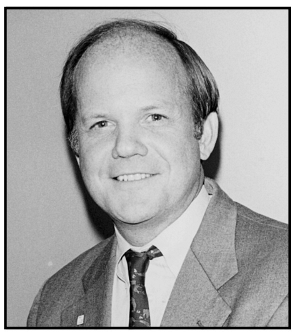
THE BULLETIN
NEW YORK STATE PSYCHIATRIC ASSOCIATION
Summer 2001, Vol. 44, #2 • Bringing New York State Psychiatrists Together

President's Message
ECT Under Attack - NYSPA Responds

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


Jim Nininger, M.D.

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

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

In response to these challenges, NYSPA has taken the following steps. Laura Fochtmann, M.D., Associate Professor of Psychiatry and Behavioral Science, SUNY Stony Brook University Hospital and Director of the ECT Therapy Service at Stony Brook (and the DB Representative from the Greater Long Island Psychiatric Society) met with Martin Luster, Chair of the Assembly committee holding the hearings, and his staff, to provide

[See **President's Message** on page 3]

New NYS Medicare Carrier Policy on Mental Health Services

NYSPA Advocacy Results in Over $2 Million in Annual Medicare Reimbursement

by Seth Stein, Esq.


Seth Stein, Esq.

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

The policy establishes new requirements for documentation of the initial diagnostic interview (90801), psychotherapy and pharmacotherapy (90862), new coverage definitions for psychiatric services and new standards of medical necessity that will be applied by all the Medicare carriers in their review of Medicare services.

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

[See **NYSPA Advocacy** on page 8]

What PA Reps Do

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

When they first take the job, DB public affairs representatives begin to realize that they are expected to perform the range of activities of a trained PR person. Few would even have thought of public relations as an alternative career, yet we do learn to "stay on message," write letters to the editor, build coalitions, talk to reporters and put on events. For the coming year, the goal of the PA Committee will be to help broaden the skill set of each DB rep with public relations tools and techniques taken from professionals. The Committee will work to facilitate knowledge transfer from the new APA Division of Communications and Marketing in Washington.

Over the past year, the Public Affairs Representatives of the DBs have continued to come up with creative and powerful ways to keep psychiatry in the public eye. Working with their very active mental health coalition, West Hudson reported how members from other organizations such as NAMI may have better contacts with the press than we do, and can facilitate communication. Moreover, coming from a consumer group, a message favorable to psychiatry will not risk the appearance of being self-serving.

New York County DB is studying the possibility of producing a newsletter for the general public focusing on the theme of "Good Medicine." The publication would be patterned after one from the Louisiana DB, where it was helpful in a fight to educate the public about psychologist prescribing. Westchester's Mental Health News is another model, where an independent consumer publishes a periodical that is positive towards psychiatry and has received enthusiastic support from the DB and local hospitals.

What is the top issue in the minds of PA reps? In a recent email survey, there was little uniformity about which was the top priority, but three areas were seen as important: The image of psychiatry, access to affordable care, and stigma. What can we do to promote our message on these issues? "Scan for OPPORTUNITIES to communicate about our ISSUES using PR TOOLS like speaking, writing, relationship building, organizing and, most of all, supporting the energy and work of others." ■

INSIDE THIS ISSUE:

The Other Side of Parenting

by Roxanne Lanquetot, MA, MS.

Ms Lanquetot worked at Bellevue's Public School 106, serving the educational needs of the children hospitalized on the in-patient psychiatric units. Two years ago she retired after more than a quarter-century of service in order to devote herself to writing. In conjunction with the Nursing Service, Ms Lanquetot has led support groups for the extended families of the hospitalized children. She understands families of the mentally ill and can identify with them, not only because of raising a son who became ill with schizophrenia, but also because she was brought up by a mother with schizophrenia. Ms Lanquetot's articles have appeared in The Wall Street Journal, Newsday, Schizophrenia Bulletin, Access, and NAMI publications. She is a member of the Leadership Council of NARSAD, and of NAMI and its affiliates.-Ed.

By now many people have written about the sadness and loss that parents experience when their children become mentally ill. Parents who formerly kept silent, fearful of the stigma attached to parenting a mentally ill child, are telling their stories to help the public and professionals understand the burden of mental illness on families and friends and the difficulties in getting optimal treatment. But what about the families who don't speak out? How do they feel?

