THE BULLETIN

NEW YORK STATE PSYCHIATRIC ASSOCIATION

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Timothy's Law

By Barry Perlman, M.D.

Barry Perlman, M.D.

Despite intensive advocacy and lobbying during the current legislative session, the New York State Legislature again failed to reach agreement on Timothy's Law, the NYS version of a mental health insurance parity bill. The Legislature's failure to pass this principled legislation after 5 years of deliberations represents a great disappointment to NYSPA and the other organizations of the hard working Timothy's Law Campaign team. However, we must also recognize that even the passage of such legislation would not in itself mean that we had reached our goal of equitable consideration and treatment of persons suffering with mental illness. That aim is a far broader one and seeks the integration of persons with mental illness into all realms of life to the extent of each of their capacities. In other words, it requires dealing with persons with mental illness as individuals rather than predominantly as members of a class. It means eliminating "stigma".

By definition "stigma" refers to "a mark of disgrace or infamy" or "a brand". Within the mental health community it connotes the prejudice based on stereotype with which those with mental illness, whether severe or other, are viewed in our society. The stigmatization of individuals with serious mental illness implies that others prejudge them based on preconceptions about the diagnostic group to which they belong. Even when we believe that we have personally sidestepped such a perspective, closer examination may reveal how we have fallen into the trap. "Stigma" is both insidious and pervasive.

Two situations recently reminded me of how unintended stigmatization may insert itself into the functioning of well intended and respected medical institutions and public agencies. In a recent case report Le Melle & Entelis provide insight into the prejudices which need to be overcome even within the medical community by discussing the initial, automatic rejection for cardiac transplant of their patient who suffered with schizophrenia based solely on his psychiatric diagnosis and related concerns. (Clinical Case Conference: Heart Transplant in a Young Man with Schizophrenia. Amer J Psychiat 2005: 162; 453-457.) They point out that having a diagnosis of schizophrenia is the basis for exclusion for heart transplant in the major-

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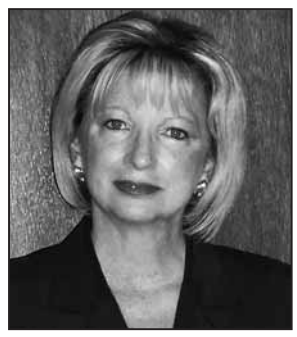
SPEAK Now: New York's Model Program on Suicide Prevention

By Karin L. Moran, M.S.W.



Sharon Carpinello, R.N., Ph.D.

According to the most recent statistics published by the National Institute of Mental Health, suicide was the 11th leading cause of death in the United States for the year 2001, totaling 30,622 deaths. Alarmingly, it was the third leading cause of death among adolescents. Even more staggering is the rate at which our elderly population is completing suicides. According to the National Strategy for Suicide Prevention, elderly individuals take their own lives at a rate of one every ninety minutes.

New York State specific statistics from the New York State Department of Health cite that approximately 1,300 New Yorkers take their own lives each year; in addition, it is estimated that for every suicide death, there are anywhere from 8-25 suicide attempts. To put these numbers into context, the New York City Department of Health and Mental Hygiene reported that more New Yorkers lost their lives to suicide in the years 2000 and 2001 combined, than were killed in the September 11th World Trade Center disaster.

Although a myriad of articles have been published focusing on suspected contributing factors and the after effects of such a traumatic event, perhaps not enough ink has been spent on proactive projects to reduce the number of suicides. One such initiative in New York State has been led by our own Commissioner of Mental Health, Sharon Carpinello, R.N., Ph.D.

In May of 2004, following the President's New Freedom Commission Act Report naming suicide prevention as a top priority, Commissioner Carpinello introduced an innovative prevention campaign aptly named SPEAK (Suicide Prevention Education Awareness Kit). Based on the Commissioner's concern that suicide rates pose a serious public mental health challenge and her belief that suicide prevention programs and early intervention efforts will saves lives, SPEAK was created to raise New Yorkers' awareness about this issue and supply them with potentially life saving information.

Designed for both clinicians and lay people, the Kit clearly identifies the effects of depression, suicidal symptoms and various prevention strategies. Although comprehensive in its scope, the Kit is a user friendly tool broken down into six population specific sections, each focusing on the associated risk factors of depression and suicide. Kits also include common questions and

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Sentencing Advocates

By Chris Napierala

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

WHO WE ARE

Sentencing advocates are effectively utility players, variable parts forensic social worker, legal advocate, investigative journalist and community-resource specialist. Those credentialed to do so also conduct clinical assessments. While social workers predominate among sentencing advocates, the field draws people from a broad variety of disciplines, including psychology and other social sciences, education, law, and related disciplines. I, for example, studied journalism and urban history, and worked as a social-policy researcher. Ideally an advocate possesses a combination of strong written, oral, research, interview and analytical skills, an abiding belief in the value of offender rehabilitation, and the ingenuity and persistence necessary to devise and successfully advocate for alternative-sentencing proposals in an atmosphere that can be highly adversarial.

WHO WE SERVE

Most advocates serve the full spectrum of criminal offenses and offenders, from petty theft to murder and sex offenses, from adolescents to the elderly, first and repeat offenders, male and female. Like the larger defendant population, our clients are primarily indigent and possess among them a multitude of social, mental, educational, behavioral and medical issues and conditions. The majority have significant substance-abuse histories, limited education and/or a learning disability, limited employability, low social competency, and highly dysfunctional families. Mentally ill clients, most of them SPMI, additionally struggle with the symptoms of their illness, its behavioral consequences, and characteristically a poor continuity of treatment, which leads to their offense conduct. Some have been previously committed to state psychiatric hospitals, most have had intermittent outpatient or residential treatment, and most have been prescribed psychiatric medication but complied intermittently. With many SPMI defendants, we are intervening long after the cycle of addiction and relapse, psychiatric decompensation, hospitalization and incarceration has been established. Despite this recognizable pattern, we often find that they have never been offered treatment as an alternative to incarceration (ATI).

