eSynapse

December 2015

Editor’s Comments

James Flax, MD, MPH, DFAPA

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You will find below a synopsis of our meeting so all readers will have an idea of district branch business. But, it’s only a synopsis. Please come to a meeting to appreciate the rich discussions. There are reports from the APA, NYSPA and about the coalition’s annual Forum held in Rockland annually every October. Of particular note to me, Dr. Bark has written of his attendance at the Assembly this past fall. I want to underline his comments about the importance of the APA PAC (“Aided by contributions to the APA Political Action Committee (PAC). However much we may dislike it this is the way American politics works: more important than the amount of money contributed is the number and percentage of members who contribute. Politicians want to know how many people feel strongly enough about the issue to give to the PAC.”) If you haven’t contributed, please consider doing so. Even $1 adds your name to the list and number of donors.

Dr. Abdullah has again sent us a new article in his long line of erudite essays – this time on coffee. Keep ‘em coming, Dr. Abdullah. There is another poem. There are ads and announcements that may interest you. Please scroll all the way to the end to see it all. And, if you are not receiving the MSSNY eNews, here’s a link where you can read about issues of interest to all of medicine in New York State: http://www.mssny.org.

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IT’S A FREE LUNCH!
Next Executive Council Meeting
Il Fresco Restaurant, Orangeburg, NY
Friday, January 8th, 2015
Journal Club (15 minutes) PROMPTLY at 12:30
Followed immediately by Business Agenda
Please contact Mona Begum, MD (drmonabegum@gmail.com) if you are planning to attend.
Dear West Hudson psychiatric society members, colleagues and friends:

I am very saddened by the recent mass shootings and wondered what we can do as psychiatrists or responsible members of society to prevent this happening again. I know that individuals have a constitutional right to possess firearms in the home unless they fit into certain prohibited categories such as being convicted felons or having been civilly committed. Two thirds of US households have guns, even though statistics show guns kept in the home are more likely to be involved in a fatal or non-fatal unintentional shooting, criminal assault or suicide attempt then to be used to injure or kill in self defense. According to the center for disease control and prevention, there are over 21,000 firearm suicides every year in the United States. When some one is severely depressed & suicidal having access to a gun makes it easier to commit suicide than by other means like overdosing or hanging.

Recently I came across an article in Mother Jones Magazine titled “Inside the race to identify and stop the next mass shooter”. Brief summary of this article: Behind the scenes, the federal government has ramped up its threat assessment efforts: Behavioral analysis unit 2, a little known FBI team, marshals more than a dozen specialists in security and psychology from across five different agencies to assist local authorities who seek help in heading off would be killers. Those calls have been flooding in. Since 2012, the FBI unit has taken more than 400 cases.

The science behind threat assessment is still young, but it is attracting growing interest; last year the American psychological Association launched the Journal of Threat Assessment & Management. The public, law enforcement, prosecution, hospital clinicians & other professionals need to be trained on their roles in helping to manage the threats. Mass murder is not an impulsive crime – and therein lies the promise of threat assessment. The concept of police & mental health experts helping hand-in-hand to stop violent crimes before they occur is relatively new. Threat assessment is essentially a three-part process: Identifying, evaluating & then intervening. A case usually begins with a gut feeling that something is off. A teacher hears a student’s dark comment and alerts the principal. Or someone gets freaked out by a coworker’s erratic behavior and tells a supervisor. If the tip makes its way to a local threat assessment team, the group quickly analyzes the subject’s background and circumstances. They may talk with family, friends or coworkers to get insight into their intentions, ability to handle stress, and most importantly, potential plans to strike. One of the first things focused on this process is access to weapons. Possible responses range from helping the subject blow off steam and refocus on school and work, to providing longer-term counseling. If violence seems imminent, involuntary hospitalization or arrest may be the safest approach. Often the best initial step is the most direct - conducting a “knock and talk” interview, which has the dual benefit of offering help and putting the subject on notice. In a sense, threat assessment is an improvised solution of last resort: if we can’t muster the courage or consensus to change our underlying policies on firearms and mental heath care, at least we can assemble teams of skilled people in our communities and try to stop this awful menace case by case.

California recently became the first state to have a Gun Violence Restraining Order (GVRO) statute. It enables a concerned family member and/or law enforcement officer to remove guns
from individuals who are at risk of being dangerous to themselves or others before a tragedy occurs.

I fully agree with APA president Renee Binder, M.D. who recently wrote in an article “GVRO’S will not prevent all gun violence. However, they may serve as a useful tool that will temporarily keep guns out of the hands of high-risk individuals during periods when they are a danger to themselves or others. In addition to advocating for GVRO’s, there are other actions that we can take to decrease gun violence. We should advocate for strategies to increase responsible gun ownership including background checks and waiting periods before gun purchases, closing gun-show and Internet sales loopholes, product-safety regulations, safe-storage requirements, and gun-free college campuses and hospitals. We also should be able to talk to and educate our patients about the dangers of having guns at home (especially in the presence of children, adolescents, people with dementia, people who abuse children or partners, people with mental illness including substance use disorders, and others who are at risk of harming themselves or others). I welcome your ideas and exchanges.

