The goal of civilly committing sexually violent predators (SVP) in New York State at the completion of their terms of incarceration, which had long been a "back burner" issue, jumped to the fore with the publication of an article in The New York Post during the summer of 2005 which informed that, using current civil commitment laws, the Patkai administration had quietly begun locking up dangerous sex fiends in a state psychiatric hospital after they complete their prison terms. As I read The Post article, I was aghast to learn that many of the "monsters", as they were referred to, had received sentences of only 3 1/2 years in prison. I was also appalled that such heinous crimes had been so lightly punished. The New York Times of November 16, 2005, contended 2 related articles. One told of a repeat sex offender being sentenced to 50 years to life for the murder of a 12 year old boy in 1998. The other informed that a judge had ruled that NYS was illegally holding 12 convicted sex offenders in a mental hospital after they had served their prison sentences. We believe the former, imprisonment, is the better way to go rather than the latter, civil commitment.

The controversy regarding the use of civil commitment at the end of terms of imprisonment has been an issue of national concern since 1987 when it was first utilized by the state of Washington in 1987 and 1997 when the U.S. Supreme Court upheld Kansas' SVP law. [Please see Karin Moran's article, "Civil Commitment for Sexually Violent Predators" in The Psychiatrist Winter 2005 - 2006, Vol. 49, #1.] From the time the debate was first joined the APA has taken a clear and unequivocal position in opposition to such use of civil commitment. The APA has written to the appropriate state, U.S. Supreme Court case Kansas v. Hendrickx. At that time Richard J. Ciccone, M.D., a NYSPA member, was quoted as saying that the Kansas law does not refer to a mental disorder or disorder which would allow for civil commitment if an individual, as a result of a mental abnormality which it defines "as having been convicted of committing or attempting to commit a sexual crime and being likely to commit the act again", based on a preponderance of the evidence. In 1998 the APA's Board of Trustees approved a report by the Council on Psychiatry and the Law addressing sexually dangerous offenders. At that time Paul Appelbaum, M.D., who had been Chair of the task force at its creation, said, "We were concerned that psychiatry was being used to preventively detain a class of people for whom confinement rather than treatment was the real goal. This struck many people as a misuse of psychiatry." Despite many states having adopted statutes similar to that of Kansas, the APA has continued to reject the use of civil commitment in these situations as being poor public policy since it first wrote a memorandum of opposition in 1989 to Senate Bill 57-5. Today NYSPA opposes proposed legislation which would permit the civil commitment of SVPs at the end of their term of incarceration for a number of reasons. First, it creates an unwarranted link between persons with mental illness and sexually predatory behavior. We believe this is a retrogressive step in the face of the APA's position work along with other groups which advocate on behalf of those with mental illness to erase the stigma which often accompanies the condition. Second, the cost of "housing and treating" SVPs would likely rise to close half billion dollars per annum within a decade. (It is estimated that it would cost $200,000 per year in today's dollars to house and treat an SVP, it is projected that the commitment of SVPs to NY would enter the system annually. Thus in a decade the cost to the state of NY would be greater than $400 million per year.) We are concerned that those funds will be attributed to the cost of providing publicly funded mental health care.

Barry Perlman, M.D.

Legislative Brunches

Barry Perlman, M.D.

By Karin L Moran, M.S.W.

T he Westchester Psychiatric Society and New York City based district branches of the APA held their annual Legislative Brunches on December 4th and 16th. The Westchester Branch was moderated by Viviane Penn, M.D., New York County District Representative. As customary, each of the events included a legislative overview of the coming year, presented by Westchester APA President, Barry Perlman, M.D., who highlighted NYSPA's legislative priorities for 2006 - Timothy's Law, Sexually Violent Predator legislation, the Commission on Health Care Facilities in the 21st Century and Crossover Funding. During each of his addresses, Dr. Perlman articulated his desire to see mental health parity legislation finally enacted in New York State; his concern over the potential misuse of psychiatry in relation to pending sexually violent predator legislation; the need for more programs by the Commission on Health Care Facilities in the 21st Century; and the continued need to fully restore and support the Co-insurance Payments for Medicare / Medicaid dualy eligibles. Although Perlman’s remarks encompassed the above mentioned array of topics, it was parity that seemed to capture the attention of legislators at the Westchester event, where despite an early morning snowstorm, Congressional Representatives Nita

[See Brunches on page 4]

Albany Report

By Richard J. Gallo and Karin L. Moran, M.S.W.