WHAT WE DO

It is a core principle of our advocacy that justice, offender rehabilitation and public safety need not be discrete and competing interests. In the case of SPMI defendants, whose symptoms often precipitate the offense conduct, we believe it is particularly important that their conditions be fully known and considered if all of these interests are to be equitably served.

Advocates intervene both during plea negotiations, when the judge or prosecutor might be moved from a more-punitive posture towards a treatment-based disposition, and after conviction, when a judge is seeking information to determine an appropriate sentence. We advocate both in writing, usually in a pre-pleading or pre-sentence memorandum that presents a highly detailed psychosocial history and disposition proposal, and orally, in court and in case conferences with the prosecution. When legally viable, we advocate for offender rehabilitation through humane, constructive

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Albany Report

By Richard J. Gallo and Karin L. Moran, MSW

End of Session Summary

The "regular" 2005 Legislative Session ended on June 24th. The Senate and Assembly passed and sent to the Governor a total of 894 bills, of which, 421, to date, have become law and 58 have been vetoed.

If asked, most legislators would say that the foremost accomplishment of the Legislature as a whole this session was the passage of an on time budget for the first time in twenty-one years. As we reported in the last issue of the Bulletin, the decision and determination to complete the budget by the April 1st deadline dramatically altered the customary character and pace of the early weeks of session.

Suddenly, everything at the Capitol was thrust into high gear and anyone interested in how the State would ultimately apportion in excess of $100 billion between April 1, 2005 and April 1, 2006 had to shift into that gear as well. It was a grueling exercise made slightly less so for those whose areas of interest were treated generously in the Governor's budget request. One such area, richly supported by the Governor's request, at least in comparison to most other state agencies was the proposed budget for State Office of Mental Health (SOMH). Hence, NYSPA's traditional fight for SOMH funding was less strenuous this year than in prior years. However, as previously reported, the Governor's budget proposal did seek massive cuts in health care spending generally with potentially dire consequences for mental health services funded by or through the Department of Health; most notably, Medicaid, HCRA related financing and the Family Health Plus program.

NYSPA was among the first to identify and respond to obscure budget bill language that, if enacted, would have eliminated coverage for mental illness under the State sponsored health insurance program for low income families: Family Health Plus (FHP). NYSPA was successful in helping to convince the Legislature to reject the Governor's FHP cuts relative to mental health coverage. The Governor's budget also proposed, and the Legislature ultimately approved, the creation of a Preferred Drug List (PDL) for the Medicaid Program. NYSPA was also successful in maintaining previously secured exemptions for atypical anti-psychotics and all anti-depressant medications. In addition, NYSPA joined forces with the Greater New York Hospital Association to help defeat a budget proposal that would have resulted in massive cuts in reimbursement rates for hospital inpatient services for chemical dependency care.

Timothy's Law

Throughout the 2005 Legislative Session, NYSPA continued its leadership role in advocating for the passage of legislation to require that health benefit plans in New York State provide coverage for the treatment of mental illness and chemical dependency on the same basis applicable to other medical conditions under such plans. NYSPA's work on the issue was primarily linked to our participation as a key member of the Timothy's Law Campaign (TLC). This year, our Government Relations Advocate, Richard Gallo, was asked to Chair the Campaign's Legislation Committee. Among other things the Committee was charged with preparing a new or revised bill that, while maintaining the high principles of the original legislation, would be responsive to the widely held concerns regarding the economic impact of such legislation on small businesses (fifty employees or less).

The resulting proposal, the product of many, many hours of internal discussions and compromises within the Campaign, was released to the Legislature in mid-March and the public in May. Although the bill itself was not formally introduced in either house, it did serve as a catalyst for renewed discussions between the two hous-

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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.

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

Harvard President Discusses Impact of Psychiatric Treatment


Jeffrey Borenstein, M.D.

This past June, I had the pleasure of attending my 25th Reunion at Harvard. In addition to spending time with friends and visiting our favorite places, one of the most interesting moments of the reunion was the speech by the President of the University to the Class of 1980. President Summers was listing a number of differences between our class and the current classes at Harvard. He initially spoke about a number of demographic changes, such as the number of various minorities, number of women, number of students from foreign countries. But then he said:

"Here's a second difference. And it's one that people don't ever list, don't think of as a difference, but I actually think it's a very, very important difference. One of the unsung and wonderful things that has happened in our country in the last 25 years, 35 years, due to medical research, has been a tremendous increase in the capacity to treat a whole range of conditions that affect adolescents and young adults. Conditions relating to depression, conditions relating to hyperactivity, conditions of other kinds that interfere with the learning process.

I asked our Provost, Steve Hyman, who's the former head of the National Institute of Mental Health – recognizing that he couldn't make a precise scientific estimate – "What fraction of the Harvard class today was made up of people who because of various kinds of medical issues, could not have been in the Harvard class 25 or 30 years ago?" He said he didn't know.

I said, "Yeah, but make a guess."

And he made his best estimate, and his best estimate was 10 to 15%. Think about that: that's Lowell House, made up of students who have a chance to come to Harvard, who never would have had a chance to come to Harvard 30 years ago. And that's a very important bit of progress in our country. It's a very important bit of progress that comes with a great obligation for all of us.

And if you look at the efforts on our campus today in student mental health, at the Bureau of Study Council, in counseling of various kinds, they are vastly greater than they were at the time when you were students. And I think that too is a very important indicator of progress.

After President Summers spoke, a number of my friends knowing I'm a psychiatrist asked me what I thought. I said that I am pleased that the President of Harvard was focused on such an important trend, especially in the context of all the controversy in the press about psychiatric treatment.