Our next meeting is on January 8, at 12:30pm in Il Fresco restaurant in Orangeburg. Have a great holiday season!

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Summary from Executive Council Meeting
Friday, November 13, 2015
Il Fresco, Orangeburg, NY

Attendees Present: Mona Begum, Jim Flax, Raj Mehta, Nigel Bark, Russ Tobe, Lois Kroplick, John Fogelman and Liz Burnich.

Journal Club: For Journal Club this month, Dr. Russ Tobe presented a study entitled Early Cannabis Use, Polygenic Risk Score for Schizophrenia, and Brain Maturation in Adolescence. This led to an interesting discussion on treatment of adolescents with regard to cannabis exposure and a family history of Schizophrenia.

Fall 2015 Educational Meeting Recap:
- Speaker Don Goff presented on the topic of “An Update on Schizophrenia and Its Treatment” at our October 2nd meeting. We had a very successful turnout of 32 attendees but were disappointed that we didn’t get more public psychiatrists to attend.

Spring 2016 Educational Meeting:
- Russ Tobe reached out to Dr. Jonathan Stewart to present at our Spring meeting on the topic of Treatment Refractory Depression. We have tentatively selected May 6 or April 15 as potential dates for this meeting. Russ will try to finalize a date with Dr. Stewart next week.

NYSPA Area Council Meeting:
- Nigel Bark gave a recap of the NYSPA Area II Council meeting that took place on October 10.
- NYSPA President Seeth Vivek and Executive Director Seth Stein will be meeting with the Justice Center soon over issues about how complaints are handled and investigations are handled.
- Nigel advised that he will put an update in our newsletter.

APA Assembly Meeting:
- Nigel Bark gave a recap of the APA Assembly meeting held at the end of October in Washington, DC and will put a comprehensive update in our newsletter.
The American Psychiatric Foundation (APF) is running a program to educate teachers to recognize students with mental illnesses. They expect to educate over 70,000 teachers in the US.

The APF will also be hosting a gala event next April at the Mayflower Hotel in DC where they will honor a psychiatrist with a “profile in courage” award.

Public Forum Update:

Lois Kroplick advised that the Public Forum took place on October 21 at Rockland Community College on the topic of ADHD. Dr. Laura Antar was the expert speaker and attendees heard from a patient diagnosed with ADHD. Both speakers were excellent, over 350 people attended and the feedback was great.

Lois and Leslie Davis (one of the DBSA founders) put on a presentation for over 100 school nurses in Rockland County.

Women’s Meeting:

The next Women’s Meeting will take place on Nov 20th at Laura Antar’s office at 12:30pm. The following Women’s Meeting will take place on Dec 18th at Alex Berger’s house.

Future Guests to invite to our Executive Council Meetings:

Liz will invite Dr. Ulrick Vieux, the Director of the Psychiatric Residency Program in Orange Regional Medical Center to join us at our next Executive Council meeting.

Other Business Items:

NYSPA, WHPS and the Westchester Psychiatric Society will join forces to sponsor a VA educational event using a grant from the VA and support from PRMS. The event will take place on the evening of Wednesday, April 6, 2016. More details to follow.

Dom and Liz are trying to plan a meeting with the ORMC residents.

Liz will work with the APA to partner with them on re-branding.

More discussion took place about the next steps on enhancing our website.

Next Executive Council Meeting - Friday, January 8, 2015 at 12:30pm at Il Fresco, Orangeburg, NY.

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Nigel Bark, MD, West Hudson Psychiatric Society, District Branch Representative to the Assembly

At the NYSPA fall meeting there were two really important issues discussed: one, the Justice Center which concerns everyone working in an Office of Mental Health (OMH) facility or any facility licensed by OMH; two, parity and the recent ruling by the Appeals Court supporting NYSPA’s case against insurance companies, which concerns all our patients who have insurance and the reimbursement to psychiatrists and facilities.

Most people working in OMH facilities have suffered from the excesses of the Justice Center, a body founded with the best of intentions to try and prevent abuse of vulnerable persons, but that has grown out of control. Many psychiatrists have been affected, suspended, or left their job because they felt harassed and if they left their job they found they were reported to the National Practitioner Data Bank. So NYSPA sent a letter to the Chair of the Justice Center with a series of specific complaints (see full text below). It was sent from the President, Seeth Vivek, and the
Executive Director, Seth Stein, (who is a lawyer and represents many health care facilities and residencies, and has seen there the devastation the Justice Center can cause). In response a meeting was arranged for November 16 with the Justice Center. NYSPA is asking for information on any problems its members (and anyone else who works in New York) have had with the Justice Center.

