AAPA On-line: www.psychiatricadministrators.org

Arthur Lazarus, M.D., M.B.A.

Dear Colleagues:

As we head toward the APA meeting in Washington, DC and close in on the first of my two years as your President, I am delighted by what we have accomplished, yet sobered by the thought of the ongoing challenges ahead.

The 2-day AAPA-run course "Basic Concepts in Administrative Psychiatry" was once again accepted by APA and will be given May 6 and 7. Dr. Barry Herman and I will co-chair the course, which has been substantially revised since last year. We have added faculty to teach the basics of marketing, information technology, and performance management, in addition to retaining faculty to teach essential aspects of finance, human resource administration, and other topics. We have also attempted to make the course more relevant to psychiatrist administrators by presenting material in a "case" format and de-emphasizing a traditional didactic approach. In order to cover new ground, we needed to pare down or eliminate some topics taught in the past, which meant streamlining the faculty. My heartfelt thanks go to all AAPA members, past and present, who have been associated with the course.

As always, the AAPA annual educational luncheon and business meeting will take place during the APA meeting. Please note that this year the day of the luncheon has been changed from the customary Tuesday to Monday, May 5, at the Hotel Palomar, from 12 noon to 2 p.m. This scheduling change was necessary to avoid a conflict with Part 1 of the AAPA course in administrative psychiatry, which occurs all day Tuesday.

I am pleased to announce that the guest speaker at our luncheon will be Dr. Geetha Jayaram, associate professor and physician advisor, The Johns Hopkins Hospital and Department of Psychiatry, Baltimore, Maryland. The title of her talk is: "The Physician Advisor's Role in Contemporary Psychiatry and Quality of Care." Dr. Jayaram was formerly chair of the APA Scientific Committee. She has spoken at many national and international meetings and has lectured throughout the country. She is involved in patient care, teaching and research. Dr. Jayaram's administrative focus is to improve the quality of health care for patients, including minimizing adverse events and reducing medication errors.

The APA Committee on Psychiatric Administration and Management will conduct a workshop geared toward early- and mid-career psychiatrists. The title of the workshop is: "From Bedside to Balance Sheet: The Many Facets of Administrative Psychiatry." I would like to encourage seasoned administrators to attend this workshop and share their experiences with younger colleagues. The workshop is scheduled May 5, 9-10:30 a.m., at the convention center, level 1, room 147A.

Looking beyond the APA meeting, our most pressing concern continues to be our financial situation. We must try and put AAPA on a stronger footing, and I believe this task will predominate the agenda of AAPA leaders for the foreseeable future. Toward that end, I am happy to report that in fiscal year 2007 we received grant income from Wyeth Pharmaceuticals as well as income from a mature certificate of deposit from the disbanded Georgia chapter of AAPA. In order to qualify for additional funding specifically in the form of a charitable grant, it has become necessary to change the IRS tax status of AAPA from a 501(c)(6) organization to a 501(c)(3) organization.

Although I have taken on many "survival" initiatives by myself, with the much-appreciated assistance of our executive team and director, I cannot underscore how important it is for all AAPA members to "spread the good word" about our group. Clearly, increasing the membership is the most viable strategy to ensure the future of AAPA. However, we are challenged in this endeavor, as are most of the APA allied organizations, and we receive no financial support directly from APA. In addition, the APA Office of Education may move to eliminate the certifying examination in administrative psychiatry.

So please keep the future of AAPA top-of-mind, and remember to wear your lapel pin at the APA meeting, the one that says, "Ask Me About AAPA" (contact Frances Bell, our Executive Director, if you don't have one).

In closing, I am reminded of the hard work and dedication required to run an organization–any organization. Last summer, during a fishing trip with my children, I was disappointed at our catch after four hours of fishing in the back bays of southern New Jersey. I was hoping to come away with a few prized flounder for dinner, but all I caught was a crab and a sand shark. "Scavengers and bottom-feeders," I mumbled. My kids overheard me and burst out laughing!

Looking back, I think my comment had more to do with the way some people behave in organizations than it did with the behavior of denizens of the deep. Slackers and opportunists in the workforce cannot sustain an organization into the future. The leadership potential of each and every one of us must surface to make AAPA a continued success. I know I can count on your support, and I thank your for your help.

From Bedside to Balance Sheet: The Many Facets of Administrative Psychiatry
Monday, May 5 – 9:00 a.m. - 10:30 a.m.
Room 147A – Level 1, Convention Center
APA Committee on Psychiatric Administration and Management

The Progress of an Democratic Organization for Young Psychiatrists and Trainees: The WAYPT
Forum
Monday, May 5 – 12:00 noon -1:30 p.m.
Room 102A/B, Level One, Washington Convention Center

Addiction and Sex: "Spun" Out of Control
Tuesday, May 6 – 9:00 a.m. - 12 noon
Room 140B – Level 1 Convention Center
Chair, Petro Levounis, M.D. and Co-Chair. Jose Vito, M.D.

Basic Concepts in Administrative Psychiatry CME Course
Tuesday, May 6 and Wednesday, May 7 – 9:00 a.m. - 4:00 p.m.
Renaissance Washington 2 – Meeting Room Level
Chair, Arthur Lazarus, M.D., MBA and Co-Chair, Barry Herman, M.D.

Leadership in Psychiatry
Workshop
Wednesday, May 7 – 9:00 a.m. - 10:30 a.m.
Room 147B – Level 1, Convention Center

MEDICAL DIRECTORS, INSURERS, AND MURDER: LESSONS FROM THE CASE OF NATALINE SARKISYAN

James E. Sabin, M.D.

The heartbreaking story of Nataline Sarkisyan's death and her family's conflict with CIGNA was front page news in December 2007. In this article I first summarize the story as it exploded into the media, and then discuss potential lessons the situation offers to psychiatrist administrators.

The case:[1] In 2004, 14 year old Nataline Sarkisyan, from Glendale, California, was first diagnosed with leukemia. After a period of remission the illness recurred, and on November 27, 2007 she received a bone marrow transplant from her older brother. After the procedure she developed acute liver failure and went into a coma. On December 6 her doctors at UCLA referred her for an emergency liver transplant, and a compatible donor was identified. CIGNA, Nataline's family's health insurer (on an ASO/administrative services only basis for one of Nataline's parent's employer), denied coverage, with the rationale that her benefit plan "does not cover experimental, investigational and unproven services." On December 11, four doctors from UCLA, including the director of the pediatric liver transplant program, appealed. They argued that the procedure was not "experimental" and had a 65% chance of providing 6 months of survival. UCLA told the family that the only alternative to insurance coverage would be to make a $75,000 down payment for the operation. The family could not afford this.

The family hired attorney Mark Geragos, a prominent Los Angeles lawyer, whose clients have included former Congressman Gary Condit, actress Winona Ryder, and singer Michael Jackson. On December 20, CIGNA agreed to pay for the procedure, but that same day Nataline's condition deteriorated. Life support was removed, and she died with her family by the bedside at 5:50 PM.

Given Nataline's youth, her parents' powerful statements about their love for her, their belief that a liver transplant would save her, and their lawyer's aggressive advocacy, her story touched the national heart. A widely read Daily Kos blog entry was headlined "Murder by Spreadsheet: CIGNA Denies Claim and 17-Year-Old Will Die."[2] On the morning of December 20, before Nataline died, the California Nurses Association organized a widely publicized protest march to CIGNA headquarters.[3] After Nataline's death, just before the New Hampshire primary, Nataline's parents and brother spoke at a campaign rally with John Edwards.[4] Attorney Geragos asserted that CIGNA "maliciously killed her" and threatened to bring murder or manslaughter charges.[5] (To get a fuller sense of the wave of anger at CIGNA, do a Google search under "Nataline Sarkisyan.")

Potential lessons for psychiatrist administrators. In its clinical aspects, Nataline Sarkisyan's situation is far from psychiatry. But the basic elements – treatment recommendations from UCLA, passionate family advocacy, insurer assessment of "medical necessity," and an intense public spotlight – will be familiar to most AAPA members. I have distilled four potential lessons for psychiatrist administrators from the case. I am sure others will identify more.

1. Don't hide behind insurance jargon. I have not seen the letters sent by CIGNA to the Sarkisyan family or to UCLA, but most media reports suggest that the transplant was referred to as "experimental." This is a typical term of insurance jargon, used for interventions that are seen as unproven and lacking evidence for effectiveness. A December 31 press release from Jeffrey Kang, M.D., M.P.H., Chief Medical Officer at CIGNA explains the term clearly: "The clinical determination…based on the best medical evidence and guidelines established by the medical community…concluded that this procedure would be unproven and ineffective in this situation and

therefore experimental and not covered under the patient's benefit plan."[6] (emphasis added)

Those of us who work in managed care settings cannot expect the public to understand our jargon. The first liver transplant was done in 1963. It has been a standard treatment since the 1980s. Liver transplantation is not experimental. CIGNA concluded, quite reasonably I believe (as discussed below), that liver transplantation for a person with recurrent leukemia who had undergone bone marrow transplantation, who, if she survived the surgery, would require lifelong immunosuppression, could not reasonably be expected to be effective. But that doesn't make liver transplantation "experimental," except in the jargon meaning of the term.

