



Synapse



THE WEST HUDSON PSYCHIATRIC SOCIETY NEWSLETTER

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Robert N. Sobel, M.D., Editor & Syed Abdullah, M.D., Co-Editor

President's Message: Education, Research, and MITs

Ten years ago our district branch had a significant number of Members-in-Training (MITs). These individuals usually went on to remain in the community and become General Members. They served as our lifeblood and allowed our organization to grow. Today they are gone and we are faced with the challenge of a smaller organization.

The reason for this has been the reduction and elimination of residency program activities within Rockland and Orange counties. The residency program at Middletown Psychiatric Center ceased operation a few years ago. This had consequences for hospitals in both Orange and Rockland as these residents rotated through Middletown Psychiatric Center, Rockland Children's Psychiatric Center, and the Rockland County Department of Mental Health. In addition, residents from New York University no longer have a regular rotation at Rockland Psychiatric Center, as their numbers have been cut back significantly in recent years.

Fortunately, the recent renovation and expansion at the Nathan S. Kline Institute for Psychiatric Research, a state-operated facility located on the grounds of Rockland Psychiatric Center, may be a fertile field to attract trainees interested in clinical

research. Already there have been residents coming for elective rotations. Perhaps there will be more interest in trainees coming and staying longer. They will see that our geographic area is a nice place to live and they will settle down in our community.

In this manner, research and training are tied together and provide a possibility that our District Branch will regain membership. Your support is needed. This editorial is intended to bring you up to date and to tell you of the opportunities that exist here for psychiatrists-in-training.

Educational opportunities for our current members deserve mention as well. There are regularly scheduled psychiatric CME Meetings and Grand Rounds at our community and state hospitals. Would members be interested in knowing about them by a notice in this newsletter or by a posting on our web-site? Would contact numbers or being placed on a mailing list suffice? Let me know by calling me at 914-398-5595 or e-mail at Citrome@nki.rfmh.org.

This newsletter is now available in "Adobe Acrobat" format on our website. Adobe Acrobat (also known as "PDF" format) refers to a computer program that allows you to view a document as it was originally printed,

complete with color and illustrations, right on your computer monitor. You can also print it out. What you print out is an exact "clone" of the

regular newsletter that is mailed out. This is a major advance in document technology and allows us to have at our fingertips, copies of documents that would otherwise take up shelves of space (not to mention misfiled or lost). In order to use Adobe Acrobat you will need a copy of the program. The good news is that it is free. Please visit our District Branch's website at <http://www.rfmh.org/whps> and follow the links to get your copy of Adobe Acrobat, then download the Synapse. This is the shape of things to come. Enjoy! ▲

Leslie Citrome, M.D., M.P.H.



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Child Custody Controversy

Periodically the APA prepares a "resource document", which while not representing official policy, does provide some guidelines about the current research in the field.

Gay & Lesbian Parenting

1. There currently are between two and eight million gay & lesbian parents, and six to fourteen million children in the

United States with at least one gay or lesbian parent.

2. Women, whether heterosexual or lesbian, once they have children, identify their primary role as a mother.

3. There are no differences between heterosexual & lesbian mothers in demographics, maternal instincts, parenting styles, childrearing practices, sex roles, social supports or use of professionals for help,

4. Single gay and lesbian custodial parents put their relationship with their children above new relationships for themselves.

5. There appears to be no statistically greater incidence of homosexuality in the children of gay & lesbian parents.

6. Regarding "psychological health", there were no identifiable differences in peer relationships, emotional development, intelligence, popularity with peers, self-esteem or moral maturity.

7. The children of divorced lesbian mothers were more likely to have contact with their fathers than those of heterosexual mothers, and there appeared to be more conflict about visitation in the heterosexual mothers.

8. Lesbian mothers had more adult friends and included more adult male friends and relatives in more activities, more often than heterosexual mothers.

9. The children of gay and lesbian parents had greater acceptance of their own sexuality, increased tolerance, increased empathy for others and increased exposure to a variety of viewpoints.

