep Six" The Bulletin?

I’m the printed Bulletin obsolete? Will eliminating it be a mercy killing or murder? Call me today at 845 398-5595 or e-mail <citrome@nki.rfmh.org> and voice your opinion. The results of this informal opinion poll will be reported in the next issue.

The Bulletin has a long tradition of reporting back to NYSPA members news and events that would have a state-wide appeal. It continues to serve as a reminder that there is a state-wide organization that actively lobbies on the state level for our concerns. It also serves as a forum that has the potential reach of all 5,000 NYSPA members. Funding of the Bulletin comes from a combination of NYSPA dues (56%) and advertising revenues (34%). On a per-member per-issue basis, the Bulletin costs about $1 of dues revenue. Advertising revenues are cyclical, and past performance is no guarantee for future returns.

Ten years ago, the Bulletin was the only practical mechanism to get NYSPA news to as many of its members. Today, the internet has emerged as a reliable and relatively easy method of communication. With the proliferation of office and home computers connected to the internet (and their presence in almost every public library), we can reach 100% of the NYSPA membership. The only obstacle to making the printed Bulletin come passively in your mail box, and the NYSPA website must be actively accessed. The latter requires some effort, especially if you have to go to the library. An alternative is to continue to maintain an up-to-date website, and issue on an annual basis a printed report from NYSPA. The latter can be in an easy-to-read newsletter format that would give a clear and concise summary of the year’s activities. It can include advertising to defray the cost of publication. This report can be distributed at the same time as the Medicare Fee listings that we have grown accustomed to receiving each year.

The web-site would replace the printed newsletter for the functions of president reports, legislative issues, trustee reports, letters from members, news from the district branches, and general interest articles. Time-measurable information would be communicated directly to the district branches by mail or fax as being done currently. There is rarely need for a big print run for the entire membership (at a cost that approaches that of one issue of the printed Bulletin). Of course, NYSPA members who receive Psychiatric News, the national APA newspaper.

At the last Area Council Meeting held on March 24th at the LaGuardia Marriott I asked your DB representatives for their advice. All spoke favorably about the Bulletin, and suggestions were made to continue producing a printed version. The idea of having an “Annual Report” in the Fall issue was promoted, giving members feedback as to what the NYSPA Committees are doing.

Let’s now hear from you about the Bulletin’s future. As they say in Florida, every vote counts!

Shall We “Deep Six” The Bulletin? Call or Email Today, and Vote Yea or Nay!

Letters to the Editor are welcomed but must be sent electronically. Send your submissions to:

Leslie Citrome, M.D., M.P.H.
e-mail: citrome@nki.rfmh.org

Seth Stein, Esq.

Executive Committee 2000-2001

James Nimeringer, M.D., President
Barry Pearlman, M.D., Vice President
C. Deborah Cross, M.D., Secretary
Howard Telson, M.D., Treasurer
Ann Sullivan, M.D., Area & Trustee
Jeffery Smith, M.D.
Howard Owens, M.D.

Howard Owens, M.D.

Thomas E. Gift, M.D.

Seth Stein, Esq.

Ann Sullivan, M.D.

Jeffery Smith, M.D.

Howard Telson, M.D.

Executive Committee 2000-2001

James Nimeringer, M.D., President
Barry Pearlman, M.D., Vice President
C. Deborah Cross, M.D., Secretary
Howard Telson, M.D., Treasurer
Ann Sullivan, M.D., Area & Trustee
Jeffery Smith, M.D.
Howard Owens, M.D.

Howard Owens, M.D.

Thomas E. Gift, M.D.

Seth Stein, Esq.

Ann Sullivan, M.D.

Jeffery Smith, M.D.

Howard Telson, M.D.

Executive Committee 2000-2001

James Nimeringer, M.D., President
Barry Pearlman, M.D., Vice President
C. Deborah Cross, M.D., Secretary
Howard Telson, M.D., Treasurer
Ann Sullivan, M.D., Area & Trustee
Jeffery Smith, M.D.
Howard Owens, M.D.

Howard Owens, M.D.

Thomas E. Gift, M.D.

Seth Stein, Esq.

Ann Sullivan, M.D.

Jeffery Smith, M.D.

Howard Telson, M.D.

Executive Committee 2000-2001

James Nimeringer, M.D., President
Barry Pearlman, M.D., Vice President
C. Deborah Cross, M.D., Secretary
Howard Telson, M.D., Treasurer
Ann Sullivan, M.D., Area & Trustee
Jeffery Smith, M.D.
Howard Owens, M.D.

Howard Owens, M.D.