When administrators use jargon terms like "experimental," "medical necessity," and even "cosmetic," patients, families, clinicians, and the public, can easily conclude that we are simply covering up a purely cost-driven decision. In psychiatry, controversy is more often about whether a treatment is "medically necessary" than "experimental." Saying "the treatment is not medically necessary" has the grammatical form of a statement of fact. In truth, however, it is a judgment, about level of evidence, likelihood of success, or cost-worthiness, not a statement of fact.[7] I know from experience that it is more comfortable to say "X is not medically necessary," than "I do not believe that there is enough evidence for X to justify your insurance paying for it," or "I believe that Y is just as effective as X but less costly, so it is not reasonable to expect the insurance fund to pay for X rather than Y."

I am not suggesting these as actual scripts to use with patients and families. We need to learn to explain our decisions to patients and families in ways that help them understand the rationales behind these decisions. If we put the cards on the table, patients may disagree, but they are less likely to regard us as liars and murderers!

2. Use independent external review wisely. Administrators who make determinations of "medical necessity" are making judgments about clinical practice. It is one thing to conclude that additional psychotherapy will not be covered because a patient's insurance benefit plan covers only 20 sessions. This amount of treatment may be insufficient and regrettable, but it is part of an explicit contract. It is entirely different to conclude that further psychotherapy is not "medically necessary." That's a clinical assessment, not a matter of contract.

How should this kind of clinical disagreement between providers/patients and payers be handled?

Patients and the public cannot and should not be expected to trust an insurance company's determination of its own financial liability. Since 1991, when William McGivney at Aetna first turned to outside experts for independent recommendations about controversial, high impact decisions, independent external review has become a standard practice.[8] Independent review is recognized in Section 5, Annotation 3, of the AAPA Ethical Principles for Psychiatric Administrators: "In order to avoid conflicts of interest, which may compromise patient care, the psychiatric administrator should make available consultants, clinicians, or reviewers outside of the system to provide objective opinions, care, appeal, or review."[9]

CIGNA appears to have applied the independent review process well. One of the two outside reviewers was an oncologist specializing in hematologic malignancies including leukemia and bone marrow transplantation, and the other was a surgeon on a transplant team that performs almost 100 liver transplants per year.[6] We should not be surprised, however, that independent review did not assuage the intense public reaction in December. Photographs of a beautiful 17 year old on the verge of death outweigh reference to two anonymous experts. But apart from the public relations challenge in negative coverage determinations, psychiatric administrators should see independent external review as a practice that promotes fair resource allocation, not as divine revelation. Psychiatrist medical directors should assess the reviewer's reasoning, especially for negative (non-coverage) reviews. In consulting to insurance com-

pany appeals committees I have, at times, advised not accepting independent recommendations against coverage – even if I agreed with the conclusion – when these were poorly argued and could not be expected to persuade skeptical but fair-minded critics. And, hospital administrators should be prepared to ask to see the content of independent reviews, which will allow them to argue for their own perspectives on the clinical issue.

3. Don't confuse caution or compassion with insurance coverage. There were two good – but very different – reasons for CIGNA to pay for Nataline Sarkisyan's treatment at UCLA. First, given a 17 year old in a "last chance" situation and specialists at a respected institution pleading for coverage, a public relations disaster was inevitable. (In the 1990s the general counsel for a prominent insurer told me "I don't care what the evidence is about bone marrow transplant for breast cancer – I am not going to court to argue against coverage for a 30 year old mother of three!" That treatment, widely covered at the time, was subsequently found to be ineffective.[10]) Second, compassion could reasonably lead to a decision to pay for a transplant having close to no likelihood for successful outcome, in accord with what is often called the "rule of rescue."

CIGNA presented its decision to pay as motivated by compassion. The medical director put it this way: "Given our empathy for this family, and the unique circumstances of this situation, CIGNA volunteered, entirely independent of any plan or coverage decision and outside of the medical review process, to pay out of our pocket, not the employer's pocket, for a transplant should Ms. Sarkisyan's doctors decide to proceed."[6] I believe this was the right decision, but it would have been more effective if it (a) had been done before the explosion of protests and (b) was more clearly defined as an act of charity, as by saying something like "although independent experts have concluded that there is no evidence to suggest that transplant will be effective, if UCLA chooses to try the transplant we will make a gift to the UCLA transplant research fund to support UCLA's efforts to devise a new treatment."

Limits on health care are disappointing, but they must be set. It is heartbreaking for a 17 year old to die before having a chance to live a full life. But if a proposed treatment does not have an evidence base, collective insurance funds should not pay for it. Setting such a limit would be consistent with the AAPA Ethical Principles for Psychiatric Administrators annotation to the Preamble: "the psychiatric administrator will need to pay more attention to the needs of society…than would the typical psychiatric clinician." Individuals should be free to purchase care that is not covered by insurance. When they cannot do so, others are free to purchase the care for them as an act of charity. If CIGNA had defined its readiness to pay as a charitable donation to support research it would have contributed to a societal learning curve about setting limits fairly. While psychiatric administrators will rarely be dealing with end of life issues as occurred with Nataline Sarkisyan, they still have an important role to play in societal learning about setting limits on health care in a fair and ethically justifiable manner.

4. Help others understand the emotional aspects of administration. The fact that so many otherwise rational people construed CIGNA's decision not to cover a treatment that had been subjected to a fair limit setting process as an act of murder shows how powerful the emotional aspects of administration are.[*] Psychiatrist administrators can be helpful by interpreting these emotional forces and helping ourselves and our colleagues understand and manage them.

The interaction between UCLA and CIGNA is a classical situation of splitting. The transplant team made its treatment recommendation knowing that CIGNA was responsible for judging "medical necessity." The U.S. "system" typically asks providers to think only of the individual patient and asks insur-

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[*] As of the end of March, CIGNA was not aware of any litigation associated with the case.

ers to take responsibility for the commons – for allocating the resources made available for the insured population. This division of responsibility invites the public to see one party as "carers" and the other as "bean counters." Psychiatric administrators are in the middle of this split. At hospitals and provider groups, administrators are responsible for managing interaction with payers and for structuring the advocacy process. At insurers, psychiatric administrators are responsible for utilization management and appeals.

Over the years I have had the opportunity to observe and study hospital-based advocacy systems, insurer-based utilization-management systems, and independent external appeals. At its best, splitting clinical and financial responsibility leads to what Saul Feldman, former editor of Administration and Policy in Mental Health called "constructive tension." Ethical health systems must consider the numerator (the needs of individual patients) and the denominator (the needs of the total population). When constructive tension prevails, we are able to deliberate about the evidence-base for the treatment proposal, alternative treatment approaches, the needs of the total population, and wise use of the available resources. At its worst, splitting leads to destructive name calling, disinformation, and, at the extreme, threats of murder charges and accusations of Nazism. Psychiatric administrators can play a crucial role in determining whether the split between purchaser and provider unfolds as constructive tension or destructive mayhem.

Conclusion. After Senator John Edwards made CIGNA's decision about Nataline Sarkisyan the focus of a campaign event in New Hampshire on January 6, Dr. Jeffrey Kang, the CIGNA chief medical officer said "I'm perplexed that this has become a campaign issue…It is highly unlikely that any healthcare insurance system, nationally or internationally, would have covered this procedure."[11]

If Dr. Kang had consulted with an experienced psychiatric administrator when the case first surfaced, he would not have been perplexed by what happened, and would have been better positioned to anticipate and fend off the eruption. If CIGNA chose to go with the non-coverage decision, he could have marshaled CIGNA's public affairs specialists in crafting a series of messages that explained to all parties – not via insurance jargon – what CIGNA was doing and why it was doing it. At the same time, CIGNA could have proactively prepared its staff for the public backlash that was likely to ensue, and which, it was reported, troubled employees greatly. If CIGNA chose to make a charitable donation to UCLA to allow the "experimental" treatment to go ahead, which is the course of action I would have advised, it could have done so promptly, before issuing a denial and experiencing an explosive backlash, and could have used the opportunity to do some teaching of the public about fair resource allocation and the difference between insurance coverage and charity.