Additional Justice Center issues: the Justice Center has been telling agencies not to tell parents or guardians when an intellectually disabled person is the subject of an investigation! I understand a Bill has been passed to rectify this. Seth Stein recommended that if you are the subject of an investigation get a lawyer, don’t be intimidated, they are bullies. More generally the Justice Center is very much Governor Cuomo’s pet project and the only way it could possibly be changed would be if all those involved (eg Hospital Organizations, Unions, all services) get together with unified action and that is not happening.

On parity, NYSPA has a law suit against United Health Care claiming that they were violating both Federal (Parity Act 2008) and State law in providing less mental health coverage than general medical coverage; for example disallowing psychotherapy to continue once the patient is better or requiring prior authorization when this is not required in general medicine. It was dismissed by the lower court on the grounds that it was the employers who organized the insurance and they should be sued, not the insurance company. This was not supported by the 2nd Circuit Appeals Court (for NY, CT and VT) that ruled the insurance company was the body that made the rules and designed the plan so they should be sued. It is a ruling that will have National Implications supporting other such suits, even if this particular suit fails. At the meeting the lawyers pursuing the suit for NYSPA spoke – very interestingly. Seth Stein said that out of network out-patient coverage was not being paid appropriately and he wants examples of EOBs (Insurance Company Explanation of Benefits) for psychiatry and medicine showing the underpayment in psychiatry and especially a patient willing to be a plaintiff in the law suit. Following this the NYS Attorney General has brought similar suits against other Insurance Companies. (In network cases are harder to pursue because the provider signs a contract.)

This year the Assembly meeting moved from the Marriott on Pennsylvania Avenue close to the White House where it was held for years to the Omni in the Embassy district. I missed being in the center of town but was able to run down Rock Creek Park to the Lincoln Memorial and then after the meeting ended on Sunday we went to have brunch at the Willard Hotel (nearer the White House) on the sidewalk on a beautiful fall day. (It always is on the day the meeting ends.)

The meeting was expertly and efficiently run by the new Speaker, New York’s Glenn Martin, with a bit of fun as we were encouraged to dress appropriately for Halloween! The business of the Assembly is to guide the APA to improve the lot of psychiatrists and their patients by passing Action Papers and to state the opinion of the APA by passing position papers. A very important action in the latter category was the unanimous approval of the Practice Guidelines on the Use of Antipsychotics to Treat Agitation or Psychosis in Patients with Dementia. (If not already, they will soon be available on the APA’s website.) Don’t be put off by the 235 pages. The summary is in 15 ‘statements’ of two or three lines each. The evidence behind these statements is all there in great detail. With it you can defend yourself against anyone who might accuse you of increasing the risk of stroke in someone with dementia who is clearly psychotic or dangerous.

Many Position Papers are ‘obvious’ but they do state the APA’s position and sometimes with important qualifications. For example a Position Statement on sexual harassment was proposed to
be retired because sexual harassment is now against the law. The Assembly voted to keep it because it emphasizes the need for treatment. There were position papers passed on opioid overdose education and naloxone distribution, on segregation of juveniles with mental illness in correctional facilities, substance abuse in older adults. A position paper on direct to consumer advertising was not passed but referred to make it stronger. There were action papers passed supporting AOT, access to care of Veterans, exploring payment for prior authorization, exploring the feasibility of developing an electronic clinical decision support product, supporting more NIMH research funding, strengthening residency training to improve access to buprenorphine, advocating for Medicaid expansion and making access to treatment of erectile disorder available under Medicare.

We had a talk from the Chief Psychiatrist of St Quentin prison with its 730 death row prisoners and saw their group therapy in cages! The President of the APA, Renee Binder also spoke on the theme of the incarcerated mentally ill. She told of a major publicity (for APA) and fundraising (for the American Psychiatric Foundation (APF)) event on April 18 in Washington where awards akin to the Kennedy awards will be presented. The APF does fantastic work and is well worth your support. Saul Levin, CEO and Medical Director of the APA is also APF’s CEO. He and the Executive Director, Paul Burke, spoke of it’s work: for example a school program “Typical or Troubled” in which 70,000 teachers have been trained to recognize who needs further help; and a plan to reduce mental illness in jails which has been adopted by 138 counties.

The report from Dr Levin included the actions by APA and State Psychiatric Societies on parity, on scope of practice, on opposing insurance company mergers, on pharmacy benefit complaints (there is a form on APA’s web site), the new members’ registration, and membership has increased by 1.1%. What he did not say was what a fantastic job he is doing. He has appointed lots of new, excellent, staff leaders. To mention just one: Roger Currie, Chief of Government Affairs. He has had a significant influence on Capitol Hill. (Aided by contributions to the APA Political Action Committee (PAC). However much we may dislike it this is the way American politics works: more important than the amount of money contributed is the number and percentage of members who contribute. Politicians want to know how many people feel strongly enough about the issue to give to the PAC.) One example is the greatly improved Murphy/Johnson Bill HR2646 just voted out of Committee. See below for the Psychiatric News report of this, and write to your representatives to support it.

