President's Message: Should the APA Have an Assembly?

By C. Deborah Cross, MD
When I became President of the New York State Psychiatric Association three years ago, I assumed the most basic duty of representing the interests of New York State psychiatrists to the leadership of the APA and the rest of the membership. I also assumed the role of representing New York psychiatrists in the APA Assembly. I have written many times in this column about various aspects of the APA Assembly and, hoping I won't bore all of you who have patiently read through these columns, I want to write about it once more. The reason I am choosing to write about it now is that the very existence of the APA Assembly is in jeopardy. I have tried to explain the function of the Assembly in these columns, but the role of the Assembly is a complex and diverse one—which is very difficult to explain in a short column. Others (namely Dr. Jack McIntyre and Dr. Herb Peyser) have written about the history of the Assembly and its crucial role in the development of the APA. When the APA was formed in 1844 there was no Assembly—and there were no District Branches. At that time the APA was called the Association of Medical Superintendents of American Institutions for the Insane! The District Branches (originally "Societies") began in 1925. Later, in 1949, the DBs pushed to create an Assembly of District Branches, which was to be an advisory body to the "Council" (now the Board of Trustees). This relationship between the Assembly and the Board (of an advisory nature) continues to this day, even though there have been attempts through the years to change the Assembly to something more resembling the American Medical Association in which the Board is governed by the House of Delegates. The APA Board of Trustees is a relatively

C. Deborah Cross, MD

Albany Report: NYSPA Co-Sponsors Veterans’ Mental Health Training Initiative

By Richard J. Gallo
NYSPA recently partnered with the National Association of Social Workers—New York State Chapter and the Medical Society of the State of New York to sponsor the newly instituted Veterans’ Mental Health Training Initiative (VMHTI), a program aimed at training mental health professionals in mental health issues affecting returning veterans and their families. VMHTI was made possible through a grant from the NYS Office of Mental Health and is supported by an advisory panel of policy experts, clinical experts, veterans and family members. As service members return home, they and their families are often in need of expert mental health care, yet there is a short supply of mental health professionals who are adequately trained in veteran-specific mental health issues. In addition, recent studies demonstrate unprecedented rates of alcohol and substance abuse among deployed and returning service members who are struggling to cope with the war and its effect on themselves and their families. In order to provide training in veteran-specific mental health issues, the VMHTI is planning five regional training sessions throughout New York State for social workers and other mental health providers that will focus on the unique needs of returning veterans and their families. The sessions include information for providers on assessing and treating combat-related mental health disorders, such as post-traumatic stress disorder, traumatic brain injury and substance abuse disorders, as well as family issues related to deployment and re-entry. The trainings are offered free of charge and are open to mental health professionals, members of the military, veterans and their families.

The first training session, entitled "Symposium on Enhancing Community

From left: Frank Dowling, MD, Vice Chair of the Emergency Preparedness Committee for the Medical Society of the State of New York, Ray Cardona, Executive Director, National Association of Social Workers—NYS Chapter, NYS Senator Charles J. Fuschillo Jr., Rachel Fernbach, NYSPA Associate Executive Director, and NYS Assemblyman David McDonough.

Healthy Minds Premieres Nationwide on Public Television

The Healthy Minds series is premiering nationally this month. In the NYC Metropolitan Area, the series is being broadcast on Channel 13 Saturdays at 7pm with repeats on WLIW 21 Sundays at 9:30am and Tuesdays at 11:30am. All of the ThinkBright digital public television stations in New York State are broadcasting the series on Tuesdays at 2:00pm and 8:30pm.

Hosted by Jeffrey Borenstein, M.D., each half-hour in the 16 episode series humanizes a specific mental health condition through inspiring personal stories and interviews with leading researchers and experts, who provide the latest information about diagnosis and treatment. Healthy Minds covers a wide range of topics, including autism, depression, chemical dependency, post-traumatic stress disorder, eating disorders, and bipolar disorder, to bring viewers a better understanding of disorders that can affect anyone at any age.

