



West Hudson Psychiatric Society
of the American Psychiatric Association
serving Rockland, Orange, Sullivan & Delaware Counties



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The address above has been changed to:
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eSynapse

February 2015

Editor's Comments

James Flax, MD, MPH, DFAPA

Once again, I **“THANK YOU”** to all those who have contributed to this issue of eSynapse! Please scroll through everything that follows, as there are many items you will find interesting and useful throughout.

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. You have **got to come** to a meeting to appreciate the rich discussions.

We had a presentation on Integrative Healthcare, a focus of the national APA, at our last Executive Council meeting on 12/12. Please see the synopsis below and read Dr. Tobe's summary in his column. This is important as this model is spreading throughout the country but seems ill suited to our area. I personally question the wisdom of the APA advocating this model as currently envisioned.

If you are wondering about the available services in Rockland you can check out this website: <http://rocklandgov.com/departments/mental-health/provider-agency-links/>. We are hoping to have information that reviews the services in Orange, Sullivan and Delaware in future editions of eSynapse.

Dr. Abdullah has again sent us a new article in his long line of erudite essays. And there is an anonymous poem that captures one aspect of psychotherapy. There are ads 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>.

WEB SITE Your district branch is still in the process of improving it's website. Thanks to Dr. John Fogelman. If you have expertise or ideas about web page design, please chime in. You can see the existing “under construction” site at WestHudsonPsych.org. I recently created a website for my private practice. JamesFlaxPsychiatry.com. If anyone

wants advice on how one can create their own (simple) website, I'm happy to discuss it. 845-362-2557 or DrFlax@aol.com.

PRIVATE PRACTICE: FEES Here is a link to a legal public site where you can look up fees for a given zipcode. <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

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.

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 private offices and never getting a return phone call. If true, this reflects very poorly on our profession. Yes, I know how 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. I screen callers with my greeting message that gives enough detail about my practice so many callers know immediately not to bother leaving a message because I don't take their insurance. This saves valuable time for all.

IT'S A FREE LUNCH!

Next Executive Council Meeting
Il Fresco Restaurant, Orangeburg, NY
Journal Club (15 minutes) PROMPTLY at 12:30pm
Followed immediately by Business Agenda
Friday, March 20th @ 12:30 at Il Fresco in Orangeburg, NY.

Please contact Dr. Russell Tobe, MD (rtobe@NKI.RFMH.org) (845) 398-6556) if you are planning to attend.

Congratulations to the following members for achieving special membership status in the APA:

50-Years of Membership

Thomas K Boyce, M.D.
Hae Ahm Kim, M.D.

Distinguished Life Fellow

Mary Irene Mavromatis, M.D.
Monowara Begum, M.D.

Life Fellow

Marc E. Tarle, M.D.

Life Member

Scott Lawrence, M.D.
Nelson D. Hidalgo, M.D.

All of the above members will be honored at the Convocation of Distinguished Fellows Ceremony on Monday, May 18, 2015 at 5:30pm at the Metro Toronto Convention Centre, Exhibit Hall A (North), Level 300.

Congratulations to members Lisa and Nick Batson who had a publication this month in Journal of the American Academy of Child and Adolescent Psychiatry. The article is a clinical perspective regarding the development of psychiatric services within the emerging healthcare delivery model of an Accountable Care Organization.

Drs. Lisa and Nicholas Batson write that: This article highlights how the use of electronic health care records, co-management, and tracking of quality measures are being utilized to improve the health and experience of patients as well as decreasing cost of care at Crystal Run Healthcare. The integration of Psychiatry in an Accountable Care Organization is an emerging healthcare delivery model for Psychiatry. The Batson's believe that Psychiatrists are in a unique position to make a significant difference in this model of health care delivery and are looking forward to continuing to develop innovative ways to support a successful integrated system.