Thomas E. Gift, M.D.

Seth Stein, Esq.

Ann Sullivan, M.D.

Jeffery Smith, M.D.

Howard Telson, M.D.

Executive Committee 2000-2001

James Nimeringer, M.D., President
Barry Pearlman, M.D., Vice President
C. Deborah Cross, M.D., Secretary
Howard Telson, M.D., Treasurer
Ann Sullivan, M.D., Area & Trustee
Jeffery Smith, M.D.
Howard Owens, M.D.

Howard Owens, M.D.

Thomas E. Gift, M.D.

Seth Stein, Esq.

Ann Sullivan, M.D.

Jeffery Smith, M.D.

Howard Telson, M.D.

Executive Committee 2000-2001

James Nimeringer, M.D., President
Barry Pearlman, M.D., Vice President
C. Deborah Cross, M.D., Secretary
Howard Telson, M.D., Treasurer
Ann Sullivan, M.D., Area & Trustee
Jeffery Smith, M.D.
Howard Owens, M.D.

Howard Owens, M.D.

Thomas E. Gift, M.D.

Seth Stein, Esq.

Ann Sullivan, M.D.

Jeffery Smith, M.D.

Howard Telson, M.D.

Executive Committee 2000-2001

James Nimeringer, M.D., President
Barry Pearlman, M.D., Vice President
C. Deborah Cross, M.D., Secretary
Howard Telson, M.D., Treasurer
Ann Sullivan, M.D., Area & Trustee
Jeffery Smith, M.D.
Howard Owens, M.D.

Howard Owens, M.D.

Thomas E. Gift, M.D.

Seth Stein, Esq.

Ann Sullivan, M.D.

Jeffery Smith, M.D.

Howard Telson, M.D.

Executive Committee 2000-2001

James Nimeringer, M.D., President
Barry Pearlman, M.D., Vice President
C. Deborah Cross, M.D., Secretary
Howard Telson, M.D., Treasurer
Ann Sullivan, M.D., Area & Trustee
Jeffery Smith, M.D.
Howard Owens, M.D.

Howard Owens, M.D.

Thomas E. Gift, M.D.
The meeting of the Assembly of the New York State Psychiatric Association took place May 4 through 6, 2001 in New Orleans, Louisiana.

Not all APA members are aware of the existence of the Assembly, one of the key structures of the American Psychiatric Association. The Assembly provides a site for the discussion and action on issues emanating from the membership of the district branches and specifically identified groups of the Association. Members are represented by Area Representatives and Deputies (in our case the New York State Psychiatric Association President and Vice-President), District Branch Representatives and Deputies, Minority Representatives and Deputies, Members-in-Training Representatives and Deputies, Early Career Psychiatrist Representatives and Deputies, and Allied Groups Representatives. Each body elects its own presiding officers (Speaker, Speaker-Elect and Recorder).

The entire Assembly meets two or three times a year, including once in Washington, DC, and right before the May APA Annual Meeting at the Annual Meeting city. The national APA pays travel and expenses for all Assembly members for the November meeting but not for the May meeting, however some District Branches reimburse their representatives for some of their costs.

The meetings themselves take place in large ballrooms filled up with rows and rows of tables. Each DB has a nameplate in front of where they sit.

President’s Message

Continued from page 1

an in-depth review of ECT and the issues of informed consent and incapable patients.

At the May 18th public hearings, testimony was presented on behalf of APA and NYSVA by Dr. Fochtmann and Richard D. Weiner, M.D., Professor of Psychiatry at Duke University Medical Center. Both Dr. Fochtmann and Dr. Weiner met with the editorial board that authored the recently revised edition of The Practice of Electroconvulsive Therapy. The testimony focused on the well established safety and efficacy of ECT in the treatment of depression and other severe psychiatric disorders and also emphasized that current administrative and legal procedures provide more than adequate protection for patients while at the same time insuring access to medically necessary treatment.

Copies of the testimony will be available at the Assembly.

Finally, in response to a request from OMH, the NYSVA Executive Committee has authorized the preparation of an Assembly position issue and a letter to be submitted to the Appellate Division supporting the safety and efficacy of ECT and supporting the current procedures for authoring court ordered ECT. NYSVA will vigorously defend the safety and efficacy of ECT and advocate to insure that patients who need ECT, including patients in state psychiatric centers who may be incapable of giving consent because of severe mental illness, can secure this valuable and effective treatment.

MediComment:

Coding Q & A

By Edward Gordon, M.D.

Q: As a geropsychiatrist I end up doing detailed cognitive exams on my patients. Where and how do I code for this?

