Journal of Psychiatric Administration and Management ISSN: 2163-3878
Volume 3, Number 1

CURRENT PERSPECTIVES ON PSYCHIATRIC ADMINISTRATION AND LEADERSHIP

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ABSTRACT

Psychiatrists as administrators face many challenges. This paper presents the results of a survey conducted in 2012 by the Committee on Psychiatric Administration and Leadership (C-PAL) of the Group for the Advancement of Psychiatry (GAP). GAP is a think tank of top psychiatric minds whose thoughtful analysis and recommendations in the field serve to influence and advance modern psychiatric theory and practice.

Psychiatrists in key leadership and administrative positions were asked to identify their most challenging issues from a menu of options provided in a survey instrument sent electronically and completed by the responders anonymously.

The survey provided interesting data regarding gender differences with older men being overrepresented in administrative/leadership positions. The data showed what appears to be a transition occurring in the field with more women taking on administrative/leadership positions. Another key finding was that the majority of the incumbents were recruited for the administrative/leadership position from within their organizations without actively seeking the position. The major challenges listed by the respondents included fiscal issues, recruitment, quality of care, and monitoring of outcomes. In that respect, an unexpected finding was that ethics was not viewed as a major challenge to the respondents, except by the most experienced administrator/leaders. The authors discuss the importance of leadership in the psychiatrist's managerial, strategic, and professionally senior roles.

INTRODUCTION

The last major texts on psychiatric leadership and administration were published several years ago [1, 2, 14] Ever since the 1960s [3], at least until our time, a major administrative psychiatry text seemed to be published about every decade to reflect the challenges of the times [4,5,6]. The early 1960s text focused on psychiatric state hospitals; the early 1970s on deinstitutionalization and the emergence of community mental health; the early 1980s on the failures of community mental health; the early 1990s on the emergence of managed care; and the beginning of the new millennium on the "graying" of America, new electronic

technologies, the dominance of for-profit, cost-containing managed care, and all its ensuing ethical challenges and conundrums [7]. In the early 2000s a new text emphasized business planning, finance and budgeting, information technology, and leadership issues. [2]

The decline of physician leadership in public and private systems of health care delivery is an ongoing trend; according to one source only 4 % of hospitals are led by physicians. There has not been significant research on the reasons for this decline or its impact on the quality of health care delivery. Although there have not been many studies of this phenomenon several possibilities have been raised including cost effectiveness, better administrative skills of managers with business background, lack of interest in administration by physicians, and lack of trained physician administrators.

Over the past fifty (50) years the numbers of psychiatrists in administrative positions have been decreasing [9] while at the same time there continue to be persuasive assertions that psychiatrists have the broadest and best skill sets to be leaders and administrators [10]. When we look at psychiatric administrators the challenges are even bigger; very few training programs have well developed administrative psychiatry tracks in their programs. This poses a barrier to recruiting psychiatric administrators since the lack of introduction to administrative issues early in training generally precludes early career psychiatrists thinking about administration as a career track.

Over the last sixty (60) years, the Group for the Advancement of Psychiatry (GAP) has addressed numerous issues in our field through a series of cutting-edge deliberations and publications. Recently, this challenge of the state of psychiatrist administrators/leaders led to the formation of a new committee, that of Administration and Leadership. From its inception, this committee recognized that not only were some of the historical trends still a challenge, but new ones were about to emerge, such as the role of psychiatrist administrators/leaders in the present healthcare reform environment with its focus on the integration of behavioral and primary care, Accountable Care Organizations (ACOs), behavioral health homes, behavioral health IT, and needed advocacy on such issues as the Affordable Care Act (ACA) and Mental Health and Addiction Equity Act (MHAEC). In addition to these is the question of whether or not psychiatry should remain a distinct field or should be merged with neurology. The committee also recognized the historical dearth of actual surveys of what psychiatrist administrators were doing, as well as their reactions to such challenges. Therefore, one of the first formal activities of the newly developed Committee on Psychiatric Administration and Leadership (C-PAL) was to develop such a survey and analyze the results.

METHODOLOGY

The Group for Advancement of Psychiatry (GAP) Committee on Psychiatric Administration and Leadership (C-PAL) was founded in 2011 and its goal, as of GAP in general, is to function as a think tank producing timely and relevant publications to advance our field. For this project, C-PAL surveyed our field's key leaders and administrators to find out the most prevalent challenges and areas where guidance can be of help in developing or sharing best practices in the increasingly challenging field of psychiatric administration and leadership.

