WEB EDITION

THE BULLETIN

NEW YORK STATE PSYCHIATRIC ASSOCIATION

Fall 1999, Vol. 42, #3 • Bringing New York State Psychiatrists Together

President's Message: Aggressive Advocacy For Our Patients and Our Profession

by Jim Nininger, M.D., President, New York State Psychiatric Association

Jim Nininger, M.D.

Our theme for the new millennium — *Aggressive Advocacy For Our Patients And Our Profession* — articulates in a few words our organization's mission to advance the interests of our patients and psychiatrists in New York State. I extend my appreciation to the members of our NYSPA Task Force on Strategic Planning who developed this theme that succinctly crystallizes our organization's mission and purpose. I am asking every component of our organization to focus its efforts over the next year on developing an agenda for action focused on advocacy issues.

The articles in this issue of the Bulletin highlight some of our continued efforts to advance the interests of our patients and our profession:

- During this last legislative session, NYSPA worked with the Medical Society of the State of New York to meet the serious challenge posed by the Mental Health Professions Bill. NYSPA forcefully and effectively advocated that any new scope of practice for non-medical practitioners should not include the practice of medicine and that medical consultation

[See **President's Message** on page 4]

Blumenfield Appointed Chair of National APA JCPA

by Michael Blumenfield, M.D.

Dr. Michael Blumenfield is Professor of Psychiatry at New York Medical College and in private practice in Scarsdale, New York. Dr. Blumenfield is one of two representatives to the Assembly from the Psychiatric Society of Westchester County (DB), as well as the Public Affairs Chair for NYSPA, and is now the newly appointed Chair of the APA's Joint Commission on Public Affairs (JCPA). The Bulletin is pleased to have Dr. Blumenfield on its editorial board. What follows is his account of the JCPA. –Ed.

Michael Blumenfield, M.D.

When I first heard of the name Joint Commission on Public Affairs, I pictured a large room with a group of stern looking commissioners sitting above witnesses who were testifying in great fear. In reality it is nothing like this but one of the many hard working committees of the APA. It was created in 1976 to replace the Committee on Public Information originally established in 1948. It is composed of the Public Affairs chairpersons for each of the APA's seven areas. The JCPA also includes five members–at–large appointed by the APA President–Elect. The President–Elect and the Speaker–Elect jointly select the chair and vice chair of the JCPA.

The Commission is concerned with all matters that impinge on the public image of psychiatry to the end that this image is accurate and contributes to greater public understanding of the profession and of the illnesses treated by the profession. This is easier said than done. The key becomes the working relationship with the APA Division of Public Affairs (DPA) who are a staff of very skilled and dedicated professionals. They have their fingers on the pulse of the daily beat of the media while also working on various public affairs campaigns at APA headquarters. Another important role for JCPA is advising and assisting the DPA in

[See **JCPA Chair** on page 4]

INSIDE THIS ISSUE:

Two Major Managed Care Companies Roll Back Fee Decreases

On June 1, 1999, Magellan Behavioral Health implemented modest fee increases for certain codes for the Empire Blue Cross Blue Shield contract effective June 1, 1999 that reverse in part some of the fee decreases imposed on January 1, 1999.

- Code 90801 (initial diagnostic interview) for *children* is increased from $120 to $125.
- Codes 90805, 90811, 90817 and 90824 (20-30 min. psychotherapy with medical management) are increased from *$45 to $60 for adults* and from *$50 to $65 for children*.
- Code 90862 (pharmacological management) is increased from *$40 to $50 for adults* and *from $50 to $60 for children*.

In its memorandum to providers, Magellan acknowledged the role of NYSPA providing input regarding the January 1999 fee decreases and their impact on patients and psychiatrists. Since the Magellan fee decreases were imposed, Seth Stein, NYSPA Executive Director has been in communication with Magellan representatives to bring to their attention the serious problems caused by the fee reductions.

On February 10, 1999, United Behavioral Health announced that it decided to reverse its previous decision to reduce fees for participating providers in New York State. According the UBH, the fee reductions were imposed in error and UBH never had any intention of reducing fees. All fees for all services were restored to their 1998 levels. UBH has also promised that providers who were paid in 1999 at the lower rates will receive a retroactive fee adjustment.

In its original correspondence with both UBH and Magellan, NYSPA suggested that the severe decreases would have an adverse impact on patient access. We also noted the failure to recognize the value of integrated treatment (where the psychiatrist provides both psychotherapy and medical management) by providing additional reimbursement for the psychotherapy codes that include medical management, i.e., 90805 and 90807. NYSPA will continue our efforts to address the fee schedule reductions to insure adequate access to care by patients. ■

NYSPA Supports Class Action Lawsuit Against Managed Care Companies

See also Letter to the Editor on page 2.—Ed.

On July 27, 1999, the NYSPA Executive Committee authorized NYSPA to join with the APA in providing financial support for a class action litigation filed in May, 1999 against nine large managed care companies. On July 10, 1999, the APA Board of Trustees authorized a contribution of $10,000 and the NYSPA Executive Committee added a contribution of $1,000. This lawsuit entitled *Holstein v. Green Spring Health Services, Inc., et al.* is currently pending in federal court in the Southern District of New York. Plaintiffs in the lawsuit include psychiatrists, psychologists and social workers who participate in provider networks operated by the major managed care companies. Plaintiffs allege that the managed care companies have conspired to restrain trade by limiting fees and by unreasonably restricting access to care for the treatment of mental illness. The court in the case recently denied a motion to dismiss the lawsuit and the case is proceeding with the discovery process. ■

NYSPA is conducting a search for a new chairperson for the Committee on Public Affairs. District Branches should forward names of potential candidates to the NYSPA office.

New APA-NYSPA Joint Recruitment Effort

NYSPA is embarking on a new recruitment effort with the APA to target psychiatrists practicing in New York who are not NYSPA and APA members. Early in 1999, NYSPA received a request from the APA President, Rodrigo Munoz, M.D., seeking recommendations for joint APA-NYSPA activities. In response, NYSPA proposed that APA and NYSPA develop a plan for a joint recruitment effort to attract psychiatrists who are not members.