Batson N, Batson L. Accountable Care Organizations and Child and Adolescent Psychiatry. JAACAP. J Am Acad Child Adolesc Psychiatry. 2015 Feb;54(2):81-2.
<http://www.ncbi.nlm.nih.gov/pubmed/?term=batson+accountable>

PRESIDENT'S COLUMN

Russell Tobe MD (russell.tobe@gmail.com)

Dear West Hudson Psychiatric Society (WHPS) membership, colleagues, and friends:
I hope you all are staying warm and comfortable in the midst of this perpetual chill. Following a somewhat longer hiatus, the executive council reconvened this past Friday.

There was a rich discussion of integrative healthcare led by Dr. Lois Kroplick (past president, women's group leader, and executive council member) and Dr. Bruce Levitt (internal medicine-primary care) who both attended the integrative healthcare meeting in Chicago this past year. While I encourage you to review their summary of the materials shared during that meeting, for those of you not at the Executive Council meeting on 2/6, the discussions were rich and stimulating.

Two things seemed apparent. (1) WHPS was unique amongst other district branches in having both psychiatric and primary care representation at the integrative healthcare meeting, but we have also been unique in actively evaluating pros and cons of integrative healthcare. A number of other NYS district branches have dismissed integrative healthcare as irrelevant to their membership. (2) While evidence-based and oriented towards maximizing limited mental health resources, implementation of integrative healthcare will require significant reframing and restructuring. Most importantly this restructuring is not simply implementation of infrastructure but a deeper redefinition of numerous aspects subsumed in our role as psychiatrists.

The collaborative care team structure brings with it several inherent role definitions. The most important being that the psychiatrist is a consultant rather than a direct care provider in the vast majority of instances. This has several downstream effects driven by the conversion of the psychiatrist to an advisory consultant to the team. In the advisory role, it is the team that activates the consultation, rather than the client (at least at face value). Similarly, it is the team that generally gathers the clinical history and examination of mental status, relaying these to the psychiatrist. Finally, it is the team that implements the directives of the consultant and monitors for effectiveness and side effects. Though flexibility is built into the model to facilitate direct patient care when required, the goal of this model is to avoid this at all costs towards the goal of maximizing the amount of advisory time available. In essence, this model's greatest strength is its capacity to maximize the number of patients accessing psychiatric consultation in a world with limited psychiatric resources.

But there are clear tradeoffs in this process which, by the way, has strong evidence base across numerous psychiatric disorders, particularly in geographic areas with uniquely limited psychiatric access. The most glaring to me is the subjugation of the psychiatrist under the guise of authority. The goal here is for rapid care applied to the greatest number of patients. Accordingly, I would not consider the psychiatrist consultation role in this model akin to that of, for instance, supervisor in a residency program, reviewing process notes in detail while discussing transference factors and biopsychosocial contributions. Instead the psychiatrist is relegated to an advisor of psychopharmacologic management. This is, of course, no new battle for the field. It has been an ongoing consequence of insurance reimbursement and a major reason why many psychiatrists opt out of plan participations. But the overt nature is, nonetheless, upsetting at many levels. As an aside, Dr. Levitt also raised the point that primary care physicians (PCPs) are not an unlimited resource themselves. There remain significant numbers of people within the United States with limited access to primary care. Accordingly, adding psychiatric management tasks to PCPs may overwhelm already tenuous care systems.

Pragmatically, numerous questions with uncertain answers follow. Who is responsible for the medication management decisions: the consultant psychiatrist advising the recommendations through case presentation and generally no direct examination. Or, the non-psychiatric prescriber who is physically sending the prescription to the pharmacy? How can the psychiatrist maintain confidence in the reporting of the behavioral care manager and implementation team? What is the reimbursement structure for such consultation and how is the 'level' of consultation defined?

To what degree will psychiatric care quality be impacted in this model? These and other questions remain to be determined. What is clear, nonetheless, is that this is an evolving process both in its own formulation and in its integration into existing systems of care. I am perplexed by some district branches, as I understand, disregarding this process. We remain in communication with NYSPA around concerns with integrative healthcare.