A: For the kind of tests you are performing, you can bill for Psychological tests using codes in the groups starting with 96010. Aphasias testing is coded at 96015. The definition is: “Assessment of aphasia includes assessment of expressive and receptive speech and language function; language comprehension, speech production ability, reading, spelling, writing, e.g., by Boston Diagnostic Aphasia Examination” with interpretation and report, per hour.”

There are five psychological testing specialties set of two books, (CPT plus specialities) available to all members on the APA website. This will provide the opportunity to see what exactly the Assembly is doing and how these recommendations are being followed up. Your Assembly Representative can provide you with additional information.

Note: the use of screening tests such as the Mini–Mental Status Exam during a diagnostic assessment or consultation is considered part of the assessment or consultation, and not billed separately.

Q: If someone is in therapy with a psychologist and I do supplementary psychotherapy in addition to medication management, can I charge using code 90805? Is there any problem if the two codes (one for psychotherapy by a psychologist and one by me) are at the same site of service?

A: You can charge for any service you actually provide. If you provide 90805, Individual psychotherapy with medical evaluation and management services, 20 to 30 minutes, by all means charge for that service.

The general Medicare rule in this situation, however, is that the same service may not be provided on the same day by two members of the same specialty for the same diagnosis. Since you are not a psychologist, you may bill Medicare.

However, a question might arise on audit as to whether the patient really has two therapists. You might consider use of the E/M Codes for Office visits, if you are actually doing counseling on the effects of medications, interactions, etc. and not psychotherapy. You should document the amount of time spent in counseling and/or coordination of care and select the code for office visit ([99211-99215] according). Compare the procedure code definitions as well as the fee schedules in selecting which code to use.

If billing is by a clinic, however, or a group practice, the Correct Coding Initiative (CCI) rules may prohibit payment for two services on the same day in the same facility. (This will be the subject of another Medi-Comment.)

CPT codes are listed in CPT, published annually by the AMA, and you can order them by small investment to buy and learn how to use. It will increase your income, and reduce your exposure to audits. CPT 2001 can now be ordered from the AMA at 800 621-8335 or online at «www.ama-assn.org/catalog». Order the Medical Specialties set of two books, (CPT plus the specialty mini book), Catalog # OP054201BDB.

Send questions regarding coding, Medicare, managed care practices and denials, documentation, other problems with managed care, or other practice problems that you have experienced, together with documentation to: MediComment c/o The Bulletin (address on page 2) or by e-mail to NYSPA at centraloffice@nyspsych.org.
Pros and Cons of Medem
by Herb Peyser, M.D.

Medem, the AMA and six specialty societies website, has led some problems but we feel we should move ahead with it. Some thoughts and suggestions follow.

We joined Medem in July 1999, admittedly without full preparation and with some urgency. We had been advised that the mental health content area could possibly have gone to the primary care practitioners or psychologists.

Medem offers high quality health care information on the Internet. Making money was not primary but it had to pay for itself, which requires advertising, which requires member websites to attract advertisers. Although Medem overall has a number of subscriber websites (other medical societies have joined, not as investors but as subscribers), APA contributes only 500 to 600 subscribers and doesn’t attract advertising.

Some APA members feel websites Medem funds have been a failure and Medem and Medem are useful, others don’t. Some point toward better–capitalized competition, already in place. Some point toward better–capitalized outfits to offer member websites patient–physician interaction, appointments, clinical information, billing, claims form submission, prescriptions, refill reminders, etc. Medem came back to the Board last February for review of APA’s license with Medem, to make Medem more commercially attractive.

The problem, several of us felt, was not so much that Medem might not make money, might even lose some, but that Medem, needing capital to keep going, might have to pressure the investing organizations to loosen control and become more commercially attractive.

APA and another specialty society balked. We compelled Medem to work out much better terms, so both societies went along with it. We have a long commitment to Medem and should make every effort here. It might well turn out to be of significant practice management value to our members in addition to its public service value.

**Caveats**

There are potential problems, however. We would not want to be badgering our members in a commercial enterprise. We would be concerned about being in bed with managed care industries (with billing and claims forms arrangements) or with pharmaceutical concerns (with prescription management). We would not want to be engaged in a failing enterprise.

But we should go on with it now, for weighing everything there is value to member websites and solid content and we look forward to getting practice management services (although there is, true, significant competition from well capitalized outfits). And the members may become more interested. We’ll closely monitor Medem’s activities, protecting APA members and property. We have been effective in negotiating with Medem and we’ll continue to be, but I would oppose further investment and loosening of control of our intellectual property.