All 16 episodes are available for viewing on line at www.wliw.org/healthyminds.
President's Message
continued from page 1

s small body (and growing even smaller through downsizing!), while the APA is in voting, those from the remaining last representative of District Branches to including representation of Residents, “Early Career” Psychiatrists, Minority and Underrepresented Psychiatrists (Hispanic, African American, etc., and Allied Organizations (Child, Geriatric, etc.). The Assembly is a large, diverse, and often extremely unwieldy body. Discussions on the floor of the Assembly can be raucous, and tedious sometimes accomplishing little. However, it is democracy at work! Everyone is heard—and every viewpoint is accorded a fair hearing. Through this process ultimately much significant work is accomplished. The psychiatrists who make up the Assembly give a lot of their time, and a lot of their professional time—usually uncompensated if they are in private practice! They spend hours reading tons of material, they go to numerous meetings, spend enormous amounts of time on conference calls and on emails. All believe that the entire psychiatrist needs someone to represent their interests in the national arena of politics. They also feel that the Board of Trustees MUST be held accountable to the membership! The Assembly gets reports from the Board and the APA officers. Tough questions are asked and accountability is demanded. In the last 10 years the Assembly has been the one part of the APA that has the Board to thank for allowing a past Medical Director to spend down virtually all of the APA’s monetary reserves. The APA officers are elected by the APA membership at large. However, the average psychiatrist knows little to nothing about the presti-
igious offices of President, President Elect, Secretary, etc. There are Area Trustees and sometimes these psychia-
trists are known at the local level, and we in New York are often fortunate in that our Area Trustees are able to reach out to our membership. This is not generally the case in other Areas where you have one Trustee for 15 States.

Because the candidates for national office are often not known, there is lit-	le interest in voting—such as the vote return for 10-15 years has been around 30-35% of the membership! When a member does vote, they often vote on “name recognition” so that we now have a President who many say voted for because they recognized his name, not his policy.

As I referred to above, there have been attempts over the years to have the Assembly be the controlling body of the APA (similar to the AMA). We opposed to the small Board of Trustees. This has not occurred. At present, in fact, because the APA is experiencing a significant negative financial situation there is a push to downsize the Assembly to such an extent that it will be virtually non-existent. What is occurring now is that the Board has given the Assembly the task of cutting its budget by 20%, with the potential of another 20% cut next year. Because the way in which this can be achieved has been left to the Assembly, we, the psychiatrists, are now asked to fight-
ing among ourselves as to how to do this. It is an extremely unpleasant state of affairs, in which every Area and State is trying their best to represent their constituents. As your President, I am committed to making sure that New York is treated as fairly and equitably as any other state. This is a difficult task, since New York has been seen by many in the Assembly as being overly repre-
ented in the past. We are one of 3 states with more than 1 District Branch. Most DBs are States, while New York has 13 DBs. Other members of the Assembly often forget that New York has over 4,000 psychiatrists! There are many other states—a situation that I, as your President, will not tolerate for 10-15 years has been around 30-35% of the membership! When a member does vote, they often vote on “name recognition” so that we now have a President who many say voted for because they recognized his name, not his policy.

As I referred to above, there have been attempts over the years to have the Assembly be the controlling body of the APA (similar to the AMA). We opposed to the small Board of Trustees. This has not occurred. At present, in fact, because the APA is experiencing a significant negative financial situation there is a push to downsize the Assembly to such an extent that it will be virtually non-existent. What is occurring now is that the Board has given the Assembly the task of cutting its budget by 20%, with the potential of another 20% cut next year. Because the way in which this can be achieved has been left to the Assembly, we, the psychiatrists, are now asked to fight-
ing among ourselves as to how to do this. It is an extremely unpleasant state of affairs, in which every Area and State is trying their best to represent their constituents. As your President, I am committed to making sure that New York is treated as fairly and equitably as any other state. This is a difficult task, since New York has been seen by many in the Assembly as being overly repre-
ented in the past. We are one of 3 states with more than 1 District Branch. Most DBs are States, while New York has 13 DBs. Other members of the Assembly often forget that New York has over 4,000 psychiatrists! There are many other states—a situation that I, as your President, will not tolerate for 10-15 years has been around 30-35% of the membership! When a member does vote, they often vote on “name recognition” so that we now have a President who many say voted for because they recognized his name, not his policy.