10. There have been no reported cases, of pedophilia, committed by gay parents or their lovers against their children.

Transracial Adoptions (TRA)

1. In practice, the numbers of adoptive parents available for TRA's are overwhelmingly white, while the

numbers of available children are overwhelmingly of color.

2. In 1972, the National Association of Black Social Workers denounced TRA as "cultural genocide", which temporarily slowed the adoption of black children by non-black families.

3. TRA parents are characterized by humanitarian or religious motives, rather than childlessness and are geographically or socially isolated from extended family. Their childrearing tends to be active civically and in the community and they tend to have borne children before adopting.

4. There have been no significant differences on psychological testing between TRA and intraracial adoptees on measures of family integration, self-esteem, school performance or overall adjustment.

5. There may be some differences in group identity and racial identity, although it is unclear from the research done how "white looking" biracial children are defined where they fit, or what their racial identity is. Thus, TRA children appear, at least through childhood up to adolescence, to fare as well as intraracial adoptees.

Joint Versus Sole Custody and Gender Issues

1. 40%-50% of children will experience the separation and/or divorce of their parents. Joint legal custody is awarded (or agreed upon) in 80%-90% of divorces with physical custody to the mother in 80% of divorces. (This statistic is not representative of custody cases decided after Forensic evaluations, and by Judges since Forensic experts



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SYNAPSE designed by Lydia Dmitrieff

PAN Award Winners Again! for 2000

Once again, we are the winners of the PAN award (Public Affairs Network Award) for the year 2000 in the area of small district branches-overall public affairs. This coveted award is given to the group which demonstrates exemplary performance in the area of public affairs. Many thanks to members of the Mental Health Coalition of Rockland County and West Hudson Psychiatric Society who participated in Public Affairs activities in order to achieve this award. The award will be presented at the APA's Joint Institute for Legislative and Public Affairs scheduled for February 2000 in Miami, Florida.

Every person who contributed to coalition and WHPS deserves a piece of this award!!

Meanwhile, Public Affairs continues to be active!! The Mental Health Coalition is planning a spring project to go to different Rotary Clubs in the community to

"destigmatize mental illness and promote mental health". The programs will consist of a professional and either a consumer or family member speaking about their experience dealing with mental illness. The Rotary Clubs consist of a variety of different businesses and will provide excellent exposure for all psychiatrists and mental health professionals, as well as for consumers and family members. If you are interested in participating in a lunchtime conference at a Rotary Club meeting, please contact me ASAP.

In addition, we are planning to have our usual college programs and participate in the Picnic for Parity in May!! The coalition will also co-sponsor with NAMI FAMILYA a conference in May on the topic "Bridging the Gap Between Mental Illness, Chemical Dependency, and the Legal System".

Please join us for exciting projects!! It is an opportunity to network and meet professionals, family members, and consumers all working towards the goal of promoting mental health.

The next coalition meeting is scheduled for Thursday, March 9, 2000 at 12 noon in the Rockland County Department of Mental Health- Building F Conference Room. We welcome new members! Anyone interested in joining, please call Dr. Lois Kroplick at 914-364-2428. ▲



Lois Kroplick, D.O.
Chairperson Public Affairs

Child Custody Controversy continued

generally do not recommend joint custody because a case which requires evaluation is ipso facto, one which could not be decided between the parties themselves, amicably and thus is unlikely to be successful in a joint custody arrangement).

2. The literature is unclear about the advantages of either arrangement (both are supported, but frequently related to different circumstances, such as the post-separation acrimony between the parents).

3. Freud, Solnit & Goldstein, in a series of books published between 1973 and 1996, disapprove of joint custody, and even believe that the custodial parent alone should make decisions regarding the non-custodial parent's visitation. (We generally disagree with this position).

4. There appears to be no difference in child adjustment, based on joint versus sole custody arrangements.

5. It is better to be in a low-conflict divorced family than high-conflict intact family.

6. Children do best when they have regular contact with the non-custodial parent, provided the parent is reasonably stable and emotionally healthy.