There was much more but I will only mention the Profile in Courage Award given to someone who stuck their neck out at personal risk to support the mentally ill or psychiatrists. This year it went to Dr Steven Scharfstein who was APA President in 2005. On hearing about the interrogations at Guantanamo Bay he asked the Defense Department to let him go there and see for himself. He went with a delegation that included the heads of psychiatry and psychology of each of the armed services and the leadership of the American Psychologists Association. Dr Scharfstein was shocked at what appeared to be going on and our APA came out with a very strong statement against psychiatrists participating in torture or "enhanced interrogation". The psychologists did not; and as we recently learned, they participated in these interrogations in return for the Defense Department supporting Psychologists’ prescribing.

**NYSPA letter to Justice Center**

**New York State Psychiatric Association, Inc.** 400 Garden City Plaza, Garden City, New York 11530 ● (516) 542-0077

**Area II Council of the American Psychiatric Association**
Dear Mr. Wise:

We are writing on behalf of the New York State Psychiatric Association, Inc., representing over 4,500 psychiatrists practicing in this state. Our members provide psychiatric care and treatment to individuals with serious mental illness in facilities licensed by the NYS Office of Mental Health and thus, under the jurisdiction of the Justice Center. These facilities include inpatient psychiatric units in general hospitals, CPEPs and outpatient mental health clinics. Recently, we have received numerous reports from our members regarding the conduct of the Justice Center investigators in connection with incident reports filed with Justice Center.

1. Legal Representation. We have been informed from multiple sources that Justice Center investigators routinely advise individuals who they seek to question that such individuals may not have the assistance of legal counsel when they are interviewed. We cannot identify any provision in the Justice Center statute that precludes individuals who are being questioned by Justice Center investigators from having an attorney present during the interrogation. Furthermore, there is nothing in the statute that authorizes the Justice Center to object to an individual bringing an attorney with them when they are being questioned by Justice Center investigators. What is even more disturbing when individuals have insisted on being represented by legal counsel, Justice Center investigators have threatened them that if they refuse to be interviewed without legal counsel and insist on their attorney being present, the Justice Center will consider such conduct to constitute the obstruction of a Justice Center investigation and thus, misconduct subjecting the individual to Justice Center statutory sanctions.

The persistent efforts by Justice Center investigators to prevent individuals being questioned from having the assistance of legal counsel and threatening those who refuse to comply with having obstruction charges filed against them is unworthy of an agency charged with upholding the rights and dignity of the persons with special needs. The rights and dignity of persons with special needs cannot be advanced by denying the rights and dignity of others including those being questioned by Justice Center investigators.

We call upon the Justice Center to forthrightly confirm that all individuals being questioned by Justice Center investigators may choose to have legal counsel present when they are interrogated and also that individuals who insist on having legal counsel present when being questioned are not engaged in the obstruction of a Justice Center investigation.

2. Clinical Decisions. The jurisdiction of the Justice Center includes facilities licensed by NYS OMH that provide psychiatric care and treatment to individuals with serious mental illness. Psychiatric inpatient facilities treat many patients who have been involuntarily hospitalized under provisions of the NY Mental Hygiene Law. In certain instances, such patients may be given medication over objection pursuant to court order or in emergency situations when there is an imminent threat to the safety of the patient or others.

In such cases, patients may be physically restrained and given medication intended to control violent and dangerous behavior. It is hardly surprising that patients with serious mental illnesses may strongly object to the care and treatment that they receive even when such treatment is entirely consistent with generally accepted psychiatric practice. In fact, we have been advised that many patients have become aware that they can file multiple complaints with the Justice Center regarding their medical care and treatment and that these complaints will each receive the full focus of the Justice Center and demand a significant diversion of resources by the treating facility.
When the Justice Center receives a complaint about the care and treatment of a patient in an OMH licensed facility, the Justice Center should first determine whether the care and treatment was consistent with generally accepted psychiatric practice. Justice Center investigators are not licensed physicians qualified to make determinations regarding generally accepted psychiatric practice. If the complaint involves medical care and treatment provided to the patient that is consistent with generally accepted psychiatric practice, then there can be no patient abuse or neglect.

The Justice Center statute mandates the formation of a "Justice Center Medical Review Board" composed of physicians in various medical specialties including psychiatry. While the primary focus of the Medical Review Board is the review of deaths in facilities under the jurisdiction of the Justice Center, the Justice Center statute (Section 556(f)) authorizes the Medical Review Board to “advise the executive director on medical issues relevant to the functions, powers, and duties of the justice center including allegations of abuse or neglect or a patient or resident referred to it.”