I want to thank Harvard University for sending me a transcript of President Summers' remarks. ■

I am pleased to welcome Karin L. Moran, M.S.W., who now serves as the Assistant Editor of the *Bulletin*.

President's Message continued from page 1

ity of transplant programs worldwide. In their report they describe how a patient of theirs diagnosed with schizophrenia had been a priori denied transplant at their institution until their appeal to the medical center's ethics committee resulted in reconsideration of the decision. They inform that the ethics committee "concluded that the only criteria for denying Mr. A a heart transplant were 1) that the transplant would not significantly improve the quality of his life or 2) that he could not comply with the rigorous treatment protocols and the follow-up care required after transplant." They report that Mr. A successfully underwent transplant and his life then returned to its status quo ante.

Another example of the stigmatizing of persons with mental illness arose in the early draft regulations which addressed the question of who might serve as a live liver donor in New York State. Subsequent to the death of a live liver donor at a major teaching institution, the Department of Health created the, " New York State Transplant Council's Committee on Quality Improvement in Living Liver Donation." The Committee's report to the Commissioner (12/19/02) contained a section devoted to the evaluation of the potential donor which recommended that, "The donor should be free of current psychiatric disorders. In situations where a past history of psychiatric illness exists, the illness should be in full remission with a low likelihood of reoccurrence as documented by a psychiatric evaluation." The Committee called for the creation of an Independent Donor Advocate Team (IDAT) which was to include, "a medical social worker, with the participation of a psychiatrist and/or ethicist as appropriate." These recommendations, made without a clear factual basis in the medical literature, were transformed into draft regulations. I had the opportunity to comment on the proposed regulations when they were presented to the State Hospital Review and Planning Council, a state council integral to the regulatory process of the DOH. As a result, the a priori exclusion of persons with mental illness as live liver donors was dropped and the suggestion accepted that a psychiatrist be included as an integral member of the IDAT in order that decisions be made on an individualized basis.

Both the medical center which was the subject of the Case Report and the NYS DOH initially rejected out of hand the involvement of persons with mental illness from participation in the transplant process. In the first case they were rejected as recipients and in the latter as live donors. To each of their credit, when their respective stigmatizing perspectives were challenged, each adopted a more rational and humane approach. The two situations described serve to remind psychiatrists, their professional organizations and other advocacy groups of the need to be vigilant in order to assure that persons with psychiatric illnesses are not excluded from access to important medical procedures based on unfounded, preconceived notions about their inability to endure the vicissitudes associated with the procedures. ■

NYS Pharmacy & Therapeutics Committee By Glenn Martin, M.D.

As part of the legislation authorizing the New York State Medicaid's pharmacy benefit program to adapt a preferred drug model, the Pharmacy and Therapeutics (P&T) committee was re-activated after a period of inactivity mandated by the New York State Legislature. The period of inactivity, which lasted more than a year, was mandated as the governor's office and the legislature worked out an agreement on the new preferred drug program. Dr Aron Satloff, former Treasurer of NYSPA and I remained as members of the newly functioning Committee, and at our June, 2005 meeting I was elected as the Committee's first chairman.

The P&T Committee reviews specific clinical issues regarding Medicaid pharmacy policy. After hearing public comments, and reviewing information provided through the exemption requests, the Committee makes recommendations to the Commissioner of Health on proposed changes. The Commissioner will make final determinations after considering the Committee's clinical recommendations and input from advocacy and other interest groups.

The initial focus of the P&T Committee was on generic substitutions. In general, where an appropriate generic exists it must be dispensed with certain exemptions. For example, anti-rejection and anti-HIV drugs are excluded from this rule. In addition the committee has specifically reviewed the use of second-generation anti-histamines, gastric acid reducers, and erectile dysfunction medications. Certain limitations were placed on using these medications, but a physician is not prohibited from prescribing any medication in these classes. The doctor is at times required to get telephone prior approval before Medicaid will pay for the medication. The prior approval process is done on the phone, is entirely automated, and takes about 3-5 minutes. It is annoying to all and reportedly burdensome to some. The committee has asked the department to minimize the disruption to physicians and is monitoring the length of calls, dropped calls, etc. It has also asked that other systems be considered, especially as e-prescribing is becoming closer to a reality in New York State.

The members of the P & T Committee consist of physicians, nurse practitioners, and pharmacists who have been appointed by the Commissioner of Health to serve in an advisory capacity. A conflict of interest policy including detailed reporting requirements is in place. The members bring specialized expertise in areas such as mental health, geriatrics, internal medicine, HIV/AIDS and children's health. All clinicians on the committee have to be actively practicing. With the passage of the new drug program the size and composition of the committee is expanding. Our first new member is Janice W. Gay of the Epilepsy Coalition of New York State.

The impact of this committee on the psychiatric treatment of Medicaid recipients in NYS may in fact be rather limited. Firstly, the legislation governing the program specifically exempts anti-depressants and anti-psychotics from the program. The legislation doesn't exactly define what these terms mean, but suffice it to say many of the drugs prescribed by psychiatrists will not be subject to the new formulary/preferred drug list. Additionally, for those patients who are dually eligible for Medicaid and Medicare they will not be directly involved in this program as their source of pharmacy benefits will shift to part D of Medicare beginning in 2006.

Nevertheless, the Committee will have some impact on psychiatric care. In fact, on the agenda for the in the meeting of October 14th is a proposal to reimburse Risperdal Consta, with prior authorization, for selected, qualified mental health programs. The initial proposal is based on the recommendations of the Office of Mental Health, but public testimony will be heard and the committee will make its recommendations to the commissioner. Frequently the committee's discussions are focused on the need for prior approval, the number and type of questions that need to be answered, and the duration of the prior approval. Other items on the agenda, as well as the results of the meeting, and other information about the committee and related matters can be found at: http://www.health.state.ny.us/health_care/medicaid/program/ptcommittee/ ■

AREA II TRUSTEE'S REPORT By Ann Sullivan, M.D.