In an effort to delineate, study, and report matters of primary concern to psychiatry's leaders and administrators, C-PAL electronically sent a survey, via Survey Monkey, to

members of GAP, the American Association of Community Psychiatrists (AACP), and the American Association of Psychiatric Administrators (AAPA). (Appendix A: GAP Administration Committee Survey.) The survey aimed to obtain a profile of psychiatric leadership/administrative experiences as well as perceived challenges in that role. The data that were collected tabulated and analyzed by the committee using Excel spreadsheets. The results are shown throughout this paper in either graphical and/or narrative form.

RESULTS

The survey was sent to approximately eight hundred (800) members of GAP, the American Association of Community Psychiatrists (AACP), and the American Association of Psychiatric Administrators (AAPA). The response rate was nineteen (19%). At the time of data analysis, 149 psychiatrists had returned the survey, which included 34 (22.7%) women and 115 (77.3% men). (Figure 1)

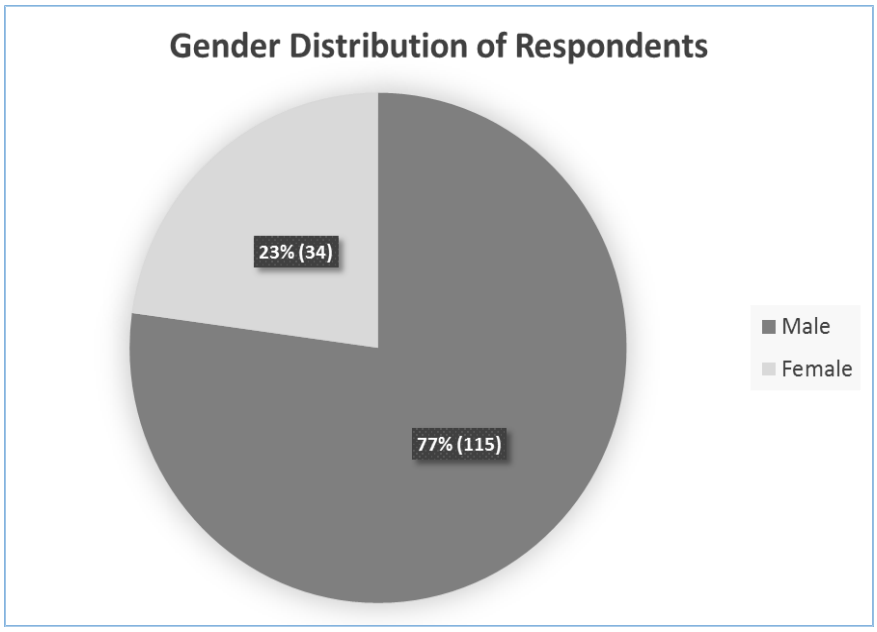


Figure 1. Gender Distribution of Respondents [n = 149].

A large majority of respondents (81% of the 149 respondents) reported some degree of administrative/leadership role in their professional lives. (Figure 2). Of the respondents who reported an administrative/leadership role 80% were over the age of 50 (Figure 3). Figures 4 shows the responders distributed by gender and their experience (number of years) in administrative/leadership positions. Most women reported fewer than twenty (20) years of experience in administrative/leadership positions (88%), while 47% of men reported more than twenty (20) years. These roles have evolved over the years for women as shown in Figures 4A and 4B reflecting administrative/leadership experience by age groups.