7. Children's post-divorce adjustment is inversely related to the ongoing level of interparental conflict, and frequent visitation is advisable only if conflict between parents is low, although there are exceptions.

8. Gender - Boys are more negatively affected by divorce than girls; girls may, later in development, experience

more problems in interpersonal relationships; the sex of the custodial parent does not predict the child's post-divorce adjustment, although boys may be less well-adjusted in mother-custody arrangements, and girls in father-custody arrangements.

9. Children of high conflict divorce are 2-4 times more likely to be clinically disturbed than children in the general population.

10. A custodial mother's approval of paternal visitation improves the children's adjustment.

11. There is no real consensus in the literature regarding what connotes the child's best interests in custody disputes and determinations must be made on a case by case basis. ▲

Alan J. Tuckman, M.D.

Avicenna, The Prince Of Physicians

Sir William Osler declared Avicenna the 'Prince of Physicians', for he wrote the first definitive text book of medicine: Cannon of Medicine. This remained the prevalent source book on medicine in Europe and the Middle East for more than six centuries. Avicenna wrote in Arabic although he was a native of Persia and his mother tongue was Farsi. He was born near Bukhara, which is presently in Uzbekistan, in 980 AD - more than a thousand years ago. He is known as Ibn Sina in his native land and all of Middle East, India and Pakistan. Avicenna was a child prodigy who had memorized the Quran by the age of 10 and by age 12 had mastered Jurisprudence. But his thirst for knowledge was insatiable. He soon became interested in learning the writings of Greek philosophers, particularly Aristotle, while engaged in the study of medicine from the leading physicians of Bukhara, which was a major center of learning in Persia.

After developing excellence in the study of Logic under a renowned teacher, al-Natili he went on to the study of Philosophy. Probably the first Greek

book that Avicenna studied was the introduction written by a Neoplatonist, Porphyry, to the Categories of Aristotle. This writing had passed through a Syriac translation before it appeared in Arabic. It was this Arabic version that Avicenna had access to. He also studied the writings of Euclid and Ptolemy, he thus mastered logic, mathematics, and astronomy while studying medicine. Avicenna's own words were: *Next I desired to study medicine, and proceeded to read all the books that have been written on this subject. Medicine is not a difficult science...* by the time he was sixteen years old he was treating the sick thus adding to the corpus of medical learning from his own practical clinical experience. He was an ardent observer of the processes of health, sickness, healing, recovery, aging, and dying. He made extensive notes of his findings and the teachings of others who preceded him particularly Galen the great physician in the Hippocratic tradition.

As he became a distinguished healer he was called upon by the ruling princes for consultation and treatment. He took

advantage of the royal libraries to quench his thirst for knowledge. He describes one of these libraries:

I entered a mansion with many chambers, each chamber having chests of books piled one upon another. In one apartment were books on language and poetry, in another law, and so on; each apartment was set aside for books on a single science. I glanced through the catalogue of the works of the ancient Greeks, and asked for those which I required; and I saw books whose very names are as yet unknown to many- works which I had never seen before and have not seen since. I read these books, taking notes of their contents; I came to realize the place each man occupied in his particular science. So by the time I reached my 18th year I had exhausted all these sciences...

Avicenna's psychology was essentially Peripatetic having been derived from Aristotle's natural philosophy. It concerns itself with the moving and animating force or Soul in the members of the three kingdoms - vegetative, animal and rational. The intelligence and souls descend from the 'World Soul' to the four elements in varying proportions, in accordance to their capacity to attract them. The faculty of movement of the body is in response to emotions of anger and lust as well as the power of comprehension. He believes that the capacity of comprehension is based on five external and five internal senses. The external senses consist of touch, smell, taste, hearing, and sight which appear in an imperfect state in the lower animals and are developed in full only in man. The five internal senses are: the power of



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retaining forms and representation, sensitive imagination, estimation and retention, and recollection. These faculties Avicenna locates in various parts of the brain following the teachings of Galen. The workings of the soul is part of a cosmic drama representing the unity of all creation.

