

# *The Westchester Psychiatrist*

*A quarterly publication of the Psychiatric Society of Westchester County*

Spring 2016

## **2015-2016 Executive Council**

**Barbara Goldblum, MD**  
*President*

**Anthony Stern, MD**  
*President-Elect*

**Karl Kessler MD**  
*Secretary*

**Richard McCarthy, MD**  
*Treasurer*

**Carlo Bayraktarian, MD**  
*Past-President  
(2014-2015)*

**Alex Lerman, MD**  
*Program Coordinator*

**Sally Ricketts MD**  
*Program Coordinator-Elect*

**Susan Stabinsky, MD**  
*Legislative Representative*

**Eve Kellner, DO**  
*RFM Representative*

**Richard Altesman, MD**  
*APA Representative*

**Edward Herman, MD**  
*APA Representative*

**Karen G. Gennaro, MD**  
*NYSPA Representative*

**Enrique Teuscher, MD**  
*Councilor*

**Mansukh Bhatti, MD**  
*Councilor*

**Jerry Liebowitz, MD**  
*Newsletter/Website Editor*

**Megan Rogers**  
*Executive Director*

## **Message From Our President - Barbara Goldblum, M.D. ATTENTION PSYCHIATRISTS: Your Future is Already Here and It's Called COLLABORATIVE CARE**



I have been hearing about something called "the Collaborative Care Model" of psychiatry, and decided to attend the APA's April 30th information/training session held at Columbia Presbyterian Medical Center to learn more about it. While some may already have good information about this subject, I was totally in the dark about where it came from, what it is, and where it will go.

To put the importance of this topic in sharp perspective: In September 2015, CMS gave \$685 million in grants to launch the Transforming Clinical Practice Initiative (TCPI). The funds go to twenty-nine national and regional collaborative healthcare transformation networks, called Practice Transformation Networks (PTNs), and to ten Support and Alignment Networks (SANs). This is to establish a system of population focused, integrated health care centers. The APA, as a SAN awardee, has received a grant of \$2.9 million to train 3,500 psychiatrists to participate in these primary care teams as the mental/behavioral health support specialist. The APA training will be in collaboration with the University of Washington's AIMS (Advancing Innovative Mental Health Solution) Center, where this concept of Collaborative Care began.

Here is a brief overview:

### **a) Where It Came From**

Collaborative Care is a concept that originated in a research culture in 1990 at the University of Washington, Seattle, by Wayne Katon as he looked for a way to treat anxiety and depression in primary care settings. This gradually evolved into

the establishment of their AIMS (Advanced Integrated Mental Health Solutions) Center in 2008. The AIMS Center focuses on getting proven research ideas into the real world where they can help large numbers of people with mental health treatment in the medical model. One of the slides presented showed that while an ideal psychiatric visit is 50 minutes, in the real world, to see all the patients who need psychiatric attention, psychiatrists could only give 6 minutes per patient visit to serve urban populations, and only 1.5 minutes per patient visit for rural populations. They developed this medical model for population based psychiatric care, which apparently was positively reviewed by CMS in its direction towards "value based care."

### **b) What It Is**

Located in a primary care setting, medical and behavioral care professionals work together as an integrated team for mental health care. The psychiatrist is the consultant to the team and the patients are not his, but the primary responsibility of the PCP. The premises are that mental health is part of overall health and that people would be more comfortable consulting their PCP about anxiety and depression before seeking other routes. That already established relationship would foster better follow-up, especially if the follow-up was integrated into the treatment plan.

The basic team members: the primary care physician, the consulting psychiatrist, the care manager and the patient. The training background of the care manager was not defined. The psychiatrist, who can be part-time, consults with the team members by phone, in person or by telepsychiatry. The psychiatrist does not bill for his services in his consulting role; he is salaried. The PCP writes the prescriptions as these are his

*(Continued on page 2)*

## Message From Our President - Barbara Goldblum, M.D.

(continued from previous page)

patients.

The AIMS Center defines Collaborative Care as "a specific type of integrated care that operationalizes the principles of the chronic care model to improve access to evidence-based mental health treatments for primary care patients." Patients are listed in the office data base registry and the care coordinator keeps track of the visits. Evidence-based medication or psychosocial treatments are provided based on evidence-based parameters. On-going consultations with the psychiatrist on the team, either with the PCP or care coordinator, are performed and treatment adjustments are made. Outcomes are measured. The coordinator keeps the registry up to date and will reach out to the patient for follow-ups if needed.