Perhaps the key lesson psychiatrist administrators can take from the Nataline Sarkisyan situation is heightened understanding of just how much they have to contribute to overall health system function, not just in their direct administrative responsibilities, but also as interpreters and managers of processes like splitting and other organizational dynamics!

Dr. Sabin is the Director of the Ethics Program at Harvard Pilgrim Health Care and a clinical professor in the departments of psychiatry and ambulatory care/prevention at Harvard Medical School

1. The case narrative was constructed from so many sources on the web that I have cited only a limited number.

2. Daily Kos, December 20, 2007. http://www.dailykos.com/story/2007/12/20/92943/929/400/424700 Accessed on March 26, 2008.

3. California Nurses Association. *Life Denied.* http://www.calnurse.org/media-center-press-releases/2007/december/life-denied-nurses-family-of-sick-teen-march-on-health-insurance-company-thursday-17-year-old-girl-needs-liver-transplant-

CIGNA-denies.html Accessed March 26, 2008.

4. See YouTube for Nataline's father http://www.youtube.com/watch?v=yMT_6QiaFdk&feature=relat-ed, mother and brother http://www.youtube.com/watch?v=z3umpzLHCfs&feature=related. Accessed March 26, 2008.

5. ABC News. *Health Insurer to be Charged with Teen's Murder.* http://abcnews.go.com/GMA/CancerPreventionAndTreatment/story?id=4038257 Accessed March 26, 2008

6. Kang, Jeffrey. Statement on December 31. http://newsroom.cigna.com/article_download.cfm?article_id=840 Accessed March 26, 2008.

7. Sabin, James E., Daniels, Norman. Determining Medical Necessity in Mental Health Practice. *Hastings Center Report* 24(6): 5-13, 1994.

8. Daniels, Norman and Sabin, James E. *Setting Limits Fairly: Learning to Share Resources for Health.* (second edition) New York: Oxford University Press, 2008. Pages 73-76.

9. American Association of Psychiatric Administrators. *Ethical Principles for Psychiatric Administrators.* http://www.psychiatricadministrators.org Accessed March 26, 2008.

10. Rettig, Richard A., Jacobsen, Peter D., Farquhar, Cynthia M., and Aubry, Wade M. *False Hope: Bone Marrow Transplantation for Breast Cancer.* New York: Oxford University Press, 2007.

11. Wang, Shirley S. *Edwards Invokes Teenager's Death in Campaign.* http://blogs.wsj.com/health/category/transplants/ Accessed March 30, 3008.

So You Want to be a Clinical Investigator!
Issue Workshop #98
Thursday, May 8 – 9:00 a.m. - 10:30 a.m.
Room 207A – Level 2, Convention Center
Chair, Arthur Lazarus, M.D., MBA

Quality and Outcome Assessment in Diverse Clinical Settings
Symposium
Thursday, May 8 – 2:00 p.m. - 5:00 p.m.
Room 144C – Level 1

The Meaning of Life "In Medicine"
WebMD Medscape's Webcast
Presented by Steve Moffic, M.D.
For information on this, contact Doctor Moffic (smoffic@mcw.edu)

CHILD AND ADOLESCENT SYSTEMS OF CARE: KEYS TO TRANSFORMATION

Kaye L. McGinty, M.D.

Abstract

Child mental health services in the United States began early in the twentieth century and over time there have been many challenges in serving children and youth with psychiatric disorders. Since the 1990s, the Child and Adolescent Service System Program has promoted the development of local systems of care for children and families in order to serve this population. Two recent reports that are influencing the further development of child and adolescent systems of care include the Institute of Medicine initiatives and the New Freedom Commission on Mental Health. These developments point to the need for a transformation of the mental health service delivery system. Five vital components needed for the transformation of child and adolescent mental health services and systems of care are discussed including family-driven, youth guided care; cultural competence; evidence-based practice; interdisciplinary collaboration; and inclusion of child and adolescent psychiatrists in systems of care.

Introduction

The earliest child mental health services in the United States were aimed at the population of homeless youth at the beginning of the twentieth century. The child guidance movement grew out of these earlier efforts and focused on serving the entire population. During this era a new focus on the importance of the child's development, the role of the family, and the effects of societal forces on the child and family led to improvements in the field. Then, the Federal Community Mental Health Center program (1960s) led to the development of local mental health centers to serve various populations including adults with severe and persistent mental health problems. Despite clear intentions to provide preventive services, children and families were not the focus of care. Various attempts were made to include services for children (e.g., Part F amendments, Mental Health Systems Act) with variable success due to lack of funding.[1, 2]

Jane Knitzer's study, *Unclaimed Children*[3] provided an understanding of the state of child mental health in the previous two decades. The study described a survey of child-serving agencies and a review of the most promising programs. A variety of agencies (e.g., child welfare, education, health, juvenile justice, mental health, sub-stance abuse) had responsibility for children with emotional, mental, or behavioral disorders. These agencies did not have the resources or organization to serve the children adequately and this resulted in the children being passed back and forth among agencies. Of the three million children with the most severe disturbances, only a third of the children were receiving services and most of those were inappropriate.

In an effort to improve the system, the National Institute of Mental Health (NIMH) developed the Child and Adolescent Service System Program (CASSP). This program gave small planning grants to state mental health agencies to organize joint programming among agencies at the state and local level. This framework has arisen out of recognition that: access to services has been limited; services available have not been well-coordinated, have been excessively restrictive, and often involved seeing families as part of the problem rather than as part of the solution; and cultural differences in populations served have received insufficient consideration. The goals of CASSP included developing interagency systems of care, enhancing the role of child mental health agencies, enhancing the role of the family, and promoting cultural competence.[2]

Recent developments with implications for child and adolescent systems of care include the Institute of Medicine's (IOM) initiatives regarding the health care system and the recommendations of the President's New Freedom Commission on Mental Health. The health care system is now facing many of the same issues seen in mental health. The IOM made an urgent call for change in *Crossing the Quality Chasm: A New Health System for the 21st Century*.[4] This report suggests changes to close the quality gap, recommends a redesign of the American health care system, and provides overarching principles for specific direction for policymakers, health care leaders, clinicians, regulators, purchasers, and others. The new "rules" suggested for a 21st Century Health Care System include the following: care is based on continuous healing relationships; care is customized according to the patient's needs and values; the patient is the source of control; knowledge is shared and information flows freely; decision making is evidence-based; needs are anticipated; transparency

is necessary; cooperation among clinicians is a priority; waste is continuously decreased; and safety is a system property.

Meanwhile in February 2001, President George W. Bush announced his New Freedom Initiative to promote increased access to educational and employment opportunities for people with disabilities. The Initiative also promoted increased access to assistive and universally designed technologies and full access to community life. This presented an important opportunity for those with psychiatric disabilities. The President launched the Commission to address problems with service delivery in the current mental health system. The Commission concluded that the mental health system is not oriented to the single most important goal of the people it serves – the hope of recovery. To improve access to quality care and services, the Commission recommended fundamentally transforming how mental health care is delivered.[5]

Transformation of the mental health service delivery system rests on two principles: First, services and treatments must be consumer and family centered. Secondly, these services must focus on increasing consumers' ability to successfully cope with life's challenges, on facilitating recovery, and on building resilience, not just on managing symptoms. The Commission identified six goals as the foundation for transforming mental health care. The goals include helping all Americans understand that mental health is essential to overall health; providing care that is consumer and family driven; eliminating disparities; providing early screening, assessment and referral to services; providing excellent mental health care delivery and accelerated research; and using technology to access mental health care and information. These goals are intertwined and each one is important to achieve the restructuring that is needed.[5]

The transformation of child and adolescent mental health services is dependent on further development of child and adolescent systems of care. In order to support this progression five vital components should be emphasized and will be discussed.

Family-Driven, Youth-Guided Care

Family-driven, youth-guided care is a core concept in systems of care and is an essential framework for all the child serving systems. Family-driven care means families have a primary decision-making role in the care of their own children as well as the policies and procedures governing care for all children in their community, state, tribe, territory and nation.[6] This includes: choosing supports, services, and providers; setting goals; designing and implementing programs; monitoring outcomes; part-

nering in funding decisions; and determining the effectiveness of all efforts to promote the mental health and well-being of children and youth.

An important component of family-driven care is providing strengths-based care where strengths, as well as problems, are identified and used during the evaluation and treatment planning process. Services and supports must be individualized, built on strengths to meet the needs of the youth and family across all life domains in order to promote success, safety, and permanency in the home, school and community.[7] In this process mental health professionals provide youth-guided care by supporting the youth to have a voice and choice within the treatment process. Care must focus on increasing the youth's ability to successfully cope with life's challenges, on facilitating recovery, and on building resilience. Furthermore, the integration of natural supports with professional services is a key element in helping youth and families achieve self sufficiency.