O n January 17, 2006, Governor George Pataki delivered his 2006-2007 Executive Budget Request. In general, NYSPA is pleased with the Governor's Executive Budget Request as it proposes to increase funding for mental health programs. The proposal is more generous to mental health than in previous years and includes a program for a number of new community-based initiatives. Such one initiative, referred to as "Delivering the Promise for New York's Children and Families," is an expansive and comprehensive mental health program dedicated to children's services. The initiative has several components, including a $33 million Child and Family Clinic Plus program that OAH leads as a "transformation of local mental health clinics from passive programs waiting for clients to present, to active programs that will intervene earlier in a child's developmental trajectory." In addition, the initiative seeks to substantially increase children's mental health screenings and assessments, expand clinical services, and increase in-home treatment services. Also, $2.15 million is slated to fund an additional Home and Community Based Waiver (HCBW) slots (300 OAH and 550 OCFI), $0.45 million for telepsychiatry services, and $6.3 million for a three-year 2.5% Cost of Living Adjustment (COLA) for children's community based program staff. In total, the Governor proposes an annual investment of $62 million for the program.

Other noteworthy mental health appropriations include:

- $30.9 million to fund a three-year 2.5% COLA for residents in both for-profit and non-profit community non-residential programs
- $2.6 million in supplemental payments for COPs, CSHCN, and COPS
- $26.8 million to support the common implementation of sexually violent predators increasing their capacity to implement such plans.

At the Summit, Elise and Gerald Weyrauch, center, founders of the Suicide Prevention Action Network (SPAN) presented GHW Commissioner Sharon Cardinello, left, and Gary Spielmann, right, with SPAN's Fire and Ice Award. The "Fire" symbolizes the grief that a survivor experiences following the death of a loved one, and the "Ice" represents the conversion of grief into suicide prevention activities that will spare others grief.

[See Suicide Prevention on page 6]
President’s Message

continued from page 1

tal health care in NYS which then will be said to be too expensive and subject to unwanted cuts. At the bottom line the SVP program will become an unstoppable competitor for community treatment dollars to the detriment of the latter. Third, we remain concerned about using the public mental health (MH) system in an expedient manner to solve a problem inchoate to the criminal justice system. While making use of the public hospital system for what appear to be political ends may not seem like a “big deal” to many, it alarms psychiatrists who have seen governments misuse mental health systems in other countries with terrible consequences for the public’s trust of our profession and the MH system. The definition of a SVP is a judicial finding not a psychiatric diagnosis. No psychiatric diagnosis is contingent on the presence of an individual having committed a felony from a defined class. Finally, we question why if deemed mentally ill receive no targeted treatment during their term of incarceration. It would seem disingenuous given the expansion of criteria to initiate treatment only at the conclusion of their sentences. While NYSPA will continue to raise its concerns about and oppose the passage of SVP bills as presently proposed, we do recognize society’s legitimate concern for securing public safety. In recognition of that concern we offer an alternate approach based in the State’s past use of civil commitment when it created the Narcotic Addiction Control Commission (NACC) in 1966 for those suffering with additions who had been arrested or convicted for related felonies or misdemeanors. Despite some success that program was ended due to being too hastily made operational and its being poorly administered and implemented. However, the NACC precedent is worthy of consideration. The creation of a either a new agency or one under the auspice of the Department of Correction which purchased treatment services from either an outside vendor or to “treat” SVPs would offer several advantages over the current proposals. It would avoid identifying SVPs with persons diagnosed with and requiring traditional psychiatric care and would be less likely to engender an inadvertent mistrust of the public MH system. It would assure that SVPs were not mixed with persons being treated in the state psychiatric centers for usual psychiatric disorders, an expressed concern of many advocates for persons with mental illness. It would separate the budget for the SVP program from the budget of the media attention. We provide information about the program, in particular how the program will impact the benefits of a significant population: people with dual eligibility for Medicare and Medicaid. We also provide information about Preferred Drug Programs and the recommendation of NYSAPA’s task force on this important topic. The Albany report focuses on the upcoming Legislative Session including the budget and programs in the Area II Trustee Report as well as an overview of the Fall Area II Council Meeting. ■

FROM THE EDITOR’S DESK... By Jeffrey Borenstein, M.D.