We recommend that when a complaint is made involving whether treatment was consistent with generally accepted psychiatric practice, Justice Center investigators as a preliminary matter should consult with the Medical Review Board to determine whether the treatment that is the subject of the complaint was consistent with generally accepted psychiatric practice. The investigation of the complaint should proceed further only if the Medical Review Board determines that the treatment was not consistent with generally accepted psychiatric practice. If the Medical Review Board concludes that the treatment was consistent with generally accepted psychiatric practice, the investigation should be concluded immediately with a determination that the complaint was unsubstantiated.

3. Multiple Baseless Complaints. Recently, we have received reports that patients with serious mental illness have learned that they can make baseless complaints to the Justice Center to gain attention, secure a forum to voice their baseless complaints and merely harass their treatment provider. In this regard, the Justice Center should consider implementation of a protocol to address the problem of patients filing multiple baseless complaints. Currently, there is no way to address the problem of patients who continually file baseless complaints. We suggest the Justice Center review guidelines adopted on June 2, 2014, by NYS Office for Persons with Developmental Disabilities that address “Frequent False Reporting of Abuse, Neglect or Mistreatment. This protocol may be downloaded from the OPWDD website at http://www.opwdd.ny.gov/opwdd_resources/incident_management/Memo-FrequentFalseReporting. The protocol includes a detailed procedure for facilities to respond to individuals “who have a documented pattern of making false reports of abuse, neglect or mistreatment.” It serves neither the Justice Center nor the facilities charged with treating patients with serious mental illness to respond to baseless complaints by patients seeking to manipulate the system and waste scarce treatment resources.

4. Firearms. We have received a report from a hospital regarding Justice Center investigators who have brought firearms into an inpatient psychiatric unit. The Justice Center investigators refused to place their firearms in a locked container for the duration of their stay on the unit. Firearms on a psychiatric inpatient unit raise an unacceptable risk that patients could overwhelm the bearer of the firearm and wreak havoc on the unit. For that reason, police, sheriffs and other members of law enforcement routinely and without objection will lock their firearms away if there is need to visit a inpatient psychiatric unit. We strongly urge the Justice Center to direct all its investigators who carry firearms to comply with all facility rules regarding the possession of firearms.

We are ready to work with the Justice Center to address these issues to enhance the ability of the Justice Center to fulfill its statutory mission.

Sincerely,
Seeth Vivek, M.D.
President
Seth P. Stein, Esq.
Executive Director and General Counsel
cc: Ann Sullivan, M.D., Commissioner NYS OMH
PUBLIC FORUM 2015-A GREAT SUCCESS!

Lois Kroplick, DO, DFAPA
Founder of the Mental Health Coalition of Rockland County, Inc.

On October 21, 2015, the Mental Health Coalition along with its Partners - NAMI ROCKLAND, DBSA, and RCC had its annual Public Forum at Rockland Community College. This year’s topic, ADHD, marked the 20th year of the Coalition’s Public Forum.

Over 350 people came to the Public Forum and heard one of the best presentations the group had ever had.

The two speakers, Dr. Laura Antar, a renowned psychiatrist from New City, NY and Brian Christgau, a board member of DBSA, gave the audience a first hand look into the world of ADHD. Their presentations were clear, concise, and yet personal and moving.
Dr. Laura Antar, who has both a PhD in Neuroscience and a MD from Albert Einstein Medical School, spoke about the causes, symptoms and treatment of ADHD. Her message was clear that ADHD is treatable. There are many options of medications including stimulants and non-stimulants. Often a patient won’t respond to one medication but will respond to a different medication. She emphasized the importance of working with your doctor, being persistent and don’t give up!

She also spoke about how this is a medical condition which is hereditary. There are three types of ADHD, the combined type, inattentive type and hyperactive type.

The impact of not treating ADHD is huge. People with untreated ADHD have difficulty remaining at jobs, are involved in more car accidents, self medicate with drugs and alcohol and are more likely to get divorced.

What can parents to help their child with ADHD? Encourage structure, routine, compliance with medication, institute reward systems for positive behavior. Another important point is for the parents to seek professional help for themselves. She gave the analogy that when a parent is on the plane they must put the oxygen mask on themselves first before helping their child. The best thing a parent can do for their child is to get mental health treatment for themselves.

Brian Christgau, a comic book author, shared his personal story of what it was like when he was diagnosed with ADHD at the age of 46. As a teenager he struggled in school as he had difficulty concentrating and would tune out in class. For years he suffered with anxiety and depression. Brian spoke eloquently about this wellness plan. He now has tools that help him with symptoms of ADHD and his anxiety and depression. Brian feels his medication has helped his functioning tremendously. He also has gotten a lot of support from his peer support group, DBSA. He was proud to say he is a board member and facilitator of DBSA. In addition, Brian practices meditation on a regular basis, which helps him to focus on the present.