In the University of Washington AIMS Center model, the psychiatrist who spoke to us at the training session said she did not see the patient and only the PCP wrote the prescriptions. She was available to the teams by phone because of the multiple sites involved and the definition of her role.

The TRAINING FOR CERTIFICATION in Collaborative Care is available free to all APA members by the APA. There are seven modules in the training and it can be done on-line or at one of the in-person sites. The information is on the APA website, see below.

### c) Where Is It Going?

This will surely bring great mental health benefit to thousands of underserved psychiatrically ill people and will do great good. It keeps mental health assessment and care in the medical model. There will be large economic issues that will be influenced by government as integrated care is connected to the "value-based care" initiatives now underway. I am unable to speak to the reimbursement issues at this time.

Whether one is interested in being part of this model or not, I strongly encourage everyone to read about it and follow its development and implementation. This will be a very large part of our future. APA's "Psychiatric News" already has a Psychiatry and Integrated Care column, and our DB member, Dr. Sally Ricketts, Medical Director of Behavioral Health Integration at the Montefiore Care Management Organization in Yonkers, is co-author of its May 6, 2016 article.

### Websites:

1) [www.psychiatry.org](http://www.psychiatry.org) (Login and go to Psychiatrist>Education>Signature Initiatives; in the Teaching Collaborative Care paragraph, click on the blue "Find more information and how to participate in TCPI" link.)

2) [aims.uw.edu/who-we-are](http://aims.uw.edu/who-we-are)

It has been my pleasure to serve as your President this past year, and I wish everyone a very good summer. ■

## A COLLABORATIVE CARE PHILOSOPHY: CONNECTIONS BETWEEN MENTAL HEALTH CARE AND PRIMARY CARE By: Tony Stern, M.D.

What is the relation between the worlds of psychiatry and general medicine? The former stresses the less concrete reality of mind, and primary care/family medicine has a greater focus on the more concrete facts of the body.

The Jewish philosopher Martin Buber writes, **"Our faith has our humanity as its foundation and our humanity has our faith as its foundation."** What an evocative reminder. For those of us inclined toward faith, Buber nudges us to ponder how fully our humanity plays a role in it, and for those of us identified strongly with our humanity, he invites us to consider faith as more meaningful than we might have realized. Paradox is alive in Buber's brief words, as it often is when we stand at the threshold of wisdom. An aphorism like this one deserves the same kind of reading and re-reading as a good poem. When we honor it with our soulful attention, we can play with its reverberations and mull over its multiple potential meanings and implications. I have made a beginning to that happy task, and what follows are reflections that are the outcome.

Trees draw their life from both the sunlight and the soil; symbolically speaking, human beings are no different. As doctors we draw from the

"light" of faith, whatever the specific beliefs we hold. For example, when we keep hope alive for our patients at their most dire moments, we lean on a kind of faith in the unknown, in things unseen. But this hope, this faith, also draws from our humanity in action, our kindness and patience and ongoing work with the known world in countless situations, past and present. The "soil" of nitty-gritty clinical experience gives us reason to hope - we have all been surprised at times by an unexpected healing or unanticipated step toward acceptance and peace. Our simple humanness also gives us the very power to be present in a hopeful stance. The ability to be present as well as our perspective on these down-to-earth situations draw in turn from our ever-renewed sense of meaning and higher purpose.

In other words, the stance of strength that we provide for our patients has an intangible, immeasurable, unworldly aspect that is faith, or a quality closely allied to faith. It also has a more tangible and worldly aspect to it, which is our humanity, or a quality intimately connected to our humanity. In this light, Buber's words can be read to imply that our

(Continued on page 5)

## INTEGRATED CARE - AND WHAT DOES IT MEAN FOR PSYCHIATRISTS?

By: C. Deborah Cross, M.D.

The term “Integrated Care” in medicine goes by a number of different names and incorporates several different concepts of medical care. The delivery of medical care in the United States is undergoing a major revolution, if not to say a reinvention. The Affordable Care Act (“Obamacare”) has provided the impetus for much of the innovations. One of the most interesting concepts is that of the “patient center medical home”. Most of us at one time or another has bemoaned the growth of “specialty care” and how “no one seems to be interested in treating the whole patient!” The Medical Home attempts to correct some of this compartmentalization and with it has come the development of “integrated care” (also known as “collaborative care”).