As I referred to above, there have been attempts over the years to have the Assembly be the controlling body of the APA (similar to the AMA). We opposed to the small Board of Trustees. This has not occurred. At present, in fact, because the APA is experiencing a significant negative financial situation there is a push to downsize the Assembly to such an extent that it will be virtually non-existent. What is occurring now is that the Board has given the Assembly the task of cutting its budget by 20%, with the potential of another 20% cut next year. Because the way in which this can be achieved has been left to the Assembly, we, the psychiatrists, are now asked to fight-
ing among ourselves as to how to do this. It is an extremely unpleasant state of affairs, in which every Area and State is trying their best to represent their constituents. As your President, I am committed to making sure that New York is treated as fairly and equitably as any other state. This is a difficult task, since New York has been seen by many in the Assembly as being overly repre-
ented in the past. We are one of 3 states with more than 1 District Branch. Most DBs are States, while New York has 13 DBs. Other members of the Assembly often forget that New York has over 4,000 psychiatrists! There are many other states—a situation that I, as your President, will not tolerate for 10-15 years has been around 30-35% of the membership! When a member does vote, they often vote on “name recognition” so that we now have a President who many say voted for because they recognized his name, not his policy.
New York State Insurance Department Conﬁrms Parity in New York

By Rachel A. Fernbach, Esq.

The New York State Insurance Department recently conﬁrmed that the federal parity law will require certain employers in the state to provide full parity with respect to visit limits, inpatient days of coverage, copayments, coinsurance amounts, deductibles and in and out-of-network coverage. This mandate will signiﬁcantly expand mental health and substance use disorder beneﬁts for many New Yorkers.

The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 requires health plans that cover mental health or substance use disorder beneﬁts to provide full parity with other medical and surgical beneﬁts, with respect to treatment limitations, ﬁnancial requirements and out-of-network beneﬁts. The federal parity law applies to all new plan years starting on or after October 3, 2009. Insurance Department Circular Letter No. 20, issued on September 10, 2009, details the direct impact that the federal law will have on Timothy’s Law, New York’s mental health mandate, and another state law that requires coverage for outpatient substance use disorder treatment. NYSPA is very pleased to report that the Insurance Department has adopted many of NYSPA’s positions and suggestions regarding implementa- tion of the federal parity law.

An interesting threshold issue is the method for determining whether an employer is large or small. The federal parity law counts total employees, while Timothy’s Law counts only employees who are eligible for health insurance. For example, an employer may have 50 total employees but only 35 of them may be eligible for health insurance. As a result, this employer would be considered a small group under Timothy’s Law but a large group under the federal law. Even though the employer is considered to be a small group for the purposes of Timothy’s Law, its employees will still be entitled to parity in mental health and sub- stance use disorder beneﬁts under the federal law.

The following is a summary of the key points of Circular Letter No. 20.

Treatment Limitations: Large employers must provide parity in outpatient visit limits and inpatient days for men- tal health and substance use disorder beneﬁts.

Financial Requirements (Inpatient): Large employers may not impose greater copayments or coinsurance amounts for inpatient mental health and substance use disorder beneﬁts or subject those beneﬁts to a separate deductible.

Financial Requirements (Outpatient): The Insurance Department will continue to permit insurers to apply either the primary care or specialty care visit copayment to mental health or sub- stance use disorder beneﬁts. However, insurers applying the specialty care copayment must be able to demon- strate that the specialty care copayment is also applied to substantially all of the medical or surgical beneﬁts offered in the policy or contract. Provided, however, that HMOs may not apply the spe-
cialty care ofﬁce visit copayment to outpatient substance use disorders beneﬁts, in accordance with separate state guide-
lines.

Outpatient Substance Use Disorder Beneﬁts: New York’s minimum require- ment for outpatient coverage of sub- stance use disorders beneﬁts will be fully expanded into a requirement for parity in outpatient and inpatient coverage of substance use disorders.

Cost Exemption: The federal parity law includes a one-year cost exemption for health plans that are able to demonstr- ate that compliance will result in a 2% increase in total costs in the ﬁrst plan year and a 1% increase in subse- quent years. The Circular clarifies that even if an insurer is granted such exemption, the insurer must still pro- vide all mental health and substance use disorder beneﬁts required under New York State law.

To view the text of Circular Letter No. 20, please use this link: http://www.ins.state.ny.us/circular/2009/c-
2009_20.htm

Albany Report continued from page 1

Capacity to Meet the Needs of Returning Service Members and their Families,’ was held on Thursday, September 17, 2009, at Hofstra University on Long Island. At the event, VMHTI awarded the Public Service Award to New York State Senator Chuck Fuschillo, Jr., in recognition of his leadership and sup- port of the Veterans’ Mental Health Care Initiative in the New York State Legislature.

After accepting the award, Senator Fuschillo stated ‘those of us who have never served in combat missions may never understand the ability of our troops live with on the battlefield, but programs like this will allow profes- sional social workers to become speciﬁcally aware of the challenges veterans face when they return to their families and civilian life.’