Andrew Goldstein pushed Kendra Webdale in front of a subway train in New York City on January 3, 1999. Kendra was killed. In March or April of 1999, Julio Perez pushed E. Rivera into the path of a subway train, and his legs were severed. The assailants, both of them paranoid schizophrenics, were convicted of murder and attempted murder respectively. The main focus of both trials was the law, not the men who are mentally ill or the inept mental health system. Unfortunately Kendra Webdale is *dead*, and nothing can bring her back. Andrew Goldstein is *sick* and needs treatment. Mr. Rivera is using artificial limbs. He is *handicapped*. Mr. Perez is *sick* and needs treatment. Where were the patients' families during the trials? Why didn't they come to court to offer support for their sons? During the Goldstein trial the media intimated that Andrew Goldstein's parents were cold and uncaring since they did not attend the trial. Jurors agreed that the failure of the family to appear in court hurt the case since their absence was interpreted as support for his conviction. Nothing was said about the Perez Family. Had they given up, or did they not understand English well enough to follow the proceedings?

Everyone has been blamed for the violent acts of the mentally ill: patients, the state, the mental health system, providers, and parents for "bad" parenting of the children. It is unfair to hold parents responsible for an illness due to a biological brain disorder, as yet neither completely understood nor preventable. They are as appalled by these violent acts as the general public, but they do not necessarily reject the children because of their illnesses. As the mother of a schizophrenic son, I know from personal experience that the feelings and emotions of parents of schizophrenics are almost as complex as the diagnosis, treatment, and origins of the illness itself. The fact that Andrew Goldstein's parents did

[See **PARENTING** on page 8]

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: (845) 398-5595
Fax: (845) 398-5483
e-mail: citrome@nki.rfmh.org
http://www.nyspsych.org/bulletin

Thomas E. Gift, M.D.
Howard Owens, M.D.
Jeffery Smith, M.D.
Ann Sullivan, M.D.
Howard Telson, 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: centraloffice@nyspsych.org
http://www.nyspsych.org

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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 editor for current rates and media requirements. NYSPA members receive a discount of 50% off the basic classified ad rate.

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

From the Editor's Desk…
Shall We "Deep Six" The Bulletin?


Leslie Citrome, MD, MPH

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

The Bulletin has a long tradition of reporting back to NYSPA members news and events that would have a state–wide appeal. It continues to serve as a reminder that there is a state–wide organization that actively lobbies on the state level for our concerns. It also serves as a forum that has the potential reach of all 5,000 NYSPA members. Funding of the Bulletin comes from a combination of NYSPA dues (66%) and advertising revenues (34%). On a per-member per-issue basis, the Bulletin costs about $1 of dues revenue. Advertising revenues are cyclical, and past performance is no guarantee for future returns.

Ten years ago, the Bulletin was the only practical mechanism to get NYSPA news in the hands of its members. Today, the internet has emerged as a reliable and relatively easy method of communication. With the proliferation of office and home computers connected to the internet (and their presence in almost every public library), we can reach 100% of the NYSPA membership. The only obstacle is that the printed Bulletin comes passively in your mailbox, and the NYSPA website must be actively accessed. The latter requires some effort, especially if you have to go to the library.

An alternative is to continue to maintain an up–to–date website, and issue on an annual basis a printed report from NYSPA. The latter can be in an easy–to–read newsletter format that would give a clear and concise summary of the year's activities. It can include advertising to defray the cost of publication. This report can be distributed at the same time as the Medicare Fee listings that we have grown accustomed to receiving each year.

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

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

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

Shall We "Deep Six" The Bulletin?

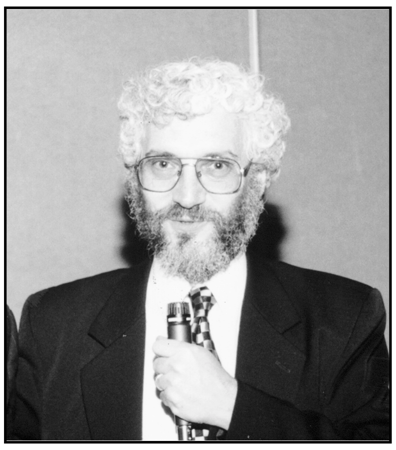
Call or E-mail Today, and Vote Yea or Nay!