Practicing family-driven care is vital as a mental health professional and for the child-serving systems to work well they need to include the many stakeholders that are concerned with youth and families. A stakeholder is a person or a group with a direct interest, involvement, or investment in an issue. There are many stakeholders concerned with youth and families including the family and friends, local community, as well as state and national community.

Cultural Competence

The concept of cultural competence is important for all mental health professionals both as clinicians and advocates for their patients and families. Culture is a source of strength and can be promoted in clinical care. Cross and colleagues[8] defined qualities that culturally competent practitioners and agencies must embody and achieve. Individual practitioners should be aware and accepting of cultural differences, be aware of their own culture and biases it may create, understand the dynamics of working across cultures, acquire cultural knowledge, and acquire and adapt practice skills to fit the cultural context of the client. There is also a need for agencies and institutions to evaluate their policies and procedures to incorporate culturally competent practice.[9]

Evidence-Based Practice

The provision of effective evaluation and treatment services for children and families is one of the goals of every mental health professional. Tools have been developed by professional organizations, clinicians, policymakers,

and investigators to promote appropriate and high-quality care while also emphasizing accountability.[10,11]

Burns[10] suggests the following six different approaches to deriving and implementing quality:

1. Best practices: set out fairly general statements about clinical practice.
2. Practice guidelines: diagnosis-specific interventions are evidence-based and may be consensus-based too.
3. Clinical protocols/manuals: designed to assure adherence to highly specific types of treatment.
4. Quality monitoring: used to monitor clinical practice, consists of general indicators to assess treatment or termination by level of care.
5. Fidelity/adherence measures: assess the extent to which a given intervention is provided as intended.
6. Regulations: specified for licensure, accreditation, or reimbursement by regulatory agencies.

Interdisciplinary Collaboration in Child Serving Systems

There are many different systems that serve children and families. The ability of these systems to work together collaboratively is crucial in helping children and their families. There are eight child serving systems including primary health care, education, mental health, child welfare, juvenile justice, developmental disabilities, early childhood and substance abuse services. Most children in the U.S. are being served by a primary care physician for developmental screening and health needs. A free and accessible public education is mandated in the U.S. and youth are required to be pursuing their education. So, most children in the United States are involved with the primary health care and educational systems. The other systems are involved with youth as they have specific needs related to the mandates of these agencies.

Children and families with more substantial mental health difficulties have more challenges. These children and their families often have an increased need for child serving agencies to provide specialized services and supports. Successful practice with these families is dependent on effective interdisciplinary collaboration. This collaborative effort frequently involves an interdisciplinary team that will usually be led by the care managers who help all parties contribute to the process. All participants lend their expertise to the team, while advocating for the youth and family. Each and every member of the team is a leader and helps move the process along. The ultimate goal is to help the youth and family become the leaders of their team. The child and adolescent psychiatrist's broad knowledge base and biopsychosocial orientation helps provide an important resource for the team. Indeed, the broad expertise of the child and adolescent psychiatrist is essential to the team when there are challenges with or barriers to care.

In child outpatient clinics, residential and inpatient programs there has been a tradition of service models that enable the collaborative work of psychiatrists, psychologists, nurses, social workers, and occupational and recreational therapists, along with other specialists. The evolving standard of care requires collaboration between professional and paraprofessional personnel with a mandate for comprehensive interagency cooperation.[12] Multidisciplinary mental health treatment services are increasingly collocated within other service system programs, such as schools or juvenile detention facilities, and other community settings. The child and adolescent psychiatrist is a vital member of all of these teams and can lend an important voice on multiple levels.

Inclusion of Child and Adolescent Psychiatrists in Systems of Care

Child and adolescent psychiatrists are physicians that have completed residency training in adult and child/adolescent psychiatry. This training takes at least five years after completion of medical school. During their training in child and adolescent psychiatry the resident physician learns a broad body of knowledge to assist them in evaluating, diagnosing and treating mental illness in children and youth from a developmental perspective. Part of this knowledge base relates to working with families and child-serving systems. With this combined knowledge the child and adolescent psychiatrist is in a unique position to adequately evaluate, diagnose, treat and advocate for their patients and families, as well as be in a position to promote coordination and cooperation among involved systems.

The child and adolescent psychiatrist (CAP) can have a variety of roles while working with a youth and family, as well as when working with systems:

1. CAP as treating psychiatrist
2. CAP as a member of a team (i.e., child and family team)
3. CAP as a consultant to a system
4. CAP as an advocate for child and family
5. CAP as a collaborator between systems
6. CAP as an advocate for the system
7. CAP as a catalyst for system improvement
8. CAP as an administrator in a system

Although there are many possible roles for CAPs in systems of care it is unclear if this resource is being effectively integrated and utilized. Etemad and Taccheri[13] describe the barriers to effective participation by CAPs in systems of care. These include the CAP role definition (i.e., defined as one who does limited psychiatric evaluations and medication management); flexibility of CAP function; flexibility in the development/delivery of treatments; and CAP training that addresses their roles and function in practice. Despite these issues the child and adolescent psychiatrist has much to offer systems and grows professionally through their interaction with systems[9]. In order to help transform child mental health services and systems of care we need to encourage the participation of all parties, including child and adolescent psychiatrists, in systems of care.

Conclusions:

Child and adolescent mental health services and systems of care need to be transformed in order to meet the needs of the children, youth and families that are served. To continue this process we need to stress the importance of five vital components including family-driven, youth-guided care; cultural competence; evidence-based practice; interdisciplinary collaboration; and inclusion of child and adolescent psychiatrists in systems of care. Attention and dedication to promoting these components will hopefully lead to improvements in delivery of mental health care and ultimately promote recovery and resilience in children and youth with psychiatric disorders.

Dr. McGinty is an associate professor and Director of Residency Training for Child and Adolescent Program in the Department of Psychiatric Medicine at East Carolina University Brody School of Medicine

References

1.) England, MJ, and RF Cole. Preparing for communities of care for child and family mental health for the twenty-first century. *Child Adolesc Psychiatr Clin N Am.* 1998; 7:469-481.

2.) Lourie I. A history of community child mental health. In: Pumariega A, Winters N, eds. *The Handbook of Child and Adolescent Systems of Care: The New Community Psychiatry.* San Francisco: Jossey-Bass; 2003:1-16.

3.) Knitzer, J. *Unclaimed Children.* Children's Defense Fund; Washington, DC: 1982.

4.) Institute of Medicine. Formulating new rules to redesign and improve care. In: *Crossing the Quality Chasm: A New Health System for the 21st Century.* Washington, DC: National Academy Press; 2001: 61-89.

5.) New Freedom Commission on Mental Health. Achieving the Promise: *Transforming Mental Health Care in America.* Final Report. US Dept of Health and Human Services; Publication SMA-03-3832. Rockville, MD: 2003.

6.) Osher, TA, Blau, GM, and DM Osher. Shifting Gears: The Ambassador's Guide to Family Driven Care. Compact disc produced by the Federation of Families for Children's Mental Health, Rockville, MD: 2006.

7.) Shelton, T. The implications of system of care for psychologists. In: Arbuckle M, Herrick C, eds. *Child and Adolescent Mental Health: Interdisciplinary Systems of Care.* Jones and Bartlett; Sudbury, MA; 2006: 105-128.

8.) Cross, TL, Bazron, BJ, Dennis, KW, and MR Isaacs. *Towards a Culturally Competent System of Care.* Child and Adolescent Service System Program Technical Assistance Center, Georgetown University Child Development Center, Washington, DC: 1989.

9.) American Academy of Child and Adolescent Psychiatry. Practice parameter on child and adolescent mental health care in community systems of care. *J Am Acad Child Adolesc Psychiatry.* 2007: 46:2: 284-299.

10.) Burns B. Reasons for hope for children and families: a perspective and overview. In: Burns B, Hoagwood K, eds. *Community Treatment for Youth: Evidence-Based Interventions for Severe Emotional and Behavioral Disorders.* New York, NY: Oxford University Press; 2002: 3-15.

11.) Drake, RE, Latimer, EA, Leff, HS, McHugo, GJ, and BJ Burns. What is evidence? *Child Adolesc Psychiatric Clin N Am.* 2004: 13: 717-728.

12.) Chenven, M, and B Brady. Collaboration across disciplines and among agencies within systems of care. In: Pumariega A, Winters N, eds. *The Handbook of Child and Adolescent Systems of Care: The New Community Psychiatry.* San Francisco: Jossey-Bass; 2003: 66-81.