Jeffrey Borenstein, M.D.

The new Medicare prescription drug plan has also received much attention. We provide information about the program, in particular how the program will impact the benefits of a significant population: people with dual eligibility for Medicare and Medicaid. We also provide information about Preferred Drug Programs and the recommendation of NYSAPA’s task force on this important topic. The Albany report focuses on the upcoming Legislative Session including the budget and programs in the Area II Trustee Report as well as an overview of the Fall Area II Council Meeting. ■

In Memoriam

Harvey Bluestone, M.D.

Dr. Harvey Bluestone, past President of the New York State Psychiatric Association, past Speaker of the Assembly of the American Psychiatric Association, and past Area II Trustee to the Board of Trustees of the American Psychiatric Association, died on March 11, 2006.

Dr. Bluestone was recognized as an outstanding clinician, educator and administrator as Professor Emeritus of Psychiatry at the Albert Einstein College of Medicine and past Director of the Department of Psychiatry at Bronx-Lebanon Medical Center.

On behalf of the members of the New York State Psychiatric Association, we mourn his death and extend our sympathy to his wife, Eleanor, and their children.
T he Board of Trustees met March 5th for their annual spring meeting, focusing on policy issues, finances, and advocacy. A key policy position on psychiatrist participation in interrogation was drafted, this is a critically important issue due to the interrogation of detainees in Guantánamo.

THE HIGHLIGHTS ARE:

Policy on Interrogation of Detainees

The APA has been in the heat of the controversy regarding the role of psychiatrists in the interrogation of detainees in military custody. The APA position paper on absolute opposition to torture in any form has been in place and promulgated for over 15 years. However, the ethical position of psychiatrists, as medical professionals, in their role as specific individuals interrogating detainees in custody needs to be clearly defined. The APA Board with much input from members and has a draft position statement that is going to the Assembly for further discussion and hopefully ratification. The entire position statement can be read on the website but a key paragraph reads as follows:

3. Psychiatrists should participate directly in the interrogation of persons held in custody by military or civilian investigative or law enforcement authorities, whether in the United States or elsewhere. Direct partici- pation includes being present in the interroga- tion room or questioning or advising authorities on the use of specific techniques of interrogation with particular detainees. However, psychiatrists may pro- vide training to military or civilian inves- tigative or law enforcement personnel on recognizing and responding to persons with mental illness, on the possible mental and psychological effects of particular tech- niques and conditions of interrogation, and on other areas within their professional expertise.

It is important to note that this refers only to detainees in custody. As our country faces increasingly difficult questions in the arena of human rights, it becomes important that the issues relevant to psychiatrists be thoroughly and firmly delineated.

Membership

Membership was up again in 2005 nationwide, showing a healthy increase in positive trend for the APA. However, the members who may be dropped for non-payment increased slightly in 2006. Often this improves in the first quarter of the new year, but after we are members remain- ing with us! We need all psychiatrists to be effective!

The President of the Louisiana District Branch, Dr. Patrick Wright, met with the Board and expressed her gratitude to all the members, district branches and national and local for all their ongoing support and help in the wake of the Katrina disaster. It was also clear that much still needed to be done to be effective!

Advocacy

The APA has been your active and vigilant spokesperson in Washington on the key issues of Medicaid and Medicare cuts, electronic databases and sharing of medical information, pay for performance and Medicare Part D. A few key points about these issues:

• The 2006 Budget Reconciliation Bill calls for extensive cuts to Medicaid and Medicare totaling over 40 billion dollars over the next five years. APA continues to be a major advocate to preserve the necessary services for our patients. On the positive side, ABA and APA were successful in preventing cuts to payments to physicians for Medicare Part D. A 4.4% reduction was in the original bill.

• Pay for Performance is a major initiative of CMS and is affecting psychiatry in the near future. So far, performance indicators, which may be used to either increase or decrease payments to hospitals and physicians, are being developed in areas of depression treatment, man- agement and fraud, waste, as well as hospi- tal based performance indicators. APA is active in consulting with CMS and advocating for us as these indicators are developed.