Avicenna defers from the Greeks in his insistence upon the immortality of the individual soul, its incorruptible and immaterial essence, and that it is in a degraded state while in the prison of the senses. In his esoteric philosophy and in his poems he writes about the original celestial abode of the soul and the necessity to remember its heavenly origin. In this he distinguishes himself in proposing a spiritual healing of the disease of forgetfulness and negligence that befalls the soul, and to free it from its pitiful terrestrial state. This is enchantingly illustrated in his poem Ode On The Soul, an English translation by A. J. Arberry.

Medicine was the first of the Greek sciences studied by the Arabs. An important medical school had existed in Jundeshpur in Persia since the fourth

century. It was to this center of learning that the Greek scholars flocked in 529 AD when Justinian closed the Academy at Athens. The medical tradition of Hippocrates and Galen was thus preserved and transmitted, chiefly by Nestorian and Monophysite Christians, in the Eastern provinces of Islam when it had perished in Europe. The gigantic bureaus of translation in Toledo (Spain), Alexandria (Egypt), Bagdad (Iraq) and Bukhara (Persia) feverishly carried on the translation of Greek texts into Arabic. Scholars who were well versed in at least two of the languages from a list of Greek, Arabic, Syriac and Hebrew, were highly valued and found ready employment in these prestigious, state supported institutions. A Persian Jew, Masarjawaih, was the first to translate into Arabic a Greek work on medicine, the Pandects of the Christian priest Ahron of Alexandria.

Later the entire body of the Greek medical text was translated into Arabic. Thus the combined efforts of Christian, Jewish and Muslim scholars resulted in the preservation of the invaluable classics of the ancients. This included

the works in medicine, mathematics, philosophy, astronomy and other sciences. Over the following centuries the Arabs studied these and wrote extensive commentaries on them, adding their own findings, criticisms and explanations. How valuable this process was, is illustrated by an event in Avicenna's life, in his own words:


I was now a master of Logic, Natural Sciences and Mathematics. I therefore returned to Metaphysics; I read the Metaphysica, but did not understand its contents and was baffled by the author's intention; I read it over forty times, until I had the text by heart. Even then I did not understand it or what the author meant, and I despaired within myself, saying 'this is a book which there is no way of understanding'. But one day at noon I chanced to be in the book sellers' quarter, and a broker was there with a volume in his hand which he was calling for sale. He offered it to me, but I returned it to him impatiently, believing that there was no use in this particular science. However he said to me, 'Buy this book from me, it is cheap, and I will sell it to you for four dirhams. The owner is in need of the money'. So I bought it, and found that it was a book by al-Farabi On the Objects of the Metaphysica. I returned home and hastened to read it; and at once the objects of that book became clear to me, for I had it all by heart. I rejoiced at this, and upon the next day distributed alms to the poor in gratitude to Almighty God.

Avicenna describes a period of eighteen months of intensive studies which was rather typical of his days and nights: *During this time I did not sleep one night through, nor devoted my attention to any other matter by day. I prepared a set of files; with each proof I examined, I set down the syllogistic premises and put them in order in the files, then I examined what deductions

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Avicenna, The Prince Of Physicians continued

might be drawn from them. I observed methodically the conditions of the premisses, and proceeded until the truth of each particular problem was confirmed for me. Whenever I found myself perplexed by a problem, or could not find a middle term in my syllogism, I would repair to the mosque and pray, adoring the Supreme Creator, until my trouble was resolved and my difficulty made easy. At night I would return home, set the lamp before me, and busy myself reading and writing....If ever the least slumber overtook me, I would dream of the precise problem which I was considering as I fell asleep; in that way many problems revealed themselves to me while sleeping. So I continued until I had made myself master of all the sciences; I now comprehended them to the limits of human possibility.*

The philosophy of Avicenna, compiled in the Book of Healing and Saint Augustine's work in the 5th century, shaped the thoughts of the medieval Franciscan monks. Their writings in turn, contributed to European University curricula, thus Avicenna's ideas broadly infiltrated Western thought.