13.) Etemad, J and S Taccheri. The development and application of the system of care approach from the perspective of child and adolescent psychiatry. In: Arbuckle M, Herrick C, eds. *Child and Adolscent Mental Health: Interdisciplinary Systems of Care.* Jones and Bartlett; Sudbury, MA; 2006: 159-183.

THE SCIENTIST AND PUBLIC ADVOCACY

Daniel J. Luchins, MD

Public advocacy by a scientist is usually possible only when one has achieved public fame (winning the Nobel Prize, identifying the AIDs virus) or because one's subject of interest has already claimed the public's attention (the Atomic physicist after Hiroshima, these days scientists studying global weather trends). As someone who has been in neither situation, I can only speak for all us others. How can we become advocates?

If you are young and ambitious, there is the hope that through hard work either you or your discipline can achieve public recognition and then you can be an advocate. But this is reminiscent of the young radical who joins Wall Street to further the Revolution. Ten years later Wall Street will not have changed so if she succeeds it will be because she changed, in which case she will probably have lost interest in supporting the revolution.

Science is unlikely to change. It will continue to portray itself as objective, insisting that it only deals with what is, not what ought to be. Success in science means advancing the field, practical applications are secondary and advocacy is generally restricted to advocating for more funding for yourself and/or your discipline. You succeed by doing what is fundable, not that for which you want to advocate.

An alternative is to leave academia and go where decisions are made, government. But there you will find that decisions are generally not made on the basis of the strongest scientific evidence but due to political exigencies and in response to the most recent crisis. Furthermore the analytic and critical skills that may have served you well during your formal education, may be far less appreciated in an environment were you need to go along to get along.

What to do? One option is to join a think tank, advocacy group or NGO that shares your values and which can make use of your scholarship. Since never offered this option, I have had to create another alternative, trying to be in academia and government simultaneously. From 1995 through 2005, I was the clinical director of Illinois' Mental Health Authority, which ran 10 hospitals, funded 200 CMHC and had a .5 billion dollar budget. On the basis of my experiences there I want to address the issue of how a scientist can be an advocate.

As I have just mentioned governments do not usually make decisions based on controlled studies and that p<05 has statistical but no political significance. People in government however are exquisitely sensitive to publicity; they are risk aversive and always want to make sure their behind is well covered. In 1995 the MHA was being sued by the ACLU for violating patients' constitutional rights by providing substandard care. There was the prospect that this would cost the State millions of dollars, but even more importantly it was a source of both local and even national publicity, bad publicity. I was brought in to be Clinical Director, as an academic fig leaf to provide respectability. I retained my tenured position at the University, and had the State pick up through a contract my salary and that of my research group. We established a Clinical Evaluation Unit that had access to a tremendous amount of clinical and administrative data routinely collected by the MHA.

I would like to describe an example of how I used our Evaluation Unit to advocate for better care.

About 85% of seriously mentally ill persons are unemployed. Illinois through its Division of Rehabilitation Services runs many vocational programs in which clients are given job counseling, job training or made 'job ready.' Although these might be helpful for some people they just don't work for people with serious mental illness. What has been shown to work and leads to employment in over 50% of cases is 'supported employment' in which those who want to work are immediately placed in a job and given on going support. Unfortunately neither the MHA nor DRS ran such programs.

So we analyzed outcomes for all the clients referred by CMHCs to the DRS for vocational rehabilitation during a single year and showed only 25%

were accepted for 'training' and ultimately only 7% were actually employed six months later. Interestingly, the programs that were least restrictive in whom they accepted had the overall highest success rates. These findings were published in Administration and Policy in Mental Health[1].

Now the peculiar thing is that if I had run to the Tribune with this data, assuming they would publish it, I'd be out of a job. But by following a few simple rules I was able to publish it and put pressure on the system to change for the better.

First, don't embarrass anyone. The article was published in a scientific journal as a study in a 'large Midwestern state.' Although it was obvious that it dealt with Illinois, it never actually said so.

Secondly make the bosses look good. Since Directors of state agencies usually turn over every couple of years it was easy to study a year before the Director of RS had come into office.

Thirdly always give things a positive spin. Before publishing we had received a small training grant to roll out a supported employment program in a few CMHC. Our study therefore only showed that the previous system hadn't worked but we were already replacing it.

Finally, the study did not reveal a failure pointed out by someone else; instead it documented that Illinois' government supported critical analyses in order to improve itself. In fact, well before these findings were published it was presented by the new Director of RS at a National meeting with other State Directors.

Now, you could argue that this all wasn't public advocacy. Perhaps it wasn't. I did not hold press conferences nor lead demonstrations. Instead I used the public forum to which I have access and where I have credibility, the scientific literature.

You could also argue that this wasn't science. This work was not high tech not a national epidemiological nor a multisite treatment study. Our studies were published and are cited but far less frequently than much of my earlier, biological work measuring arginine vasopressin or the size of anterior temporal lobes in schizophrenia.

Finally, you could argue that they did not help me get what you need in government, a political base. In 2003 when the Governorship went Democratic, after 20 years of Republican control, my position and my contract were viewed with suspicion, and ultimately not continued.

So, you have to decide, what's most important, advancing in academia, advancing in government or advancing your cause. Only after you win the Nobel Prize can you have it all.

Dr. Luchins is an Associate Professor of Psychiatry at the University of Chicago. The article was presented at a Forum on Public Advocacy, Harris School of Public Policy, and University of Chicago on February 20, 2008

References:
1. Hanrahan P, Heiser W, Cooper AE, Oulvey G, Luchins DJ: Limitations of system integration in providing employment services for persons with mental illness. Adm Policy Ment Health. 2006 Mar;33(2):244-52

GLOBAL WARMING AND PSYCHIATRIST ADMINISTRATORS

H. Steven Moffic, M.D.

Given the complexity of our work as psychiatrist administrators, it is not surprising that we have varying ethical priorities and responsibilities. As our own "Ethical Principles For Psychiatrist Administrators" states in Annotation (1) to the Preamble: "*Thus, the psychiatric administrator will need to pay more attention to the needs of society and other health professionals than would the typical psychiatric clinician.*" Generally, this is interpreted to mean the needs of our organization as it serves a societal function, as well as the needs of the staff and colleagues who work there. But it can mean even more than that. This outer ring of ethical responsibility is spelled out in Section VII of the American Medical Association's ethical principles: "*A physician shall recognize a responsibility to participate in activities contributing to an improved community.*" In our own Annotation (2) to that Section, we apply it in the sense of: "*Psychiatric administrators should use their knowledge and management of healthcare systems to improve the well being of our communities.*" Al Gore, in his Nobel Prize acceptance speech for his work in addressing global warming, said something that complements this perspective: "We must abandon the conceit that individual, isolative, private actions are the answer. They can and do help. But they will not take us far enough without collective actions. . . When we unite for a moral purpose that is manifestly good and true, the spiritual energy unleashed can transform us." Reading that, I do not think it is much of an ethical stretch to see why we psychiatrist administrators should be doing something to help cool down global warming.

There are several ways we can do so. As we are often the highest – or one of the highest – medical personnel in our organization, we should use that authority and knowledge to educate others on the health and, particularly, the mental health risks of global warming. The health risks are fairly well known: increased infections, new infections, heat-related illnesses, and malnutrition are the most obvious. All of these risks depend on geographical location and time,

of course. The mental health risks are more unknown and therefore need more communication. They include research that there is increased violence associated with small, sustained increases in temperature (especially in warmer climates), anticipatory anxiety, and the PTSD and related disorders that often come after the trauma and dislocation of natural disasters. When I was in Toronto last summer, I noted that they were beefing up their health and mental health systems in anticipation of so-called "climate" refugees.

Then there is the energy use and carbon footprints of the buildings we work in and the transportation we take to get there. It is now well established that human behavior is a major cause of the climate crisis, and we are the experts in behavior and its consequences. Therefore, we should try to use this expertise to help decide how to balance temperature control and lighting with the comfort of staff and patients. There is information to help, including the Green Guide for Health Care, www.gghc.org/. Small, comfortable behavioral steps, like recycling, can have big impact.

Perhaps, though, our biggest impact could be in the behavior we model about global warming. It is now known that the observable signs about how physicians take care of their own health influences the behavior of their patients. For instance, overweight physicians have less success in addressing the dietary needs of their patients. It stands to reason, then, that what we do in reference to global warming may have a modeling effect on staff and patients. That could include the kind of car we drive, whether we car pool or not, how much paper we waste (mea culpa), and whether we bring our lunch in a tote or plastic bag. For example, Rick Levin is the President of Yale University, one of the universities on the forefront to conserve energy. He drives a Prius. Or, as Mahatma Gandhi once said: "You must be the change you wish to see in the world."