• The new federal budget passes aside 1.6 million dollars to accelerate progress for health information technology; including the development of health care data bases nationwide as well as the individ- ual electronic health record. Clearly pri- vacy and confidentiality of sensitive med- ical information is a key issue for our patients and profession, and APA through its committees and staff is a constant advocate to protect patient confidentiality.

• Medicare Part D has caused serious prob- lems for our dual eligible patients. APA is providing information, advocacy for safety net services, and works with our members to try and ensure our patients get the care they need.

• The Medicare Prospective Payment System for acute patient psychiatric care had its first series of annual revi- sions. The joint efforts of APA and the Thomp- son group at the Greater NY Hospital Association have had a major influence on preserving dollars in the system for patient care.

• Other issues on Capitol Hill that we continue to fight for include: elimina- tion of the discount from 50% to 65% Medicare Co-pay; parity; and incentives to increase the child psychiatry work- force. In the midst of budget cuts, the APA fought and defeated the expansion of Medicare to allow marital and family therapists to bill directly for services. This victory is only because of the vigi- lance of APA in reviewing all, however small, pieces of legislation that affect us and our patients as they proceed through Congress!

• Good news from California! An attempt to gain sweeping and inappropriate transfer privileges for psychologists was defeated by our hard working California colleagues.

• Finally, the battle against psychologist prescribing continues and is particularly fiercer this year in New York. The Hawaii psychologists with considerable assurance both monetary and strategic from national are fighting aggressively to prevent passage of another psychologist prescribing law. The laws and regula- tions in Louisiana and New Mexico, which allow for psychologist prescribing, are seriously flawed with inadequate training and supervision and the APA is struggling to modify these as much as possible at the local level.

Other Actions

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Other Actions

• The Board voted to join the Federation of Medicine Campaign to establish a National Health Insurance in Washington DC, at a cost of $1.000,000 this year. If successful, this would offer a major opportunity to educate the public and reduce the stigma of mental ill- ness.

• The board established a legislative fel- lowship in memory of Jay Cutler, the previous Director of Governmental Affairs, who championed the causes of the APA for decades in the capital. The presence of a fellow in the Congress is a very positive enhancement to our lobby- ing efforts.

So far, 2006 has gotten off to a good start! Let me know your thoughts and comments and as always thanks for your support of the APA! You can reach me at annsullivan@msn.com or 718-334- 3516.

Albany Report

continued from p. 1

• $35 million in capital resources for the modification of existing facilities and programs related to civil commitment.

• $135 million in capital resources for the construction of a new facility on the grounds of Camp Rucker in Chenango County.

Another key budget issue for psychiatry, once again, is the expensive drug coverage. The Governor’s proposal to address the continued discrimina- tion against psychiatry with regard to the expansion of Medicare and Medicaid, i.e., “crossover” restoration. NYSPA representatives will again work to more fully restore Medicaid and Medicare coverage for pharmaceuticals, with a special reduc- tion in reimbursement for services to patients who are dually eligible for both Medicare and Medicaid, most common in the small, pieces of legislation that affect us and our patients as they proceed through Congress!

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Additional items of interest in the Governor’s Budget proposal include:

• A reduction of Clinton’s Independent Education (GME) fee-for-service pay- ments by using the lower of current pay- ments or the costs effective on or after 3/1/06.

• Cutting inpatient detoxification rates for uncomplicated cases.

• Eliminating specialty rates for hospital outpatient mental health programs; and

• Eliminating the six-month health insur- ance coverage gap that prevents covered enrollees in Medicare managed care or Family Health Plus (FHP)

OTHER LEGISLATIVE MATTERS OF CONCERN FOR 2006

Health Insurance Parity for Mental Health and Chemical Dependence

The Health Care 

Insurance Reconciliation Act of 2006 is the 


...went to the floor of the House with a 


...went to the floor of the House with a
Medicare Fees for 2006

By Seth Stein, Esq.