COMMENTARY

Teaching 101: Healing

by William M. Greenberg, M.D.

Dr. Greenberg is an Attending Psychiatrist on the Clinical Research and Evaluation Facility at the Nathan S. Kline Institute for Psychiatric Research, a joint venture with Rockland Psychiatric Center, in Orangeburg, New York. He is active in the New Jersey Psychiatric Association (NJPA) and was formerly the Director of Residency Training at Bergen Pines Regional Medical Centerin Paramaus, New Jersey.What follows is his award-winning editiorial that appeared in the NJPA Newletter in Winter 2000.This article won the prize for best editorial in the 2001 APA Newletter Competition. –Ed.


William M. Greenberg, M.D.

"Doctor Greenberg, maybe you could help me with what medication this patient should be getting." My resident began her case presentation with this question. The patient carried a diagnosis of Schizoaffective disorder, bipolar type, had mild tardive dyskinesia, and was taking several medications, including Prolixin decanoate – should she instead be on an atypical antipsychotic? Always good to have a specific question – just like a consultant, you can focus your thinking.

The case became the story of a woman who had deliberately killed her then two-year-old son some years ago. As I listened I did not think of medication adjustments as a first, second or third priority, but of finding a way for her doctor to establish a real and reliable connection, to be able to fully empathize with what this woman would have to live with for the rest of her life, to support defenses that not only currently worked for the patient but would also allow her to continue to live with this terrible knowledge, to find adequate meaning and purpose in her life, and to support and expand her psychosocial functioning with a suitable program and social skills training.

I never got around to discussing medication.

I did, however, get around to thinking about how I might be coming across to the residents in my training program – perhaps too much as someone principally interested in teaching them psychopharmacology in depth. And if they finally learned every medication's receptor actions in detail, its pharmacokinetics and metabolic pathways, and which hepatic enzymes were inhibited or induced – then indeed, what wonderful technicians they might be.

I felt very unsettled. This was not the way I worked with my patients. Moreover, our future will not be in treating the worried well, or those who easily respond to their internist's hopeful words and Prozac. If we are to be working with the more-difficult-to-engage-and-to-treat patients, those with formidable resistances, those labeled "treatment–resistant," those most ambivalent about indicated treatment, those most suicidal, those with the least hope, most impulse-control problems, most cognitive problems, the most lonely, the most rejected, we need to be more than technicians with good knowledge, good intentions and good manners. We need to be healers.

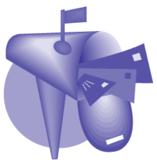
How can I get this message across to my residents? They are surrounded by messages of what is supremely important – efficiency, productivity, measurable outcomes, up-to-date treatment plans, pharmaceutical company mantras, liability dilemmas, caveats about how one must behave professionally and how to not get too involved and cross boundaries when trying to practice psychoanalytic psychotherapy. And, they are constantly facing their own anxieties about still being new at all this, still being in training.

I will share my secrets with them – what has worked for me, and can for them. Often still feeling like a beginner and having much room for improvement, I nonetheless know when I am doing well. It is when I genuinely care and that attitude is apparent and gets actualized. It is when I try to know the whole person and family, and try to help them know the possibilities of mindfully living every moment without low self-esteem, self-defeating thoughts and feelings they may not be able to tell another living soul, while I have the attitude of a healer. Scientific-minded and agnostic, it is when I can yet connect meaningfully with a patient at a spiritual level, but be able to find enough objectivity and a professional stance to not do injustice to boundaries. It is all right, I tell my residents, not to be perfect. It is all right to be anxious, or have been seriously depressed once yourself: the wounded healer can bring depths of empathy and knowledge unknown to others. It is all right to make honest mistakes, if you can admit them. It is all right to apologize. It is all right to feel overwhelmed at times, fully sharing horrible truths. It is not all right not to care enough. ■

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

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

email:
citrome@nki.rfmh.org



APA Assembly Acts Assiduously

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

The meeting of the Assembly of the American Psychiatric Association took place May 4 through 6, 2001 in New Orleans, Louisiana.

