**Sentencing Advocates**

By Chris N. Hipraela

Advocates, also known as defense advocates or mitigation experts, are little known outside of the criminal justice community. Yet our work on the defense team is often the determinant factor in a case disposition; for defendants with severe and persistent mental illness (SPM), this can mean the difference between incarceration and treatment. As an advocate in New York City and the region for the last decade—the last eight years with two agencies that I founded, Sentencing Advocacy Services—IL, like my colleagues, have served among our clients a steady stream of SPM defendants whose condition was previously diagnosed. Because we routinely interact with and rely upon a wide range of mental health professionals, we, as advocates, I would like to provide here a brief introduction to the profession and an outlook on prospects for systemic change.

**WHO WE ARE**

Sentencing advocates are effectively utility players, spoil sports, social worker, legal advocate, investigative journalist and community resource specialist. These credentials to do so also conduct clinical assessments. While social workers predominate among our ranks, defense advocates have come from a broad variety of disciplines, including psychology and other social sciences, law, education, and related disciplines, for example, studied journalism and urban history, and worked as a social policy researcher. In this unique position, they possess a combination of strong written, oral, research, interview and analytical skills, an abiding combination of strong written, oral, research, and investigative skills, an abiding interest in public policy and systemic change.

**WHAT WE DO**

It is the nature of our advocacy that justice, offender rehabilitation and public safety need not be discrete and competing interests. In the case of SPM defendants, if certain pa-...
President's Message

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by Glenn Martin, M.D.

s part of the legislation authorizing the New York State Medical’s phar- macy and Therapeutics (P&T) Committee, the pharmacy and Therapeutics (P&T) committee is re-activ- ated after a period of inactivity mandated by the New York State Legislature. The peri- od of inactivity, which lasted more than a year, was mandated by the governor’s office and the legislature worked out an agree- ment on the new preferred drug program, Decision Support, formerly Treasure of New York and removed members of the newly functioning Committee, and at our June, 2005 meeting I was elected as the Chairperson of the P&T Committee.

The P&T Committee reviews specific clinical issues regarding Medicaid pharmacy policy. After hearing presentations, and reviewing information provided through the exemption requests, the Committee makes recommendations to the Commissioner of Health on proposed changes.

The Commissioner will make final determina- tions after considering the Committee’s clinical recommendations and input from advoca- cy and other interest groups. The initial focus of the P&T Committee was on generic substitution, and in general, where an appropriate generic exists it must be dis-patched with certain exemptions. For exam- ple, where the generic is not available, or ex- cluded from this rule. In addition the committee has specifically reviewed the use of second-generation antihistamines, gastric acid reducers, and erectile dysfunction medications. Certain limitations were placed on using this program to add a pre- ferred drug model, the Pharmacy and Therapeutics (P&T) committee was re-activ- ated after a period of inactivity mandated by the New York State Legislature.
New Clinical Study of Science-Based Treatments for Opioid-Dependent Teens

By Ramon Sollikhan, M.D.

Although, overall, recent studies of adolescents and adults show a slight decrease in drug use, adolescent substance abuse remains a public health concern, particularly as relates to the use of opioids such as heroin and prescription pain killers. Opioids are drugs of abuse that mimic the action of natural chemicals in the body, and are often used to treat pain. They can be addictive, leading to dependence and withdrawal symptoms if not used as prescribed. The treatment of opioid addiction is a complex and challenging area of medicine, with various approaches and modalities being used to help individuals overcome their dependence. This article focuses on a recent clinical study that evaluated the efficacy of different treatments for opioid-dependent adolescents.

The study was a Phase II clinical trial, which aimed to evaluate the safety and efficacy of buprenorphine, a medication used to treat opioid dependence and withdrawal symptoms. The trial enrolled 126 opioid-dependent adolescents aged 12-18 years, and randomized them to receive either buprenorphine or a placebo for 12 weeks. The primary outcome measure was the change in opioid use as measured by the Drug Abuse Screening Test (DAST-20). The results showed that buprenorphine was superior to placebo in reducing opioid use, with a significant reduction in DAST-20 scores in the buprenorphine group compared to the placebo group.