In order to develop a listing of non–NYSPA psychiatrists, NYSPA will work with the Medical Society of the State of New York. MSSNY maintains a list of over 7,500 psychiatrists licensed to practice in New York. MSSNY is currently comparing our NYSPA membership list of 4,800 psychiatrists against MSSNY's list of 7,500 psychiatrists and develop a listing of psychiatrists who are not NYSPA members.

Once that list is developed, APA will break down the listing by DBs and forward to each DB a listing of non–NYSPA members with addresses in their DB. Each DB will then be sent its listing and will be invited to screen the list for further refinement in order to develop a final listing for the recruitment mailing. APA will prepare and mail the recruitment package to these non–NYSPA psychiatrists inviting them to join the APA. Each DB will be encouraged to contact these potential members directly by telephone or otherwise to assist in the recruitment effort. ■

THE BULLETIN
NEW YORK STATE PSYCHIATRIC ASSOCIATION

Editorial Board
Leslie Citrome, M.D., M.P.H.
Editor-in-Chief
Nathan Kline Institute
140 Old Orangeburg Road
Orangeburg, NY 10962
Tel: (914) 398-5595
Fax: (914) 398-5483
e-mail: citrome@nki.rfmh.org
http://www.nyspsych.org/bulletin

Syed Abdullah, M.D.
Michael Blumenfield, M.D.
James Chou, M.D.
David Harwitz, M.D.
Craig Katz, M.D.
Howard Owens, M.D.
Ann Sullivan, M.D.
Seeth Vivek, M.D.

Robert J. Campbell III, M.D.
Editor–in–Chief Emeritus

New York State Psychiatric Association
100 Quentin Roosevelt Blvd.
Garden City, NY 11530
(516) 542-0077; Fax: (516) 542-0094
e–mail: nyspamd@idt.net
http://www.nyspsych.org

Executive Committee 1998-99
James Nininger, M.D., *President*
Barry Perlman, M.D., *Vice President*
C. Deborah Cross, M.D., *Secretary*
Ann M. Sullivan, M.D., *Treasurer*
Herbert Peyser, M.D., *Area II Trustee*
Seth Stein, Esq., *Executive Director*

Information for Contributors
The Bulletin welcomes articles and letters that NYSPA members will find timely, relevant, and compelling. Articles should be between 750 and 1500 words (three to five double–spaced manuscript pages) and letters no more than 750 words. All submissions must be made electronically, preferably by email to the editor. All authors are encouraged to also provide a photograph of themselves which will be printed alongside their article.

Information for Advertisers
The Bulletin welcomes advertisements from both NYSPA members and commercial enterprises. Total circulation averages 5,500 copies per issue. The Bulletin is received by all 5,000 members of the American Psychiatric Association who belong to a district branch in New York State. The Bulletin is also sent to the leadership of other district branches across the United States and to New York State legislators, medical libraries, and science writers. The Bulletin is published quarterly. Both classified advertisements and display advertisements are available. Please contact the managing editor for current rates and media requirements. NYSPA members receive a discount of 50% off the basic classified ad rate.

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

Graphic Design & Production
Donna Sanclemente, Point of View
donna@ptofview.com

From the Editor… Advocacy for Ourselves

If I am not for myself, who will be for me? But if I am only for myself, what am I? … And if not now, when? — Rabbi Hillel, ca. 60 BCE


Leslie Citrome, M.D., M.P.H.

The American Psychiatric Association's strategic goals, as adopted by the Board of Trustees in 1998, are (in order):

- Advocating for Patients
- Advocating for the Profession
- Supporting Education, Training and Career Development
- Defining and Supporting Professional Values
- Enhancing the Scientific Basis of Psychiatric Care

Advocating for Patients was placed first on the list. This is a laudable stance — selfless, altruistic, honorable. One would hope that all professional organizations in the health care arena would place *Advocating for Patients* first on their list of priorities. But alas, this is not the case. While other professional organizations have been vocal and effective in taking care of the *guild* issues necessary to maintain and grow their professional futures, we as psychiatrists appear to be embarrassed at doing the same. As a group we don't give as much to *Political Action Committees* and we are not as politically active as some other providers of mental health care. This will hurt us.

Yes, *Advocating for Patients* is clean, wholesome, and makes us feel good. At the same time we must be *Advocating for the Profession*. The dues–paying members of the American Psychiatric Association look towards the organization to stand up for them and to help them in their work. Maurice Rappaport, MD, PhD talks about *Marketing Psychiatry* (The Bulletin, Volume 41, Number 3 (Fall), 1998), where the organization would focus more on educating the public about what we do, and how well we do it. We need to place these efforts first, or else there won't be any of our own patients for us to advocate for.

A balance between guild issues and other pursuits is what we are all about. We must be for ourselves because no one else will do this for us. Of course, we must also be for our patients, but let's not be uncomfortable with marketing our profession. ■

LETTERS TO THE EDITOR

Letters to the Editor are welcomed but are limited to 750 words.

Antitrust Action Gets "Go Ahead" in Holstein v. Greenspring - Hard Work Ahead

On June 16, 1999, Judge Lewis A Kaplan gave the *Holstein v. Greenspring* antitrust action a resounding "Go Ahead." His opening words to the eight lawyers for the defendant managed care companies (MCs) were, "I think you are in trouble on this one, and I pretty much don't agree with anything that was done in Stephens."

After a spirited courtroom debate, Judge Kaplan told the defendants' lawyers they were creating "edifices" with their arguments but should know this is a "real" case. He went on to give an immediate ruling from the bench denying the defendant MC's motion to dismiss the multibillion dollar class action lawsuit, *Holstein et al. v. Greenspring et al.*

In his ruling, Judge Kaplan stated that the complaint adequately alleged both the antitrust injury and the existence of an antitrust conspiracy by the defendant MCs who are the administrators of mental health benefits. The court explained that the alleged conspiracy, if proven, would be illegal because it substitutes "pricing by agreement among the defendants for pricing through competitive processes." (The text of the complaint and a press release can be found at: < www.nohmo.com> or from <www.managedcaresurvival.com /ClassAction.html>.)