In actuality, the concept, of course, is not new – it was practiced for hundreds of years, and some of the HMOs (in particular Kaiser Permanente) in the 1960s and 70s tried to re-invent this by having all the so-called specialists in the same building so a patient could see his/her internist, go down the hall to the GI doctor and then on to the psychiatrist. The Medical Home seeks to again promulgate this concept by allowing patients the ability to have one place where their medical care is based and overseen. This Medical Home (by definition in the ACA legislation) can be located within an Internal Medicine Group, or even a psychiatric practice. An outgrowth of this is the Accountable Care Organizations (ACOs).

Variations of this concept are many. Of particular importance to psychiatrists are concepts such as co-location, care management, and reverse co-location/care management. Simply put (and I will explain in more detail later), with co-location, mental health services are embedded in a medical practice. Reverse co-location of course means that primary medical care is embedded in a mental health clinic or practice. With Co-location, either the primary care physician or the psychiatrist/mental health professional continues their routine practice, BUT it is done in the same physical space as the other medical professional so that the two disciplines (primary care and psychiatry) can talk together and consult as frequently as needed. And, of course, the patient only has to go to one location for their appointment!

Care Management is, in some ways, a much more complicated concept – it is easy to define, but much more difficult to develop. The basic concept is that the primary care physician treats the patient for his/her psychiatric problems and (with reverse Care Management) the psychiatrist treats the patient for his/her

medical problems! WHAT, YOU SAY – you want ME to prescribe for and treat my patients for hypertension or diabetes?? This is, in fact, already happening across the country! Psychiatrists are going back and taking refresher courses to be able to treat uncomplicated illnesses such as diabetes and hypertension and then are doing so in mental health clinics that have become Medical Homes for their chronically ill psychiatric patients (how many times have we tried to get our patients to go see their primary care physician – and failed!).

What is of more interest to a large number of psychiatrists is the growth of a new career path – that of being the “consultant” to a medical practice with a Care Manager (usually a Social Worker or Nurse) and “helping” the primary care physician “manage” (that is prescribe and treat) their patients with uncomplicated psychiatric illnesses such as depression, anxiety, and even Bipolar Disorder. Interestingly, I know that most of us at one time or another has had patients come to us with psychiatric illnesses incompletely treated by their primary care doctor and have wished that somehow these physicians could have at least understood that 10 mg of Prozac will more than likely NOT treat the patient’s depression adequately! One of the major issues facing our profession today is the shortage of trained psychiatrists. This new approach enables us to help our non-psychiatric colleagues learn to treat appropriately these uncomplicated issues and allows us to use our greater expertise in dealing with the more complicated patients.

A lot of work has gone into developing various ways to set this up, and, more importantly PAY for it. Currently, the “consultant” model, where the psychiatrist is paid for through funds generated in the practice, ACO or by a capitated model, appears to be the only viable way, since at present there is no mechanism to bill for such consultant work. The Care Manager is the mental health professional who sees the patient, works directly with the primary care physician and is the link between the patient and the psychiatrist. The psychiatrist, in this model, does NOT see the patient, but rather develops a treatment plan with the Care Manager who then works with the primary care physician to implement it. When necessary, the psychiatrist talks directly with the primary care physician to refine the treatment. An interesting facet of this approach is the integration of specific rating scales so that everyone involved can see the progress (or lack) and