Along these lines, we are elated that Seeth Vivek, President of NYSPA, will be able to join us on Friday March 20th 12:30PM at the next Executive Council meeting. He will be updating us on recent events at NYSPA and what is on the horizon. We will also be exploring a brief hiatus from Journal Club to implement a series exploring specific relevant topics of discussion salient to practice and the field. Marc Tarle has agreed to help launch this initiative and plans to lead discussion on a topic to be determined. Also, a quick reminder that Dr. Summergrad will be speaking at our next educational forum. If you have not yet done so, please mark your calendars for May 1, 2015. RSVPs will be going out soon. As always, please stay connected and relay feedback about or ideas for branch activities to me.

INTEGRATIVE/COLLABORATIVE HEALTH CARE

Dr. Lois Kroplick

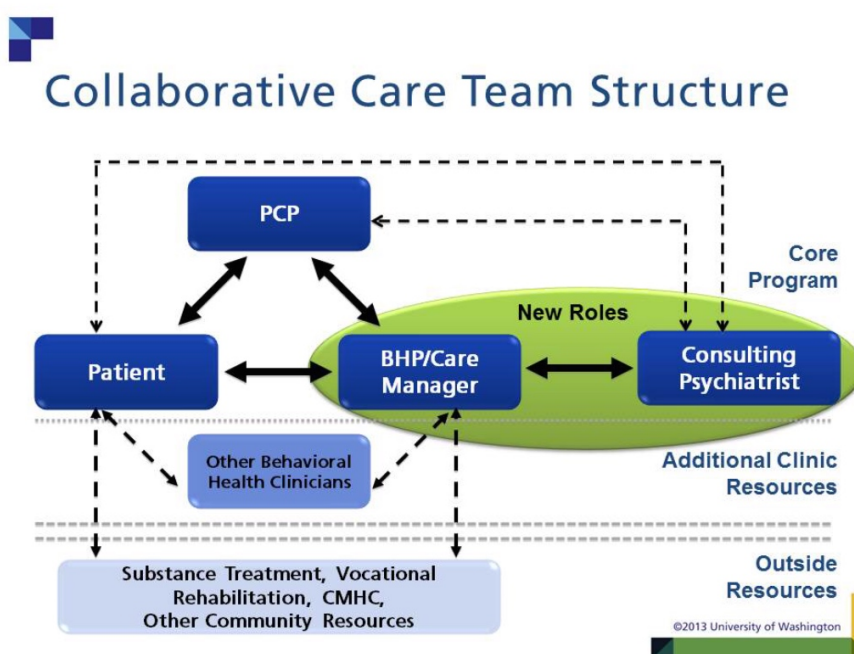
On June 21 and June 22, 2014, Dr. Bruce Levitt and I attended a conference in Chicago called **“Health Reform Policy and Practice Implications for Psychiatrists.”**

We met with 90 district branch leaders and psychiatrists from around the country. The goal was to provide psychiatrists with details of the changes in healthcare and bring information back to the individual district branches.

The Collaborative Health Care Model helps to coordinate both medical and psychiatric care by having patients treated in one setting (either the primary care physician’s office or the behavioral health setting). The hope was that this system would improve the health of the population, give better patient care, increase patient compliance and lower the costs of healthcare.

The Collaborative Care Model

The Collaborative Care Model was developed in response to the need for coordinated care. This model involves the primary care provider (PCP), a behavioral care manager (BHP), a consulting psychiatrist and the patient.



How does this Collaborative Care Model work?

First, the primary care physician identifies if the patient has a mental health problem (depression, anxiety). The patient will see the care manager, who takes a history from the patient, uses the PHQ-9 depression screener and educates the patient about behavioral interventions to reduce anxiety and depression.

The care manager will report their findings (diagnosis, medication recommendations, behavioral plan) to the primary care physician. They will track patients in a registry so that no one will fall through the cracks. The primary care physician will be responsible for writing prescriptions for the patient.

Psychiatrists are consultants to both primary care physicians and to the care managers.

Who are the care managers?

The care managers are nurse practitioners, social workers or psychologists. In some studies, the care managers were medical assistants, or licensed practical nurses. Outcomes in studies didn't differ depending on the educational level of the care manager. This suggested that the more costly care managers may not be necessary to provide cost effective collaborative care.

What is the role of the psychiatrist?