APA Board of Trustees Action

Our Board of Trustees, in their July 10th Washington, D.C. meeting, agreed to the following courses of action:

- Immediate release of $10,000 from the litigation fund
- Assistance in identifying and approaching psychiatrists best suited to serve as experts regarding clinical matters at issue in the lawsuit
- Publicize the lawsuit and the APA's support through *Psychiatric News* stories, columns, APA web site entries, stories provided to DB newsletters, etc.

What We Can Do as Individuals

First, we can take heart that such a definitive action against the MCs is in court before a Judge who cited a case which states: "When buyers agree illegally to pay suppliers less than the prices that would otherwise prevail. Suppliers are obviously injured in fact". By citing this case the Judge has told us he knows exactly what is at stake. It remains for us to prove the case.

Over the course of the next months, we must continue to develop the evidence to present at trial that supports the allegation that we as plaintiffs suffered from such MC actions. This process has already moved far ahead with the help of psychiatrists familiar with the workings of the MCs and will go further as others are heartened by the case and come forward with information.

This is a Fight

We must realize we are in a fight to change current practices of managing mental health care. This case has the potential to be the equivalent of *Brown v. The Board of Education* which struck down "separate but equal" and paved the way for a flood of meaningful civil rights legislation that changed our country. This case is a *Civil Action* (read the book or see the picture) which could be instrumental in getting a meaningful patient Bill Of Rights passed and federal legislation that has the scope that would set new directions for our profession and the lives of our patients.

In this suit, psychiatrists as a class, are intent upon changing the way MCs are practicing medicine. Through requests for injunctive relief and presentations to the court of the actualities of treatment for mental illness, we are looking for no less than changes in MC practices that restore our ability to be Doctors rather than managed care compatible functionaries in a profit vs treatment system.

We are also asking the court for judgments against the MCs for billions of dollars for the economic injury we have sustained. If we prevail in this suit, consideration will also be given to setting money aside to rebuild the training and research facilities that have been destroyed by years of under funding of mental health treatment.

This suit which has been in the making for five years finally gives us a chance to take psychiatry back to psychiatrists. Our patients' needs, our professional ethics, and our civic duty demand that we take action to ensure that any of these companies that have engaged in unfair and illegal trade practices now be forced to conform their behavior to the requirements of the law.

This August, the doctor is in. I can beeped at 917-960-1430. The lead counsel, Mr. Joseph Sahid can be contacted at 212-308-5930. "**Sticks in a Bundle Can't be Broken.**"

Ed Stephens, M.D.
Director, Am. Assoc. of Private Practice Psychiatrists

Referrals and the Searchable Database

By Michael Blumenfield, M.D.

NYSPA psychiatrists are now receiving referrals through the searchable database. In June 1999 there were 286 searches generated at the NYSPA searchable database (almost twice as much as the month before).

Only 16% of the NYSPA membership have signed on. This is way too low. If you haven't signed up, please do so now. Consider the advantages: It is a lot easier and less expensive than listing your office in the yellow pages, or some new directory. The use of the Internet by the average person is growing by leaps and bounds. Our own overall web site is averaging overall 3250 "hits" or visits per month. One of the most popular pages has been the searchable database.

It is easy to sign up online. Go to the website <http://www.nyspsych.org> and then follow the directions and pathway to the member's only section and then the directions of how to sign up on line. If you are not yet on line, just ask your DB Executive Director for the sign up form or call Barbara at NYSPA - Tel: (516) 542-0077 and the forms will be mailed to you. ■

APA Board of Trustees More Active Than Ever

by Herb Peyser, M.D.

Herb Peyser, M.D.

As of this writing the Board is considering how to:

- simplify the dues structure and lower the central dues without curbing APA activities that members want;
- return part of the central dues money to the DBs/state organizations either across the board or for targeted purposes; and
- roll back central APA expenditures.

Under President Allan Tasman's direction the Board is reorganizing its and APA's method of operation. Everything is to be brought under the APA's strategic priorities: the budgetary process, expenditures, revenues, the work of the staff, the dues process, advocacy programs, publishing and educational activities, relationships with the DBs/state organizations, everything — all better to deal with the radically changing health care system.

Into the Future

No one knows for sure where it will go in the long run, but in the near future it appears as though the originally unregulated and chaotic marketplace of managed care is becoming increasingly organized and regulated — by private for–profit health care industry as it expands, merges and concentrates control, by the growing non–profit hospital networks, and by the increasing interventions of state and federal governments.

We are seeing a hybrid system emerging, including all the above and the coalescence of the public and private sectors, with no one system (MSAs, single payer, etc.) able to take over completely for the present. The number of players in the game decreases, the burgeoning technology continues to expand, costs continue to rise, and the number of uninsured grows, moving us progressively toward further government intervention with what seems to be increasing private participation, to alleviate the situation and correct the abuses. The power of the individual psychiatrist, alone, is weakening in the face of these changes.

Bringing it Together

APA's task is to get the profession together, keep them informed, and act as a bargaining agent, an advocate, fighting for the patients, the profession and the members through governmental advocacy and legal initiatives, direct interaction with the managed care industry, direct work with the business community as long as it too is a major purchaser of care, and supporting good provider controlled groups. APA must bargain for us with whatever organization controls any portion of the health care system. The patients, the profession and the members have no one but APA on their side to do this, and there is no magic. No one case, no one law or regulation will change everything. It is a continuing battle.

While these struggles go on APA has other tasks as well — membership, ethics, communications, education, conventions, publications, the election process, policy making on multiple issues, budgeting, administration, and on and on. These too are priorities given us by the members, or material requirements for carrying them out.