**Watchdog**

My suggestion is the development of an independent, external finance/business advisory group to help governance and management with APA enterprises such as Medem. That would also help decision–making be in overall accord with APA priorities. There’ll be an Assembly action paper on this, and we should continue pushing for more governance contact with management projects, our information services and technology systems, our membership system, etc.

**Contracts**

The end of the Medical Director’s five–year contract is approaching, and there was review and discussion of Steve Mirin’s performance. There had been interviews with many people at all levels in APA concerning that performance and these were reported. The Board then voted to begin negotiations with him on a new contract, incorporating many of the suggestions.

Nancy Anderson’s five–year contract as Editor of the American Journal of Psychiatry was renewed, and Alan Levenson’s eight–year contract on the Psychiatrists’ Benefit Corporations was extended. However the Board, noting the sale of the professional liability insurance company (reported previously), voted to look into the future of the Corporation for it may no longer be needed. However, APA will continue to monitor closely the insurance company activities and protect the members’ interests.

**NYSPA NOTES:**

At the Spring Area II Council meeting, the Council unanimously approved the recommendation to award Herbert Peyser, M.D. Area II Trustee, the 2001 Warrren W. Illiams award in recognition of his outstanding contributions to psychiatry.

**CONGRATULATIONS!**

**Fellowship**

A few years ago, at the urging of the Early Career Psychiatrists and others, the Membership Committee proposed automatically elevating members to Fellowship after five years of General Membership, having boards, obtaining three letters of recommendations from APA Fellows, and with the agreement of their DBs. This was in line with many other specialty societies. The present Fellows would become Distinguished Fellows, and the elaborate and restrictive former process for creating Fellows would now be shifted toward the appoint ment into the category of Distinguished Fellows.

This had been overwhelmingly approved by the Assembly, the Board, and the members in a referendum, but the referendum had failed because insufficient numbers of members had voted. With the APA corporate restructuring, the Board was able to enact this change in fellowship requirements.

**Info Systems**

The Medical Director will develop and present to the Board a strategic plan for Information Systems, and management will work with some members from governance in an ad hoc workgroup in reviewing and making recommendations to such a plan.

**Advocacy**

The Board approved funds for the California Psychiatric Association for advocacy litigation, and for the Psychiatric Association of New Mexico for public education regarding scope of practice issues.

The Ritalin lawsuit has had a favorable (to APA) decision in California but additional suits in Puerto Rico and Florida are anticipated. Our position is a strong one.

**Additional**

The Board voted a position statement opposing discrimination against IMGs. The Board had voted to fund the DBSS Legislature for the Federal Institute last March. Air miles will be added to the APA Credit Card. APA elections will continue to use online voting as well as paper ballots.
BOOK REVIEW

Schizophrenia and Comorbid Conditions: Diagnosis and Treatment
Reviewed by William M. Greenberg, M.D.

Dr. Greenberg is active in the New Jersey District Branch but has kindly agreed to write this book review for The Bulletin of the New York State Psychiatric Association. Dr. Greenberg is an Attending Psychiatrist at the Clinical Research and Evaluation Facility, a joint venture between the Nathan S. Kline Institute for Psychiatric Research and Rockland Psychiatric Center. The book reviewed below was edited by NYSAPA members and contains several chapters written by NYSAPA members.—Ed.

This is a new volume in the American Psychiatric Press Clinical Psychiatry Series of monographs, evolving from an APA Annual Meeting Symposium conducted several years ago. I had some specific hopes for this modest-sized volume. I hoped that it might serve as a reminder of the great individuality of our patients, a tonic for those tired dark moments when one thinks of the next patient as “another schizophre- nia,” that one needs to somehow get to take his/her medication reliably, rather than someone needing appro- priate biopsychosocial understanding, and with comorbid needs to be addressed. Disillusioned with our current nosology of the psychoses, I had also hoped for support for a dimensional diagnostic approach to psychopathology, rather than the DSM-inspired exclusively categonal handrails. Indeed, persuasive arguments for both of these principles are to be found in this book.

But what of the subtitle? Diagnosis and Treatment. Considering what the authors call the associated syndromes in schizophrenia (depression, obsessive-compulsive symptoms and panic attacks), what could one make of a literature in which samples of patients with schizophrenia are found to have rates of depression of anywhere from 7% to 75%, of obsessive-compulsive symptoms of 1% to 39%, of panic attacks in 6% to 63%? And what of the very few treatment series, often open-label and sometimes just isolated case reports? The authors of this book offer intelligible under- standing of the nosological and epidemiological disparities, and provide concise reviews of the available studies of treatments. The writing is clear, the controversies of the field succinctly summarized by authors who have been seminally involved in the topics (e.g., Sam Siris on depres- sion and schizophrenia). Given the sparse number of small studies and case reports of uneven scientific quality, however, these first few chapters do not provide “how to” approaches for treatment; the clini- cian still has only a few footsteps before him or her, in fairly muddy terrain.