Ann Sullivan, M.D.

I hope you all had a great summer!!! The Board of Trustees met July 29 to 31, and dealt with a number of hot issues in addition to the weather! Here are the Highlights:

FINANCE:

While last year was a very good year with a substantial surplus, this year we must be more cautious! The meeting in Atlanta, while successful, was less profitable than last year, generating 3.9 million dollars less in revenue. There has also been a decrease in publishing revenue and there will be an increase in expenses due to increased health care benefits costs and cost of living. While we will still add the 500,000 minimum to our reserves, it may not be possible to add much more this year. That is why it was wise to save last year! Our target continues to be to reach reserves equaling 40% of our budget (20 million dollars) by 2012! And once again, the budget will be balanced this year.

The independent audit done by BDO Seidman, LLP showed no significant findings and found us to be in compliance!! The excellent work of Dr. Scully, Ms. Swetnam and finance staff have made the financial state of the organization accurate and transparent!

The investment oversite committee had a comprehensive search for new investment advisors, and recommended Smith-Barney Consulting Group, which the Board approved. The investment oversite committee, chaired by Maria Lymberis, has done well with a year to date investment gain of $792,000.

POLICY:

The Board voted to approve the Position Statement in Support of Same Sex Civil Marriage which recommended that the APA should expand its current Position Statement in Support of Same Sex Civil Unions and now support legal recognition of same sex civil marriage. This position paper was widely circulated to the Assembly, Area Councils, District Branches, Components and interested members for several months with much useful discussion. The Area II Council also strongly supported this position at its last meeting.

The Position Statement on the Use of the Concept of Recovery, which endorses and affirms the application of the concept of recovery to the comprehensive care of the chronically mentally ill, was also passed. This is an important step in recognizing the value of this concept to our patients and their advocacy groups.

The approved Position Statement on the Publication of Findings from Clinical Trials puts the APA on record as supporting "public accessibility to all methods and findings in clinical trials" whether positive or negative. It further states, "the suppression of negative findings has the potential of exposing patients to ineffective and potentially harmful treatments.

The Board defeated the action to adopt as official APA policy the termination of the IMD exclusion on a national basis. After much discussion, the majority decided that this complex issue had different ramifications in different states, and that it was not at all clear that such a policy would always be in the best interest of our patients or our members. The APA however continues to support legislation that would provide payment through Medicaid for emergency treatment at IMD excluded facilities.

MEMBERSHIP:

Many District Branches have long had difficulties assuring the timely transfer of members between district branches as well as the upgrade of members from MIT to general member. The board voted to approve the Membership Committee's recommendation to implement automatic MIT to GM advancement, as well as an automatic District Branch transfer process. The details include checks and balances to ensure accuracy. This has long been an issue for the MIT's and ECP's who have requested this for many years. It is hoped it will enhance member retention, and simplify the paperwork!

The membership committee also revised the operation's manual as regards impaired physicians. Since this affects members directly, I thought I would include the text: "When a member has had a license suspended or revoked because of physical or mental illness or substance abuse, he/she will not automatically be dropped from membership in the APA, and instead may be placed on inactive status until recovery. This will be handled administratively in the APA Central Office, with concurrence of the district branch, the Chair of the APA Membership Committee, and the APA Ethics Committee."

In response to the fluctuations in revenue from annual meetings, and to try and balance the meeting budgets, the Board approved a 10% increase in the annual meeting registration fees.

The Membership council received a record number of proposals totaling almost $700,000 from the District Branches and State Associations for innovative initiatives for membership recruitment, retention, outreach, community education, etc. The proposals were creative and high quality! The council will make its recommendations to the Board in October.

ADVOCACY:

The ongoing struggle against scope of practice issues continues!! Despite our losses in New Mexico and Louisiana, we successfully prevented psychologist prescribing legislation in 3 states, including Missouri, Tennessee and Florida. The Board also approved an expedited decision making process for District Branches and State Associations on requests for APA grant assistance for scope of practice issues. This is crucial if our response is to be timely and effective!

Victory for our team on expanding the prescribing capacity for Buprenorphine! Physicians in group practices and clinics can now individually prescribe for 30 patients, rather than limiting the entire practice or clinic to only 30 patients. Reason prevailed!

Advocacy continues strong and steady in key areas: opposing Medicaid cuts; ending the discriminatory 50% Medicare co-pay; increased funding for mental health research; supporting the Genetic Non-Discrimination Act (prohibiting employees and insurers from discriminating based on genetic profile or family history); the Child Health Crisis Relief Act to provide incentives to increase the number of Child Psychiatrists; active public relations to dispel the myths about psychotropic medication and children and adolescents; opposing the discriminating Parental Consent Act which prohibits mental health screening of children; and active involvement in the Medicare pay for performance initiatives. The list goes on and on! The APA is truly our spokesperson in Washington on key issues affecting us and on our patients. This is just a sample of the wide range of critical activities!

The Healthy Minds/Healthy Lives Campaign, focusing on public awareness of the what, why and how of what we do as psychiatrists is rapidly moving ahead! We have already received good press on a variety of local and national media. The APA also directly responded to the "Tom Cruise Interview" in national media and has been pro-active on the issue of anti-depressants and adolescents. The campaign responds to member requests that the APA aggressively advocate for our profession and its critical role in treating mental illness!

An outgrowth of the campaign is the campaign logo: a stylized caduceus in blue and gold. It was suggested that the logo become the official APA logo, instead of the Benjamin Rush medallion. If you don't know the "new" logo you can see it on the APA website! What do you think??