To do all this our $36,000,000 organization has a staff of over 240 headed by a Medical Director, Councils, Committees, Task Forces, and governance by the Board and Assembly, the latter made up of Representatives from the 75 or so DBs/state organizations. These latter must be supported, tightened up and oriented toward the same goals, and the disconnects between them and with APA corrected. APA is a federation of these semi-autonomous, separately incorporated DBs/state organizations, and it must always remember that whenever it is inclined to some kind of top-down imposition of a program.

Board Takes Action

More specifically, the Board acted to:

- Fund NYSPA, Georgia and other DBs to help in some way with their initiatives for parity, against discriminatory coverage, and against extending the scope of practice of inadequately trained other health care professionals; and to support suits on the national and state levels involving these matters and others, such as anti discrimination and antitrust suits, etc.;
- Continue work on its information technology to further the development of its electronic communications systems, deal with the Y2K problem, restructure and update its information systems and databases, develop its local area network, its wide area network linking the DBs/state organizations and connecting the members together, and ultimately to work itself onto the Internet itself, developing such instruments as a Website where it can give information to the community and serve the members; to this end it …
- Began working with the AMA and a number of other specialty societies to develop such a combined health care Website where there would be supplied truly expert health care information and health care activities to people seeking such on the Internet (where up to now those seekers could find only unregulated, uncredentialed purveyors of such information), and while doing so APA will also be…
- Giving information to the members, interacting with them, and reminding the public of what psychiatry is and where the best information can be obtained;
- Is definitely working, as noted, to lower dues in some way; with partial dues payments first going to the DBs and only after that to the central APA, and it is looking into revenue sharing with the DBs/state organizations, returning money to them, for they exist for the most part only on dues and APA has significant non–dues income;
- Is working towards reforming and improving the APA election process which has grown increasingly expensive and at times rather unseemly, the number of members unhappy with the process growing and accounting for the increasing number of non–voters;
- Approved the revision of our Eating Disorder Practice Guidelines, the first Guidelines we came out with six years ago, thus fulfilling APA's promise to keep updating them as well as coming out with new ones;
- Approved a method of documenting psychotherapy for reviewing agencies while pushing for and decreasing the limitations on psychotherapy in managed care;
- Reviewed the issue of physician assisted suicide and sent it out to the DBs and the members, including the minorities and the components such as the Ethics, AIDS and End of Life Committees, for their input and advice;
- Reviewed the AMA AMAP program for accrediting and credentialing physicians, and joined with a number of other specialty societies in strongly recommending major changes and great caution in implementing it, for AMAP has significant implications for our members and we will guard their interests and the interests of the profession and our patients very carefully;
- Completed reorganizing the components, committees, councils and task forces, moved the line item budget toward a functional budget with functional analyses of central APA departments, and prioritizing expenditures, cutting down on those with lower priorities, increasing those with higher ones, and making our expenditures conform to our strategic priorities;
- Working to influence the Residency Review Committee to increase and extend the teaching of psychiatry during residency programs;
- Working with other organizations to respond to general concerns about ethical considerations in psychiatric research involving human subjects;
- Supporting a neuroleptic malignant syndrome information service;
- Creating an Early Career Psychiatrist spot on the Board to replace one of the Trustee–at–Large positions, so as to increase the representation on the Board of those members who will constitute our future;
- Endorsing a meeting in October of the Mexican and World Psychiatric Associations, and another with both those organizations and the Canadian Psychiatric Association in January.

There are other matters, but this will give you an idea of some of what the Board is doing. I have never seen it more active.

Dr. Peyser's web site can be found by pointing your browser to: <http://members.aol.com/hspeysermd>.—Ed.

News From the District Branches

by Syed Abdullah, M.D.

The Bulletin would like to report on the activities of the District Branches throughout the state. To do this effectively we need a constant flow of information, including Newsletters, reports of professional, educational, legislative and community activities, etc., from all the DBs. We have already sent letters and E-mails, and have made phone calls to the DBs, only some of whom have responded promptly. We urge all of you to participate in this project of sharing information with your colleagues through the Bulletin. You can send your pieces to: Syed Abdullah, M.D. at 2 Hawk Street Pearl River, N.Y. 10965; Tel: (914) 735-5078; Fax: (914) 735-0318; E-Mail: <sydabd@aol.com> -Ed.

New York County District Branch

The following news bits were collated from the Newsletter of the N.Y. County District Branch:

The Task Force on Reparative Therapy met regularly for a year and held a total of eight meetings. They reviewed the literature and tried to get input from both proponents and opponents of Reparative Therapy. Based on this work, they have prepared a report to submit to the Council and are preparing to 'sunset' the Task Force.

All of the eight nominees for APA Fellowship were approved.

The Committee on Public Psychiatry is presently working on a proposed conference on jails/prisons and the Mentally Ill. This one–day program to be held Friday October 8, 1999 at the New York Academy of Medicine, will attempt to address the current crisis in our mental health care system as individuals with mental illness transition from the forensic system into the community.

West Hudson Psychiatric Society

A special program for police took place on May 11, 1999, under the initiative of Lois Kroplick, DO, Chair of Public Affairs. There was active participation by police departments from Rockland, Orange and other surrounding counties.

On Sunday May 23, 1999 a Picnic for Parity was held at the Mental Health Association Building in Valley Cottage. The keynote speaker at this event was Mr. Glenn Liebman, Executive Director of NAMI-NYS.

The West Hudson Psychiatric Society's award winning newsletter, Synapse, will be celebrating its 10th anniversary of continuous publication with the September/October issue. ■

Bronx Rolls Out Fall Art Show

Samples of work from upcoming art show sponsored by the Bronx Mental Health Coalition

The Bronx Mental Health Coalition (under the leadership of the Bronx District Branch) is sponsoring an art show this October at the Bronx Museum of Art. The show will consist of paintings, drawings, sculpture and other art forms produced by artists who are, themselves, in psychiatric treatment. These works will be judged by a curator staff of artists, art therapists, and others under the auspices of the Mental Health Coalition. The art show will be the focus of The Bronx's Mental Illness Awareness Week and Depression Screening activities for October 1999.