After an introductory chapter critically reviewing limitations in our nosology, and individual chapters devoted to the associated syndromes noted above, subsequent chapters cover medical and surgical illness, pregnancy, cognitive impairment in older individuals, aggression and violence, and substance abuse in patients with schizophrenia. These sections generally succeed very well in what they present, e.g., Leslie Citrome and Jan Volavka efficiently review the epidemiology and treatment of aggression and violence, and Doug Ziedonis and Connie Nickou clearly present the newer, practical models for treating substance-abusing patients with schizophrenia, incorpo- rating motivational enhancement and relapse prevention techniques. For my purposes, though, I would have preferred a somewhat expanded discussion of medical issues. The important problem of individuals with schizophrenia who have poly- dipisia with hyponatremia is ad- dressed only in the chapter on cognitive impairment in older individuals, and it there only receives passing mention in one sentence, without discussion of treatment. Confounding an expectation I had, both for clinical pertinence and considering the vast sums of advertis- ing monies directed towards these issues, antipsychotic medication-induced hyperprolactinemia receives but very brief acknowledgment, and antipsychotic medication-induced weight gain, glucose intolerance and ECG QT prolongation none at all. There are also a few typos: e.g., disulfiram generates its therapeutic action by inhibiting aldehyde dehy- drogenase, not alcohol dehydroge- nase; cigarette smoking induces cytochrome CYP450 1A2, not 1A4.

This is a thoughtfully written, well-referenced and well-edited book, and is rather up-to-date. Tables and illustrative case vignettes are usefully included in most chapters. Not only does this volume serve as a reminder to look at our patients with schizo- phrenia more thoroughly and to think of dimensions of psychopathology, but it also serves as a compact sum- mary of the current state of the field in the areas of comorbidity it addresses. It can be profitably read by both psychiatry residents and by experi- enced clinicians.

LEGISLATIVE UPDATE

Scope of Practice
By Richard Gallo, NYSAPA Legislative Consultant

In late March and early April, several bills concerning licensure and scope of practice of mental health practitioners were introduced in the State Assembly. Once again, the psychologists, social workers, marriage and family therapists, behavioral arts therapists, mental health counselors, and psychoanalysts are asking for new or amended licensing laws with respect to their occupations.

However, this year the manner in which the proponents are approach- ing the issue is different. Instead of one all encompassing “omnibus” bill, they have opted for several “stand alone” bills: two for psychology (A7364 Mager, and A6727 Sanders), one for social work (A5779—A Prettlow), one for marriage and family therapy (A6014 Christensen), and one for behavioral arts therapy, mental health counseling, psychoanalysis, and marriage and family therapy (A6726 Sanders).

As for the bills themselves, the psychology proposals (A7364 and A6727) are not what we would have expected. They are brief, bare bone additions to the profession’s existing “title” licensure law and as such are probably not finished products.

A6726, in relation to the four want- to-be licensed professions, is a spin off from the related text of last year’s omnibus bill. In fairness to its au- thors, the new bill is an earnest attempt to address many of the concerns raised by NYSAPA and the State Medical Society over the past two years. How- ever, the bill still seeks to create a separate profession of psychoanalysis, opposed by NYSAPA, and lacks adequate specificity with respect to other areas of concern.

The social workers bill (A5779—A) is a three-tiered career ladder for clinical practice. The “A” suffix to the bill number connotes amendments to the original made on March 29. The amended version is very different from the original. While we have seen in previous bills most of the words and concepts that appear in the current version, they have never been woven together quite the way they are now. Perhaps upon a thorough analysis of the new bill, it will appear to be less of a quest for the brass ring than it does at the moment.

With regard to the stand alone bill on marriage and family therapy (A6014), this bill has been around for many years and is considered subordi- nate to the broader mental health practitioners’ bill (A7364).

Now that the licensing proposals have surfaced and we have confirmed what it is we are dealing with this year, the lobbying/negotiation process has resumed. Additional information on each of the bills will be forthcoming, probably with a request for some form of grassroots action.

Eli Lilly ad
Contribute to the PAC!