A special thank you to the steering forum committee who worked all year to put together this great presentation. This years’ public forum not only accomplished the Coalition’s mission of destigmatizing mental illness and promoting mental health but once again showed how positive it is when professionals, family members and consumers work together on joint presentations.

We would love to have more psychiatrists join the Coalition. Please contact me (845 641-1770) if you are interested helping us in our mission to destigmatize mental illness and promote mental health. It is a great way to network with colleagues, make friends, and make a difference in our community. The next general meeting is January 19, 2015 at 12 Noon at the Robert Yeager Health Center, Building F. We welcome all new members!
News and Notes for APA District Branches/State Associations
November 2015

This monthly newsletter is prepared by APA’s Communications Team as a benefit for our District Branches and State Associations. Feel free to share the articles below in your own newsletter. If you have any questions, please contact James Carty at jcartypych.org or 703-907-8693.

Want to keep up with APA in between newsletters? Connect with us on Facebook, Twitter (@APAPsychiatric) and LinkedIn for the latest news and updates.

What’s New at the APA

- APA’s State Advocacy Leadership Conference took place in Florida Oct.23-25. Representatives from district branches and state associations came together to discuss state legislation relevant to the field of psychiatry and parity for mental health care.
- On Oct. 7, APA President Renee Binder, M.D., participated in a panel discussion on comprehensive mental health reform hosted by the National Journal. Rep. Tim Murphy and Sen. Chris Murphy also spoke at the event. Watch a recording of the discussion here.
- The APA Assembly met in Washington, D.C., Oct. 30-Nov. 1.
- APA organized a congressional briefing on mental illness and prisons, which took place Oct. 29 and included remarks from APA President Renee Binder, M.D. Dr. Binder was joined on the panel by Mary Ann Borgeson, Chair of the Douglas County Board of Commissioners in Nebraska; Rich Stanek, Sherriff of Hennepin County in Minnesota; Robert Trestman, M.D., Ph.D, a Professor of Medicine and Psychiatry at the University of Connecticut Health Center and the Executive Director of Correctional Managed Health Care; and Ron Honberg, National Director for Policy and Legal Affairs at NAMI. You can read Dr. Binder’s blog post on the event here.

Mark Your Calendar

- Mental Health Awareness Observances—November
  - National Alzheimer’s Awareness Month
  - Mental Health Wellness Week (Nov. 8-14)
  - Great American Smokeout (Nov. 20)
  - International Survivors of Suicide Loss Day (Nov. 21)
- Nov. 11-14: Academy of Psychosomatic Medicine Meeting – New Orleans
- Nov. 13-17: AMA Interim Meeting - Atlanta
Briefs For Your Newsletter

APA Twitter Chat on Holiday Mental Health

On Thursday, Dec. 3 at 1 p.m., APA will co-host a Twitter chat on Holiday Mental Health with the Association for Behavior Health and Wellness’s Stamp Out Stigma campaign. Seasonal affective disorder, stress and a host of other issues will be covered. Follow the hashtag #SOSChat to join the conversation.

APA Meetings App Now Available

APA’s new meetings app was rolled out during IPS: The Mental Health Services Conference to great success, and is available now on the Apple App Store and Google Play. The app, developed with help from tech company DoubleDutch, can be used on your phone, tablet and laptop. To download the app, visit psychiatry.org/app.

2016 Membership Dues

The deadline to pay 2016 Membership dues is Dec. 31, 2015. To renew today, you can pay online, pay by phone at (888) 357-792, or enroll in the scheduled payment plan to pay your dues on the schedule most convenient for you: monthly, quarterly, biannually or annually.

New APA Member Benefit Connects Patients with Psychiatrists

APA has launched a new tool to help patients find and connect with psychiatrists across the United States and Canada – the Find a Psychiatrist database. APA members accepting new patients are invited to opt in to the database by clicking here. If you have questions or need help, please contact APA Customer Service at 1-888-35-PSYCH or email apa@psych.org.

CORRESPONDENCE

(Editors note: I vowed when I started this publication to publish anything sent to me. Please send me announcements, news, notices, rumor, recipes, innuendo, ads etc).

The Saga of Coffee
Syed Abdullah, M.D.

The history and development of the popular drink, coffee, is more fascinating than the beverage itself. Chance observation, political intrigue and the pursuit of wealth and power were behind this humble medium of a social and personal stimulant.

The story goes that around 850 AD, an Arab named Khalid was tending his goats in the Kaffa region of southeastern Ethiopia, when he noticed his animals became livelier after eating a certain berry. He experimented by chewing the red berries and felt its stimulating effect on himself. After several repetitions of the experiment, he informed his village elders of the effect of this plant on goats and man. Some of the elders suggested boiling the beans and making a muddy drink—thus
making the first coffee. They called it mocha after the nearest town and trading center.