This year a formal opening reception will take place on Friday, October 8, 1999 between 11:00 a.m. and 1:00 p.m. during which the Bronx Borough President will issue the annual proclamation of Mental Illness Awareness Week.

The Bronx Museum of Art is located on the Grand Concourse at 165th Street. Its shows and activities for artists in the Borough were recently featured in the *New York Times*. The purpose of the show is to display the creative abilities and capacity to express feelings and ideas of people, who have, themselves, been affected by some mental illness and are now engaged in various forms of psychiatric treatment.

The art show will be open for viewing by the public for viewing by the public for the whole month of October.

The Bronx Mental Health Coalition, led by Michael M. Scimeca, M. D. of the Bronx District Branch, has been in the forefront of celebrations of Mental Illness Awareness for over six years. There are some 25–member organizations related to all levels of interest: hospitals, clinics, patient/consumer groups, family organizations, city/borough government offices. ■

President's Message

Continued from page 1

should be required when non-medical practitioners treat patients with serious mental illness.

- Since the January 1, 1999 managed care fee reductions were first introduced, NYSPA has worked to get our message out to managed care companies about the adverse impact of fee reductions on patient access to care. This has successfully contributed to reversals of fee decreases implemented by United Behavioral Health and Magellan.
- NYSPA is currently implementing a major joint APA-NYSPA recruitment effort targeted to reach psychiatrists in New York State who are not members of APA.
- At the recommendation of the NYSPA Task Force on Strategic Planning, NYSPA is establishing a new NYSPA Committee of District Branch Presidents to enhance communication with and between our DBs and improve the effectiveness of our state organization. The committee will hold it's first meeting at the Fall 1999 NYSPA Components Meeting.
- The Executive Committee has authorized NYSPA to join with the APA to provide financial support of the litigation in an important antitrust class action lawsuit (*Holstein v. Green Spring*) brought against the nine major managed care companies in the United States.

Finally, I wish to extend a special thanks to Leslie Citrome, M.D., M.P.H., Editor of the Bulletin and the entire Bulletin Editorial Board for maintaining the high standards of our organization's publication. This year the Bulletin was awarded an Honorable Mention by the APA. The Bulletin is a critical component of our organization's success. Through effective communication in the Bulletin, we can catalyze membership involvement in aggressive advocacy for our patients and our profession. ■

JCPA Chair

Continued from page 1

the development and implementation of its public affairs initiatives and strategies.

The JCPA develops recommendations for the Board of Trustees, which is the engine of change for the APA. It also receives Action Papers from the Assembly concerned with any aspect of public affairs. JCPA also reviews, advises and cooperates with all APA components regarding issues affecting the public image of psychiatry and public understanding of mental illness. JCPA and JCGR (government relations) work together on areas of mutual interest.

There is close synergy between JCPA and the Public Affairs Network, which is made up of the public affairs representative from each DB. All the Area Reps communicate with the members of the network in their area and bring their activities and concerns to the JCPA. There is also direct communication with the network through the DPA. Since so much of public affairs is local, the network is the lifeblood of our public affairs program.

I have had the pleasure of being part of JCPA as it was led by past chairs Drs. Ed Hanin, Harvey Ruben, and Nada Stotland. Meaningful creative programs have been produced which have greatly benefited the APA. I look forward working with JCPA as we move into the new millennium. In this time of changing health care ideas, the image of psychiatry must shine through. We can try to monitor all forms of media and be sure we use them all to the best of our ability (and our budget). Our best resources are the DB public affairs rep and committee. The APA can provide the guidance for media interaction, letters to the editor, ideas how to interact with police, libraries, schools, clergy, depression screening type programs, and so much more. We all must work together for a successful public affairs program. ■

Interview with Howard Telson, M.D.

By Martha Crowner, M.D.

Dr. Telson has directed New York State's outpatient commitment pilot program since July of 1995. On June 20, 1999 Dr. Telson was interviewed by Dr. Crowner, a psychiatrist at Manhattan Psychiatric Center. What follows are excerpts about the meaning of outpatient commitment, the Bellevue pilot project and the future. –Ed.

What is Outpatient Commitment?

Howard Telson, M.D.

Outpatient commitment specifically means one thing: that a court has ordered a patient with mental illness to comply with outpatient treatment. Commitment laws, whether for inpatient or outpatient care, have traditionally been the responsibility of the states. There are wide variations across the country regarding legal eligibility criteria, enforcement and patient protections in commitment laws. Implementation also varies because of differences in policy, administration and service funding. Some form of outpatient commitment is currently available in forty states.

What About Outpatient Commitment in New York?

While New York has permitted involuntary inpatient hospitalization since the nineteenth century, outpatient commitment has only been available for the past four years. After much debate, our state legislature called for the New York City Health and Hospitals Corporation to operate a pilot program, and for an independent evaluation to be performed. The New York City Department of Mental Health funded and strongly supported the Bellevue pilot. There was enormous cooperation also from the New York State Office of Mental Health, and from the provider community throughout the five boroughs.

Why Was There So Much Interest?

Outpatient commitment was intended to fill a gap. Clinicians and families wanted a way to help individuals with severe mental illness live safely in the least restrictive setting. Deinstitutionalization improved the lives of many patients, but did not address the needs of many others. Some patients who do not fit dangerousness criteria for inpatient admission are nonetheless highly symptomatic. The government wanted to deal with the well known problem of severely ill patients living in the community and repeatedly decompensating because of noncompliance: the so-called "revolving door syndrome." It became clear that in addition to housing and outreach-oriented community mental health programs, there was a need for a legal tool to promote compliance. There was a recognition that mental illness sometimes interferes with a patient's acceptance of available services.

What Are the Criteria for Outpatient Commitment Under the Pilot?