While being the physician to the ruling princes opened the doors of the royal libraries, they also caused hazardous working conditions. The Rulers, impressed by his multifaceted talents, burdened him with administrative responsibilities. He became the advisor in military, political and economic matters. More than once he was appointed the Vizier to the Prince reaching the rank of the Prime Minister. This led to extreme jealousy and hatred in the ranks of the other functionaries of the court. They would conspire against him and

advise the Prince against retaining him in that high rank. They attacked Avicenna's practice of having nightly sessions with his students in his house where he carried out his teachings and had late night parties of music and merry making. This was construed as a conspiracy to undermine the religious and secular authorities. It was suggested that the Physician be arrested and summarily killed. The ruler finally agreed to imprison Avicenna but spared his life. This happened on more than one occasion. Once while in the prison, Avicenna, busy writing his treatises, was surprised to find his erstwhile patron join him. The ex-ruler apologized to Avicenna and explained that the same courtiers who had conspired against Avicenna had now deposed the Ruler.

Later the Prince escaped from the prison and regained his kingdom. He

offered to restore Avicenna to his former position but he declined the offer and went into hiding. Avicenna left the kingdom and went over to the ruling Prince of Isfahan in the south. He was received with much honor and again appointed the royal physician and an advisor to the Ruler. There he spent the last fourteen years of his life in relative safety. He was however required to accompany the Prince on military expeditions even when he was not feeling well. While on his way to the battle, Avicenna continued to dictate his treatises from horseback. On his return from the expedition, the colic attacks worsened and he decided to leave Isfahan and move on to Hamadan. There he died in the year 1037 at the age of 58. ▲

Syed Abdullah, M.D.



NOVARTIS



What Kendra's Law Means To You: Part I

This article is reprinted with the permission of the Editor of the NYSBA Bulletin.

By D.J. Jaffe and Jonathan Stanley, Esq. Treatment Advocacy Center, Arlington, VA.

Background

Kendra's Law (New York Mental Hygiene Law ' 9.60) allows courts to order certain individuals with brain disorders to comply with treatment while living in the community. This court-ordered treatment is called assisted outpatient treatment (AOT). The law takes effect November 8, 1999. (Footnote 1)

Kendra's Law is an important advance in that it allows individuals to be ordered into treatment without ordering them into a hospital. In addition, the criteria to place someone in assisted outpatient treatment are easier to meet than the "imminent dangerousness" standard often required for inpatient commitment in New York. Kendra's Law allows someone to be ordered into treatment "to prevent a relapse which or deterioration which would likely result in serious harm to the patient or others." In other words, there is no need to wait until a deteriorating consumer actually is dangerous to self or others, as in the inpatient standard; under Kendra's Law you can start procedures to "prevent a relapse" that could lead to dangerousness. The law includes numerous consumer protections and requires individuals to meet multiple criteria.

In enacting Kendra's Law, the legislature found that some people, as a result of mental illness, have great difficulty taking responsibility for their own care, and often reject outpatient treatment offered to them on a voluntary basis. These individuals often commit suicide; become homeless; end up in jail; or, on rare occasions, are involved in acts of violence. Family members and caregivers often must stand by helplessly and watch their loved ones and patients decompensate to actual "dangerousness" before they are allowed

to facilitate treatment. Assisted outpatient treatment is a new tool that may help in these situations. But it is not a panacea. AOT is designed to help consumers, not punish them. AOT exists in 40 states, but is new to New York.

Overview

The procedure for arranging for assisted outpatient treatment is technical and somewhat cumbersome. AOT is only available to individuals who meet certain defined criteria. Consumers can only be placed in the program by a court, which must first receive a petition from one of a defined group of individuals. The petition must give the reasons why the petitioner believes the consumer meets the criteria and be accompanied by an affidavit from a physician who has examined or tried to examine the consumer within 10 days prior to filing the petition.

Once the court receives the petition and the physician's affidavit it will schedule a hearing within 3 days. Notice of the hearing must be given to the consumer and certain other individuals. The consumer is provided with free legal representation from mental hygiene legal services and extensive due process protections throughout the assisted outpatient treatment process.