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

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

The meetings themselves take place in huge ballrooms set up with rows and rows of tables. Each DB has a nameplate in front of where they sit. DBs are organized into Area Councils (ours is Area II/New York State Psychiatric Association). The DBs in each Area sit together. It is an impressive sight and reminds one of parliament, and in fact parliamentary procedures are used.

Members can bring up issues in the form of Action Papers, which are debated and voted upon. In this way, the Assembly can influence what the APA does for itself and its members. Because all DBs are represented, the Assembly is probably more representative of APA membership than the other structures of our organization, such as the Board of Trustees (a relatively small elected body) or the Components/ Committees (appointed).

The first meeting of the Assembly was held May 5, 1953 (then known as the Assembly of District Branches). Then-President Kenneth E. Appel, MD, made some introductory remarks that the Assembly "…try to devise ways and means to tap the pool of energy that exists in the younger men who are members of the APA, and to devise ways and means whereby they may become more interested in the activities of the Association and work for it." The Assembly today affords the opportunity to witness firsthand how the APA functions and by sheer size, provides a realistic way in for interested members.

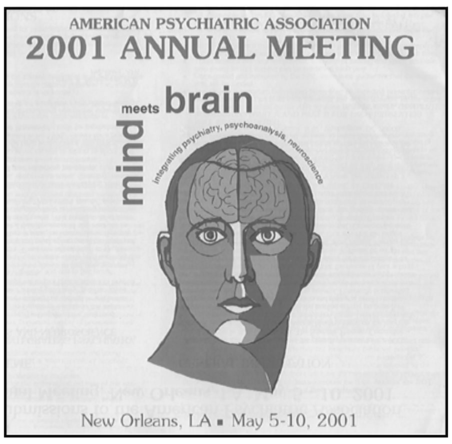
Recently there have been moves to economize by decreasing the expenses of the Assembly. This is being done in several ways, including the elimination of direct funding for Deputy Representatives to attend the November meeting, and the elimination of Orientation. Although preferable to eliminating these positions entirely, it poses a hardship to the local DB who may want to send a Deputy/President-Elect.

The total number of votes in the Assembly is 31,368, representing the number of APA members eligible to vote. Each Assembly representative can carry from one vote (members of the Assembly Executive Committee such as the Speaker, Speaker–Elect, Recorder, etc.), to several hundred (representatives from the large District Branches). Usually votes are done by a simple count of "yeas" and "nays", but for election of officers and by request, some votes are conducted "by strength", that is, the votes of each representative will vary in number depending on the numbers of eligible voters they represent (similar to stockholders voting their stock).

In New Orleans this year several action papers were actively debated. Among those that passed include:

- Medicare Discrimination Against the Mentally Ill
- Tag Line to Accompany APA Logo
- Condemning the Chinese Government's Misuse of Psychiatry
- Faculty Competencies for Residency Training in Psychotherapy
- Have the APA Explore the Issue of the Separation of Axis I and II Disorders
- Establishment of Child Psychiatry Fellowship Award for General Psychiatric Residents
- Advocating for the Clear Implementation of Privacy Protections
- Physician Prescribing Information Being Shared with Third Parties for Commercial Reasons
- APA Responsiveness to membership
- Parity in Representation Within the APA
- Optimizing APA's Financial and Business Expertise
- APA Commitment to Psychiatrist Members Who are Parents of Young Children

An Assembly Action Paper Tracking System was demonstrated and will be available to all members on the APA website. This will provide the opportunity to see what exactly the Assembly is doing and how these recommendations are being followed up. Your Assembly Representative can provide you with additional information. ■



President's Message

Continued from page 1

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

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

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

MediComment: Coding Q & A

By Edward Gordon, M.D.

Ed Gordon, M.D.

Q: As a geropsychiatrist I end up doing detailed cognitive exams on my patients. Where and how do I code for the Boston Naming Test, Hopkins Learning tests, Thurstone, etc.

A: For the kind of tests you are performing, you can bill for Psychological tests using codes in the groups starting with 96100. Aphasia testing is coded at 96105. The definition is:

> "Assessment of aphasia (includes assessment of expressive and receptive speech and language function, language comprehension, speech production ability, reading, spelling, writing, e.g., by Boston Diagnostic Aphasia Examination) with interpretation and report, per hour."

There are five psychological testing codes in the section called: "Central Nervous System Assessments/Tests (e.g., Neuro-Cognitive, Mental Status, Speech Testing)."