The statute defines eight criteria for patient eligibility. The individual must be over 18, suffering from a mental illness, and be incapable of surviving safely in the community without supervision, based on a clinical determination. The individual must be a Bellevue inpatient, and must have a history of two involuntary psychiatric hospitalizations due to noncompliance within the 18 months prior to referral. The referring physician must also predict that the patient is unlikely to voluntarily participate in the recommended treatment, and be in need of and likely to benefit from outpatient commitment. The judge, of course, makes the final determination of whether the clinical recommendation becomes an actual court order.

What Happens if Patients do not Comply?

Violation of an outpatient commitment order carries no criminal sanctions. The law provides a mechanism for involuntarily transport to Bellevue if a patient is noncompliant with an outpatient commitment order, efforts have been made to solicit compliance, and the patient may be dangerous and require admission. A physician must examine the patient and make these determinations, and a designated Bellevue psychiatrist must agree before the Sheriff can bring the patient to the hospital. The actual protocol took over three years to negotiate, and has not been used to date in the pilot. Patients have, of course, been re-hospitalized, using the various legal mechanisms already in place in New York.

It's important to recognize, though, that a court order may have great value before a patient requires hospitalization. In some cases, the order allows initial engagement with service providers. In other cases it serves as an ongoing reminder that clinicians and the court believe that compliance with outpatient treatment is necessary to prevent relapse. Outpatient commitment can counteract the profound ambivalence that is so often a part of psychotic disorders. It increases accountability, both from patients and from the mental health system.

What About Medication Noncompliance?

Of all the states that have outpatient commitment, only Wisconsin provided for the involuntary administration of medication until the New York pilot. The New York guidelines defining the manner and place for this were the result of a long, collaborative process. The guidelines state that a physician can only force medication by injection; you can't use NG tubes at all. They also indicate that if the patient refuses medication, but offers no physical resistance, the physician may administer an injection. However, if the patient shows physical resistance, medication may only be administered in a hospital or emergency room.

What Has the Pilot Taught Us?

Outpatient commitment research around the country over the past twenty years has found that it helps reduce rehospitalization rates and length of stay, and reduces dangerousness in the community. While the independent research about the pilot reported no statistically significant findings, the numbers suggested trends that are consistent with the positive results of other studies.

There is no question that good, coordinated clinical services help seriously ill patients do better in the community. Beyond that, though, it is clear that outpatient commitment often helps patients accept necessary treatment, and improves outcomes. It's value during the pilot has been apparent to many providers, family members, and others. Despite the fears of some critics, it really has not been found to be harmful. Outpatient commitment is not a panacea, but when used carefully and appropriately, the benefits are compelling.

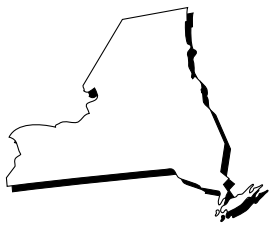
What Do You See for the Future of Outpatient Commitment in New York?

The Bellevue pilot is authorized by statute until June 30. Over the past few months a number of bills have been proposed to make outpatient commitment available statewide. Because court ordered outpatient treatment appears to have substantial bipartisan support, I think that there is a real possibility that a state law can be passed and signed. I strongly support this, and hope that the Bellevue experience will inform the process. A clear, fair law, that can be effectively administered and enforced, would be a great asset to our patients, their families, our professional colleagues and our community.

Nothing is certain, though. Some consumer advocacy and other organizations oppose outpatient commitment. Some providers are quite concerned about liability. Supporters have a variety of goals and expectations for a state law. Negotiating something that is satisfactory to the many interested parties will be a delicate process.

There are currently 115 patients with outpatient commitment orders under the Bellevue pilot; the vast majority are in the community and in treatment. I certainly hope that they can continue to benefit from a legal intervention which promotes compliance with their outpatient care and improves their quality of life.

As the Bulletin goes to press, the NYS Legistature is working on a statewide outpatient commitment law. —Ed. ■



Albany Report: A Close Call!

Barry B. Perlman, M.D.,
Chair, NYSPA Legislation Committee

Richard J. Gallo,
NYSPA Government Relations Advocate

During this legislative session NYSPA faced its greatest challenge in many years — the Omnibus Mental Health Licensing Bill. Despite concerted efforts by the sponsors and supporters, at the end of the session in August, the bill remains on hold. The Senate bill, S.2990-D by Senator LaValle (R-Suffolk) has been recommitted from the floor of the Senate to the Senate Rules Committee. The Assembly companion bill, A.5410-D by Assembly member E. Sullivan (D-Manhattan) remained in the Assembly Codes Committee since late June.

The bill would create four new mental health professions — mental health counseling, marriage and family counseling, creative art therapy and psychoanalysis — and establish a scope of practice for each new profession that includes the treatment of mental disorders without qualification or limitation of any kind. The bill also includes a new scope of practice for psychology and social work that also includes the diagnosis and treatment of mental disorders.

The bill seriously encroaches on the scope of practice of medicine and confers an unlimited scope of practice on all six professions. The bill would permit all six non–medical professions to treat independently and without any medical involvement all mental disorders including serious mental illnesses such as schizophrenia, major depressive disorder, manic depressive disorder, panic disorder, obsessive compulsive disorders and any other mental illness with a history of serious functional impairment.

The bill is supported by associations for all six non–medical professions representing hundreds of thousands of non–medical practitioners in this state. In the face of this juggernaut, NYSPA mounted a vigorous and active response. Barry Perlman, M.D., NYSPA Vice–President and Chair of the Legislation Committee, Richard Gallo, NYSPA Legislative Consultant, and Seth Stein, NYSPA Executive Director and General Council, met with the sponsors early in the session to express serious objections to the bill. They also met with representatives from the Medical Society of the State of New York to secure its support. The response from MSSNY was swift, unqualified and unambiguous — MSSNY vociferously expressed its opposition to the bill in its present form as an unwarranted encroachment on the scope of practice of medicine. Throughout every stage of the session, MSSNY staff and leadership stood shoulder to shoulder with NYSPA representatives in the halls of the state legislature expressing opposition to the bill in its present form.