The psychiatric consultant supports the primary care physician and the care manager in treating patients with mental health problems. Except on rare occasions, the psychiatrist does not see the patient and does not prescribe medication. Some examples of when a psychiatrist will see a patient include when the patient has bipolar disorder or when a patient is a danger to themselves or others. The psychiatrist is also expected to screen for medical problems and may even manage basic medical problems when the primary care physician isn't available. The psychiatrist will coach the primary care physician and the care manager on how to work with difficult patients.

How does this team function?

The care manager and the psychiatrist meet weekly to review the patient's progress and to provide treatment recommendations. The care manager follows up with the patients. There is communication between the psychiatrist, care manager and primary care physician during the week by email, text, or phone.

What is the liability of the psychiatrists?

When the psychiatrist consults on multiple cases on weekly basis, it was recommended that they write a disclaimer note. This note states that the treatment recommendations were based on consultations with the care manager and a review of information available and that the psychiatrist did not see the patient. However, it was also pointed out at the conference that the psychiatrist could be sued for "informal consultation." It is important for the psychiatrist to know who they are supervising and that they are liable for the actions of the professionals they supervise.

How does the psychiatrist get paid?

There were no provisions made for how the psychiatrists would get paid for this work. There are no billing codes to support reimbursement for collaborative care. The concern is not only how psychiatrists would get reimbursed but also would the fee be so low that there wouldn't be an incentive to provide these services.

Are their studies that show that Collaborative Care works?

Yes! There are many studies that prove that collaborative care is effective.

Cardiac- Collaborative care reduced the risk of heart attacks and strokes by 48% in those individuals without preexisting heart disease.

OB-GYN-Patients who had collaborative care were more likely to follow up appointments, more likely to comply with antidepressants, and expressed greater satisfaction with their care.

Pediatrics-Children with ADHD and disruptive behavioral disorder improved 99% with collaborative care vs. 54% in usual care.

Medicine-Patient's HgA1C, blood pressure and cholesterol levels improved with collaborative care.

Cancer-Patients with collaborative care had greater improvements in depression, anxiety and quality of life.

Psychiatric-Bipolar patients who had collaborative care needed more intensive services. The psychiatrists needed to be integrated in person into the clinics. Only 1/3 of patients with Bipolar disorder improved with collaborative care. Studies show that patients with anxiety disorders, substance abuse disorders, and PTSD all improved with collaborative care.

Conclusion

Although there is evidence from many studies that collaborative care works to improve patient care, many of the psychiatrists expressed concern with this model. Reimbursement of services and liability remain unanswered questions. It is clear that more answers to these questions are essential before moving forward.

West Hudson Psychiatric Society was the only district branch that had both a psychiatrist and an internist attend this conference on Integrative Care. It was interesting to hear the concerns from both a psychiatrist and an internist.

Although the collaborative care model is a team approach, it appears that the internist has the major role and liability. While there seemed to be too much responsibility placed on the internist, the psychiatrist's role seemed undermined as we were no longer seeing patients or prescribing medications. Consequently, many of the psychiatrists who attended this conference choose not to present this model to their district branch, as it did not pertain to their area. Dr. Levitt and I chose to share this information, as we believe Collaborative Care is going to be part of the healthcare system in the future. Hopefully there will be some changes and more specific information about reimbursement and liability.

Psychiatrist Lori Raney, MD, a leader in integrated care, presented at this conference and told the audience, "Don't be surprised when you see in the near future an advertisement looking for a psychiatrist to work part time as a consultant to a primary care practice." Her point was that the Collaborative Care Model is here and the psychiatrists need to embrace it and become leaders in helping to make the necessary changes in this health care model.

Thank you to the WHPS board members for sending me to this conference and giving me the opportunity to share this information with you.

Summary from Executive Council Meeting Friday, February 6, 2015

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

Journal Club: In lieu of Journal Club, Dr. Lois Kroplick and Dr. Bruce Levitt gave a comprehensive presentation on Collaborative Care. They both attended the APA training session on Collaborative Care in 2014. Dr. Kroplick presented from the viewpoint of the psychiatrist and Dr. Levitt presented from the viewpoint of an internist. The collaborative team structure, roles and responsibilities were presented and discussed at length. Issues, questions and limitations were commented on with all in agreement that this type of model works best in rural areas.