NASSW-NYS-Executive Director Reinaldo Cardona explained that ‘the impetus behind this project was a response to both NASSW membership and citizen requests to increase the quality of, and access to care for veterans and their families, what it morphed into was a commitment to providing New York’s veteran population with the best care possible. Senator Fuschillo stood shoulder to shoulder with us in this endeavor…his support and sponsorship of this project, even in a considerably difﬁcult budget year, never wavered. He and his staff believed in the project from its inception and worked tirelessly with the Gillian life’s project staff to make it a reality.’

NYSPA was represented at the event by Rachel A. Fernbach, Associate Executive Director, who added ‘creating a highly trained mental health provider work- force is a crucial ﬁrst step in the identiﬁ- cation of mental health and other neuro- logical issues that disproportionately afﬂict returning veterans and their families. Awareness and identiﬁcation of the issues will allow the ability of veterans to be referred for psychiatric and neurological assessment, which will in turn lead to greater access to necessary medical care and treatment for individuals in need.’

Subsequent Training Institute dates and locations are as follows:

October 23, 2009 Lake Placid – High Peaks Resort
November 20, 2009 Brockport – SUNY Brockport
April 23, 2010 NYC – Fordham University
May 21, 2010 Hudson Valley – SUNY New Paltz.

Comparative Effectiveness Research: An Introduction

By Barry B. Perlman, MD

On February 17, 2009, in his inauguration, President Barack Obama signed into law the American Recovery and Reinvestment Act (ARRA) of 2009, the $787 billion economic package meant to stabilize and stimulate the nation’s economy. Contained within the Act was $1.1 billion dollars designated for Comparative Effectiveness Research (CER). CER looks to improve health- care by development of evidence based practice guidelines. These guidelines are based on systematic reviews and synthe- sis of existing basic and clinical research, through data mining of reg- istrars and cohort studies to understand the natural progression of diseases and factors which inﬂuence their clinical outcomes, among other approaches. This large infusion of funds into an already evolving area of research placed CER at the center stage of the push towards national healthcare reform and thus evoked a great deal of controversy. Important stakeholders immediately started weighing in on the issue, either supporting it as a path to more rational and cost-effective therapeutics or con- demning it as antithetic to individual- ized, person centered care. Each group’s arguments often seem marked by hyperbole. How the CER is structured, what questions are asked, and how its ﬁndings are engrafted into clinical decision making will be of the utmost importance to physicians, including psychiatrists, other providers, as well as patients/consumers and their fami- lies. My interest was piqued.

Clearly, no one should fear well done research. Rather, we should be embraced as invaluable in informing clinical care. However, concern should arise when research ﬁndings are used to dictate clinical decisions rather than to inform them. This is so because medical sci- ence is complicated, difﬁcult to control and dynamic. This observation is especially true for clinical science due to the complexity of research methodologies make- ing informed in order to advocate for their own care while stakeholders use infor- mation to advocate with government and other powerful organizations, such as health insurers, that increasingly decide which therapies will be accessi- ble and covered. In an age marked by calls for adherence to “best practices” and “evidence based medicine” it is important to be aware of the shallow and narrow nature of many of those clinical guidelines. Skepticism and humility about clinical research is war- ranted. We would do well to remember an interchange about Miles, the pro- pounded in Woody Allen’s 1973 movie Sleeper. A doctor observing Miles’ “wheat germ, organic honey and Tiger’s milk.” Another informs that, ‘Those are the charmed substances that some years ago were thought to contain life pre- serving properties.’ The ﬁrst continues, and ‘You mean there was no deep fat? No steak or cream pies …?’ The response was, ‘Those were thought to be unhealthy … precisely the opposite of what we now know to be true.’

That humorous yet cynical interchange draws attention to the often tenuous basis of what we think we know. While there are undoubtedly domains in which CER is likely to yield clear guid- ance, perhaps with medical devices, comparative therapeutics, etc., its ability to provide clear pathways is not always evident. Many recent clinical examples suggest that CER is not a panacea but rather is more nuanced. Recent examples of radical reversals of policy within relatively short time frames have emerged from clinical research in the ﬁelds of cardioli- ogy, hypertension, endocrinology, and psychiatry, among others. They have involved positions of federal agencies, the JCAHO, and medical specialty soci- eties. For example, as evidence mount- ed that antidepressants, when pre-
Research continued from page 3

scribe for children and adolescents, might evoke suicidal thoughts, the FDA in 2004 required that a "black box" warning be added to medication package inserts. It now seems that the FDA's warning resulted in a decline in the prescribing of antidepressants for the identified groups and, inadvertently, resulted in the reversal of what had been a declining rate of youth suicide. The take away message from these episodes is of the overriding power of government, accreditation organizations, and large health insurers. Policies to influence care on a vast scale, for better or worse.