The Team That Saved the Day

Left to right: Richard Gallo, Government Relations Advocate; Gerard Conway, Director, Government Relations, MSSNY; Barbara Ellman, Legislative Associate, MSSNY; Elizabeth Dears Kent, Counsel, MSSNY; Seth Stein, Executive Director & Counsel, NYSPA; and Barry B. Perlman, M.D., Vice President, and Legislative Chair, NYSPA.

However, NYSPA and MSSNY agreed to do more than simply oppose the bill. NYSPA and MSSNY also agreed to try to work with the sponsors of the bill to pass a bill that would address the issue of unlicensed and unregulated therapists while maintaining the distinction between physicians and non–physicians and protecting persons with serious mental illness who need treatment. In order to make sure that NYSPA exerted the maximum effort, NYSPA retained the services of Philip Pinsky, Esq., former counsel to the NYS Senate Majority Leader, and Andrew Roffee, Esq., former counsel to the Assembly Speaker, to help craft language to address the concerns of the sponsors, NYSPA and MSSNY. Pinsky and Roffee provided many years of combined expertise in the Albany legislative process and the bill drafting process. Because of the potential national impact of this bill, NYSPA requested and received financial assistance from the American Psychiatric Association to help defray the additional cost of responding to the challenge of this bill.

Over several weeks, Mr. Pinsky and Mr. Roffee worked with NYSPA staff and legislative chair to review the bill, sharpen our arguments and develop bill language for presentation to the sponsors. Pinsky and Roffee, together with NYSPA and MSSNY staff, spent many hours with the sponsor's staff reviewing the bill, identifying issues and trying to achieve agreement. While some progress was made, on the critical issues NYSPA could not secure any agreement. NYSPA objected to designating psychoanalysis as a distinct profession and argued that psychoanalysis is a treatment modality, not a profession. Most important, NYSPA maintained that the bill should include language requiring non–medical mental health practitioners to secure medical input and evaluation when treating persons with serious mental illness.

At the end of this session, because of the combined efforts of NYSPA, MSSNY and other groups opposed to the bill, the bill remained on hold when the legislature adjourned for the summer. However, the battle over this bill is just beginning. The sponsors and proponents of the bill have not given up and will undoubtedly redouble their efforts next year to pass this bill. In turn, NYSPA and its membership must be prepared to meet this challenge. ■

Pizza for Parity

Delivering a pizza with a slice missing brings the message to legislators that health insurance is incomplete without mental health benefits. More on the fight for parity in forthcoming Bulletins. Left to Right: Tracy Tress (NYS Psychological Association), Glenn Liebman (New York Alliance for the Mentally Ill), Davin Robinson (State Communities Aid Association), Richard J. Gallo (NYSPA), Senator Thomas Libous (prime sponsor of the parity bill), Brian O'Malley (NYS Association of Social Workers), Joe Glazer (Mental Health Association - NYS), and Ruth Foster (NAMI).

Does the APA Need a Minority Trustee?

By James C.-Y. Chou, M.D.

Dr. Chou is a member of the Bulletin Editorial Board and recently chaired the APA Assembly Committee of Minority/Underrepresented (MUR) Groups. He is also the Assembly Deputy Representative for the APA Caucus of Asian-American Psychiatrists. Dr. Chou welcomes your comments and would like your input. -Ed.

James C.-Y. Chou, M.D.

Does the APA Need a Minority Trustee? This question has been under discussion in some components of APA and will receive more thorough discussion this fall. APA prides itself as being committed to supporting minority and underrepresented (MUR) issues and promoting diversity. Such a laudable position is stated virtually everywhere throughout APA policy, and the many APA actions that deal with minority issues suggest a strong commitment.

But how serious is this commitment? Is it reflected in the governance of the organization? How diverse is the membership, and more importantly, how diverse is the leadership? The data for the membership and the Board of Trustees (BOT) are shown in the following table. From this data, it becomes clear that the BOT is not nearly as diverse as the membership (See table).

First, among the seven identified MUR groups, only Blacks have had elected BOT representation comparable to their representation among the membership. Although Hispanics and Women have achieved some representation on the BOT, they continue to be markedly underrepresented. Some of the women elected to the BOT were the Member–in–Training Trustee, a position with much more diverse representation than the other Trustees.

Asians and IMGs have essentially had no representation on the BOT. This is particularly troubling since these groups are fairly large within the APA membership and have had BOT representation less than 1/20 of their representation in the membership.

The low BOT representation of Native Americans and Gay/Lesbian/Bisexuals (GLB) is more difficult to interpret because the Native American membership is so small, and the counting of GLB is an underestimate due to underreporting and confidentiality.

Table: Minority/Underrepresented (MUR) Representation on the APA BOT 1970–1998

	Current APA Membership (%)	Among 210 BOT Members Elected Since 1970 (%)
Women	28.2	19.0
Black	2.3	3.8
Hispanic	4.4	2.4
Asian	9.0	0.5
Native American	0.07	0
Gay/Lesbian/Bisexual caucus	0.45	0
IMG	22.5	0.9

Thus, the inescapable conclusion is that the BOT is significantly less diverse than the membership, In fact, the BOT is largely a group of heterosexual, American–trained, White males over the age of 50 making policy decisions for an APA that prides itself in being sensitive to minority issues. The message that this sends to the MUR membership is very clear.

What Mechanisms Currently Exist to Enhance BOT Diversity?

Currently, several mechanisms have, either inadvertently or by design, affected MUR representation on the BOT. The three Trustee at Large positions are sometimes viewed as being more accessible to MUR candidates. The Nominating Committee, which includes diverse representation and nominates all national candidates, has worked actively to nominate many MUR candidates. Other mechanisms which may enhance MUR representation on the BOT are the Member–in–Training Trustee (MITT) and the proposed Early Career Psychiatrist Trustee (ECPT). Both of these Trustees are selected from younger and more diverse constituencies, which should over time enhance diversity on the BOT. Unfortunately, all these mechanisms together have so far been unsuccessful at producing a diverse BOT.