T he New York State Psychiatric Political Action Committee (PAC) is asking for your financial support. 2000 was the PAC’s most successful year. Over $28,000 was raised and contributions were received from 375 psychiatrists—a 75% increase over 1999—but still less than 10% of the NYSPA membership. However, during the upcoming legislative session, this year will again be filled by efforts from non–physician mental health professionals to enunciate upon the scope of practice of psychiatry.

A recent version of the Mental Health Professionals Bill would have created a scope of practice for psychologists and social workers, as well as create four new mental health professions—mental health counselors, marriage and family counselors, crisis intervention, and psychiatric nurse practitioners. Analysis—and establish a scope of practice for each of these practitioners that includes the treatment of mental disorders without any medical evaluation or consultation.

Your representatives in Albany worked literally night and day to get our legislation across the legislature—these mental health professions should not have an unrestricted and unlimited scope of practice; the creation of a scope of practice for each of these practitioners that includes the treatment of mental disorders without any medical evaluation or consultation. Your representatives in Albany worked literally night and day to get our legislation across the legislature—these mental health professions should not have an unrestricted and unlimited scope of practice; the creation of a scope of practice for each of these practitioners that includes the treatment of mental disorders without any medical evaluation or consultation.

Your representatives in Albany worked literally night and day to get our legislation across the legislature—these mental health professions should not have an unrestricted and unlimited scope of practice; the creation of a scope of practice for each of these practitioners that includes the treatment of mental disorders without any medical evaluation or consultation.

The Bulletin is the 2000 contributors list for your review. If your name is not on the list, please make a donation today. If you contributed last year, please be sure to join again this year and contact your colleagues and ask them to join. The PAC needs your help now!
Discharges From State Hospitals: An Interview with Rhoda Cataldo, CSW

by Martha Crowner, M.D.

Here is another interview in an ongoing series by Martha Crowner, M.D. Dr. Crowner is on the medical staff of Manhattan Psychiatric Center, one of the approximately 20 psychiatric hospitals operated by the New York State Office of Mental Health. Rhoda Cataldo, CSW, is the Discharge Coordinator for the discharge team at Manhattan Psychiatric Center. Discharge Coordinators have had a pivotal role for several years now. From over 20,000 beds in 1987, the census is currently approximately 4,500 for the adult facilities. There has been much criticism in the popular press about public safety regarding this new wave of deinstitutionalization. What follows is a description of the planning process and programs of place to ease the transition of patients as they leave in-patient care. Comments are welcome and, space permitting, will be published as letters to the editor. This interview took place in March 2001.

How long have you been working for the State?

Thirty years. Twenty-five years in mental health. I started as a secretary, then went back to school and got my masters as a social worker. Because of my record for successfully placing clients into the community, I became discharge coordinator for several state hospitals; I was called in to help where I was needed. In the early and mid 1990's, I worked on the Kings Park (Way) and Central Islip project in the Parallel Program. Three facilities merged into one.

Those were big State hospitals in Long Island. How many patients got discharged?

I don’t have an exact total, but it was many patients. It wasn’t about numbers, it was about being ready for discharge and being able to maintain community living. We had to put in place systems such as tracking and bridgers. We would not discharge until patients got the services they required.

My job was to make sure we had quality-based discharge planning for all patients deemed ready for discharge and I had to make sure that possible: nursing staff, social work staff, therapy aides for bridgers. Bridgers were my idea.

When you helped to merge Kings Park, Central Islip and Pilgrim, could you discharge more patients because more services were available?

Yes. But also, there was the mind set that chronically mentally ill people could maintain community living — even those who had been hospitalized for years — provided the appropriate services are available. The facility had that mind set. The community mental health providers had that mind set.

A lot of programs came into existence at the same time to accommodate the new mind set: bridge programs, ICM’s (Intensive Case Management) ACT (Assertive Community Treatment) teams, MICA (Mentally Ill Chemical Abuser) community residences, vocational work programs, vocational rehab services.

What is quality-based discharge planning?

That’s when there is an individual plan based on actual client needs. What level of care do they need? You need to provide three levels of care for the patient to have some success. For instance, it may be a supervised residence or a nurse home setting. Along with that, you need to have the necessary aftercare providers. This includes psychiatric follow up, and, where indicated, medical follow up or vocational programs. The plan also means support services, like an ICM and significantly, tracking, to ensure that these services are not only in place, but working.

What are bridgers?

They work with clients one to one. They accompany them on interviews, they practice interview skills, they take patients to see possible placements. They do well with clients who are fearful of discharge. They provide the one to one support system that helps move them through the discharge process and then through the transition into the community.

What are Intensive Case Managers?

They follow patients in the community, then stay with them as long as they’re needed. They’re on call 24–hours–a–day, seven–days–a–week, for any issues: problems, financial problems, family problems, issues with the program, with the residence, anything that could threaten community living.