Why choose to raise the matter of CER for the readers of the Bulletin? First, ARRA directed the Institute of Medicine (IOM) to identify national priorities as research questions to be addressed by CER using ARRA funds. The Institute Of Medicine, which had no psychiatrist or other mental health expert on its Committee on CER Priorities, published its recommendations on 6/30/09 which addressed a wide array of mental health concerns. (The American Psychiatric Association was invited to present very brief comments at one of the Committee's listening sessions.) It is unclear whether the questions brought forward in the report were ones those in the field would have posed and whether if translated into research they will provide direction to the field’s critical concerns. (The IOM Report is easily reviewed on the web.) I suggest that NYSPA members familiarize themselves with the report and the CER process as envisioned.

Second, as the IOM research topics and others are undertaken as CER is pursued, we must wonder how and by whom they will be applied to public policy and individual plans of care. Let me provide an example from the arena of psychopharmacology. What psychopharmacologic treatments will be considered acceptable and paid for in caring for persons with serious and persistent mental illness such as chronic schizophrenia remains an important and exemplary question. It is a fact that to date there has been no research which shows a "significant" benefit from using two atypical antipsychotics simultaneously. Anecdotally such cases exist and there is some support for using two atypicals in the clinical literature. These medications are very expensive and costly to state Medicaid programs or private insurers. Given this background, the question then is, what latitude will clinicians retain when treating persons who have remained refractory to the evidenced based care laid out in clinical guidelines? NYS OMH will be using its PSYCKES data base to identify cases for which two "atypicals" are being prescribed as part of its quality indicator study. The NYS Office of the Medicaid Inspector General, charged with rooting out fraud and abuse, planned to review such cases as part of its 2008 work scope but deferred that project pending the PSYCKES results. The question is should all such use be adjudged improper? Scientifically the resounding answer should be "no." As a matter of policy, the answer is less certain. From a statistical perspective, the absence of a finding of significance does not mean there may not be meaningful subgroups or individuals which would benefit. The criteria of large clinical trials are so broad as to obscure what might be important treatment effects for subgroups. As statisticians know, the absence of evidence is not evidence of absence (of an effect). Once government focuses on a practice, such as the "inappropriateness" of prescribing two atypical antipsychotics at once, doctors become far less likely to treat a patient with the "targeted" combination, even when they have exhausted standard options, due to their fear of being cited. Likewise, if time consuming hoops are created as barriers to such prescribing by insurers, will time pressed doctors make the necessary effort to clear the hurdles? Will clinics, whose quality may be judged on such criteria, discourage their physician employees from going beyond the "approved" prescribing practices when they perceive a need? Can we be comfortable that an insurer's policy is clinically not financially based given that industry's problematic record? Will large governmental agencies or insurers be nimble enough to adapt their policies to clinical science's rapidly changing landscape? (Perhaps, going forward, the use of data mining on vast data sets such as those of Medicaid, Medicare or private insurers might help identify those for whom less recognized approaches to care such as the two "atypicals" is beneficial, if there are enough cases to provide the statistical power to perform the analysis.)

Alerted to CER and what we may expect over the coming years as this process gains momentum, how might readers think about this movement? Readers should welcome the use of CER and other avenues to improved treatment and recovery. However, we should do so with open yet skeptical minds. Dr. Jerry Avron, Professor of Medicine at Harvard and Director of the Harvard Interfaculty Initiative on Medications and Society, in a recent article in the New England Journal of Medicine, asks, "What is the moral responsibility of the physician to care for a patient for whom the best therapy may not meet the conventional standards of cost-effectiveness?" He continues, "These aspects of the debate will need to continue as we begin to implement CER with this vital new funding." While all cannot become statisticians or methodologists, we can inform ourselves and raise questions and concerns with policy makers, both governmental and private sector, when they promote or act to circumscribe access to a variety of approaches to care.

Dr. Perlman is the Director of the Department of Psychiatry at Saint Joseph's Medical Center in Yonkers, N.Y. He is a NYSPA Past President and is currently Chair of the NYSPA Committee on Legislation. Dr. Perlman is also a past Chair of the NYS Mental Health Services Area II Council.