ASSEMBLY ACTION ITEMS:

Several items referred by the Assembly were postponed to the next board meeting, with requests for more detail and or further clarification, input, etc. from various components or staff:

- Expansion of the charge of the Corresponding Committee on Medical Records to include a wide range of growing issues involving electronic records and communications.
- Assembly authority to override a Board decision by a three quarter vote, on issues that do not affect the Board's "fiduciary" responsibility.
- Adding level of care criteria to all practice guidelines.

The Board will take up these issues for full discussion at a future meeting.

GOVERNANCE:

As an update, the Board formally found the Texas Society of Psychiatric Physicians (TSPP) to be out of compliance with APA established membership policies. A letter was sent explaining this to the Texas Membership, also stating that the Board is hopeful that the TSPP will change its current relationships to conform to established APA policies.

NOTEWORTHY REPORTS:

The Report of the Task Force on Prevention of Mental Disorders and Promotion of Mental Health is an excellent document on the state of the art of mental health prevention! It is well worth reading and can be accessed on the website!

Also, the APA Report of the Task Force on Research Ethics, which will soon be submitted for publication, is also available on the website and makes solid recommendations as to the complex ethical issues presented by current psychiatric research. Again, a thought-provoking document!

Once again, I hope you had a great summer! As always, let me know your thoughts, ideas, comments, etc. at 718-334-3536 or email me: ann.sullivan@mssm.edu ■

New Clinical Study of Science-Based Treatments for Opioid-Dependent Teens

By Ramon Solhkhah, M.D.

Although, overall, recent studies of adolescents and adults show a slight decrease in drug use, adolescent substance abuse remains a public health concern, particularly as relates to the use of opioids (such as heroin and prescription pain killers) and designer drugs (ecstasy and others). Opioids are the broader class term that includes those opiate drugs derived from the opium plant (e.g. heroin) as well as synthetic narcotics. Increasingly, clinical concern has been directed to the opioids. Commonly used opioids include oxycodone (OxyContin), propoxyphene (Darvon), hydrocodone (Vicodin), hydromorphone (Dilaudid), meperidine (Demerol), and diphenoxylate (Lomotil). To help address this national concern, the Behavioral Science Research Unit and the Child and Family Institute in the Department of Psychiatry at St. Luke's and Roosevelt Hospitals has launched a new outpatient, clinical research program to evaluate strategies for optimizing outcomes from combined behavioral-pharmacological treatments for opioid-dependent adolescents (ages 13-18).

School-aged children and adolescents are increasingly abusing and becoming dependent on heroin and opioids. The annual Monitoring the Future survey (see http://www.monitoringthefuture.org/) shows that in 2004, heroin use within the past year was reported by approximately 1 percent of teens across all grade levels. Moreover, OxyContin use in the past year was reported by 5.0 percent of 12th-graders, 3.5 percent of 10th-graders, and 1.7 percent of 8th-graders. The annual prevalence rate for Vicodin was considerably higher than for OxyContin, at 9.3 percent in 12th-graders, 6.2 percent in 10th-graders, and 2.5 percent in 8th-graders in 2004. Considering the addictive potential of oxycodone and hydrocodone, these are concerningly high rates of use. Unfortunately, to date, little research has focused on the unique status of the opioid-dependent adolescent. This research is designed to evaluate effective treatments for this largely unstudied and expanding population of opioid-dependent youth.

This research examines varying durations of treatment with the partial agonist medication, buprenorphine. Buprenorphine is approved by the Food and Drug Administration (FDA) in the U.S. for pain relief in children, adolescents and adults, as well as a medication for the treatment of opioid dependence in adults. Our prior research has shown that buprenorphine is also safe and effective in treating opioid dependence among adolescents. Adolescents in this study are provided with a 1 or 2-month medication-assisted withdrawal with buprenorphine.

All adolescents are also provided with a multi-component, intensive, behaviorally-based treatment program throughout the detoxification. Specifically, the program includes individual behavioral therapy based on an intervention that has been previously shown to be efficacious in the treatment of adolescent substance abusers. Family therapy with parent(s) and adolescents is an optional part of this therapy. Moreover, the program includes voucher-based contingency management interventions to promote opiate abstinence and clinic attendance (in which vouchers are earned contingent on opiate abstinence and clinic attendance and may be exchanged for goods and services congruent with the adolescent's treatment plan). Adolescents are required to provide urine samples three times per week, which are screened onsite for illicit drugs.

This study also examines the use of the opiate antagonist, naltrexone as part of multi-component, relapse prevention interventions. Naltrexone is a medication, which if taken regularly, can block the effects of any opiates one may use and prevent one from getting high from opiates. During this phase of the study, we will evaluate if providing incentives for taking naltrexone increases compliance with naltrexone treatment. At the end of the program, we will work with adolescents to refer them for further treatment/aftercare at appropriate community treatment centers.

All treatment provided to adolescents in this study is free, outpatient and confidential.

This research will contribute new empirical information that will inform the development of effective treatment interventions for the largely unstudied population of opioid-dependent youth.

This project is being conducted by Lisa A. Marsch, PhD (Principal Investigator) in collaboration with Ramon Solhkhah, MD (Medical Director) and Deborah L. Haller, PhD. This research is supported via a research grant from the National Institute on Drug Abuse (NIDA) and is being conducted in collaboration with the National Development and Research Institutes (NDRI).

To learn more about this program, please call Dr. Marsch at 212-523-5232 or Dr. Solhkhah at 212-523-3069. ■

Families Together in NYS, Inc. The Little Engine that Could

By Karin L. Moran, M.S.W.

Paige MacDonald

From a mutual concern among parents of children with emotional, behavioral, and/or mental disorders regarding access to mental health services, a power house advocacy and support organization called Families Together in New York State was born. It was a simple concept predicated on a movement begun in the late 1980's that sought to include parents of children with emotional disorders into policy and program planning. With this in mind, the Mental Health Association in New York State applied for and received a grant in 1989 that allowed them to expand their staff to include a parent that would begin the process of connecting parents throughout the state whose children were afflicted with an emotional disorder; thus, the Parent Support Network was formed.