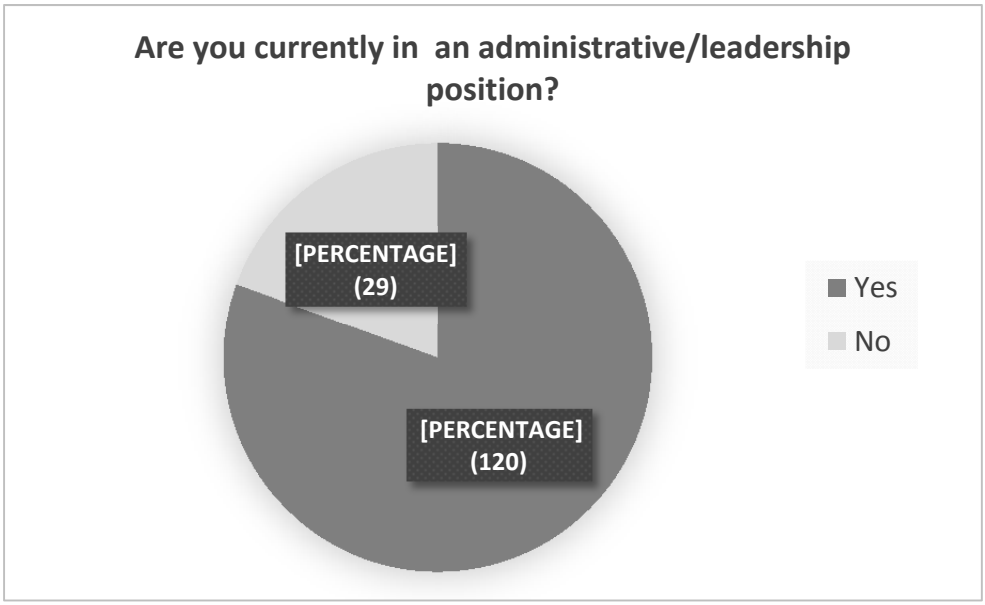


Figure 2. Current Administrative/Leadership Position Distribution [n = 149].

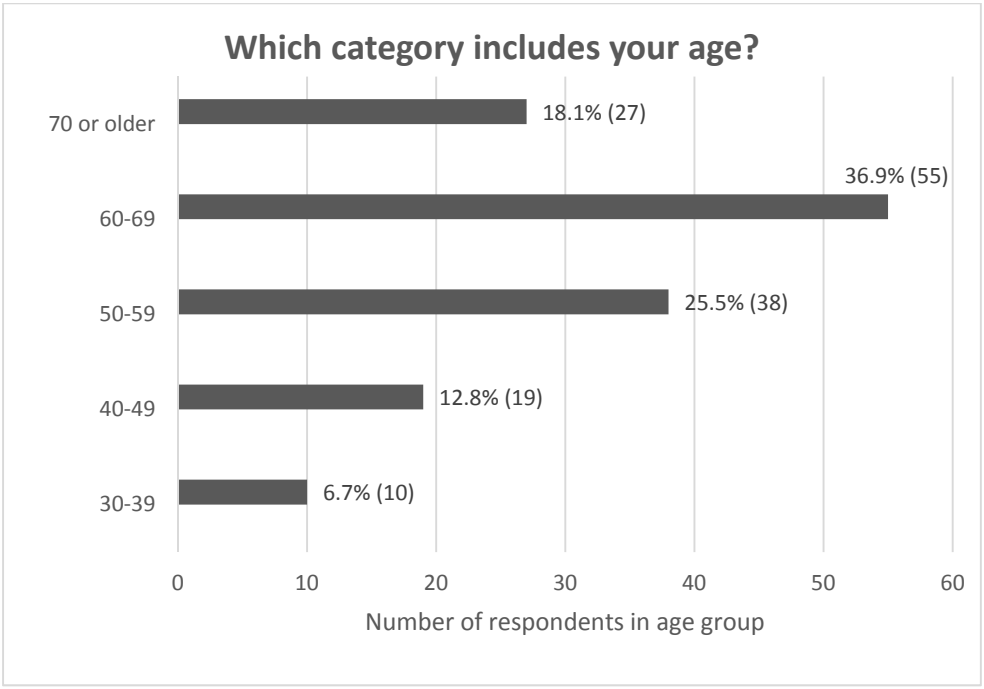


Figure 3. Age Categories.

In the case of females, most forty (40) to sixty (60) year olds reported fewer than twenty (20) years of experience, while males in this cohort reported twenty (20) to thirty (30) years. No women reported more than thirty (30) years. Thus it seems that more women have taken administrative roles, but at later ages in their careers. (Figure 4A and 4B)