O n February 8, 2006, President Bush signed the Deficit Reduction Act of 2005 into law. The Act prevented implementation of a 4.4% reduction in Medicare Part B payments to physicians by mandating use of the 2005 conversion factor in 2006. Because of problems in how the annual Medicare conversion factor is updated, Medicare Part B fees would have decreased by at least 4.4%. However, even with the roll-back of the conversion factor reduction, Medicare psychiatric fees for 2006 were decreased by approximately 1% because of changes in the work value, practice expense and malpractice expense components of many psychiatric services.

Medicare carriers will re-process claims previously submitted by participating providers for services rendered in 2005 at Medicare psychiatric fees for 2006. Psychiatrists who submitted higher 2005 rates. This re-processing process should be completed by July 1, 2006. Psychiatrists who have not yet submitted claims to Medicare should use the 2006 new fees for all services provided on and after January 1, 2006.

New NYS Medicare Fee Schedules for 2006

Once the 4.4% fee cut was rescinded, NYSAAA prepared 2006 fee schedules and a explanatory memorandum that was mailed out to all NYSAPA members in mid-March. This mailing included a summary of the new program, the new prescription drug plan and a comparison of drug coverage for 13 benchmark plans. You can access the information by clicking the Medicare Part D link on the left side at the bottom of the NYSAPA home page.

The follow-up inpatient consultation codes (99241-99263) were deleted. In their place use the following codes for follow-up consults: in hospital settings, use the usual hospital care codes (99231-99233); in nursing home, use the new (see below) subsequent nursing facility codes (99307-99310); and in the office or other outpatient settings, use the office established patient codes (99211-99215).

The psychological testing code (99301-99303) and the nursing facility care subsequent codes (99304-99306) were also deleted. They were replaced by the following new nursing facility codes: initial nursing facility care codes (99304-99306) and subsequent nursing facility care codes (99307-99310).

The CPT Coding Changes Effective January 1, 2006

There were several changes in CPT codes that became effective January 1, 2006 and were implemented immediately.

The psychological testing code (96100) was deleted and replaced with three new codes: psychological testing by physician with report (96101); psychological testing by technician with report (96102); and psychological testing by computer with physician report (96103).

Medicare Part D

As an additional service to NYSAPA members and their patients, the NYSAPA website includes a detailed memorandum prepared by Seth P. Stein, Esq., and Rachel A. Fernbach, Esq., on the new Medicare Part D prescription drug program which went into effect January 1, 2006. The website includes a description of the new program, the new prescription drug plans, information for dual eligibles covered by both Medicare and Medicaid, and a comparison of drug coverage for 13 benchmark plans. You can access the information by clicking the Medicare Part D link on the left side at the bottom of the NYSAPA home page.

The E-Bulletin

Throughout the year, NYSAPA provides members with important updates and recent developments in Medicare, confidentiality, managed care, legislative action and other issues of interest to members through the E-Bulletin. In order to receive E-Bullets, members must provide their email address to the NYSAPA central office either by email or by phone. In the future, NYSAPA will relay more and more on email and our website to transmit important information.

Additional Medicare Payment for Treatment Provided in Shortage Areas

Psychiatrists should be reminded that effective January 1, 2005, physicians will automatically be paid a 10% bonus payment when treating patients in both primary medical care Health Professional Shortage Areas (HPSAs) and mental health HPSAs. In order to be eligible for the ten percent bonus payment, the service being billed must have been provided in an area designated as a HPSA.

To be considered for the bonus payment, the name, address, and zip code of where the service was rendered must be included on all electronic and paper claims submissions. The incentive payment is 10 percent of the amount actually paid, not the approved amount, of both assigned and unassigned claims. Incentive payments will be paid separately from the claim payment, on a quarterly basis, totaling $430 million. Physicians in New York is listed on NYSAPA website.

Legislative Brunches

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Barbara Rosenfeld, M.D., Senator Liz Krueger, and Herb Peyser, M.D.

Lowey (D-White Plains) and Sue Kelly (R-Frisco). Senator Kelly and Assembly members Adam Bradley (D-White Plains-Pleasantville) and Herb Peyser, M.D. all attended and addressed the importance of providing New Yorkers with increased access to mental health services, via mental health parity legislation.