Two years later in 1991, the New York State Office of Mental Health received a grant from the Child and Adolescent's Service System Program to develop an individualized care approach to serving children and families. As part of that grant, five additional parent advisors were hired to work with families in five regions across the state. By 1993, the Parent Support Network received a three year grant from the National Center for Mental Health Services to develop a statewide, parent run, not-for-profit organization. With this, the Parent Support Network worked in conjunction with OMH to further expand the network's reach. A steering committee, an organizational mission statement, and bylaws were formed to create the newly named Families Together in New York State.

In a matter of just a couple of years, the idea to connect parents with a common cause had resulted in the formation of an organization that has served thousands of families across the state and shows no signs of slowing down. Since its official formation, Families Together has become an independent organization with an affiliation membership to the National Federation of Families for Children's Mental Health. Their breadth of knowledge regarding children's mental health services in New York State has grown as quickly as their organization and they are seen throughout the state as providing a strong voice for families of children with emotional, behavioral and social needs. Paige Macdonald, Executive Director of Families Together, shared how the organization's work and ability to provide that voice is guided by the principle that "All children and their families deserve timely and affordable access to appropriate mental health services within their community. The formulation of Families Together is a direct result of parents running into a brick wall when faced with the monumental task of accessing mental health services for their children. Time and time again we hear stories from parents about excessive waiting lists, interrupted care, abbreviated hospitalizations, and encouraged custody relinquishment as a vehicle for obtaining publicly funded services. We need to do better for our children. Organizations like Families Together need to look at creative measures with which to provide increased access to mental health services and continuity of care."

Brooke Schewe, Director of Outreach & Development for Families Together, discussed issues regarding the shortage of child psychiatrists both around the capital district and throughout the rural areas of New York State. "We have heard from countless families about situations when a child is in crisis only to be told that there is a four to six month waiting list to see a child psychiatrist. In many instances, the child is eventually seen by a psychologist for an assessment or a non-psychiatrist physician or physician's assistant for a prescription, but this does not constitute comprehensive care. Families Together looks to organizations such as the New York State Psychiatric Association (NYSPA) and its affiliates to help address the shortages of child psychiatrists; incentives need to be created to recruit more physicians into the field of child psychiatry. We would welcome working with NYSPA toward this goal."

In an effort to scratch the surface of these barriers to care, Families Together has recently received a substantial grant which will allow them to enter into a partnership with the Albany County Department of Children, Youth and Families (DCYF). Through this relationship, the *Albany County Family Partnerships for Change* will build upon a system of care project initially begun by the county in 1997. With the goal of enacting system wide improvements to the counties mental health services system, the efforts will be Herculean, but the hope is that it will be replicated throughout the state.

On the county-wide level, the project proposes to create a more efficient and integrated system of care by strengthening many aspects of the current system; including, but not limited to: reducing waiting times for psychiatric assessments, developing integrated and standardized assessments and care review protocols, establishing a Multi-Cultural Advisory Committee and increasing the capability of the county to address the needs of four under-served populations: early childhood (0–5), at-risk (8–14) or with co-occurring disorders (12–21) ; and, transitioning youth (16–21).

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

In the tri-cities – capital district area, the project will establish culturally competent family-run *Family Resource Centers* in three neighborhoods around the area (urban, suburban & rural), from which families can access an array of mental health and support services.

In closing, Macdonald expresses her understanding that there is "Undoubtedly a lot of work ahead with regard to increasing access, but we at Families Together have no doubt that it will be accomplished one step at a time." Those of us who have worked with Macdonald and her staff…believe her. ■

Albany Report

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es which had broken down at the end of the 2004 legislation session. Also, the attention given to the issue this year by Senate leadership, in an effort to find common ground with their Assembly counterparts, was unprecedented and bodes well for future resolution. Please refer to the box below for more details about the revised bill.

Kendra's Law Extended

As expected, the expiration and ensuing debates over the future of Kendra's Law was fraught with controversy. While a number of advocates called for the death of such an initiative, other groups vocalized their support of the law, albeit with a number of modifications, which in the end is exactly what transpired.

As NYSPA had suggested, the final version of Kendra's Law extended the statute for an additional five year period. Also included in the provisions was a mandate calling for increased reporting mechanisms such as an independent evaluation of the program to be completed by June 30, 2009 (one year before the extension sunsets) and quarterly spending reports. Additionally, the extender:

- increases state funding for AOT related costs in rural counties;
- requires county mental health officials to report the length of time at which they process investigations;
- requires service providers who are included in the written treatment plan to be so notified; and
- adds licensed psychologists and social workers to the current list of persons authorized to initiate a petition for court ordered AOT.

Scope Expansion Attempted

Two of the three separate bills dealing with the expiration of Kendra's Law permitted psychologists to initiate an AOT petition as mentioned above. However, one of those bills called for authorizing psychologists to also prepare the affidavit required by the court relative to the examination of the subject individual and treatment alternatives, including those involving hospitalization and medication. Specifically, the language granted psychologists the authority to describe for the court the types and classes of medication available and the beneficial / detrimental effects of such medications, as may be prescribed.

While NYSPA did not oppose adding psychologists to the list of people authorized to initiate a petition, we did oppose the proposed broadening of the role of psychologists into areas heretofore reserved to physicians. With seventy-one percent (71%) of individuals receiving an AOT court order having a diagnosis of schizophrenia and thirteen percent (13%) having a diagnosis of bipolar disorder, the indications for psychopharmacology are clear and beyond the statutory definition of the practice of psychology. Our position ultimately prevailed and the extender legislation was enacted without major changes with respect to the role of psychologists.