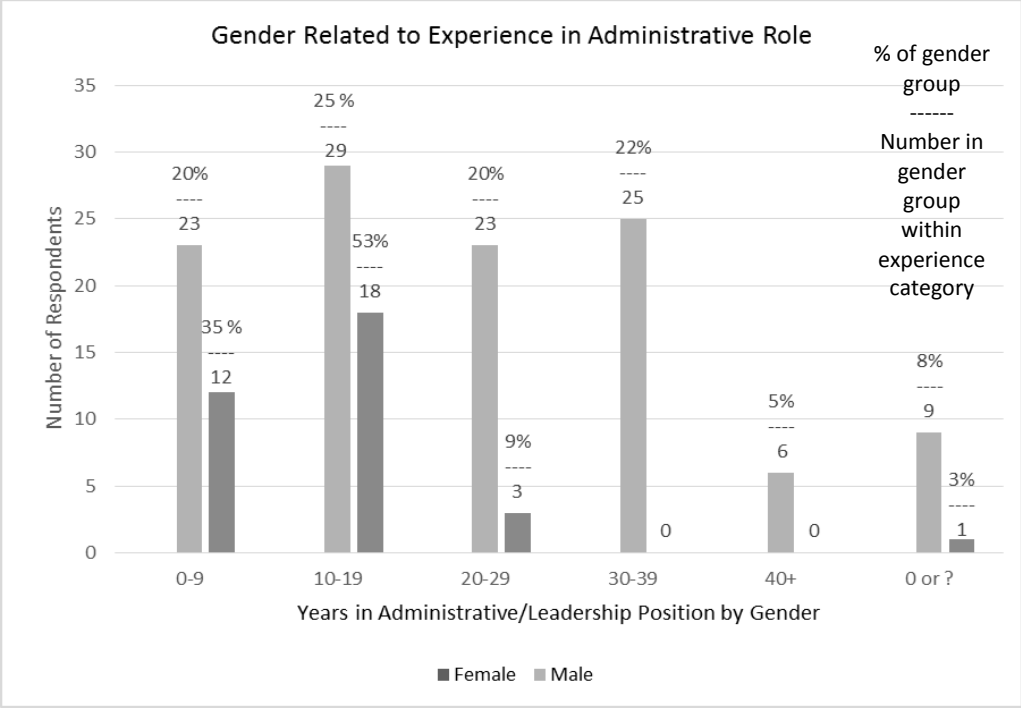
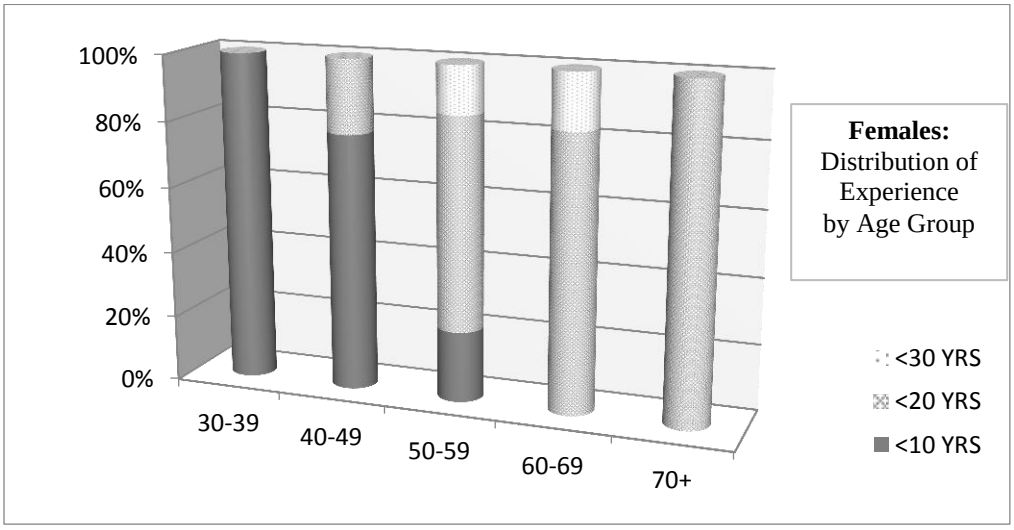


Figure 4. Gender Related to Experience in Administrative Role.