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

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

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

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

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

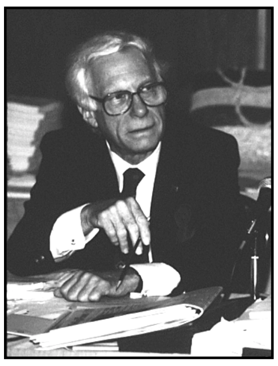
If billing is by a clinic, however, or a group practice, the Correct Coding Initiative (CCI) rules may prohibit payment for two services on the same day in the same facility. (This will be the subject of another Medi-Comment).

CPT codes are listed in CPT, published annually by the AMA, and well worth the small investment to buy and learn how to use. It will increase your income, and reduce your exposure to audits. CPT 2001 can now be ordered from the AMA at 800 621-8335 or online at <www.ama-assn.org/catalog>. Order the Medical Specialties set of two books, (CPT plus the specialty mini book), Catalog # OP054201BDT. ■

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

Pros and Cons of Medem

by Herb Peyser, M.D.


Herb Peyser, M.D.

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

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

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

Some APA members feel websites and Medem are useful; others don't. Some point toward better–capitalized competition, already in place. Some are concerned about advertising on their websites, or the cost of unsponsored ones.

More Capital Needed

Medem, as several of us expected, needed more capital and came back to the Board in October 1999 for a second round. Three of us opposed that both as getting involved with a financial situation not within our expertise and as questionably in accordance with APA's priorities and limited resources. (With our Medical Director already on Medem's board, should another $750,000 go to increase his length of stay there and APA's Medem influence and shareholdings? Or should some or all go to DBs/SSs for state level scope of practice legislative advocacy?)

The Board weighed it, decided to support it. In March 2000 dot-com share valuation and loan markets dropped precipitously, investors and advertisers faded away.

Practice Management Services

Medem had always been interested in not only content but practice management, i.e., partnering, working with, selling to, acquiring or merging with other, better capitalized outfits to offer member websites patient-physician interaction, appointments, clinical information, billing, claims form submission, prescriptions, refills, reminders, etc. Medem came back to the Board last February for review of APA's license with Medem, to make Medem more commercially attractive.

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

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

Caveats

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

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

Watchdog

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

Contracts

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

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

NYSPA NOTES:

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

CONGRATULATIONS!

Fellowship

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

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

Info Systems

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

Advocacy

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

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

Additional

The Board voted a position statement opposing discrimination against IMGs. The Board had voted to fund the DB/SS Legislative Reps to the Federal Institute last March. Air miles will be added to the APA Credit Card. APA elections will continue to use on-line voting as well as paper ballots. ■

BOOK REVIEW

Schizophrenia and Comorbid Conditions: Diagnosis and Treatment

Edited by Michael Y. Hwang, M.D. and Paul C. Bermanzohn, M.D., Washington, DC: American Psychiatric Press, Inc., 238 pages, 2001.
Reviewed by William M. Greenberg, M.D.

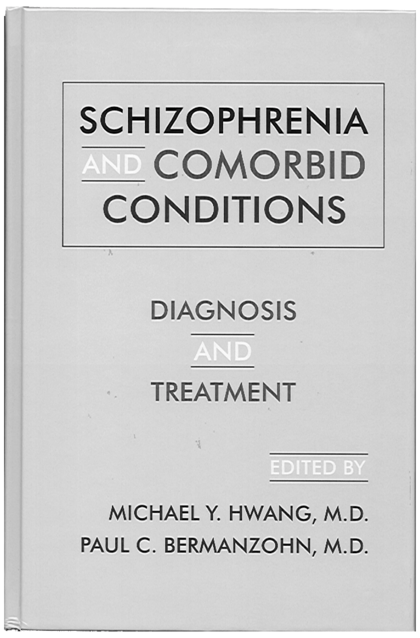
Dr. Greenberg is active in the New Jersey District Branch but has kindly agreed to write this book review for The Bulletin of the New York State Psychiatric Association. Dr. Greenberg is an Attending Psychiatrist at the Clinical Research and Evaluation Facility, a joint venture between the Nathan S.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