You mentioned that you went back to school to become a social worker. Why?

I had seen how some patients were managed in the hospital, and didn’t think that was the way. I wanted to work in the community, then stay with them as long as they needed. I wanted to be the discharge trackers or the ICM’s. To see that they were following through, and don’t follow through. Sometimes there was no oversight system in place to see that they were following through. The oversight system could be the discharge trackers or the ICM’s. We need to make sure that there are no gaps in services. We need to be sure the required services are in place. It’s not enough to say, the sample, clinic programs, are available and appropriate. Our goal is to reconnect with treatment whenever possible.

How many MPC patients are rehospitalized within 90 days of discharge?

Less than 10% of our discharges.

How do you track?

We write letters, we call, we send bridgers to their program or residence. We do outreach, face to face contact. We do whatever we can to ensure continuity of care.

You send somebody out to see the patient?

Absolutely. If we hear that there’s a problem with adjusting or in maintaining community living, we send somebody to the patient’s residence or program. Quality–based discharge planning and continuum of care — That’s its all about.

What’s it like out there for our patients who have been hospitalized for a long time?

Initially, some patients have some fear of leaving, but I think that eventually they like it out there. They feel that they are members of society. They no longer have the stigma of being in an inpatient setting. They have supports, so it’s easier. Our community–based programs, in which we take patients to introduce patients to programs and residences in the community, that’s an important tool. Just this morning we had a trip to Brooklyn Heights. Some of the patients hadn’t been out of the hospital for a long time.

How was it for them?

A sense of belonging. A client once came back to his old neighborhood and he was recognized, “Welcome back!” He was thrilled. What helps is knowing that they have support services to help them adjust.

W hat makes a discharge successful?

Often it’s the quality–based, individualized plan, the hook up and referral to necessary services, financial stability, and significantly, tracking. Those are the vital pieces for success.

We see the smile when they get into the car to drive away from the hospital on the day of discharge, that makes it worthwhile. It’s a wonderful sight to see how happy they are that day, how glowing. Of course, I like what I do.

INTERVIEW

CLASSIFIED ADVERTISEMENTS

Rates for classified ads are $60 (minimum) for the first three lines, $20 per line thereafter. NYSBA members receive a 50% discount on the minimum rate. All ads must be prepaid. Contact Donna Sandemere for pricing of your copy and payment arrangements: 732-438-0954 or email donna@ptofview.com.

Dynamic Career Opportunities! Horizon Mental Health Management, the largest national manager of behavioral health services, has lucrative Directorships and Staff opportunities available nationwide for Adult/Geriatric Psychiatrists. Our recruiters will work with you one–on–one to find a position in line with your lifestyle preferences and career expectations. Psychiatrists with H1B Visas are welcome to apply. Contact Brenda Moore, Director at 800-933-0099, Fax 972-420-8233, 1500 Waters Ridge Drive, Lewisville, TX 75057, Email: brenda_moore@horc.com. Visit Web site <www.hhm.com>.

The STAR Program, SUNY Downstate Med Ctr seeks B/C or B/E PT Psychia-trist for our MH/substance abuse service, based within the HIV/AIDS, primary care STAR Health Center program inclusive: Consultation and Education, Evaluation & Psychopharmacology services. Applicants must be experienced in providing psychiatric care in a multidisciplinary, multimodal, multidisciplinary setting. Experience with HIV/AIDS and/or substance abuse treatment and/or bilingual experience in English/French/Portuguese or Spanish an asset. Contact: David Warren, MD. Medical Director at: dwarren@downstate.edu, or Fax: 718-270-4244.
1. We are 100% mental health...
No one understands the unique needs of your profession better than we do. We offer the most tailored professional liability coverage and risk management advice tailored for psychiatrists. You're not just a customer - you're a colleague. Count on us to know your insurance needs.

2. We speak your language...
An insurance company providing coverage for psychiatrists should know psychiatry. You won’t have to explain psychiatric terminology to us. Our underwriters, risk managers and claims examiners are all behavioral healthcare insurance specialists with a demonstrated expertise. Count on us to protect you.

3. We are stable and dependable...
Since 1984, we have been committed to providing a long-term national program for members of the APA. Our rates are based on sound actuarial data, and our management approach ensures strength and stability. Count on us to be there for you.