Congressional Representatives Lowey and Kelly spoke of federal initiatives such as the Paul Wellstone bill, which has languished for years but seeks to expand on the 1996 Mental Health Parity Act by closing existing loopholes that allow discrimination with regard to co-payments, coinsurance, and deductibles. Congressman Lowey’s remarks centered on returning Iraq veterans, noting that “recent statistics estimate at least 25 percent of our service-men and women returning from Iraq will be in need of mental health benefits…we must meet these needs.” Echoing her colleague’s sentiments, Congresswoman Kelly pointed to the fact that “studies have consistently shown the correlation between increased deployments and mental illness.”

Open Access: for the patients, for the people

All too often, people who depend on public assistance are denied access to service, support and effective healthcare for mental illness. This inability to obtain the treatment they need can trigger a pattern of deterioration—becoming unemployed, being hospitalized, imprisoned, and often ending up homeless.

This destructive cycle is costly for taxpayers and devastating to the families of people with mental illness.

That’s why Eli Lilly and Company continues to support open and unrestricted access to all available treatments for mental illness.

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Sexually violent predator (SVP) legislation in its current form is a response to the social problem of release of prisoners who have completed their sentences for crimes involving sexual violence and who are perceived to be too dangerous to remain in prison and contribute to public safety. In many instances, persons accused of sexually violent crimes have been granted parole; this has resulted in the release of sexual predators who have committed sexual offenses and by plea bargaining to receive relatively short sentences for crimes that have been able to secure relatively short prison sentences. In many instances, persons who have committed sexual offenses are not housed in prison and have been released from prison sentences. In many cases, they have been released into the community. In many cases, they have been released into the community without any aftercare, supervision, or continued assessment that would determine whether they are likely to commit similar crimes in the future. In many cases, they have been released into the community without any aftercare, supervision, or continued assessment that would determine whether they are likely to commit similar crimes in the future.

The problem of the SVPs is a problem of mental illness. Mental abnormality as defined is the hallmark of the SVP legislation. Mental illness is the hallmark of the SVP legislation. Mental abnormality and mental illness appear to be synonymous. Mental abnormality as defined is a nonmedical definition of what purports to be a clinical classification which omits psychiatric terminology to achieve a social and political result. In fact, the SVPs are created by bending civil commitment laws to create a special class of persons who are eligible for release from prison should be addressed through the criminal justice system by means other than civil commitment. The SVP legislation uses a clinical definition of mental illness and the problem of SVPs is a problem of mental illness. Mental abnormality as defined in the proposed legislation is not a medical definition of mental illness and the problem of SVPs is a problem of the correctional and criminal justice system - not the mental health system.

The Commission on the Correction of the Department of Justice and due to the fact that the current SVP legislation is a nonmedical classification of mental illness and the committal procedures results from the inclusion of persons adjudged to be “sexually violent predators” or “sexually violent offenders” under Article 9 of the Mental Hygiene Law of 12 individuals who were characterized as SVPs and who were scheduled to be released from prison upon completion of their sentences. State officials attempted to use law applicable to noncriminal persons with mental illness, to evaluate sex offenders before their release to determine whether they are dangerous. Before parole under Article 9 of the Mental Hygiene Law (MHLL) a person may have been committed to a psychiatric hospital if it is determined that the person has a mental illness for which the person is a menace to the safety of others, and “which is likely to result in serious harm to himself or herself or others.” In need of involuntary care and treatment under the MHLL §91.07 means that a person has been determined by a court of law to be a “patient in a hospital in essential to such person’s welfare and whose judgment is so impaired that he is unable to understand the need for such care and treatment.” The court held that the detention of these released-violent persons violated state law because the state failed to meet these long-standing statutory standards for involuntary civil commitment of persons with mental illness. It is precisely because these SVPs do not fit into the existing statutory scheme for civil commitment of persons with mental illness that SVP legislation is being considered.