*(Continued on page 6)*

# DEDICATED TO PSYCHIATRY

PROVIDING PROTECTION, SUPPORT AND DEFENSE FOR PSYCHIATRISTS SINCE 1986



## WE PROTECT YOU



OCCURRENCE AND  
CLAIMS-MADE POLICIES  
AVAILABLE



YOUR CONSENT TO  
SETTLE IS REQUIRED WITH  
NO ARBITRATION CLAUSE



COVERAGE INCLUDED FOR  
TELEPSYCHIATRY AND  
FORENSIC SERVICES

## WE SUPPORT YOU



KNOWLEDGEABLE  
IN-HOUSE RISK MANAGERS WITH  
CLINICAL AND LEGAL BACKGROUNDS



ACCESS TO RISK  
MANAGEMENT RESOURCES  
AND TUTORIALS



ACCME-ACCREDITED WITH  
COMMENDATION OFFERING COURSES  
BOTH IN-PERSON AND ONLINE

## WE DEFEND YOU



OVER 22,000 PSYCHIATRIC  
CLAIMS MANAGED – MORE  
THAN ANY OTHER COMPANY  
IN THE UNITED STATES



UNPARALLELED EXPERTISE IN  
PROTECTING AND DEFENDING  
OUR CLIENTS' PROFESSIONAL  
REPUTATIONS AND PRACTICES



NATIONWIDE NETWORK  
OF DEFENSE ATTORNEYS WITH  
EXTENSIVE EXPERIENCE IN  
PSYCHIATRIC LITIGATION

PRMS has been dedicated to psychiatry for almost three decades, and we understand your unique needs and the risks you face. We are a trusted partner to the profession as the largest provider of psychiatric professional liability insurance in the United States with an impressive 95% client retention rate.

### More than an insurance policy

800.245.3333 | [PsychProgram.com/Dedicated](http://PsychProgram.com/Dedicated) | [TheProgram@prms.com](mailto:TheProgram@prms.com)



Actual terms, coverages, conditions and exclusions may vary by state.  
Unlimited consent to settle does not extend to sexual misconduct.

Insurance coverage provided by Fair American Insurance and Reinsurance Company (NAIC 35157). FAIRCO is an authorized carrier in California, ID number 3175-7. [www.fairco.com](http://www.fairco.com)



## A COLLABORATIVE CARE PHILOSOPHY: CONNECTIONS BETWEEN MENTAL HEALTH CARE AND PRIMARY CARE By: Tony Stern, M.D. (continued from page 2)

sense of meaning relies on our concrete life, and our concrete life depends upon our sense of meaning. For some doctors and patients, this also suggests that the worlds of religion and medical science balance and bolster each other in complementary ways. For others, it would be more accurate to speak of the underlying connection between the spiritual and secular domains. In any case, the uncanny mutuality described by Buber points to a reality of two salutary tendencies mutually embedded in each other. This can be imagined pictorially as M.C. Escher's etching of two hands drawing each other, or even as the Mobius strip that seems like it has two sides, but has only one side in reality.

Buber's most famous insight is the distinction between "I-Thou" and "I-It", and his aphorism about faith and humanity can be seen in these terms. When we bring our hearts in unreserved sincerity to the world, we are relating in an "I-Thou" way, and the world tends to reveal itself in kind, approaching in profound depths of contact and connection. When we bring our rational and reticent minds to the world, we have set up an "I-It" relation, which keeps our relationship to it well-boundaried, fully on the surface of using means to achieve particular ends. Our faith and our humanity can both contribute in their own ways to the sincerity of the heart and this to "I-Thou." We all need a balance between "I-Thou" and "I-It" modes of being, between relation and wholehearted engagement vs. distance and analytical detachment. But our culture today often limits the I-Thou connection mode too severely, keeping us in our minds and on the surface of the world.

This brings us full circle. "I-Thou" is the place of true relationship; it is also the single shared strength of mental health disciplines and primary care as compared with other medical specialties. The power of relationship has always existed as the bridge between different worlds as well as an essential, often neglected element in healing and comforting our patients.

As countless primary care docs emphasize, "It's about the relationship." The work of family doctors and mental health providers alike has the

relationship with the patient at its center. Whenever this relationship plays a role in healing, the heart is close at hand, and thus the wellspring of "I-Thou" is present, too.

I would be remiss if I failed to mention one other word that is quite central to this discussion. When we speak of "relationship" or we invoke associated phrases like "rapport-building" or "the therapeutic alliance," we are ultimately, in our own way, referring to that four letter word "love." We doctors, like all soldiers on the front lines, can be quite uncomfortable with such tender language. Thus we describe the benefits and other dimensions of love using more clinical terms, which may well be fitting for our role. But whatever we call it, psychotherapy research has revealed again and again the power of relationship as the major impetus for healing across various practitioners and spanning many schools of therapy; a fuller view of this power not only tracks the scientific literature about it, but also keeps the teachings about love in the great religions and philosophies of the world in mind. Clinical medicine has always stood at the crossroads between the sciences and culture as a whole, and we should not be ashamed of this fact.