From here the beans were loaded on barges that plied the spice route to Yemen. In Yemen the Sufis found its mild stimulant effect ideal for keeping them awake for nightlong recitations and prayers. By the late 15th century this drink arrived in Mecca where it was called Qahwa (that which prevents sleep) and became instantly popular. From here it traveled to Turkey, where the Arabic Qahwa became the Turkish Kahve. The Turks were the first to roast the beans and add spices like cardamom, clove, cinnamon and anise, and sometimes a dash of milk, to the brew. By now the world was becoming aware of the value of this beverage and countries started guarding it from indiscriminate spread via the trade routes.

Perhaps it was too late to curtail the fame and lure of this wonderful drink. Smuggling of the finished product as well as the saplings of the coffee bush were carried far and wide. One Arab by the name of Baba Budan is reported to have smuggled the beans to the hills of Mysore, India. Many centuries later the descendants of those plants were found to be thriving there and producing what is popularly called Indian coffee.

Coffee was regarded by some Christians to be the devil’s drink and there was a petition made to the Pope to ban it. Pope Vincent III decided to taste it before banishing it. He enjoyed it so much that he baptized it saying, “Coffee is so delicious it would be a pity to let the infidels have the exclusive use of it.”

In 1600 Italian traders brought coffee from Turkey to Europe. Pope Clement VIII was urged by his advisors to consider that favorite drink of the Ottoman Empire part of the Infidel threat. However, the Pope decided to ‘baptize’ it instead, making it an acceptable Christian beverage.

In 1667 Capt. John Smith, who helped to found the colony of Virginia at Jamestown, is believed to have introduced coffee to North America. In the meantime coffee houses were opening all over Europe and gaining instant popularity. The Dutch became the first to transport and cultivate coffee commercially, in Ceylon and in their East Indian colony – Java, source of the brew’s nickname.

In 1723 a French Naval Officer, Gabriel Mathieu, stole a seedling and transported it to Martinique. Within 50 years an official survey recorded nineteen million coffee trees in Martinique. Eventually 90% of the world’s coffee spread from this plant.

In 1732 Johann Sebastian Bach composed his Kaffee-Kantate. Partly as an ode to coffee and partly a stab at the movement in Germany to prevent women from drinking coffee because it was thought to make them sterile. The cantata includes the aria, “Ah! How sweet coffee taste! Lovelier than a thousand kisses, sweeter far than muscatel wine! I must have my coffee.”

In 1773 the Boston tea party made drinking coffee a patriotic duty in America. In 1901 the Japanese-American chemist Satori Kato of Chicago, invented the first soluble (Instant) coffee. In 1903 German coffee importer Ludwig Roselius gave a batch of ruined coffee to researchers, who perfected the process of removing caffeine from the beans without destroying the flavor. He marketed it under the brand name Sanka. Sanka was introduced in the US in 1923.

In 1907 Brazil accounted for 97% of the world’s harvest. In 1920 as prohibition went into effect in the USA, coffee sales boomed. At the request of the Brazilians to help find the solution to their coffee surpluses Nestle Company invented freeze-dried coffee. Nestle named it Nescafe.
In 1946 in Italy, Achilles Gaggia perfected his espresso machine. Cappuccino is named for the resemblance of its color to the robes of the monks of the Capucin order.

In 1971 Starbucks opened its doors in Seattle’s Pike Place public market, creating a frenzy over fresh-roasted whole bean coffee.

Today, coffee is a giant global industry employing more than 20 million people. This commodity ranks second only to petroleum in terms of dollars traded worldwide. The sales of premium specialty coffees in the United States have reached multi-billion dollars, and are increasing significantly on an annual basis.

Next time you pick up that flavorful cup of coffee visualize participating in a historic chain of events that brought it to the proximity of your lips. As the aroma from the cup fills the room let it transport you through the maze of centuries of history, which made it all possible. Then add to it the claims currently being made of its antioxidant properties that shield us from the ravages of some forms of cancer and other dreaded illnesses, like Parkinson’s disease, Alzheimer’s disease and Type II Diabetes.

Had it not been for the crucial observation of that humble Arab goatherd, all this would not have come about. His observation, experimentation and inference were in keeping with the scientific method to be developed centuries later. He even submitted his findings for peer review to the village elders, a routine process in contemporary scientific research.

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**Here She Is**

**Anonymous**

Let’s talk about that little girl
who walked under the slush and slime
with a winter coat on as thin as a well worn dime

doing time - 30 minutes was what she got each day
to eat lunch, so you see that was the way
Under the EL on Westchester Ave, she starved and prayed

and craved. Her nose creating steam against the windows of the pizza place
Nobody home and her feelings of shame and disgrace
her first hand knowledge of being erased and displaced

that invisible bastard that she be.