Spring 2015 Educational Meeting – Dr. Paul Summergrad will be the speaker at our Spring 2015 Educational Dinner Meeting. It is scheduled for Friday, May 1, 2015 at 6pm. It was agreed that we will have the meeting at La Terrazza again. Russ will forward Dr. Summergrad's assistant's name and contact information to Liz so that we can arrange the topic, course objectives and begin the CME application.

Miscellaneous Items:

- Fall 2015 Educational Meeting speaker
 - We would like to extend an invitation to the APA President-Elect, Renee Binder to see if she would be willing to present at this meeting.
- Future guests to invite to upcoming EC meetings
 - Jawanio
 - ORMC
- Mini-Ethics workshop – Liz Burnich attended the Ethics Workshop in November 2014 in DC and suggested that we hold our own mini-workshop at the start of an upcoming EC meeting. It would entail attendees to review a 'sample' ethics complaint prior to the meeting and then discuss the steps our DB should take to resolve the ethics complaint using the APA flowchart. Russ will pass this idea by our Ethics Chair, Marc Tarle.
- Dr. Jim Flax commented that we have NOT received any calls to our Referral phone line since the summer of 2014. It was decided that Liz will cancel our phone #. Dr. Dom Ferro has an extra mail box on his phone line that we can use for West Hudson and Liz will check this mailbox daily.

Website:

- John Fogelman presented a graphic from the Journal of American Psychiatry that he thinks would make an excellent and appropriate cover graphic.
- John will begin to work with our developer, Xsimple – Liz to put John in touch with him.

Next Executive Council Meeting - Friday, March 20, 2015 at 12:30pm at Il Fresco, Orangeburg, NY. The NYSPA President, Dr. Seeth Vivek will be our special guest speaker and will present on current issues that NYSPA is currently focusing on.

District Branch Assembly Representative's Report on NYSPA fall meeting (October 25 at the La Guardia Marriott Hotel) and APA Assembly (November 7-9 2014, Marriott Hotel Washington DC)

Nigel Bark

Apologies for the lateness of this report – but there were important things happening that are still relevant I think.

The most important for New Yorkers is electronic prescribing which will be mandatory for everyone from March 27, 2015. At the fall meeting Rachel Fernbach (NYSPA's Deputy Director and Assistant General Counsel) gave a PowerPoint summary which is on the NYSPA website and is comprehensive describing the complicated Identity Proofing, Two-Factor Authentication, Practitioner Registration and Attestation process required for Electronic Prescribing of Controlled Substances. But first you have to select an electronic prescribing software vendor. There were several promoting their wares at the Fall Meeting and NYSPA had a two part webinar which is on the website (log in and go to E-Prescribing).

At the Public Psychiatry Committee Meeting the main topic was the Justice Center: a body founded with the best of intentions to prevent abuse of the mentally ill and intellectually disabled; that allows anyone to report possible abuse and *requires* staff to do so and also to report any injury or serious incidents. We heard stories of psychiatrists feeling forced to leave their job because of complaints and not being told why they were being investigated and that they could not talk to anyone about it. Seth Stein clarified some of these issues. They do not tell you what they are investigating but when they ask you what happened on a particular day and time it becomes obvious. You can and must talk to your union, lawyer, professional insurance company: there is no gag order. Your employer can ask that you be removed from patient care during an investigation, and you are not entitled to representation during the investigation but there can be no disciplinary action without due process; and never resign during an investigation: that can be reported to the National Physicians Register. The Justice Center can prosecute facilities but only the employer can decide about your job.

We did hear that there are an enormous number of complaints about the Justice Center and that dealing with it can be unpleasant, difficult, arbitrary and unprofessional, although my own experience of reporting to it has been good. However the result at my hospital is an enormous increase in paperwork: volunteers, who are never alone with a patient, have to complete reams of forms including every address they have lived at in the past 28 years. The medical students who are thoroughly vouched for by the Medical School and come for 6-week rotations also have to do this! Initially they all had to be fingerprinted until it was discovered to be illegal to fingerprint non-employees.