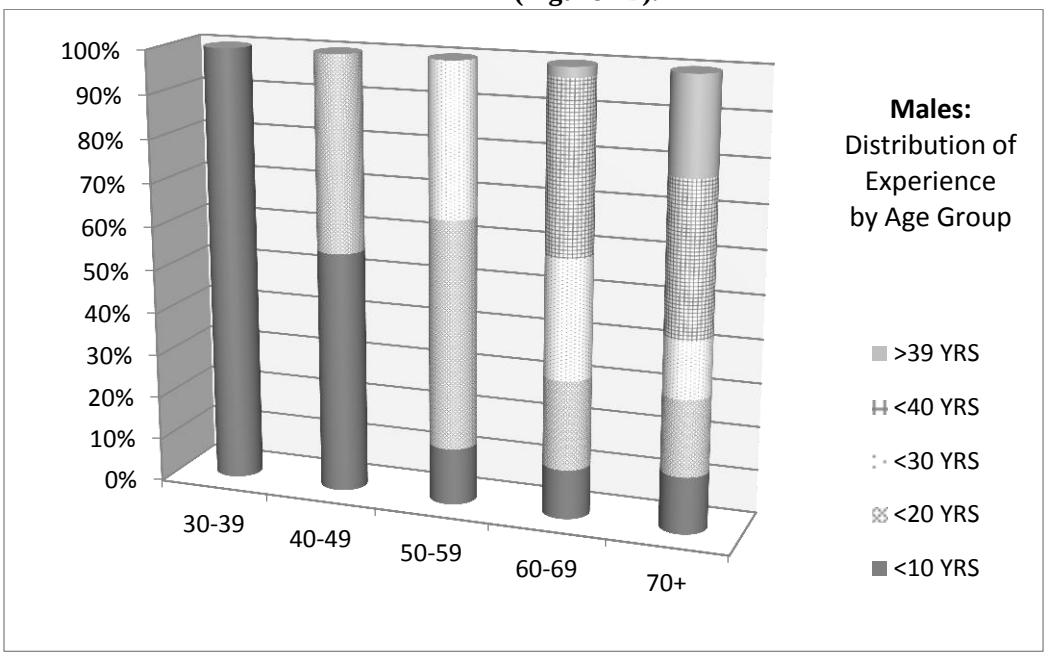
AGE RELATED TO YEARS OF EXPERIENCE IN ADMINISTRATIVE ROLE (BY GENDER):

Y = PROPORTION OF RESPONDENTS IN AGE RANGE WITH LENGTH OF TIME IN ADMINISTRATION
X = AGE RANGE OF RESPONDENTS

WOMEN (Figure 4A)



MEN (Figure 4B).



Another finding from the data was that most administrators were appointed, having not actively sought the leadership position they were in. Fewer than 20% obtained their position through a job search. Forty-six (46%) of the responders were appointed to their administrative positions from within their organization, but they were not actively seeking the positions. This compared to 35% who were appointed to the positions from within the organization and who were actively seeking those positions. (Figure 5)

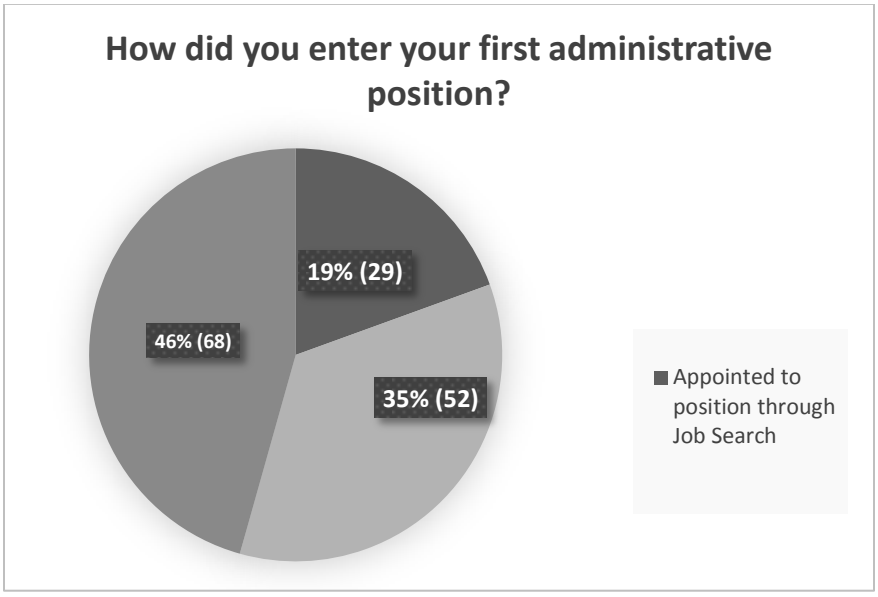


Figure 5. Recruitment into Administrative Role.