*I was in 1st grade. So was she. Thanks for the read.*

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**Psychiatrist Database** Expect to be contacted by Liz Burnich, our Executive Director who will be encouraging our members to participate in the database
offered by APA. This is a **FANTASTIC** new service that will replace the Information manual and database that your district branch has offered for years without the cost & hours of labor required to keep ours up to date. You will be invited to join this new database being added to APA's website that will enable individuals seeking psychiatric care to locate psychiatrists practicing in their area. The goal is to populate the database in the coming weeks before it goes live on APA's website. To join the database, click here. To view the functionality of the database, click here. This is a service that will be of value to psychiatrists with private practices and to anyone looking to find a psychiatrist.

If you have a practice, please join this Psychiatrist Database. The APA needs a critical mass to make this a success. There is no cost to you and it's a wonderful service to the public and all psychiatrists.

**PRIVATE PRACTICE: FEES** Here is a link to a legal public site where you can look up fees for a given zip code. [http://www.fairhealthconsumer.org/](http://www.fairhealthconsumer.org/)

**PRIOR AUTHORIZATIONS** If you are frequently bothered with cumbersome and seemingly unnecessary requests for prior authorizations, the APA is eager to hear from you: Ellen Jaffe, Director, Practice Management HelpLine/Medicare Specialist, Office of Healthcare Systems and Financing, American Psychiatric Association, (703) 907-8591 ejaffe@psych.org Practice Management HelpLine (800-343-4671) - email at hsf@psych.org. Also, one of our members posted to an international list-serv with regard to any denial of benefit, so I quote Dr. John Fogelman:

> The URL below will direct you to a database for the regional CMS (Centers for Medicare and Medicaid Services) headquarters. The names of the regional Medical Directors are listed. When you call, hang in through all the options, and at the end type in the name of the medical director. You will get either the real live doc, an assistant, leave a message, or the name of someone to call for an emergency. It usually works.

[http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Regional_Contacts.html](http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Regional_Contacts.html)

My experience has been that the higher you go in any organization (hospital, government, insurance companies), the closer you are to the decision maker, and the decision makers do not have to stay on the unvarying mindless script. They do not instruct you to have a good day, apologize for your inconvenience, thank you profusely and hear how they know how valuable your time is. They usually listen, and if you do not scream at them, a favorable result often follows.
PARITY ENFORCEMENT FROM NYSPA: If you missed the NYSPA Webinar on parity I strongly suggest you listen to it; accessible on the NYSPA website. Seth Stein and Rachel Fernbach have presented a packet of wonderful new tools that potentially will allow us to better manage and respond aggressively to insurance company efforts to restrict care.

PLEASE MAKE EVERY EFFORT TO RETURN PHONE CALLS. EVEN IF YOU HAVE NO ROOM IN YOUR SCHEDULE FOR NEW PATIENTS: I have frequently heard complaints about patients leaving voice mails with psychiatrist’s offices and never getting a return phone call. If true, this reflects very poorly on our profession. Yes, I know many people leave voice mail messages that I can’t understand, even after playing it back 6 times with the volume turned up full. Even so, the number of complaints seems to exceed the number of complaints that could be excused due to poor communication.

Psychiatry/Psychotherapy Office for Rent
Saturday all day, Sunday after 10:30
Route 45, Pomona
Shared Waiting Room, Wheelchair Accessible, Wall-to-Wall Windows, Private Bath, Full Sound Insulation, Separate Entrance/Exit
Call Lorraine Schorr, MSW 354-5040

Depression Support Group
Depression support group meets 2 times a month in Pomona, NY. We are inviting new members at this time. We are moderated by a clinical social worker. This is not a therapy group but social support for people fighting depression. Call Kathy for more information (914) 714-2837.

Rockland County Depression and Bipolar Support Alliance
Peer-to-peer run support group for people with depression, bipolar disorder, anxiety disorder or any related mood disorder & their friends & family. The support group meets every Thursday night from 6:30 - 8:30 at Jawonio, inc. 775 N Main St. New Hempstead. Reservations are not required. There is no fee for attending the support group meetings. This is a very warm and welcoming group run by people who have been there and can help. Any questions please call Leslie or Leonard at 845-837-1182.
WHAT YOUR CURRENT POLICY MIGHT BE LACKING:

A STRONG DEFENSE

"Of course we hope you'll never need our claims expertise, but if you ever report a claim, PRMS will be with you every step of the way.

Whether you need legal guidance for an adverse event or a robust full-court defense for a lawsuit, our experts will work closely with you and your defense counsel to vigorously protect you.

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Dave Torrans, II
Senior Litigation Specialist

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More than an insurance policy

Actual terms, coverages, conditions and exclusions may vary by state. Insurance coverage provided by Fair American Insurance and Reinsurance Company (NAIC 35157), FARCO is an authorized carrier in California, ID number 3175-7. www.farco.com