As always, and essentially, NYSPA is very active with the legislature in Albany on a whole range of issues that affect psychiatrists and our patients directly, including psychologist prescribing and working to raise the age of criminal responsibility. (The full report is available on the website demonstrating why you should support the NYSPA-PAC.) Of note, \$2.25 million

was appropriated in the budget for Community-Based Mental Health Services in the lower Hudson Valley, with half a million going to Rockland for a Mobile Crisis Intervention Program. It was a full afternoon with reports from all the Committees, addresses from OMH Commissioner, Ann Sullivan, APA's CEO and Medical Director Saul Levin, officers of NYSPA, Seth Stein NYSPA's Executive Director: reporting progress and problems. For example - discriminatory and illegal questions are still being asked of potential employees about psychiatric and substance abuse history, even by psychiatric facilities; parity is still an issue that has to be battled in the courts and with insurance companies; the Department of Health which has taken over the Medicaid Pharmacy Committee is not approving Suboxone; OMH and DOH support integrated care but do not pay for it; hospitalizing people with Alzheimer's and behavioral problems is almost impossible: lots of problems to be solved and requiring psychiatrists to work on in NYSPA and with MSSNY. Please join a committee and come to these Spring and Fall NYSPA meetings. They are interesting and fun (and there's a great lunch!)

The APA Assembly meeting in Washington was less contentious and more hopeful than the last few I have been to. APA membership is up slightly; revenues are up mainly because of DSM 5; reserves are good; Saul Levin, the CEO is dynamic and active and for example has a monthly telephone session with District Branch executives; both the APA and the Assembly have been seeking the views of the members on what is important to them: (if you get a survey please fill it out); a new Logo is being developed; the lease on the APA's offices in Arlington is up in 2017 and discussions are starting on whether and where to buy, (the selling of the old office in DC being seen as a terrible mistake); the APA is very active in discussions with the legislature and the executive on all kinds of issues especially Obamacare, supporting Representative Murphy's Bill etc "if you're not at the table you're on the menu" – why you must support the APA-PAC; and the young candidates for Trustees representing the members in training and early career psychiatrists were very impressive as they spoke to us.

Of the Assembly actions the revised (because of the Safe Act in New York and other developments) and updated Position Statement on Firearms Access was potentially contentious because many objected to a line about automatic weapons. The Assembly voted to take that line out and the Statement remains a strong and useful document.

Action papers were passed on improving the training in Addiction Psychiatry for the general psychiatrist, on the incorporation of Buprenorphine Therapy with Primary Mental Health, exploring whether to add symptoms to the next DSM, but changing the name of Personality Disorder to Syndrome was turned down. Papers on e-prescribing, tele-psychiatry, shortages of psychiatrists at Federal Medical Centers, EHR were passed.

As always if any of you have issues you'd like to bring to the Assembly please let me know.

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 Statue

Syed Abdullah, M.D.

He sat there in his preferred corner in the day room, almost motionless, with hands folded over his lap oblivious to the goings-on around him. He avoided eye contact or any interaction with others. At mealtimes he had to be spoon fed. He also needed assistance with other activities of daily living. John had spent the last 45 years of his life in a state of isolation as if invisible walls separated him from his surroundings. His fine features, blue eyes and tall stature made him look very distinctive. One only wished he would talk about what troubled him. Every attempt to draw him into a conversation failed.

His parents were musicians in the show business. When he was five years old they started a stormy divorce proceeding that became increasingly acrimonious. Finally, they separated, his mother moved away to California and his father took custody of him. Father was a pianist who spent many hours practicing in an empty music hall where he took John along with him. The child would sit in the cavernous concert hall listening to his father banging on the piano. He had no friends, did poorly in school and by the time he was a teenager started showing signs of odd behavior, did not participate in sports or socialize, had severe temper tantrums, showed signs of self neglect and was seen talking to himself. By age 22 he was in and out of mental hospitals with little improvement.