What Are the Choices?

The choices are basically either to accept the status quo perhaps with some minor changes, or to do something different. Several components have been discussing this issue over the past year. The proposed change under consideration is that of a designated Minority Trustee. So far, this is the only option considered likely to enhance voting representation of MURs. The Minority Trustee must be a member of one of the seven

[See **Viewpoint** on page 8]

Viewpoint

Continued from page 7

MUR groups and would be charged with speaking to all MUR issues. Nominations would come from the nominating committee in the usual manner, and the entire membership would vote on the candidates.

Many other important details of implementation have not yet been worked out and are certain to be discussed throughout APA during the fall. These may include the tenure as well as how representation should be shared among the seven MUR groups.

What are the Drawbacks of a Minority Trustee?

If one begins to consider the drawbacks, it is easy to focus on these and to forget about the benefits. The Minority Trustee could become a second class token position on the BOT with limited influence, and possibly with limited potential to attain other leadership positions. This could eventually develop into a worsening marginalization of MURs within APA. Another potential problem is the implementation process and avoiding conflicts amongst the MUR groups. It could be difficult for one individual to effectively represent so many diverse groups. Furthermore, if one group was repeatedly successful in winning the Minority Trustee election, other MUR groups might feel left out.

What are the Benefits of a Minority Trustee?

The fundamental benefit of a Minority Trustee is that MUR groups would have a voting voice on the BOT. Basically, in spite of existing well–intentioned efforts, there has been little and inadequate voting MUR representation on the BOT. When there has been any it has been transient. This is unlikely to change without a designated Minority Trustee in part due to the nature of the election process. Such a conclusion is supported by the statistics in the Table above showing MURs on the BOT. Moreover, a Minority Trustee position should create a situation allowing sufficient grooming to facilitate MUR candidates to rise further in the leadership ultimately enhancing the diversity of the BOT.

Summary

In summary, the BOT lacks diversity. An organization which is committed to promoting diversity and minority issues needs to enhance the diversity of its governance, and this should begin at the top with the BOT. If APA decides that this is a desirable objective, then the Minority Trustee may be the only way to achieve this inasmuch as nothing else has worked so far.

If APA is not convinced that there should be more diversity on the BOT, then it is easy to dismiss this as an unfeasible idea. The consequence of that will be little if any change in the diversity of the BOT.

In contrast, if APA considers the diversity of the BOT to be important, then perhaps the unavoidable problems encountered with implementation are worth addressing. These drawbacks could be resolved with a concerted effort from all MUR groups and the APA leadership. While affirmative action has its pros and cons, if the under-representation is severe, as it is in this case, then it is a reasonable alternative. ■

Forty Years Ago in The Bulletin

By Leslie Citrome, MD, MPH

Thanks to Mary Cliffe, Executive Director of both the Bronx District Branch and of the Psychiatric Society of Westchester County, I received several old issues of The Bulletin, beginning with Volume 1, Number 1 from April 1959, and continuing on through the 1960s. Extracted from the 1959 issues are some highlights that give credence to the adage "the more things change, the more things remain the same." I welcome others to send in their old issues of The Bulletin, particularly 1960-63 and 1969-1979. –Ed.

James P. Cattell, M.D. outlined the issues of interest to the 10 New York DBs in his editorial comment in the first issue of The Bulletin (April 1959). Of special concern were the practice of psychotherapy by non–medical people, health insurance coverage for patients with emotional illness, licensing of chiropractors in NY State, treatment of narcotic addiction, tax–exempt retirement savings, and the participation of psychiatrists in local mental health organizations.

Issue #2 (May 1959) had interesting classified notices (at 15 cents a word). New Jersey State Hospital in Marlboro was seeking a Clinical Director for a salary of $12,603-16,383. South Oaks Hospital on Long Island was offering $9,000-12,000 to start for a full–time psychiatrist. The issue itself included a front–page article on a study proposed on insurance for psychiatric treatment. The tentative fee schedule was $15 for 45 minutes of individual psychotherapy, plus $5 to be paid by the patient.

Page 3 outlined the news that Lester Shapiro, M.D., Nassau DB, was elected Recorder at the Assembly of Delegates of the APA. Page 4 reported on the reorganization of the New York County DB, complete with a new committee structure, and completing a merger between the DB and the former NY Society for Clinical Psychiatry.

Issue #3 (September 1959) announced a successful divisional meeting, with a scientific program chaired by Max Fink, M.D. The other front page story was of a favorable opinion by the Attorney General's office concerning lay psychotherapy – "The practice of psychotherapy is restricted to the medical profession, according to the Medical Practice Act". The issue came to a head with the N.Y. Telephone Co.'s intent to list "Psychotherapists" in the Manhattan Classified Directory.

Another hot topic was a proposed de-licensure bill which originally proposed that the Board of Regents suspend the license of anyone who was confined to a mental institution for more than 60 days.

That same issue reported that Walter Obenauf, M.D., retiring Speaker of the Assembly, recommended that each state have no more than one DB. A state DB, in turn, could have as many "chapters" or local societies as the concentration of psychiatrists warranted. This proposal was made during the meeting of the Assembly in Philadelphia, April 27-28, 1959. The Assembly voted not to accept this plan and the issue was tabled for further study. This plan was proposed in view of an increasing number of applications for the formation of new DB's in defined geographical areas that contain 20 or more psychiatrists. There is said to be a danger of "fragmentation" of existing DB's and a danger that the Assembly might become "unwieldy" with an increase in the number of delegates from DB's.

Sound familiar? ■

NON–PROFIT ORG.
U.S. Postage
PAID
New York, NY
Permit No. 4556

New York State Psychiatric Association
Area II Council - American Psychiatric Association
100 Quentin Roosevelt Blvd.
Garden City, NY 11530