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

Proposed Timothy's Law Structure of Benefits Table

50 or More Employees (Non-ERISA Exempt)	50 or Fewer Employees	Sole Proprietors Healthy NY	Additional Safeguards
Mandated Benefit 1. Mandate to encompass the DSM IV with the exception of nicotine and caffeine addiction, paraphilias, and all V-codes. 2. Coverage must be comparable in every respect to that provided for physical illness, including equal co-pays and no separate deductibles. 3. Mandated benefit is in addition to "base benefits." (See item # 2 in next column)	1. Offers all employers with 50 or fewer employees, including sole proprietors, the option to purchase full parity coverage as mandated for employees of 50 or more at a rate comparable to that of the large employer. 2. Codifies and mandates a minimum base coverage of 40 inpatient days and 30 outpatient visits currently provided by most insurers. This would apply to all policies written in New York State and include all DSM IV diagnoses. 3. Mandates financial parity within the base, i.e., an equalization of all co-payments and deductibles. 4. Does not count medication management visits against the 30 outpatient visits. 5. Creates and funds a pool to reimburse inpatient care costs above the base for employees of small employers that have not elected to purchase parity coverage, but are in imminent danger of bankruptcy, eviction, foreclosure, or child custody relinquishment proceedings. • Expected exhaustion of inpatient days will trigger a referral to the pool administrator • Pool is initially "seeded" with $1 million in state funding for the first year. Subsequent years will be funded through a minimal surcharge on all policies.	Establishes a base where none currently exists (See base as defined in previous column, # 2)	• Requires plans to maintain adequate networks. • Requires an independent study to evaluate the impact of Timothy's Law and the prospect of mandating parity for small employer's policies. • Requires certain reporting by insurers and the insurance commissioner. • Calls for a public education program.

CMS IMPLEMENTS NEW NATIONAL PROVIDER IDENTIFIER

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

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

All health care providers in the United States are eligible to receive and use an NPI. However, use of the NPI is mandatory for providers who fall into one or both of two categories: (1) providers who are subject to HIPAA (i.e., covered entities) and (2) health care providers who participate with Medicare. Therefore, all psychiatrists who are subject to HIPAA and/or who participate with Medicare are required to apply for and use the NPI.

The following is a list of key points regarding the NPI rule:

- All psychiatrists who are subject to HIPAA (i.e., engage in electronic health care transactions), must use and accept NPIs in all standard transactions by May 23, 2007.
- All psychiatrists who participate with Medicare must also use and accept NPIs by May 23, 2007, regardless of whether they bill electronically or on paper.
- Non-Medicare providers and non-HIPAA-covered providers are eligible to obtain and use an NPI, but the current rule does not require them to do so. Psychiatrists who are not subject to HIPAA and who do not participate with Medicare are free to continue using their current provider identification numbers.
- If a health care provider is not currently subject to HIPAA, obtaining an NPI will not render the provider subject to HIPAA, nor will it have any effect whatsoever on the provider's status under HIPAA.
- At this time, individual providers or practice groups may apply for NPIs in one of two ways:

  (1) by completing and submitting an online form on the internet at https://nppes.cms.hhs.gov; or

  (2) by completing a paper version of the form and sending it by mail. Psychiatrists can obtain a copy of the paper form and the proper mailing address by logging on to https://nppes.cms.hhs.gov or calling 1-800-465-3203 or TTY 1-800-692-2326.

In addition, CMS plans to accept bulk applications submitted electronically by employers or professional associations in a process called Electronic File Interchange, but this option is not yet available.

- The application form collects only basic information about the provider, including identifying information (name, gender, social security number), mailing address, physical location address, other provider numbers, taxonomy codes, and license numbers.
- Providers who obtain an NPI will use the NPI for identification purposes in all communications with health plans and in all other standard health care transactions. Providers need to apply only once for an NPI and will use that same NPI when communicating with all health care plans and third party payers.
- Providers should not begin utilizing their NPI immediately. Individual health plans have the responsibility to directly notify their participating providers about when to begin using the NPI.
- Medicare has developed a transition plan for implementation of the NPI, but will continue to accept the Medicare provider number through May 22, 2007, the day before the compliance deadline. Medicare officials have indicated that they plan to issue an NPI guidance in the near future. Psychiatrists who participate with Medicare may wish to review this guidance for clarification and instruction before applying for or utilizing an NPI.
- NPI assignment does not affect participation with Medicare, Medicaid or other health plans. Even if a provider has been assigned an NPI, the provider will still need to be separately credentialed by each health plan or third party payer with which the provider participates.

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

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

With the distribution of over 28,000 Kits throughout the state, the New York State Office of Mental Health (OMH) has brought the campaign to the community -- educating clinicians, hospital staff, local government agencies, school districts, universities, and local law enforcement agencies on the topic. "The program has been met with great interest across the board, so much so, we can barely keep up with the demand for the Kits," noted Commissioner Carpinello in a recent interview. To date, over 2,000 New Yorkers have attended SPEAK presentations and additional efforts to broaden the campaign are underway. One example of this is a collaborative effort between OMH and over 400 college and university campuses in New York State providing students, faculty and other members of the college community with information on the link between depression and suicide, prevention strategies and hotline information. In addition to the Kit, presentations and other SPEAK initiatives, OMH has a website dedicated to this program; which over the last fourteen months has had 39,805 visits, 30,527 of which have transpired since January of 2005, indicative of the campaign's momentum.

An additional initiative to increase New York's suicide prevention and awareness efforts is an invitation-only Summit planned for the fall, co-sponsored by OMH, the Public Health Service and the New York State Suicide Prevention Council. This gathering of policy makers, experts in the field, state and local officials and stakeholders will focus on helping communities develop capacity for suicide prevention.