By age 25 he was admitted for long term care and received the treatments then available, which included insulin shock therapy. His mental deterioration was unabated. Finally he was considered and okayed for lobotomy which had just been introduced. Lobotomy was regarded as successful as it made him less aggressive and more manageable on the ward. In the mid 1950s major tranquilizers came into use. John was tried on every new tranquilizer as it appeared on the scene. Unfortunately none of them worked for him.

In the meantime his father, who used to visit him occasionally, died, thus disconnecting his last link with the outside world. Nobody heard from his mother other than an occasional Christmas and birthday card. Gradually they also ceased. John maintained his downward slide and was labeled with the diagnosis of Catatonic Schizophrenia.

This form of schizophrenia is not as common now as it used to be. Possibly because of improved pharmacological and psycho-social treatments. A recovered patient describes the state of catatonia in these succinct words: "Catatonia is not a voluntary thing. You aren't purposely not moving because you think something bad is going to happen. It happens against your volition, you just get stuck... I have lost hours and have not understood how time could actually pass. I could be reaching for a glass and by the time my hand comes down with the glass I lost two hours. Sometimes you are vaguely aware of things, like nothing gets through but every once in a while you can hear someone calling your name – but there is no way to answer. Sometimes it is like your eyes are a video camera and your consciousness is watching what is being recorded but it is like you are in a dark room somewhere really far away – you cannot interact with what is going on." Catatonic stupor, mutism, negativism, rigidity, excitement and posturing may collectively lead to malnutrition, exhaustion, hyper-pyrexia, dehydration and may result in death.

During a particularly difficult period, when feeding him required much coaxing and cajoling just to get him to open his mouth, I sat next to him and asked, “John tell me what is bothering you?” To which he made no response. I persisted “Give us some indication as to what is on your mind. Why would you not eat? You know that we care enough to not let you die of starvation. Please say something before we are forced to pass this tube through the nose into your stomach to give you some nourishment. You know it is a messy business, very uncomfortable to you as well to us.”

Then quite unexpectedly John looked up and without making any eye contact with me said one precious word almost in a whisper “Divorce.” After that he fell silent again. The nurse’s aid who was with me laughed and interjected “Man, you are worried about divorce and you aren’t even married!” And yet in that single word he had expressed all the anguish, heartaches and pain that he had harbored for sixty years. To me he was no longer a sixty seven year old man but a helpless little boy caught in the turmoil of the stormy events between two significant adults who constituted his entire world. Therefore I conversed with him as if I was talking to the baby John frozen in his psyche. I talked to him in these terms: “John don’t you worry about a thing. If your parents don’t get along with each other, we will take care of you. We will take custody of you. We will not abandon you. All we ask of you is to cooperate with us in providing the help you need.” To our amazement John, although still uncommunicative, opened his mouth and took the morsel of food that was provided by one of the nurses. Thereafter he was cooperative at mealtimes and his quality of life improved to that limited extent.

POEM

Cat the Rat - gray creature #1
Bruno - gray creature #2

Two gray creatures are swirling in my swollen head
One tells me to stay alive, the other wishes me to be dead
The conflict between them is intensifying to say the least
It’s really an old tale between the beauty and the beast

It is 4 am in the rainy morning and the rest are snuggled in their beds
but when I think of going back to sleep I view it as something to dread
Because eventually the pain will wake me up with a sudden slice in my side
And all I hear is the one voice saying, “you know you could have chosen to die,”

But I close my eyes for an instant, put my slippers on and run
to the basket where the pain killers are, and take just one, just one
For again I listened to my other voice who tells me to survive
Death is so final and I have many events for which I still need to be alive

So I write this poem as affirmation and to quiet one gray creature down
And instead of crying for the pain, all I do is let escape one little frown
And I write to give spring flowers a chance despite my stage IV cancer
And I wiggle my ass to the music I blast, even though I was never much of a dancer



"The Art and Science of Adolescent Psychiatry and Psychotherapy"

Registration is now open for the joint meeting of the **American Society for Adolescent Psychiatry** and the **International Society for Adolescent Psychiatry and Psychology** in New York March 26-29, 2015 at the New York Marriott East Side Hotel, 525 Lexington Avenue. You may register for the meeting on line at <http://adolescent-psychiatry.org> or complete and return the attached registration form. To reserve a room at the hotel go to (<http://www.marriott.com/hotels/travel/nycea-new-york-marriott-east-side/>) or call: 800-242-8684 and ask for the ASAP/ISAPP room block. There is a block of rooms at the rate of \$299 per night. We are anticipating that this block will sell out quickly so you should make reservations soon.