In conclusion, the study demonstrated that buprenorphine is an effective treatment for opioid-dependent adolescents, with a significant reduction in opioid use compared to placebo. This finding is important as it provides evidence for the use of buprenorphine in the treatment of adolescent opioid dependence, which can help reduce the burden of addiction and improve outcomes for these young individuals. Further research is needed to evaluate the long-term effects of buprenorphine and other treatments for adolescent opioid dependence.
Families Together in New York State

In a matter of just a couple of years, the idea to connect parents with children was born. Hundreds of thousands of families across the state and throughout the rural areas of New York State have used the service. In many instances, the idea is currently being seen by psychologists as the vehicle for obtaining publicly funded services. In addition, many professionals are using the service to create a more efficient and integrated system of care by streamlining many aspects of the current system, including but not limited to reducing wait times for psychiatric assessments, developing integrated and standardized assessments and care review protocols, establishing a Multi-Cultural Advisory Committee, and increasing the capability of the system to serve the needs of under-served populations: early childhood (0–5), at-risk (8–14) and with co-occurring disorders (12–21), and transitioning youth (16–25).

We “see a number of positive outcomes associated with this system level focus” reported Macdonald, “such as reduced costs to the system, improved linkages, increased support for youth and transitioning adolescents, and integrated treatment plans.” In addition, “Cross agency training and consultation will result in increased knowledge among county child and family services staff and teachers regarding mental health and substance abuse prevention and treatment for children, as well as increase their capacity to identify early signs of serious emotional disorders (SED) and make appropriate referrals.”

In the tri-cities capital district area, the project will establish culturally competent family run Family Resource Centers in three neighborhoods across the area (urban, suburban, rural), from which families can access an array of mental health and support services. In closing, MacDonald expresses her understanding that “there is Undoubtedly a lot of resistance to the implementation of this program, but we at Families Together have no doubt that it will be accomplished one step at a time.” Those of us who have worked with MacDonald and her staff...be there.

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50 or More Employees

(N non-ERISA Exempt)

50 or Fewer Employees

Sole Proprietors

Healthy N Y

Additional Safeguards

Mandated Benefit

1. Mandate to encompass the DSM IV with the exception of nicotine and caffeine addiction, paraphilias, and all V-codes.

2. Coverage must be comparable in every respect to that provided for physical illness, including equal co-pays and no separate deductibles.

3. Mandated benefit is in addition to “base benefits.” (See item #2 in next column)

Scope Expansion Attempted

Two of the three separate bills dealing with the expiration of Kendra’s Law permitted the legislature to initiate a petition as mentioned above. However, one of those bills called for authorizing psychologists to also approve the affidavit required by the court relative to the examination of the subject individual and treatment alternatives, including those involving institutionalization and medication. Such an amendment would have made a significant difference to the patients concerned. After much discussion and negotiation, the bill was passed with only marginal changes in the original text.

Also this session, there were other attempts to change the scope of practice of allied mental health practitioners, most notably, the bill to limit the baseline with which a hospital could deny or restrict privileges available to psychologists and a bill to amend the social work licensing statute with respect to certain grandfathering provisions. Neither bill was successful.

Proposed Timothy’s Law Structure of Benefits Table

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CMPS IMPLEMENTS NEW NATIONAL PROVIDER IDENTIFIER

By Rachel A. Fernbach, Esq.,
NYSPA Staff Attorney

The Centers for Medicare and Medicaid Services (CMS) is now accepting applications for the new National Provider Identifier (NPI), a unique provider identification number that will eventually be used in all standard electronic health care transactions. This is a two-position numeric identifier, consisting of nine numbers plus a check-digit in the 10th position to prevent fraud. This initiative implements the January 2004, final rule entitled: "HIPAA Administrative Simplification: Standard Unique Health Identifier for Health Care Providers.”

All health care providers in the United States are eligible to receive and use an NPI. However, use of the NPI is mandatory for providers who fall into one or both of two categories: (1) Medicare and Medicaid providers who are not subject to HIPAA (i.e., covered entities) and (2) health care providers who participate with Medicare. If a provider is assigned an NPI, the provider will still need to separately credential by each health plan or third party payer with which the provider participates.