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

But what of the subtitle: *Diagnosis and Treatment*. Considering what the authors call the *associated syndromes in schizophrenia* (depression, obsessive-compulsive symptoms and panic attacks), what could one make of a literature in which samples of patients with schizophrenia are found to have rates of depression of anywhere from 7% to 75%, of obsessive-compulsive symptoms of 1% to 59%, of panic attacks in 6% to 63%? And what of the very few treatment series, often open-label and sometimes just isolated case reports? The authors of this book offer intelligible understanding of the nosological and epidemiological disparities, and provide concise reviews of the available studies of treatments. The writing is clear, the controversies of the field succinctly summarized by authors who have been seminally involved in the topics (e.g., Sam Siris on depression and schizophrenia). Given the sparse number of small studies and case reports of uneven scientific quality, however, these first few chapters do not provide "how to" approaches for treatment; the clinician still has only a few footsteps before him or her, in fairly muddy terrain.

After an introductory chapter critically reviewing limitations in our nosology, and individual chapters devoted to the associated syndromes noted above, subsequent chapters cover medical and surgical illness, pregnancy, cognitive impairment in older individuals, aggression and violence, and substance abuse in patients with schizophrenia. These sections generally succeed very well in what they present, e.g. Leslie Citrome and Jan Volavka efficiently review the epidemiology and treatment of aggression and violence, and Doug Ziedonis and Connie Nickou clearly present the newer, practical models for treating substance-abusing patients with schizophrenia, incorporating motivational enhancement and relapse prevention techniques.

For my purposes, though, I would have preferred a somewhat expanded discussion of medical issues. The important problem of individuals with schizophrenia who have polydipsia with hyponatremia is addressed only in the chapter on cognitive impairment in older individuals, and it there only receives passing mention in one sentence, without discussion of treatment. Confounding an expectation I had, both for clinical pertinence and considering the vast sums of advertising monies directed towards these issues, antipsychotic medication-induced hyperprolactinemia receives but very brief acknowledgment, and antipsychotic medication-induced weight gain, glucose intolerance and ECG QT_C prolongation none at all. There are also a few typos: e.g., disulfiram generates its therapeutic action by inhibiting aldehyde dehydrogenase, not alcohol dehydrogenase; cigarette smoking induces cytochrome P450 1A2, not 1AC.


SCHIZOPHRENIA
AND COMORBID
CONDITIONS

DIAGNOSIS
AND
TREATMENT

EDITED BY
MICHAEL Y. HWANG, M.D.
PAUL C. BERMANZOHN, M.D.

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

LEGISLATIVE UPDATE

Scope of Practice

By Richard Gallo, NYSPA Legislative Consultant

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

However, this year the manner in which the proponents are approaching the issue is different. Instead of one all encompassing "omnibus" bill, they have opted for several "stand alone" bills: two for psychology (A7364 Magee, and A7627 Sanders), one for social work (A5779—A Pretlow), one for marriage and family therapy (A6914 Christensen), and one for behavioral arts therapy, mental health counseling, psychoanalysis, and marriage and family therapy (A7626 Sanders).

As for the bills themselves, the psychology proposals (A7364 and A7627) are not what we would have expected. They are brief, bare bone additions to the profession's existing "title" licensure law and as such are probably not finished products.

A7626, in relation to the four want-to-be licensed professions, is a spin off from the related text of last year's omnibus bill. In fairness to its authors, the new bill is an earnest attempt to address many of the concerns raised by NYSPA and the State Medical Society over the past two years. However, the bill still seeks to create a separate profession of psychoanalysis, opposed by NYSPA, and lacks adequate specificity with respect to other areas of concern.

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

With regard to the stand alone bill on marriage and family therapy (A6914), this bill has been around for many years and is considered subordinate to the broader mental health practitioners' bill (A7626).

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

Contribute to the PAC!

The New York State Psychiatric Political Action Committee (PAC) is asking for your financial support.

2000 was the PAC's most successful year. Over $28,000 was raised and contributions were received from 375 psychiatrists — a 75% increase over 1998 — but still less than 10% of the NYSPA membership. However, during the upcoming legislative sessions, we will again be confronted by efforts from non–physician mental health professionals to encroach upon the scope of practice of psychiatry.