With love in the picture, we can read the Buber saying in another way, seeing in it an implied glimmer of truth about this remarkable fact of human existence: "Our unworldly love relies on our worldly love, and our worldly love on our unworldly love." Our faith has ties to a spark or hope or reality that lives beyond the world as we routinely know it; one might even say that faith is that spark. Our humanity is grounded in the world and the individuals and pursuits of this world that we know and love well.

To love a possibility beyond the things we see and to love the world we do see: these two loves depend on each other. They intertwine with each other and resonate with all we have mentioned above. The dynamic between them is two worlds working well together, helping in the healing endeavor and enriching our lives as providers of care, as receivers of this care, and in a multitude of ways that affect our life in the medical field and beyond it. ■

## **SAVE THE DATE!**

**July 13, 2016 - 6:30pm**

**Ongoing Challenges in Parity Implementation CME Dinner**

Presented by: Rachel Fernbach, Esq.

Location: Tre Angelina, White Plains, NY

*Feel free to invite your psychiatric colleagues who may not be APA Members*

**RSVP by July 11, 2016 at (914) 967-6285 or [centraloffice@wpsych.org](mailto:centraloffice@wpsych.org)**

## INTEGRATED CARE - AND WHAT DOES IT MEAN FOR PSYCHIATRISTS?

By: C. Deborah Cross, M.D. *(continued from pg. 3)*

treatment can be adjusted as needed and quickly.

Psychiatrists who seem to be drawn to this appear to be those who have already been involved in Consultation-Liaison (Psychosomatic) work and are comfortable working with non-psychiatric physicians in treating patients. The American Psychiatric Association has recently been awarded a large grant by the Centers for Medicare and Medicaid (CMS) to train psychiatrists in this concept of “collaborative care” and recently gave a four-hour presentation on April 30 at Columbia’s NYS Psychiatric Institute. There is also an online course on the APA web

site. The annual APA meeting had an “Integrated Care Track” with presentations EVERY DAY of the meeting. I’ll list just a couple of the topics: “Integrating Behavioral Health and Primary Care: Practical Skills for the Consulting Psychiatrist,” and “Primary Care Skills for Psychiatrists.”

This very brief overview hardly does justice to such an exciting “new” approach to our profession. However, this will certainly not be the last you hear of it. Don’t be surprised if you go to your primary care doctor soon and he/she has “integrated” mental health and psychiatry into their practice! ■

*The Psychiatric Society of Westchester County  
congratulates the following members that have been  
elected to the 2016- 2017 Executive Council*

<b>President</b>	C. Deborah Cross, M.D.
<b>President-Elect</b>	Karl Kessler, M.D.
<b>Secretary</b>	Alexander Lerman, M.D.
<b>Treasurer</b>	Richard McCarthy, M.D.
<b>Program Coordinator-Elect</b>	Ellen Weissman, M.D.
<b>APA Representative</b>	Edward Herman, M.D.
<b>NYSPA Representative</b>	Karen G. Gennaro, M.D.
<b>Councilor</b>	Rehana Latif, M.D.
<b>Councilor</b>	Richard Silverman, M.D.

# We've got you covered.

For over 30 years, we have provided psychiatrists with exceptional protection and personalized service. We offer comprehensive insurance coverage and superior risk management support through an "A" rated carrier. In addition to superior protection, our clients receive individual attention, underwriting expertise, and, where approved by states, premium discounts.

**Endorsed by the American Psychiatric Association, our Professional Liability Program Provides:**

- **Risk Management Hotline** – comprehensive 24/7 service for emergency issues
- **Insuring Company** rated "A" (Excellent) by A.M. Best
- **Telepsychiatry, ECT coverage & Forensic Psychiatric Services** are included
- **Many discounts, including Claims-Free, New Business & No Surcharge for claims** (subject to State Approval)
- **Interest-free quarterly Payments/Credit Cards Accepted**

Visit us at [apamalpractice.com](http://apamalpractice.com) or call **877.740.1777** to learn more.



**American Professional Agency, Inc.**

LEADERS IN PSYCHIATRIC MEDICAL LIABILITY INSURANCE



## JOINT DB MEETING ON K2 IN NYC:

### What We Know and Still Can Learn from a Recent Epidemic

By: Jerry Liebowitz, M.D.

On April 20 at the Pine Bar & Grill in the Bronx, the Westchester DB and the Bronx DB jointly hosted a CME dinner meeting titled **“K2 in NYC: What We Know and Still Can Learn from a Recent Epidemic.”** The speaker was Luke Bergmann, PhD, MSW, Senior Director of the Office of Behavioral Health, Division of Medical and Professional Affairs, NYC Health & Hospitals Corporation.