The meeting theme is **"The Art and Science of Adolescent Psychiatry and Psychotherapy."** You won't want to miss this exceptional meeting, which will offer 3 ½ days of a diverse, multi-disciplinary in-depth scientific conference. There will be over 100 presenters, with about half coming from other countries, including Canada, Europe, Asia, and Latin America, with many nationally and internationally known speakers. The **Certification Examination in Adolescent Psychiatry** is being resumed and will be held on Thursday, March 26. Information and an application for the examination may be obtained from Frances Bell at the Central Office, adpsych@aol.com, or via the website: <http://adolescent-psychiatry.org>

Thursday morning will feature an institute on critical issues in **Psychopharmacological Treatment of Adolescents**, including lectures on **"Treating Adolescent Depression: Thinking Outside the Black Box,"** and **"Are Antipsychotics an Option in Adolescent Depression?"**

Another institute will be held on Sunday on **Adolescent Addictions**, organized by **Gregory Bunt, MD**. This institute will feature a lecture on "New Psychopharmacological Developments in Adolescent Substance Use Disorders."

Efrain Bleiberg will present the William A. Schonfeld Award Lecture, "The Mentalizing Model of Emerging Borderline Personality Disorder in Adolescence: The State of the Art."

Some of the other featured speakers will be:

Robert Hendren and **Steve Adelsheim**, "New Understanding Leads to New Treatments for Schizophrenia in Youth"

William Pollack, "Hearing Young Males Voices: Healing Their Pain: Empathic Listening and 'Male-Friendly' Psychotherapy for Male Adolescents with Covert Depression"

Jack and Kerry Kelly Novick and **Enrico DeVito**, "Loneliness in Adolescence"

Lynn Ponton, "Issues & Strategies of Therapeutic Engagement with Emerging Adults Using a Developmental Frame"

Andres Pumariega, **Eugenio Rothe**, and **Rama Gogineni**, "Culture and Adolescence: Development, Psychopathology, and Treatment"

Annette Streeck-Fischer, "Shame and Narcissism in Adolescence"

Stevan Weine, "Protecting Adolescents against Radicalization and Recruitment to Violence"

The meeting will feature screenings of two award-winning short documentary films, for which **David Baron** served as Executive Producer. There will also be posters, including New Research Posters, on Friday and Saturday.

The registration fee is all-inclusive and includes admission to the two institutes, all workshops and courses, and lunch on Thursday, Friday and Saturday.

For more information, contact Frances Bell at adpsych@aol.com

Conference co-chairs

Gregory Barclay, MD, ASAP President-Elect

Lois Flaherty, MD, ISAPP President-Elect



ASAP AND ISAPP JOINT MEETING

Registration Form
March 26-29, 2015

Name: _____ Degree: _____

Address: _____

City/State/Zip _____

Phone: _____

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For Continuing Education Accreditation, check one:

☐ MD ☐ Social Work ☐ Psychology ☐ LMFT ☐ LPC ☐ Other

If Resident/Student, name of Institution/School: _____

Conference Registration Fees:

	Earlybird fee by January 31	Late fee after February 1
ASAP/ISAPP Member	\$425	\$575
ASAP/ISAPP Non-Member	\$525	\$675
Students/Resident/Fellows	\$225	\$325
One day registration	\$225	\$275

Total: _____

☐ A check is enclosed payable to ASAP. (A \$35.00 fee will be assessed for returned checks)

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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 St. John's Episcopal Church, located at 365 Strawtown Road in New City. 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.