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

Your representatives in Albany worked literally night and day to get our message across to the legislators — these mental health professions should not have an unrestricted and unlimited scope of practice; the treatment of serious mental illness requires medical evaluation and consultation; psychoanalysis is a treatment modality not a profession.

Last year, this bill did not reach the floor for a vote in either house of the Legislature. This year modified versions of the bill are being debated in committee. The PAC needs your financial support to carry forward this battle.

Of course, we will continue to advocate for parity, managed care reform and HMO liability.

In this issue of *The Bulletin* is the 2001 contributors list for your review. If your name is not on the list, please make a donation today. If you contributed last year, please be sure to join again this year and contact your colleagues and ask them to join. The PAC needs your help now! ■

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NYSPA Meets With DOH to Discuss Problems with Behavioral Carve-Out Companies

On April 25, 2001, Seth Stein, Richard Gallo and Barry Perlman, M.D., NYSPA Vice-President met with Kathleen Shure, Director, Office of Managed Care, Vallencia Lloyd, Director, Bureau of Managed Care Certification and Surveillance, and Foster Gesten, M.D., Medical Director, Office of Managed Care, together with representatives from psychology and social work to discuss problems encountered by our members in dealing with behavioral managed care carve-out companies under contract to NYS licensed HMOs.

Ms. Lloyd announced that the Department of Health has commissioned the Lewin Group to perform a study to assess the administration, utilization management and network and contracting activities of five major behavioral health managed care companies in New York State - Magellan, ValueOptions, Integra, Spectrum and American Care Management. This study and the interest of the Bureau in the carve-out industry resulted from efforts of Dr. Perlman to encourage the Bureau of Managed Care to focus specifically on the behavioral carve–out companies as part of the oversight responsibilities. Previously, the Department of Health has never studied or collected data regarding management of the treatment of mental illness specifically.

Mr. Stein, based on his extensive contacts with NYSPA's members, suggested that given the defined scope of the study the following issues should be considered in the study:

- Failure to provide psychiatrists and other providers with fee schedules and other policy manuals in the contracting process.
- Failure of managed care company staff to identify themselves by first and last names on the telephone.
- Inability of patients who are discharged from hospitals to continue on their medication because of differential formularies for inpatient and outpatient treatment.
- Inability of patients to secure treatment due to "phantom" provider networks.
- Inability of psychiatrists who have dropped a plan to get their name removed from the provider list as well as all of psychiatrists' names across plans.
- Imposition of idiosyncratic review standards and imposition of coverage exclusions for treatment of certain mental illnesses not authorized by the health plan.
- Failure to abide by the results of an external review decision determining that continued treatment was necessary.

Dr. Perlman raised concerns focused on:

- Imposition of excessive utilization review in violation of statutory requirements.
- Excessive delays by insurance company clinicians responding to calls for preauthorization of admissions to hospital resulting in preauthorization.

It is anticipated that a number of the items raised will be incorporated into the Lewin study. DOH staff indicated that they expected the study to be completed within a year. ■

NYSPA NOTES

Dr. Bovino, the President-Elect of the Medical Society of the State of New York, announced at their annual meeting this month the appointment of **Edward Gordon, M.D.**, as Chair of the Committee on Psychiatry

Dr. Gordon is the immediate Past–President of NYSPA and the NYSPA Representative to the Medicare Carrier's Advisory Committee.

Discharges From State Hospitals: An Interview with Rhoda Cataldo, CSW

by Martha Crowner, M.D.

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

How long have you been working for the State?

Thirty years. Twenty five years in mental health. I started as a secretary, then went back to school and got my masters as a social worker. Because of my record for successfully placing clients into the community, I became discharge coordinator for several hospitals; I was called in to help where I was needed. In the early and mid 1990's, 1993 to 1996, I helped merge King's Park and Central Islip into Pilgrim. Three facilities merged into one.

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

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

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

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

Yes. But also, there was the mind set that chronically mentally ill people could maintain community living — even those who had been hospitalized for years — provided the appropriate services are available. The facility had that mind set. The community mental health providers had that mind set. A lot programs came into existence at the same time to accommodate the new mind set: bridger programs, ICM's (Intensive Case Managers), ACT (Assertive Community Treatment) teams, MICA (Mentally Ill Chemical Abuser) community residences, more work programs, vocational rehab services.

What is quality-based discharge planning?