THE Psychiatrists’ PROGRAM
THE APA-ENDORSED PROFESSIONAL LIABILITY INSURANCE PROGRAM

(800) 245-3333, ext. 389
TheProgram@apa-plip.com
www.apa.plip.com

Managed by Professional Risk Management Services, Inc.
for Legion Insurance Company

NYSPA Advocacy
Continued from page 1
Medicare reimbursement rules, psychotherapy with medical evaluation and management services is assigned added reimbursement as compared to psychotherapy without medical evaluation and management services, i.e., 90807 vs. 90806. The draft policy had provided that medication monitoring was excluded and only medication adjustment would qualify for the higher level service. NYSPA successfully argued that HCFA guidelines mandated that medication monitoring must be considered a medical evaluation and management service. The carrier incorporated the full HCFA definition in the policy that included medication monitoring.

If medication monitoring had been excluded from meeting the requirements for the higher level psychotherapy service, psychiatrists providing a psychotherapy service that included only medication monitoring would have been unable to receive payment for the higher level service.

NYSPA’s vigilance and persistence on this single issue preserved a conservatively estimated $2 million in annual reimbursement for psychiatrists in New York State that otherwise would have been lost due to this proposed limitation.

Other important issues raised by NYSPA representatives included: the failure to follow HCFA rules failure to follow the HCFA definition of medical evaluation and management services, overly burdensome documentation requirements for psychotherapy services, improper definition of pharmacotherapy (90862), and overly burdensome documentation requirements for pharmacotherapy.

The final draft included revisions that addressed the most critical issues raised by NYSPA in its comments. Seth Stein is preparing a detailed memorandum on the new Medicare policy that will be available on the NYSPA website shortly and will be distributed to the district branches. In addition, Edward Gordon, M.D., and Seth Stein will be available to meet with members in district branches to present the new policy and answer questions. Every psychiatrist in New York State who treats patients covered by Medicare has received a copy of the policy from their carrier and should become familiar with it to insure compliance with its new requirements.

Parenting
Continued from page 1

not attend the trial is certainly much more complex than a simple desire for conviction.

Mental illness is extremely disruptive to families. From birth to early adulthood, the age when most people become ill, parents build up hopes and dreams for the future of their offspring. Consequently they are devastated when the dreams are shattered by emerging symptoms like fireworks on the Fourth of July. Families look for “magical” solutions to bring the children back to the way they were before the appearance of the bizarre and unpredictable behaviors or invent excuses to account for the aberrant conduct, but as the symptoms persist, they are brutally forced into the painful realization that the changes are permanent. Yet, they never stop longing for the return of the children, and the longing lasts a lifetime. It is excruciating to see formerly articulate and able to express themselves spontaneously and rationally. It is difficult to communi- cate with adult children who, due to problems in processing information, must be addressed simply and unambiguously as if they were toddlers again in order for them to understand.

Parents are obliged to learn to know the children anew as if they were not the same kids they raised from birth. Unlike professionals treating the mentally ill, parents knew an intact, whole person before the transformation caused by the psychosis, and the void caused by the absence of the former child lasts a lifetime.

All families are in mourning over the disappearance of the children they once knew, and many harbor secret guilt about their own role in the development of the children’s psychos and are tormented by the culpability. Although the concept of “schizophrenogenic” mother has largely disappeared, some professionals still consider parents “demanding and meddlesome” due to their desperate, and sometimes awkward, attempts to understand the illness and find the best treatment. Parents are also forced to accept the disappointment and pain that result from the insults and rejections by their psyc- hotic children, and they must continue to show strength and courage when confronted by “anger and hate” if they wish to remain in contact with their offspring.

Mental illness has different mean- ings for parents, and they vary in their ability to relate to schizophrenic children just as they vary in their ability to cope with the problems of daily life. Some parents are more able than others to face undeserved criti- cism and blame. Others break down under stress, burn out, and cut off all contact with their sons and daughters, destroyed by the hateful behaviors of the children and accusations of “bad” parenting from society which would make them responsible. While at first they try to remain in touch, eventually they give up and turn away. Since the degree of acceptance of the negative factors and ability to deal with the children depends on the inner strength of the families, parents who give up should not be labeled uncaring and punitive. Having depleted their inner strength, they have to turn their backs on anything related to mental illness, including their children, and mask feelings of care and concern to save themselves.

Even if Andrew Goldstein’s parents did not attend the trial, they must still feel the loss of their son. They may have turned away, because they are no longer able to face their psychotic child. Unbelievable but true according to an article published in The New York Times, families who remain in close contact with their children form a small group of only a total of five percent of all families of the mentally ill. I believe that this five percent is composed of people who advocate for the mentally ill and raise funds for research on mental illnesses while the remaining ninety-five percent is made up of Goldstein’s and Perez’s.