All of this can seem frivolous in a time when we have never-ending, day-to-day administrative prob-

lems which need more immediate attention. Money is often tight, impeding diverting resources for the environment. Yet, isn't that the paradox of global warming? Our brains are hardwired to respond to immediate danger with an emotional fight-or-flight response, which we can usually delay and polish with some cortical control. But nothing natural primes us to be very concerned with danger that may be years away, as is the case of global warming. Freud described the psychological defense mechanism of denial that allows us to put such problems out of our conscious minds. That's why the Physicians for Social Responsibility lament that the old fear strategy, so successful in addressing the risks of nuclear bomb proliferation, is failing to stir the unconcerned about global warming. We need other psychological strate-

gies, like visualization techniques, to help the risks seem more immediate.

So, have you and your organization paid any attention to global warming? If so, how? Recycling? Putting out brochures? A contest for the best suggestion to reduce the organization's carbon footprint? If not, are you planning to? Are you doing anything different in your personal life? Or do you think the topic and this column on it is just a waste of time and paper? Let us know.

Dr. Moffic is a professor in the Department of Psychiatry & Behavioral Medicine at the Medical College of Wisconsin as well as in the Department of Family and Community Medicine.

WELCOME NEW MEMBERS!

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The *Psychiatrist Administrator* invites articles on all areas of psychiatric administration and management with a focus on the roles and perspectives of psychiatrists in leadership and management roles. Please make submissions and inquires to:

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O: 252-744-2660
FAX: 252-744-3815
Email: saeeds@ecu.edu

LITERATURE SCAN

The *Literature Scan* is our regular column that reviews recent literature of interest to administrators in behavioral health care systems. The column covers a period of approximately 6 months. Papers are selected on such topics as administration, consumer satisfaction, delivery of health care, education, efficacy, ethics, evidence-based practice, leadership, and management. The daily demands of administration and practice often leave little time for browsing journals. It's our hope that this column may fill the gap.

Bilkei-Gorzo A, Rácz I, Michel K, Darvas M, Maldonado R, Zimmer A. A Common Genetic Predisposition to Stress Sensitivity and Stress-induced Nicotine Craving. *Biological Psychiatry* 2008 Jan 15;63(2):164-71.

In this article, the authors maintain clinical studies have shown that stress is one of the main causes for relapse in abstinent smokers. They asked whether animals with a genetic predisposition to high or low stress responsivity differ in behaviors relevant to nicotine addiction, in particular stress-induced reinstatement of drug addiction. For the study, they first selected animals with high, low, and average stress sensitivity from the F2 generation from an intercross of high (C57BL/6J) and low (C3H/J) emotional mouse strains. Next, these animals were trained to self-administer nicotine through a chronic intravenous catheter. After extinction of the operant behavior replacing nicotine with saline, mice were stressed with a foot shock and the reinstatement of drug-seeking behaviors was evaluated. The study showed that mice with different stress reactivity showed no difference in the acquisition, extinction, or level of nicotine self-administration. Also found was an immediate reinstatement of drug-seeking behavior in high stress reactive mice, in contrast to low or average stress reactive animals, which showed no significantly increased activity at the active (nicotine-associated) sensor. To conclude, it was suggested that a genetic predisposition to high stress sensitivity contributes to relapse vulnerability but not to the initiation or maintenance of nicotine consumption.

Byford S, Barrett B, Roberts C, Wilkinson P, Dubicka B, Kelvin RG, White L, Ford C, Breen S, Goodyer I. Cost-effectiveness of Selective Serotonin Reuptake Inhibitors and Routine Specialist Care with and without Cognitive Behavioural Therapy in Adolescents with Major Depression. *The British Journal of Psychiatry* 2007 Dec;191:521-7.

The purpose of this study was to assess the short-term cost-effectiveness of combined selective serotonin reuptake inhibitors (SSRIs) and cognitive-behavioral therapy (CBT) together with clinical care compared with SSRIs and clinical care alone in adolescents with major depression. Data was analyzed from a randomized-controlled trial that took place in the UK where outcomes and costs were assessed at baseline, 12 and 28 weeks. The trial consisted of 208 adolescents, aged 11-17 years, with major or probable major depression who had not responded to an initial psychosocial intervention. There were no significant differences in outcome between the groups with and without CBT. Costs were higher in the group with CBT, although not significantly so (P=0.057). Cost-effectiveness analysis and exploration of the associated uncertainty suggest there is less than a 30% probability that CBT plus SSRIs is more cost-effective than SSRIs alone. The study concluded that a combination of CBT plus SSRIs is not more cost-effective in the short-term than SSRIs alone for treating adolescents with major depression in receipt of routine specialist clinical care.

Correll CU. Antipsychotic Use in Children and Adolescents: Minimizing Adverse Effects to Maximize Outcomes. J*ournal of the American Academy of Child & Adolescent Psychiatry* 2008 Jan;47(1):9-20. The author of this article discusses how antipsychotics are being used in children and adolescents in large quantities for a wide range of disorders and psychopathology, including psychotic, mood, and disruptive behavior disorders. Furthermore, antipsychotics are also being used in children and adolescents to treat irritability associated with autism, tic disorders, obsessive-compulsive disorder, post-traumatic stress disorder and aggression. However, the widespread use exceeds the database regarding efficacy as well as safety and tolerability in this population. The author explains that at the time of this writing, only three antipsychotics--haloperidol, thioridazine, and risperidone--have

been approved for use in children and adolescents by the U.S. Food and Drug Administration, with most randomized controlled data being available for risperidone. To use this potent class of medications appropriately, clinicians need to actively weigh the potential risks and benefits of individual agents. The author's article aims to review available data on antipsychotic-related adverse effects in children and adolescents and provide a practical guide for the evaluation and management of antipsychotic-related adverse effects in this vulnerable population.

Dickinson T. Section 5(4) of the Mental Health Act 1983: the Art of Applying the Act. *British Journal of Nursing* 2007 Nov 8-21;16(20):1272-8.
The author discusses how section 5(4) of the Mental Health Act 1983, allows patients to be detained by nurses of the prescribed class for a maximum of six hours. There is a scarcity of research on the subject; however, the little research that has been conducted has shown that there are gaps in the knowledge of registered nurses and nursing students due to be registered with regard to the following areas of Section 5(4): duration of the holding power, can the client be treated against their will, eligibility for detention, and criteria for implementation. The author discusses how to clarify these gaps and the need to provide nurses with a comprehensive systematic guide to follow should they have to invoke the section.

Grubaugh AL, Cain GD, Elhai JD, Patrick SL, Frueh BC. Attitudes Toward Medical and Mental Health Care Delivered via Telehealth Applications Among Rural and Urban Primary Care Patients. *Journal of Nervous and Mental Disease* 2008 Feb;196(2):166-70.
Sufficient health care services are often not available in remote and rural areas. This problem is expected to grow worse in the near future. The authors of this study examined how "telehealth" interventions represent a strategy for addressing access to health-care problems. They examined and compared attitudes toward medical and mental health care delivered via telehealth applications among adult rural (n = 112) and urban (n = 78) primary care patients. They also examined attitudes toward telehealth applications among a subset of patients with post-traumatic stress disorder (PTSD). Both urban and rural patients were receptive to receiving medical and psychiatric services via telehealth. There were few meaningful differences across variables between urban and rural patients, and there were no meaningful differences by PTSD status. The authors concluded that the findings support the feasibility of telehealth applications, particularly for rural

patients who may not otherwise receive needed services.

Kishi Y, Meller WH, Kato M, Thurber S, Swigart SE, Okuyama T, Mikami K, Kathol RG, Hosaka T, Aoki T. A Comparison of Psychiatric Consultation Liaison Services between Hospitals in the United States and Japan. *Psychosomatics* 2007 Nov-Dec;48(6):517-22.
In this article the authors investigated psychiatric consultation in two hospitals, one in the United States, the other in Japan. They examined similarities and differences, and drew conclusions on possible cross-cultural values and/or temporary cultural conditions. As compared with the Japanese consultation patients, the Americans had more mood disorders, including anxiety and chemical-dependency problems, in respective diagnostic classifications. In addition, patients in the United States showed more acute and more serious chronic conditions. These differences may relate to disorder base-rates in the respective countries. Overall, psychosocial problems emerged as increasing in Japan, as compared with chemical-dependency difficulties among American patients. The results are discussed in terms of current conditions in Japan that affect the mental health professions, together with attempts by Japanese clinicians to protect collective mores for disorders to the individual, rather than the societal conditions often invoked in the United States.