Under the SVP legislation currently introduced in New York, individuals would be held for post-commitment if they meet the definition of sexually violent predator. SVP has been defined to mean a person who has committed a sexual violent offense and who suffers from a mental abnormality and who is determined to mean that the crime “was committed in whole or in substantial part for the purpose of sexual gratification.” Mental abnormality is defined in the bill as “a congenital or acquired condition, disorder or disease of the brain which results in a gross deviation from the normal or volitional capacity of a person in a manner that predisposes him or her to commit acts constituting a sexual violent offense and that results in serious difficulty in controlling behavior to a degree that the person is a menace to the health and safety of others.” Once a person is determined after a trial to be an SVP, such person “shall be committed to a secure treatment facility for care, treatment and control until such time as he or she no longer is a sexually violent predator.” This section of the SVP legislation is under the jurisdiction of the Office of Mental Health. The Commission’s enabling legislation uses the terms “mental abnormality” and “mental illness” appear to be synonymous, “mental abnormality” as defined is considered a vague and clinical categorization that has no scientific or clinical basis. The outcome of the recent attempt to use existing civil commitment laws to involuntarily hospitalize 12 prisoner releases demonstrates that individuals who would likely be selected for SVP commitment would not meet the standard current for civil commitment precisely because they do not have a mental illness as required by Article of the MHLL. “Mental abnormality” is a nonmedical definition of what purports to be a clinical classification which omits psychiatric terminology to achieve a social and political result. In fact, the bills create an improper and inadequate link between persons with mental illness and sexual predatory behavior and would only enforce the stigma currently associated with mental illness by identifying criminal behavior as mental illness.

A probable civil commitment law represents serious assaults on the integrity of psychiatry, particularly with regard to defining mental illness as a prerequisite for civil commitment. Moreover, by bending civil commitment to serve essentially nonmedical purposes, the SVP legislation commits the profession to undermine the legitimacy of the medical model of commitment.”

Review of the evidence regarding SVP legislation reveals that the 17 other states with SVP laws reveals that the individuals who are committed as SVPs cannot benefit from any psychiatric treatment and that they currently are not available. Presumably, lack of treatment prospects results directly from the fact that SVPs do not have a legitimate psychiatric diagnosis. The absence of the prospect of beneficial treatment belies the professed “treatment” purpose and renders the scheme as nothing more than preventive detention.

The cost of the proposed bills must also be considered. It is reasonably estimated that the cost of housing and “treating” an SVP will be approximately $200,000 per year per SVP. Current data suggests that as many as 200 prison inmates could enter the SVP classification and the annual cost could exceed $400 million. This extraordinary level of funding within the state budget could only be achieved as a result of a reduction in OMH funding for the current mental health system. The SVP program must be re-evaluated to determine if it is a justifiable investment and if community funds and could swallowed up mental health funding. We also question why treatment for SVPs is delayed until completion of their sentences. If the Legislature truly believes that treatments are essential to such persons, resources should be given to the Department of Corrections to provide treatment during incarceration - not after. We note that the Assembly bill does include provisions for treatment during incarceration and OMS will provide a strong alternative as a first step to properly addressing the problem.

We suggest that the Legislature consider the use of indeterminate sentences for sexually violent offenses as the best way of addressing the social concerns of recidivism. In conjunction with indeterminate sentences, treatment programs should be offered during incarceration on a voluntary basis, but such programs would be a significant bearing on the length of sentence. We strongly recommend that any SVP legislation must be considered under the jurisdiction of the Department of Correction, not the Office of Mental Health.

In conclusion, the serious social problem of the recidivism of individuals who have been convicted of sexually violent offenses and who are eligible for release from prison should be addressed through the criminal justice system by means other than civil commitment. The SVP legislation uses a clinical definition of mental illness and the problem of SVPs is a problem of mental illness. Mental abnormality as defined in the proposed legislation is not a medical definition of mental illness and the problem of SVPs is a problem of the correctional and criminal justice system - not the mental health system.

Testimony to the Commission on Health Care Facilities in 21st Century

This testimony is submitted on behalf of the New York State Psychiatric Association, the statewide medical specialty organization, representing over 4,500 psychiatrists in the state.