In recognition of her interest and expertise, Commissioner Carpinello was appointed as Chairperson of the National Suicide Prevention Lifeline Steering Committee -- a national hotline (1-800-273-TALK) launched earlier this year by the Mental Health Association of New York City (MHA of NYC) and its partners, the National Association of State Mental Health Program Directors (NASMHPD), Columbia University and Rutgers University. "As we have been working hard to raise awareness within New York State about the risks and warning signs for suicide, I now look forward to expanding that effort and promoting suicide prevention on the national level" said Carpinello.

As part of the National Suicide Prevention effort led by the Federal Substance Abuse and Mental Health Services Administration, Lifeline is the only national suicide prevention and intervention telephone resource funded by the Federal government. It is a network of local crisis centers located in communities across the nation that are committed to prevention of suicide; incorporating the best practices and research findings in suicide prevention and intervention.

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

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

A Special Note…

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

Psychiatry in Prisons Symposium

By Michael Pratts, M.D.

On the evening of November 2nd The New York Academy of Medicine, Psychiatry Section in conjunction with their co-sponsors will present The 2005 Stuart Asch Memorial Lecture: "Prisons: The New Psychiatric System. Are You Professionally Prepared?" Featuring Keynote Speaker, New York Times writer, Paul von Zielbauer. Assemblyman Richard Gottfried, 75th Assembly District NYS, Richard Rosner, MD, Forensic Psychiatrist, Pablo Sadler, MD, MPH, Jail Psychiatrist, and Charles Amrhein, MA, Bronx Treatment Alternatives to Street Crime project. The program Moderator is Jeffrey Borenstein, MD, Chair, Section on Psychiatry, The New York Academy of Medicine, the convenor is Phyllis Harrison-Ross, MD, Black Psychiatrists of Greater New York and Associates, and the event Chairman is Michael Pratts, MD, Bronx Psychiatric Center. All are members of the NYSPA.

The goals of this important educational activity include:

- Strengthening the interest of physicians and other mental health professionals in the field of forensic and prison psychiatry including diversion programs, chronically understaffed specialties
- Supporting psychiatrists and other mental health professionals who are in the trenches of this work in jails/prisons, and illuminate the challenges that they face
- Responding with recommendations as mental health providers and advocates to the recent New York Times articles and the recent PBS/TV special depicting the treatment of psychiatric prisoner patients in the New York and Ohio jails/ and prisons.

Co-sponsors of the event: Black Psychiatrists of Greater New York and Associates, United Social Services, Inc of the NY Society for Ethical Culture, Multi-Cultural Outreach Committee of NYS Alliance for the Mentally Ill, Association of Adolescent Psychiatry, Health Programs Division of the National Urban League, Council of Churches of the City of NY-Care for the Caregivers Project.

For more information contact Donald Morcone (212) 822-7272, dmorcone@nyam.org ■

Elmhurst Hospital Residents Join the 100% Membership Club

Bottom row: Maryluz Bermudez, Residency Coordinator, Neelam Varshney, MD, Carmen Faneytt, MD, Judy Tin Wai Koo, MD, Denys Arrieta, MD, Teresa Gil, MD, Raquel Choua, MD, Miguel Calimano, MD, Alex Altamirano, MD; Middle row:, Martha Alzamora, MD, Syed Jaffery, MD, Javaid Rashid, MD, Ademola Ladapo, MD, Hitendra Patel, MD, Ann Marie Sullivan, MD, Department Chair, Michel Rondon, MD, Amy Hoffman, MD, Residency Training Director, Vladimir Jelnov, MD, Savely Meyerzon, MD, Irena Danczik, MD; Top Row:, Deep Lohia, MD, Chantal Alerte-Nelson, MD, Juan Luis Castro, MD, Andres Chaparro, MD, Vincent Okabekwa, MD, Sang Ik Shin, MD, Yasmin Collazo, MD, Associate Residency Training Director, Federico Zuniga, MD. Not pictured:, Farooq Amin, MD, Walid Fawaz, MD, Silvana Garcia, MD, Abel Gonzalez, MD, Hye Lee, MD, Juraj Lukac, MD, Javier Senosiain, MD.

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and court-accountable ATIs that target specific offense behaviors and their underlying causes in a manner consistent with an interest in short- and long-term public safety. For mentally ill and substance-dependent clients, this usually involves court-mandated psychiatric or substance–abuse treatment.

Although submission of a memorandum is not always necessary, this is typically our primary advocacy tool and the platform for oral advocacy. Since we intend the memorandum to serve as the definitive source on a defendant's history, current condition and prospects for rehabilitation, as well as our perspective on the offense, the investigation is exhaustive. After reviewing the case file and interviewing the defendant at length, sometimes for several hours, we obtain and review all relevant and available records, including criminal and corrections, education, medical and psychiatric, foster care, employment and military; interview collateral sources from across a client's lifespan, including past and current mental-health clinicians; and, upon determining a client's suitability for treatment, coordinate the referral process and secure admission to an appropriate program. The historical information is distilled into a narrative, accompanied by an evaluation and a recommendation that details the treatment alternative and a release plan. In cases where an ATI is unattainable, usually due to the nature of the offense or the client's criminal record, the report serves as a tool to help determine the term and form of incarceration. At a minimum, we believe more information produces a more-prudent decision.

Where a treatment referral is required, we generally coordinate the entire process, from identification of an appropriate program through application, scheduling of intake interviews, obtainment of medications, the client's release from jail, and transport to the program. With SPMI clients, who depending on their condition might be mandated to any milieu from a residential MICA program to a hospital-based outpatient psychiatric program, this process inherently involves consultations and coordination with the entire range of mental-health professionals. Once placed, if the judge so requests, we also monitor the client for the duration of treatment and provide progress reports to the court. If treatment is a condition of probation supervision, the probation officer monitors the client.

THE OUTLOOK

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

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

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