The respondents were asked to rank what they considered their most challenging issues in their roles as administrators and leaders [see list of challenges provided on the survey below]. These data were tabulated by gender and showed little difference in ranking on this axis. Although there were many more men, Figure 6 does not weight rankings by the size of the cohorts. (Figure 6)

1. Fiscal Resources
2. Recruitment
3. Care Quality
4. Monitoring of Outcomes
5. Regulatory
6. Retention
7. Health Information Technology
8. Legal
9. Ethical
10. Physical Plant
11. Other

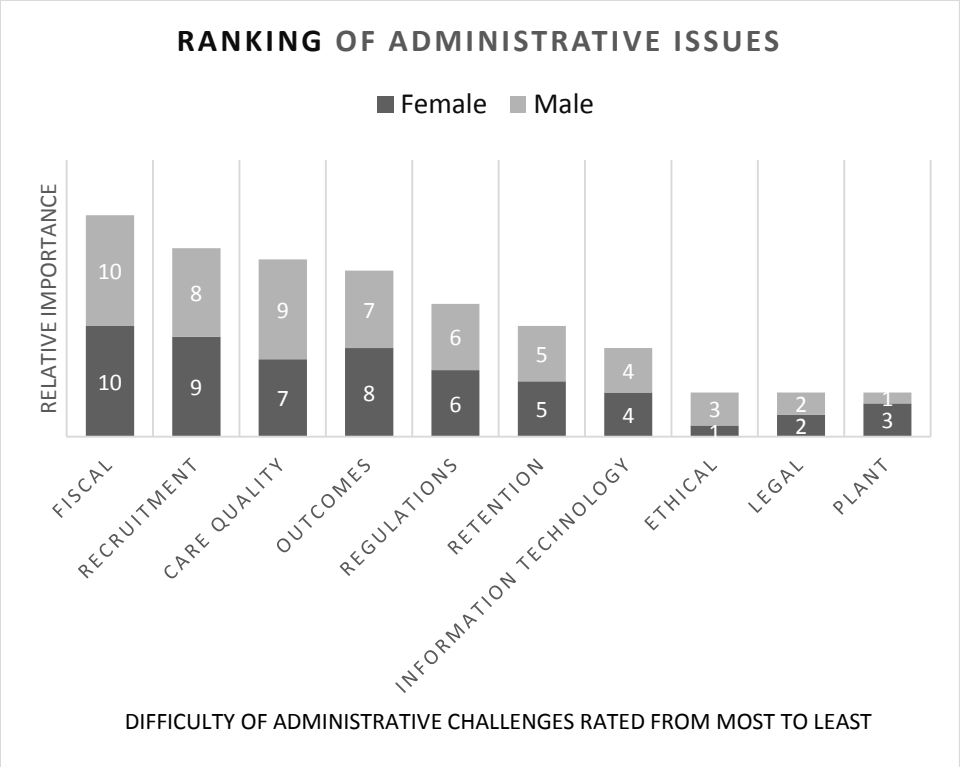


Figure 6. Ranking of Most Challenging Issues for Psychiatrists in Administrative and Leadership Positions.

The "other" category allowed for a free text narrative and the major theme(s)centered on leadership issues: dealing with people, allocation of resources, politics, and organizational culture. The comments highlighted the art of being an administrator, which is learned

primarily by experience rather than generally taught in medical training, and which is a challenge for a significant number of respondents. This raises the issue of increased attention to teaching administration and leadership principles during residency training. The authors recommend further research in this area given its significance to these respondents. (See Appendix B for Other Category Text Responses)

Questions 7, 8, and 9 on the survey sought information on the respondents' feelings about their identity as clinicians and administrators as well as the perceptions of their colleagues about them. In moving from a strictly clinical role to that of assuming administrative responsibilities, approximately one quarter of respondents felt this change to be a challenge to their identity as a clinician. (Figure 7)