As part of 2005-2006 budget process, Governor Pataki and the New York State Legislature created the Commission on Health Care Facilities in the 21st Century. The Commission was charged to review health care capacity and resources including inpatient and outpatient hospital services and nursing home services and to identify the community and private providers in each of six designated regions of the state and to make recommendations. The Commission’s recommendations include a relatively small part of the entire spectrum of services provided by the voluntary hospitals, private hospitals and nursing homes, those same institutions play an enormous role in the provision of all mental health services in New York. The report of the Commission includes data regarding the state health care system to assist the Commission in preparing its recommendations. The recommendations of the Commission breaks down the health care system into several “Major Service Categories” which include Psychiatric Inpatient Services, Psychiatric, Drug Detoxification and Rehabilitation, Alcohol Detoxification and Rehabilitation. It is critical that data regarding the mental health system be separately identified and analyzed in more detail. In 2003, the total of expenditures for reinstated services in New York was $38 billion. Of that amount, $2.5 billion (7%) was expended on mental health services including substance abuse services. Mental health expenditures were: inpatient $1.4 billion (55%), outpatient $660 million (26%). Substance abuse expenditures were: inpatient $250 million (10%), outpatient $242 million (9%). (This data was derived from 2003 institutional cost reports.) From this data, one would correctly conclude that mental health and substance abuse services comprise a relatively small part of the total expenditures of general community and teaching hospitals in the state. However, the proportion of all expenditures for mental health care by licensed facilities and programs is accounted for by expenditures for Article 28 facilities and in a relatively small part of the total expenditures for mental health services in the state. Currently, there are approximately 5,800 psychiatric hospitals licensed by OMH. These numbers do not include the non-billing facilities for which there is no known count or if we consider the number of beds in psychiatric centers. The data in Table 1
Suicide Prevention

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in the nation for the number of deaths by suicide.” In light of such staggering stats, Carpinello went on to say that "OMH was proud to bring together such a comprehensive group of suicide prevention stakeholders, organizations, survivors, and governmental officials for this two-day event to increase suicide awareness, discuss prevention tactics, and create an opportunity for all key stakeholders to share and distribute suicide prevention materials and practices.”

The event offered participants the opportunity to hear from a myriad of experts in the field of suicide prevention. To name only a few, Commissioner Carpinello, spoke of her personal experience with suicide and her work in increasing prevention efforts, Mary Jean Coleman, President of Samartians USA also spoke of her personal experience with suicide and her work to raise awareness and increase prevention efforts both on a statewide and national level, Gary Spiehmel, Director of Suicide Prevention for OMH, discussed the challenging aspects of suicide prevention, David Litts, Associate Director of Prevention Practice at the Suicide Prevention Resource Center spoke about the collaborative efforts on the national level to increase prevention strategies, Gaile Stolper, Executive Director of the Mental Health Association of New York State's history a $1.5 million allocation, as there is for the first time in New York State, the report focuses on risk factors, recommendations and action steps, prevention strategies, and county specific data regarding suicide deaths in the state, as reported by the Department of Health. Copies of the report may be accessed at www.omh.state.ny.us. As is evidenced through her continued efforts around suicide prevention, it is clear that Commissioner Carpinello has indeed set a course for New York State to address this serious public mental health challenge. Confirmation of this can be seen in the Governors 2006-07 Executive Budget proposal, as there is for the first time in New York State’s history a $1.5 million allocation that, if passed by the Legislature would increase the number of localities with a local suicide prevention plan tailored to meet the needs of their communities and allow OMH to expand upon an already successful suicide awareness and education campaign.

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demonstrates the critical role played in the public mental health system by Article 28 hospitals. As the largest component of the system, Article 28 hospitals represent 37% of all costs for adults with SMI and children with SED including 48% of inpatient and 40% of outpatient costs. Article 28 hospital inpatient and outpatient services served a population with almost as many seriously and persistently ill adults and seriously emotionally disturbed children as Article 31 facilities (inpatient private psychiatric hospitals and free-standing outpatient mental health programs). The data in Table 2 shows a $1.5 million allocation as there is for the first time in New York State, the report focuses on risk factors, recommendations and action steps, prevention strategies, and county specific data regarding suicide deaths in the state, as reported by the Department of Health. Copies of the report may be accessed at www.omh.state.ny.us. As is evidenced through her continued efforts around suicide prevention, it is clear that Commissioner Carpinello has indeed set a course for New York State to address this serious public mental health challenge. Confirmation of this can be seen in the Governors 2006-07 Executive Budget proposal, as there is for the first time in New York State’s history a $1.5 million allocation that, if passed by the Legislature would increase the number of localities with a local suicide prevention plan tailored to meet the needs of their communities and allow OMH to expand upon an already successful suicide awareness and education campaign.