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

What are bridgers?

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

What are Intensive Case Managers?

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

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

When I was a child I went to the Henry Street Settlement House. A lot of our parents were working and they wanted to keep us off the streets. The focus was on getting us goal oriented, to give us something we were lacking. The social workers there were role models. Because of them, I felt a sense of belonging. There was always someone to go to. That's how I got my introduction to social work and it never left me.

Eleanor Roosevelt sponsored that program.

You met her?

She was truly wonderful. When we were teenagers she would come to some of our group sessions or escort us to activities. Eleanor Roosevelt gave us a tour of the UN. She told us we were living in one of the greatest cities in the world.

Henry Street Settlement House is a very popular program, still.

What's your job now?

I have oversight for the discharge team at MPC, for anything related to the discharge process, from the beginning to post-discharge. I also do consulting for the whole system, but right now I'm focused on MPC and Pilgrim.

There are various components of the discharge team.Discharge coordinators assist with the initial process.They get initial appointments with necessary aftercare programs. Then after discharge the tracking team takes over to ensure continuum of care. Our tracking team is vital. It follows the patient after discharge for 90 days— more, if indicated. If clients lose contact with services post–discharge, we make efforts to connect them again. We don't close the case until we are sure that the client is followed by another system and doing well.

Let's review the steps we take to place a patient in a supervised residence or adult home. We first submit a "1995 application" for approval of funding for supervised housing to HRA, an agency of New York City. How long does it take for approval?

The applications are approved within two weeks of submission.

After the application is approved, how long does it take for the patient to get interviews at residences?

We get interviews within a month.

How long does it take for a patient to get accepted ?

That depends on bed availability. Now that we have more beds, it can take anywhere from a week to two months.

Patients can have unexpected problems after they leave. What may go wrong?

Things happen; for instance, they stop taking their medication, or they lose funding. Sometimes they don't get the hookups they need, or they do and don't follow through. Sometimes there was no oversight system in place to see that they were following through. The oversight system could be the discharge trackers or the ICM's. We need to make sure that there are no gaps in services. We need to be sure the required services, for example, clinic programs, are available and appropriate. Our goal is to reconnect with treatment whenever possible.

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

Less that 10% of our discharges.

How do you track?

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

You send somebody out to see the patient?

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

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

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

How was it for them?

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

What makes a discharge successful?

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

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

CLASSIFIED ADVERTISEMENTS

NYSPA Advocacy

Continued from page 1

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

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

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

Other important issues raised by NYSPA representatives included: the failure to follow HCFA rules on initial diagnostic evaluations, overly burdensome documentation requirements for the initial diagnostic evaluation, exclusion of Axis II diagnoses and other appropriate illnesses from the list of covered diagnoses, outdated definition of group therapy, improper inclusion of a time requirement for CPT codes that did not include a time factor, overly restrictive policy on family therapy that conflicted with HCFA rules, failure to follow the HCFA definition of medical evaluation and management services, overly burdensome documentation requirements for psychotherapy services, improper definition of pharmacotherapy (90862), and overly burdensome documentation requirements for pharmacotherapy.

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

Parenting

Continued from page 1

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

Mental illness is extremely disruptive to families. From birth to early adulthood, the age when most people become ill, parents build up hopes and dreams for the future of their offspring. Consequently they are devastated when the dreams are shattered by emerging symptoms like fireworks on the Fourth of July. Families look for "magical" solutions to bring the children back to the way they were before the appearance of the bizarre and unpredictable behaviors or invent excuses to account for the aberrant conduct, but as the symptoms persist, they are brutally forced into the painful realization that the changes are permanent. Yet, they never stop longing for the return of the children, and the longing lasts a lifetime. It is excruciating to see formerly intelligent, talented, and creative youngsters become shadows of their former selves. Schizophrenia makes the patients seem retarded although they were once quite articulate and able to express themselves spontaneously and rationally. It is difficult to communicate with adult children who, due to problems in processing information, must be addressed simply and unambiguously as if they were toddlers again in order for them to understand. Parents are obliged to learn to know the children anew as if they were not the same kids they raised from birth. Unlike professionals treating the mentally ill, parents knew an intact, whole person before the transformation caused by the psychosis, and the void caused by the absence of the former child lasts a lifetime.

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

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

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

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

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