To further assist members, NYSPA is preparing a detailed memorandum about the NPI rule which will be available for download on our website.


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answers about suicide, as well as state and national resources, including crisis hotline telephone numbers.

With the distribution of over 28,000 Kits throughout New York State, the New York State Office of Mental Health (OMH) has brought the campaign to the community – educating government agencies, school districts, universities, and local law enforcement agencies on the topic. “The program has been so successful, in fact, that we can barely keep up with the demand for the Kits,” noted Commissioner Carpinello in a recent interview. To date, over 1,200 New Yorkers have attended SPEAK presentations and additional efforts to broaden the campaign are underway.

One example of the collaborative effort between OMH and over 400 college and university campuses in New York State providing students, faculty and other members of the college community with information on the link between depression and suicide, prevention strategies and hotline information. In addition to the Kit presentations and other SPEAK initiatives, OMH has a website dedicated to this program; which over the last fourteen months has had 39,805 visits, 30,527 of which have been within the last January of 2005, indicative of the campaign’s momentum.

An additional initiative to increase New York’s suicide prevention and awareness efforts was in November of this year, when the OMH, in conjunction with the New York State Suicide Prevention Council, launched earlier this year by the Mental Health Administration, Lifeline is the only national suicide prevention and intervention telephone resource funded by the Federal government. It is a network of local crisis centers located in communities across the nation that are committed to preventing suicide, incorporating the best practices identified through research in suicide prevention and intervention.

The Commissioner hopes that a residual effect of her efforts will result in a significant reduction in the stigma so frequently associated with mental illness. “Many people attempt to hide their symptoms and avoid seeking treatment for fear of embarrassment,” said Carpinello. “It is important for all New Yorkers to know that mental illness can be successfully treated, and recovery is possible. But we need to speak up before recovery can occur. To attain this goal, we all need to work in tandem...too many mental illnesses go undiagnosed or treated because people are afraid to ask for help. This is only one step in this process...we also need to work in close collaboration with the medical community with an eye toward increased screenings.”

SPEAK Kits may be obtained by writing or calling the OMH Community Outreach and Public Education Office at 44 Holland Avenue, Albany, NY 12229, 866-270-9857. You may also visit the SPEAK website at www.speakny.org

A Special Note...

As a result of her work on suicide prevention, Commissioner Carpinello recently received the Hope Award from the Mental Health Association of New York City which honors individuals who, through their leadership, action and example, promote suicide prevention and mental wellness in our community. In addition, she also received Samaritans’ 2005 Life Keeper Memory Award for her outstanding work with Samaritans toward suicide prevention.

Pharmacy in Prisons Symposium

By Michael Pratt, M.D.

O n the evening of November 2nd The New York Academy of Medicine, Psychiatry Section in conjunction with their co-sponsors will present The 2005 Stuart Asphalt Memorial Lecture “Prisons: The New Psychiatric System. Are You Professionally Prepared?” Featuring keynote Speaker, New York Times writer, Paul von Fawaz, MD, Silvana Garcia, MD, Abel Gonzalez, MD, Hye Lee, MD, Juraj Lukac, MD, Bronx Treibach Associates to Street Crime project. The program Moderator is Jeffrey Bernstein, MD, Chair, Section on Psychiatry of the New York Academy of Medicine; the conferee is Phyllis Harrison-Ross, MD, Black Psychiatrists of Greater New York and Associates, and the event is sponsored by the New York Academy of Medicine; the co-sponsors are Brown University and the New York City Department of Corrections.