In the hearing, the court hears testimony and takes evidence from all the parties, including a doctor who has examined the consumer. If the consumer has refused to be examined and the court believes the individual may meet the criteria for AOT, the court can order an examination and adjourn the hearing until after it is completed. If the consumer has been examined and the court finds the individual meets all the criteria for placement in AOT, it will have a treatment plan developed and order the consumer to comply with it.

The time frame for creating the treatment plan varies slightly depending on who the petitioner is. If the petitioner is a government official, the treatment plan will have been prepared by the time of the hearing. If the

petitioner is anyone else and the court believes the individual meets the criteria for AOT, the court will have the state prepare a treatment plan and conduct a second hearing to finalize it within three days. The consumer will be ordered to comply with the treatment plan once the court approves it. The service providers identified in the plan will be required to supply the services ordered in it as well as monitor the patient's condition and treatment compliance.

Consumer compliance with the court's order is monitored through case managers, ACT teams, and other treatment providers. If an individual fails to comply with his or her treatment plan, interventions are triggered which can ultimately result in the individual's rehospitalization for 72 hours for treatment and evaluation to determine if he or she meets the inpatient commitment criteria.

Initial assisted outpatient treatment orders are for up to six months and each renewal can be for up to one year.

Following is a more detailed explanation of the procedures outlined above.

What services can be included in an AOT plan?

Assisted outpatient treatment orders must always include case management services or assertive community treatment team services and may also include:

- 1) medication;
- 2) blood or urinalysis tests to determine compliance with prescribed medications;
- 3) individual or group therapy;
- 4) day or partial day programs;
- 5) educational and vocational training;
- 6) supervised living;
- 7) alcohol or substance abuse treatment;
- 8) alcohol and/or substance abuse testing for those with a history of alcohol or drug abuse and for whom such testing is necessary to prevent a deterioration of their condition (court

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Kendra's Law..continued

orders for drug/alcohol tests are subject to review every six months); and

9) any other services prescribed to treat the person's mental illness and to either assist the person in living and functioning in the community or to help prevent a relapse or deterioration that may reasonably be predicted to result in suicide or the need for hospitalization.

What are the eligibility criteria for AOT?

A patient may only be placed in AOT if, after a hearing, the court finds all the following have been met. The consumer must:

- 1) be eighteen years of age or older; and
- 2) suffer from a mental illness; and
- 3) be unlikely to survive safely in the community without supervision, based on a clinical determination; and
- 4) have a history of non-compliance with treatment that has:
 - i. been a significant factor in his or her being in a hospital, prison or jail at least twice within the last thirty-

six months or; ii. resulted in one or more acts, attempts or threats of serious violent behavior toward self or others within the last forty-eight months; and 5) be unlikely to voluntarily participate in treatment; and

6) be, in view of his or her treatment history and current behavior, in need of AOT in order to prevent a relapse or deterioration which would be likely to result in: i. a substantial risk of physical harm to the consumer as manifested by threats of or attempts at suicide or serious bodily harm or conduct demonstrating that the consumer is dangerous to himself or herself, or ii. a substantial risk of physical harm to other persons as manifested by homicidal or other violent behavior by which others are placed in reasonable fear of serious physical harm; and

7) be likely to benefit from AOT; and 8) if the consumer has a health care proxy, any directions in it will be taken into account by the court in determining the written treatment plan. However, nothing precludes a

person with a health care proxy from being eligible for AOT.

Any time spent in a hospital or jail immediately prior to the filing of the petition does not count towards either the 36 or 48 months time limits in criterion No. 4, above. In other words, if an individual spent the two months prior to the filing in a hospital, the court can then look back 38 months (36+2=38) to see if he or she meets criterion No. 4(i). ▲

Look for Part II of Kendra's Law in our next Synapse issue.

Addendum

We regret our omission of Nancy Bushinsky, MSW, who co-authored the article on AIDS in our last issue. Nancy is a therapist in the Aids Related Community Service Program.

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