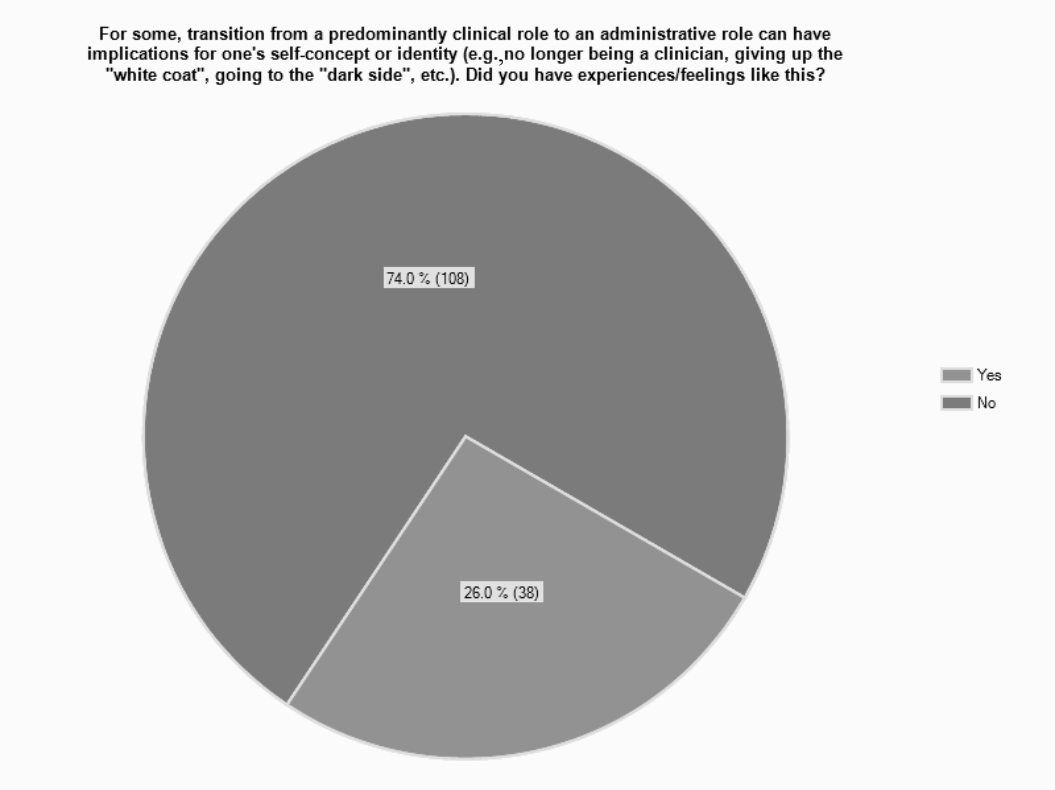


Figure 7. Respondents Self-Concept.

Sixty-seven percent of respondents identified themselves as both a clinician and an administrator; 20 % of respondents felt they maintained the identity of a clinician; 5 % felt they had assumed the identity of an administrator. To "others in the system" nearly 70% of respondents reported that they were seen as clinicians and administrators, 11% said they were viewed as clinicians and an equal number felt they were seen as administrators.

DISCUSSION

Given the relative absence of surveys assessing the demographics, practices and concerns of current psychiatric administrators/leaders, the goal of the survey was to begin to define

these variables. Our findings suggest that a large majority of our respondents (nearly 80% of the 149 respondents) identified themselves as having some degree of administrative role in their professional lives. Our sample drew upon a group of psychiatrists ranging from thirty (30) to more than seventy (70) years of age. Although the sample drew upon individuals in professional organizations (i.e., GAP, AACP, and the AAPA) it was not a random sample. The high percentage of respondents who have administrative responsibilities indicates a need for administrative training and skill development early in the career of a psychiatrist.

Our respondents reported that, at present, men are three times as likely as women to be in administrative/leadership roles in psychiatric and behavioral health settings. The reason for this is unclear but it may be a function of a greater number of men than women entering the field three or four decades ago. A second explanation for this may have been past attitudes regarding the assignment of administrative functions to men vs. women. The fact that very few, if any, female respondents had more than twenty (20) years of administrative psychiatry experience while a substantial number of men had thirty (30) and forty (40) years of experience lends support to one or both of these explanations.

This dominance of men in the role as administrative psychiatrists seems to be quickly changing. The responses of younger psychiatrists (i.e., thirty and forty years of age) show that women are entering the field of administrative psychiatry at approximately two times the rate of men. Again, the data do not indicate the reason for this change. Perhaps, changes in professional interest on the part of women and/or men as well shifts in societal attitudes toward women as administrators may explain this substantial shift. The data support this idea because the majority of woman who are approaching twenty years in administrative psychiatry are currently in their sixties and seventies suggesting that the field may have become more open to women in the past two decades. Additionally, the percentage of women entering the field of psychiatry has steadily grown.

Just over a third of our respondents indicated that they spent more than 50% of their time doing administrative work. Significant amounts of time were allocated to a variety of other tasks such as teaching, supervision, research and direct patient care. The presence of a variety of roles is contrary to the model of most administrative positions. It is unclear from the data why so many respondents had multiple roles. It is likely that this leads to a more demanding workload when compared to those who work solely as a clinician or an administrator. Does this increase in the number of professional identities dissuade people from entering administrative psychiatry? Is it a source of burnout? These questions are not answered by the current survey. Additionally, it is unclear from the study how the respondents came to have these additional roles. Were they assigned or sought out or a legacy of their prior position before becoming an administrator?