Co-sponsors of the event: Black Psychiatrists of New York and Associates, United Social Services, Inc. of the NY Society for Ethical Culture, Multi- Cultural Programs Committee of the New York City bench for the mentally ill, Association for the Mentally Ill., Association of Adolescent Psychiatry, Health Professionals Division of the National Urban League, Council of Churches of the City of NY-Care for the Caregiver’s Project. For more information contact Donald Morone (212) 822-7272, dmorone@nyam.org

Elmhurst Hospital Residents join the 100% Membership Club

Bottom row: Maryluz Bermudez, Residency Coordinator, Neelam Varshney, Carmen Fenayett, MD, Judy Tjin Wai Koo, MD, Dennis Arrieta, MD, Dora Gil, MD, Raquel Choua, MD, Iqbal Caimano, MD, Alex Altamirano, MD; Middle row: Martha Alzamora, MD, Syl Jaffery, MD, Javahid Rashid, MD, Adelaida Landam, MD, H. Kendra Patel, MD, Ann Marie Sullivan, MD, Department Chair, Michel Rondon, MD, Amy Hoffman, MD, Residency Training Director, Vladimir Jelov, MD, Savel Geyezon, MD, Irena Danczik, MD; Top Row: Deep Loha, MD, Chantal Alarcion, MD, Juan Luis Castro, MD, Andres Chaparro, MD, Vincent Okabe, MD, Sang Ik Shin, MD, Yasmin Collazo, MD, Associate Residency Training Director, Federico Zuniga, MD, Nof. pictured: Faroq Amin, MD, Walid Fawaz, MD, Silvana Garcia, MD, Abe Gonzalez, MD, Hye Lee, MD, Juraj Lukac, MD, Javier Senosain, MD.
and court-accountable ATIs that target specific offense behaviors and their underlying causes in a manner consistent with an interest in short- and long-term public safety. For mentally ill and substance-dependent clients, this usually involves court-mandated psychiatric or substance-abuse treatment. Although submission of a memorandum is not always necessary, this is typically our primary advocacy tool and the platform for oral advocacy. Since we intend the memorandum to serve as the definitive source on a defendant’s history, current condition and prospects for rehabilitation, as well as our perspective on the offense, the investigation is exhaustive. After reviewing the case file and interviewing the defendant at length, sometimes for several hours, we obtain and review all relevant and available records, including criminal and corrections, education, medical and psychiatric, foster care, employment and military, interview collateral sources from across a client’s lifespan, including past and current mental-health clinicians; and, upon determining a client’s suitability for treatment, coordinate the referral process and secure admission to an appropriate program.

The historical information is distilled into a narrative, accompanied by an evaluation and a recommendation that details the treatment alternative and a release plan. In cases where an ATI is unattainable, usually due to the nature of the offense or the client’s criminal record, the report serves as a tool to help determine the term and form of incarceration. At a minimum, we believe more information produces a more prudent decision. Where a treatment referral is required, we generally coordinate the entire process, from identification of an appropriate program through application, scheduling of intake interviews, obtaining of medications, the client’s release from jail, and transport to the program. With SPMI clients, who depending on their condition might be mandated to any milieu from a residential MICA program to a hospital-based outpatient psychiatric program, this process inherently involves consultations and coordination with the entire range of mental-health professionals. Once placed, if the judge so requests, we also monitor the client for the duration of treatment and provide progress reports to the court. If treatment is a condition of probation supervision, the probation officer monitors the client.

The OUTLOOK
As the public perception and understanding of mental illness becomes more sophisticated, so does that of the criminal-justice system. Hopefully, the cumulative effect of case-by-case advocacy, alongside persistent efforts of mental-health advocates and advocates who have for decades worked to educate legislators, the courts and the public, will improve the treatment odds for mentally ill defendants. It does seem that most judges, given adequate information and sensible options, are disposed to consider treatment if they are comfortable that public safety will not be compromised. The recent advent of mental-health courts, modeled after drug courts, are an encouraging development, and Assisted Outpatient Treatment (AOT) can provide a viable civil alternative either in conjunction with or in lieu of a criminal sanction.

Still, these alternatives and the work of sentencing advocates affect only a fraction of SPMI defendants, many of whose illnesses otherwise go unrecognized or underrepresented in the courts. Clinicians whose patients have been arrested can readily play an active role. In a system where information too often results in a poor outcome, a simple unsolicited telephone call to a patient’s defense attorney, a letter outlining the patient’s psychiatric history, diagnosis and prognosis given structured treatment, and assistance in obtaining treatment records can prove the difference between incarceration and treatment.

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For more information please contact: Jessica Temple of CBH Research at 718-288-1982 or 800-468-3205 ext 853.

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