Dr. Bergmann introduced the subject by explaining that this was first and foremost “a policy talk – how drug policy operates and can operate.” He noted that the “war on drugs” terminology was dramatic and willful and suggested that we turn away from that language to a **public health approach of demand reduction and harm reduction**. He used the recent K2 epidemic as an example. He explained that **K2 is a synthetic cannabinoid** and that it is not synthetic marijuana or one of the “classic” cannabinoids found in marijuana. Throughout his talk he kept returning to this point, emphasizing the differences between marijuana (which is mainly THC) and synthetic cannabinoids, which can be extremely dangerous, even if marketed as safe alternatives. These cannabinoids are structurally different and are sprayed on shredded plant material and sold as “Spice” and other names like “Yucatan madness,” “fake weed,” and “Crazy Clown”; they are not in the plant. Many of them are Schedule I (and II) drugs, although the manufacturers rapidly keep changing the structure of the isomers (and the “brand” names) to stay ahead of testing and avoid getting classified as a drug. He also focused on recent policy developments and discussed future policy opportunities related to synthetic cannabinoid in NYC and Westchester County.

To help us understand the pharmacology and clinical issues, as well as future research questions and opportunities related to synthetic cannabinoids, Dr. Bergmann used a slide presentation to track the use of K2 and emergency room visits for K2-related psychopathology (mainly extreme psychotic reactions with agitation and other strange behavioral symptoms) and clinical problems (including severe sedation, seizures, and other physical symptoms) from the start of the epidemic with a rapid rise in January 2014 to its fairly rapid end in March 2015. He noted the wide geographic variation of the epidemic, starting at Jacobi and moving to other ERs in the Bronx and other Boroughs. Those affected were almost entirely men over the age of 18 (median age = 37) and a high percentage were residents of homeless

shelters and/or had a previous history of psychiatric illness.

Dr. Bergman summarized the NYC HHC’s recommendations for **a patient-centered treatment with a symptom-based approach**, using medications like olanzapine (dissolvable) and/or benzodiazepines for the psychiatric symptoms – plus an awareness that the metabolites of the cannabinoids are even more potent and therefore require transfer to a medical center for management of seizures.

He went on to describe the **failure of the “whack-a-mole” approach of drug prohibition**, with its moving list of “hot spots” (including many bodegas) and the shifting molecular landscape of synthetic drugs, and instead **recommended “a walk on the supply side”** to reduce supply and end distribution, reduce demand, and ensure effective tracking and treatment services. The NYC Council’s K2 bills of 2015, he noted, are examples of **innovative drug policies**, including discontinuing cigarette licenses of stores in which K2 is found as well as making it a crime only if 10 or more packets are found on a “dealer,” rather than a user. He suggested that the **shift of policy emphasis from the molecular compounds themselves to product representation** was “a significant innovation.” He also noted policy changes on the state and federal level.

These policy changes and the **public health campaigns** that followed, he pointed out, have led to a situation in which **social stigma trumps policy** and everything else. “It’s become demeaning to use K2,” he explained.

But other harmful substances keep cropping up. We must continue to learn, he urged, about the importance of understanding substance use more generally in physical health care and the importance of social determinants of health in treating individual patients. There are many challenges ahead, he warned, affecting primary care, emergency departments, and specialty care, because of the high prevalence of harmful substance use across patient populations.

Dr. Bergmann’s talk was entertaining and exciting, as well as informative, raising many questions about the shape of addiction and our responses to it – not only in our practices, but also in our role as patient advocates for public policy. ■



## DISTRICT BRANCH HOSTS MEETING FOCUSED ON VETERANS MENTAL HEALTH ISSUES

By: C. Deborah Cross, M.D.

On April 6 at Tre Angelina Restaurant in White Plains, the Westchester DB hosted the Bronx and West Hudson District Branches in a CME dinner meeting titled “The Psychiatric Wounds of War: What Physicians and Providers Need to Know About Combat-Veterans’ Mental Health Conditions & Military Culture.” The speaker was Dr. Richard Silverman, currently a Consulting Psychiatrist at the VA Hudson Valley Health Care Systems in Montrose, who previously had spent over 20 years as the Director of their Outpatient Mental Health Services treating veterans.