Langdon PE, Yágüez L, Kuipers E. Staff Working with People who have Intellectual Disabilities within Secure Hospitals: Expressed Emotion and its Relationship to Burnout, Stress and Coping. *Journal of Intellectual Disabilities* 2007 Dec; 11(4):343-57.
Past studies involving professional carers of people with mental health problems have looked at the relationship between burnout, job satisfaction, the coping strategies employed by carers, and expressed emotion (EE). The authors undertook a similar study involving carers of adults with intellectual disabilities who were detained within a secure hospital. Twenty-seven nursing staff completed a Five Minute Speech Sample regarding a key-worked client. EE was coded and measures of coping strategies, burnout, attitudes to psychiatric treatment and job satisfaction were administered. Sixty-three percent of the sample was coded as having high EE. These subjects reported significantly higher levels of depersonalization and lower levels of personal accomplishment. They used coping strategies more frequently: specifically, they reported trying to reorganize their work and to seek support from others. The authors note that the study was not ca-

sual and the sample size was small.

Luchins D. Do You Need to Care to be Caring? *Administration and Policy in Mental Health and Mental Health Services Research* 2007 Nov;34(6):582-3.

In this article the author discusses that truthfulness requires not only practices that promote accuracy but also the intention to be sincere. In addition, questions raised are: do the intentions of clinicians or the organizations for which they work matter, and if so, how do they influence care? The author explains that with practices that have included spinning in a gyrator, chilling ice baths, dental extractions, therapeutic sterilization, malarial therapy, and frontal lobotomy, it is obvious that good intentions have not necessarily led to good practices. The author concludes that the architects of psychiatry's current best practices would argue that caring intentions along with consumer preferences are built into their programs. If these practices are faithfully followed, better outcomes will follow.

Morrato EH, Libby AM, Orton HD, Degruy FV 3rd, Brent DA, Allen R, Valuck RJ. Frequency of Provider Contact after FDA Advisory on Risk of Pediatric Suicidality with SSRIs. *American Journal of Psychiatry* 2008 Jan;165(1):42-50.

Since the Food and Drug Administration (FDA) issued a public health advisory in October 2003 on the risk of suicide in pediatric patients taking antidepressants and advised maintaining "close supervision" of such patients, a study that compared trends in the frequency of provider contacts for patients with depression before and after the advisory was issued. Retrospective cohorts of children and adults with new episodes of depression treated with antidepressants were created from a national claims database of managed care plans (1998-2005). Two standards were used in measuring patient monitoring: the Health Plan Employer Data and Information Set (HEDIS) quality-of-care criterion. Also, time-series models compared post advisory trends to the expected trend based on pre-advisory measures. After data was gathered and interpreted it was found that contrary to expectations, the frequency of visits by patients with new episodes of depression treated with antidepressants did not increase after the October 2003 FDA advisory was issued.

Myers KM, Valentine JM, Melzer SM. Feasibility, Acceptability, and Sustainability of Telepsychiatry for Children and Adolescents. *Psychiatric Services* 2007 Nov;58(11):1493-6.

The objective of this study examined the feasibility, acceptability, and sustainability of telepsychiatry service for children and adolescents living in non-metropolitan communities. Psychiatrists at a children's hospital provided care to patients of primary care physicians at four non-metropolitan sites by using high-bandwidth interactive video teleconferencing. Review of one-year utilization provided feasibility data. Data collected from surveys of referring physicians examined acceptability of telepsychiatry and reimbursement records provided sustainability data. Results found that generally 387 sessions were provided to 172 youths (mean=2.25 sessions) whose clinical profiles were representative of national samples. Referring providers endorsed high satisfaction with telepsychiatric care, although pediatricians were consistently more satisfied than family physicians. Sustainability of telepsychiatry is challenged by infrastructure costs and low reimbursement by public payers. The authors concluded that telepsychiatry is a feasible and acceptable approach to providing psychiatric services to youths in underserved communities; however, sustainability will depend on developing financial alternatives to fee-for-service, especially if caseloads emphasize publicly funded programs.

Obradovic M, Mrhar A, Kos M. Cost-effectiveness of Antipsychotics for Outpatients with Chronic Schizophrenia. *International Journal of Clinical Practice* 2007 Dec;61(12):1979-88.

The aim of this report was to evaluate the cost-effectiveness of alternative treatments for outpatients with chronic schizophrenia from the healthcare payer's perspective. The following antipsychotic drugs were evaluated for their cost effectiveness: amisulpride, aripiprazole, haloperidol (oral formulation), haloperidol (depot formulation), olanzapine, quetiapine, risperidone (oral formulation), risperidone (depot formulation) and ziprazidone. Effectiveness was measured as a percentage of patients in remission. Clinical parameters used included compliance rates, rehospitilization rates for compliant and non-compliant patients, duration and frequency of hospitalization, and adverse event rates. One-way sensitivity analysis was performed to test the robustness of the model. Data showed that the most effective treatment was treatment with olanzapine and the least effective was

quetiapine. In addition, risperidone can also be considered to be part of the cost-effective treatments based on the sensitivity analysis results. In the end, the study found that among second-generation antipsychotics, which have a better safety profile than first-generation antipsychotics, olanzapine and risperidone showed to be the most cost-effective treatment strategies for outpatient treatment of chronic schizophrenia.

Pajer KA, Kelleher K, Gupta RA, Rolls J, Gardner W. Psychiatric and Medical Health Care Policies in Juvenile Detention Facilities. *Journal of the American Academy of Child & Adolescent Psychiatry* 2007 Dec;46(12):1660-7. In this journal article, the authors' objective was to describe current health care policies in U.S. detention facilities. Telephone interviews were requested from 83 juvenile detention facility administrators across the United States. The response rate was 97.6%. Data was collected over 12 months, from 2003-2004. Additionally, data collected showed that policies for admission health screening existed in 99% of facilities; 90% included mental health screening. Most sites had policies about psychopharmacotherapy and 92% had crisis services. Continuation of existing psychotropic medication treatment was provided at 96% of facilities. Seventy-three percent of facilities used physicians to manage medications in-house; in 61% of the centers, these physicians were psychiatrists. Medication administration policies most often specified nurses, but 16% of facilities used guards. Provisions for discharge psychotropic medication existed at 84% of sites, but there was broad variation in dispensing policies. The authors concluded from the data collected that detention health care policies for adolescents have significant gaps, particularly for mental health care. They recommend future research should include an epidemiological study of detained youths, evaluating their health needs and the actual care received.

Regehr C, LeBlanc V, Jelley RB, Barath I, Daciuk J. Previous Trauma Exposure and PTSD Symptoms as Predictors of Subjective and Biological Response to Stress. *Canadian Journal of Psychiatry* 2007 Oct;52(10):675-83. The objective of this study was to assess the impact of traumatic exposure and subsequent traumatic stress symptoms on workers' response to acute stress situations. This study aimed to examine the association between prior traumatic exposure related to policing, current posttraumatic stress symptoms and biological markers of stress, and subjective appraisal of stress before, during, and after exposure to acutely stressful stimuli. The researchers created a stress-ful policing situation through the use of a video simulator room. Participants' responses to the simulated emergency were evaluated by monitoring heart rate, collecting saliva samples for cortisol analysis, and repeated administration of a subjective measure of anxiety. Results found that biological indicators of stress, as measured by cortisol level and heart rate, were not associated with previous trauma exposure or trauma symptoms; however, biological response was associated with subjective anxiety. In addition, vulnerability to psychological stress responses during an acute stress situation was also associated with lower levels of social support, previous traumatic exposures, and preexisting symptoms of traumatic stress. The importance of these factors became more pronounced as time progressed after the event. The authors of this article concluded that previous trauma exposure did not put individuals at increased risk of biological distress during an acute stress situation. Nevertheless, reduced social support and previous trauma were associated with continuing psychological distress, confirming previous research and raising concerns about the cumulative negative effects of traumatic exposure on psychological health in emergency responders.

Sadeghi M, Taghva A, Mirsepassi G, Hassanzadeh M. How Do Examiners and Examinees Think about Role-playing of Standardized Patients in an OSCE Setting? *Academic Psychiatry* 2007 Sep-Oct;31(5):358-62. The use of standardized patients in Objective Structured Clinical Examinations (OSCE) in the assessment of psychiatric residents has increased in recent years. Consequently, the aim of this study was to investigate the experience of psychiatry residents and examiners with standardized patients in Iran. Final-year residents in psychiatry took part in the study. Experienced examiners were asked to complete a questionnaire concerning the ability of standardized patients to realistically portray psychiatric patients. Results from the study showed that standardized patients can convincingly portray psychiatric disorders and act according to the requested complex scenarios. As a result of the findings, the authors recommend the use of standardized patients in OSCEs for psychiatric board certification exams.

Skale TG, Jain R. Practical Strategies for Assessing and Stabilizing Bipolar Patients in Urgent Situations. *The Journal of Clinical Psychiatry* 2007 Oct;68(10):e23. The authors of this article recommend that for patients with bipolar disorder in urgent situations, psychiatric and

non-psychiatric clinicians should employ practical approaches to achieve optimum outcomes and ensure safe and rapid reduction of symptoms such as considering the treatment setting, clinician-patient relationship, and the severity of the patient's symptoms. Since biological, psychological, and social factors affect both the development and the treatment of acute bipolar states, treatment should address each factor to manage the illness.

Strakowski, SM. Approaching the Challenge of Bipolar Depression: Results from STEP-BD. *American Journal of Psychiatry* 2007 Sept;164(9):1301-3.

The author discusses that the diagnosis of bipolar disorder is defined by the occurrence of mania or hypomania, while depressive episodes and symptoms tend to dominate the course of the illness. Also discussed is the fact that treatments for bipolar depression are vaguely defined than those for mania. Contrasted is the number of treatments approved by the U.S. Food and Drug Administration for mania with that for bipolar depression. As a result, treatment of bipolar depression typically relies on off-label medication use, particularly of antidepressants, or non-pharmacological interventions. The effectiveness of these interventions and how they affect the subsequent course of bipolar illness remain areas of limited information and moderate controversy. In addition, the author discusses that there are two articles from the Systematic Treatment Enhancement Program for Bipolar Disorder (STEP-BD) published in this month's journal that address these shortcomings in our knowledge base.

van Daal J, Verhoeven L, van Balkom H. Behavior Problems in Children with Language Impairment. *Journal of Child Psychology and Psychiatry* 2007 Nov;48(11):1139-47.

Language impairment is often associated with behavioral problems. However, detailed relations between different types of language impairment and specific behavioral problems in children have yet to be demonstrated. This study attempted to address this issue with attention to the implications to identify foci for early intervention. The language abilities of 71 five-year-old children with language impairment were assessed by means of the administration of an extensive battery of language tests. The children's behavior profile was assessed via administration of the Child Behavior Checklist. Results from the study found that factor analyses confirmed the presence of four language factors: speech, syntax, semantics and phonology. Forty percent of the children displayed serious significant behavioral problems. In addition, the most frequently occurring behavioral problems were as follows: withdrawn behavior, somatic complaints, thought problems and aggressive behavior. Behavioral problems were associated with three of the four language factors although not strongly associated with speech problems. Conclusions drawn from the study found that differential relations between specific types of language impairment and specific behavioral problems already exist at a young age. Phonological problems showed broad relations to problem behavior and semantic language problems were especially related to internalizing behavior problems. This finding implies the need for specific therapies for both types of language.

Kathy Cable, MLS is the Health Sciences Reference Librarian at the Laupus Health Sciences Library at East Carolina University – and liaison librarian to the Brody School of Medicine.

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List Serve: aapa@wpaweb.com

PRESIDENT
Arthur Lazarus, M.D., MBA (2007-2009)
AstraZeneca LP
1800 Concord Pike, B3B-425
PO Box 15437
Wilmington, DE 19850-5437
O: 302-885-4542
FAX: 302-886-4990
Email: arthur.lazarus@astrazeneca.com

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Lawrence & Memorial Hospital
365 Montauk Avenue
New London, CT 06320
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FAX: 860-444-0863
Email: dbrandt@lmhosp.org
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PO Box 2519
Corinth, MS 38835
O: 662-223-9213
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277 Upper Gulph Road
Radnor, PA 19087
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FAX: 610-687-4355
Email: barry.herman@pfizer.com

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O: 610-891-9024/104
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FAX: 610-891-9699
Email: shatti@suburbanresearch.com

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Andrew Angelino, M.D.
Department of Psychiatry
Johns Hopkins Bayview Medical Center
4940 Eastern Avenue, A4C – 461A
Baltimore, MD 21224
O: 410-550-0197
FAX: 410-550-1407
Email: aangelino@jhmi.edu
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United Behavioral Healthcare
100 Penn Square East, Suite 400
Philadelphia, PA 19107-3387
O: 215-557-5787
Email: Lawrence_goldberg@uhc.com
Term: May 2007 – May 2011

Web Master
Arthur Lazarus, M.D., MBA
AstraZeneca LP
1800 Concord Pike, B3B-425
PO Box 15437
Wilmington, DE 19850-5437
O: 302-885-4542
FAX: 302-886-4990
Email: arthur.lazarus@astrazeneca.com

Public and Forensic Psychiatry Committee Chair
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16 Hickory Creek Drive
Little Rock, AR 72212
O: 501-686-9034
Email: laurance.miller@arkansas.gov
Term: May 2007 – May 2011

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H. Steven Moffic, M.D. (May 2005 – May 2009)
MCW Department of Psychiatry – Clinics of Tosa
Medical College of Wisconsin
8701 Watertown Plank Road
Milwaukee, WI 53226
O: 414-456-8950
FAX: 414-456-6295
Email: smoffic@mail.mcw.edu
Term: May 2005 – May 2009

Thomas Newmark, M.D.
401 Hardon Avenue, Suite 356
Camden, NJ 08103
O: 856-757-7799
Email: newmark-thomas@cooperhealth.edu
Term: May 2007 – May 2011

Malini Patel, M.D.
Medical Director Community Psychiatric Services/Metro Suburban Network
Elgin Mental Health Center
750 South State Street
Elgin, IL 60123
O: 847-742-1040/Extension 2015
FAX: 847-429-4911
Email: dhs594J@dhs.state.il.us
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1300 Moursund Street
Houston, TX 77030
O: 713-500-2799
FAX: 713-500-2757
Email: pedro.ruiz@uth.tmc.edu
Term: May 2005 – May 2009

Steven S. Sharfstein, M.D.
Sheppard &Enoch Pratt Hospital
PO Box 6815
Baltimore, MD 21285-6815
O: 410-938-3401
FAX: 410-938-3406
Email: ssharfstein@sheppardpratt.org
Term: May 2005 – May 2009

Wes Sowers, M.D.
206 Burry Avenue
Bradford Woods, PA 15015-1240
O: 412-350-3716
FAX: 412-350-3880
Email: sowers@connecttime.net
Term: May 2005 – May 2009

Jeanne Steiner, M.D.
1025 Benham Street
Hamden, CT 06514
O: 203-974-7077
Email: jeanne.steiner@yale.edu
Term: May 2007 – May 2011

Ann Sullivan, M.D.
Mt. Sinai/Elmhurst Hospital
79-01 Broadway, (D 10-35)
Elmhurst, NY 11373
O: 718-324-3536
FAX: 718-334-2642
Email: ann.sullivan@mssm.edu
Term: May 2005 – May 2009

Academic Psychiatry Committee Chair
Michael Vergare, M.D.
Jefferson Medical College
833 Chestnut Street, #210-A
Philadelphia, PA 19107-4414
O: 215-955-6912
FAX: 215-923-8219
Email: michael.vergare@jefferson.edu
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NewsJournal Editor
Sy Saeed, M.D., M.S., F.R.S.H., Chairman
Professor and Chairman - Dept. of Psychiatric Medicine
The Brody School of Medicine
Brody 4E-100
600 Moye Boulevard
Greenville, NC 27834
O: 252-744-2660
FAX: 252-744-3815
Email: saeeds@ecu.edu

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Chief, Community Psychiatry
Cabrini Medical Center
227 East 19th Street
New York, NY 10003
O: 212-995-6000
Ryuchin@cabrininy.org

NewsJournal Associate Editor
Arthur Lazarus, M.D., MBA

Archivist
Dave M. Davis, M.D.
Piedmont Psychiatric Clinic
1938 Peachtree Road, NW
Atlanta, GA 30309
O: 404-355-2914
FAX: 404-355-2917

BMS Fellow Representative
Chantelle Simmons, M.D.
Emory University
1904 Variations Drive
Atlanta, GA 30329
O: 404-634-9231
Email: chantellesimmons@hotmail.com

ECP Representative
Kimberly Bogan, M.D.
10835 Grantwood Avenue
Cleveland, OH 44108
O: 216-659-1848/216-541-4195
Email: docjazzybwell@yahoo.com

APA COMMITTEE ON ADMINISTRATION AND MANAGEMENT LIAISON
L. Mark Russakoff, M.D.
701 N. Broadway
Sleepy Hollow, NY 10591
O: 914-366-3604
FAX: 914-366-1302
Email: mrussakoff@pmhc.us

AACP LIAISON
Charles Huffine, M.D.
3123 Fairview East
Seattle, WA 98102
O: 206-324-4500
FAX: 206-328-1257
Email: chuffine@u.washington.edu

ACPE LIAISON
Arthur Lazarus, M.D.

EXECUTIVE DIRECTOR
Frances M. Roton
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