The meeting was also sponsored by the New York State Psychiatric Association, who has received a multi-year grant from the NYS Office of Mental Health to train physicians in recognizing and understanding Post Traumatic Stress Disorder, Traumatic Brain Injury and Suicide in returning veterans.

Dr. Silverman gave a comprehensive overview of the pathophysiology and neurobiology of trauma and traumatic

brain injury and the resultant myriad of symptoms with which veterans present. The impact of these symptoms on veterans’ lives and their families is often catastrophic. Through the use of powerful vignettes of patients he has treated over the years, Dr. Silverman’s presentation drove home the need for better recognition and treatment of the devastating problems our returning veterans bring to us as physicians. He also focused our attention on the work the VA has done in establishing evidenced based treatments, both psychological and pharmacological, for PTSD and TBI and presented a very clear overview of the way in which we as physicians can be better prepared to meet the needs of this very special group of patients.

The evening was an exciting one, with a large turnout for an excellent presentation, dinner and an opportunity to meet and mingle with colleagues from other District Branches. We look forward to having other such presentations in the coming year and to more members joining us for our meetings. ■

## EDITOR’S COLUMN: Integrated, or Collaborative, Care in Psychiatry

By: Jerry Liebowitz, M.D.

As reported elsewhere in this issue and highlighted in the Message from Our President, a “hot” topic for psychiatry these days is integrated, or collaborative, care. Although initially unintended as such, this issue can be seen as one covering various aspects of the topic.

Our president’s column on “the Collaborative Care Model” of psychiatry provides a brief history and overview of the issue, including where it came from, what it is, where it is going.

Debbie Cross’s article (page 3) on “Integrated Care – and what does it mean for psychiatrists?” outlines the possibilities of this exciting “new” (yet very old) approach to our profession.

In another article by Dr. Cross (above), a report on the CME meeting sponsored by NYSPA and hosted by our DB and the Bronx and West Hudson District Branches on mental health issues of veterans, she notes how the speaker, Dr. Richard Silverman, “also focused our attention on the work the VA has done in establishing evidenced based treatments, both psychological and pharmacological, for PTSD and TBI and presented a very clear overview of the way in which we as physicians can be better

prepared to meet the needs of this very special group of patients.” This highlights another kind of collaborative care that we psychiatrists engage in.

Tony Stern’s philosophical opinion piece on Collaborative Care (page 2), written when he was working at Einstein in the Departments of Psychiatry and Family Medicine, is a philosophical “riff” on Buber’s aphorism, “Our faith has our humanity as its foundation and our humanity has our faith as its foundation.” Like many of Tony’s thought-provoking essays, it shows the spiritual and ethical underpinnings of our field and, in this particular case, the connections between psychiatry and general medicine.

And, lastly, my report on the Bronx-Westchester joint DB meeting on the K2 epidemic in NYC (page 8), “What We Know and Still Can Learn from a Recent Epidemic,” highlights the collaborative role psychiatrists can play, along with our medical colleagues, in guiding public policy.

These joint meetings reported on here, as well as those of our  
(Continued on page 10)

## EDITOR'S COLUMN (continued)

(Continued from page 9)

own DB throughout the year, give us an opportunity, not only to stay informed and share our concerns, but, as Dr. Cross notes, “to meet and mingle with colleagues from our and other District Branches.” And by doing so, the better we take care of ourselves, our profession, and our patients.

We look forward to having you join us at such presentations in the coming year – and to contribute your own thoughts and experiences through this newsletter.

Have a great summer! And, as Debbie Cross, notes, “Don’t be surprised if you go to your primary care doctor soon and he/she has “integrated” mental health and psychiatry into their practice!” ■

### INTERESTED IN WRITING AN ARTICLE?

### LETTER TO THE EDITOR OR AUTHOR?

### HAVE A CLASSIFIED YOU WOULD LIKE TO INCLUDE?

Contact Megan Rogers to have your article, classified or opinion

featured in our next newsletter!! (914) 967-6285



<https://www.facebook.com/PSWinc>

**We're On The Web!**

**[www.wpsych.org](http://www.wpsych.org)**

The Psychiatric Society of Westchester County

400 Garden City Plaza, Suite 202

Garden City, New York 11530

T: (914) 967-6285

F: (516) 873-2010

E: [centraloffice@wpsych.org](mailto:centraloffice@wpsych.org)