One difference that emerges from the survey is that the psychiatrist administrators continue to maintain other possibly significant responsibilities in contrast to other administrators. This may reflect their difficulty in giving up their identity as clinicians while taking on other less professionally familiar challenges. Administrative psychiatrists face complex challenges often presenting the ethical dilemmas of reconciling patient interests and system needs [2]. It is interesting that in our survey the respondents identified fiscal challenges as different from ethical challenges. This could have resulted from question wording. In a future survey these issues may be incorporated into an ethical question since lack of resources propels the ethical issues of forcing difficult choices in provision of health care and cuts to services for vulnerable populations. Thus the AMA/APA principles of ethics

present quandaries for the psychiatrist/administrator when the interests of individual patients may be in conflict with administrative directives.

Regarding the allocation of time for administrative duties compared with the various other responsibilities surveyed such as patient care, supervision, research and teaching, the respondents indicated that the amount of time attributed to administrative work peaks in their fifties (50's) and sixties (60's). One explanation for this is that as their administrative skill set improves, the number of administrative duties they are responsible for increases. Inversely, the amount of time allocated to patient care decreases during this same period. The percent of teaching by our respondents appears unaffected by age suggesting that teaching remains a professional priority throughout their career. Research conducted by our respondents remained constant at about 20% of time until the age of sixty (60) when a decline was noted to about 12%. (Figure 8)

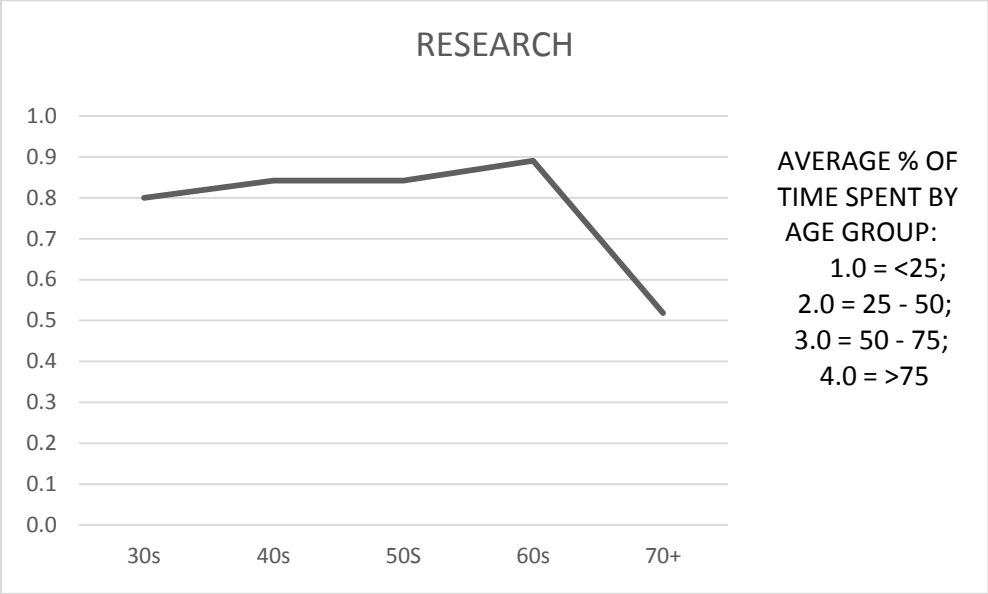


Figure 8. Research Time Commitment by Age Group.

Perhaps a change in personal and professional identities may explain this finding. Time allocation by gender showed no significant differences with the exception that male respondents showed a greater allotment of time to patient care than female respondents.

How a psychiatrist becomes an administrator does not typically seem to be through an educational pathway or a formal job search. Rather, nearly half of the responders were appointed without actively searching, especially in the case of women. How this relates to the quality of administration and the "Peter Principle" requires another kind of study. Perhaps, appointments to such positions, as in other professional organizations, stem from known talent from within the organization and rewards these individuals with promotions. Just over a third of those appointed to the job were actively seeking the position. Finally, nearly 20 % found their position by way of a job search. Men were more likely to get an administrative position by way of a job search.

Three themes emerge from the data from answering the question of administrative challenges. In our time of managed care cost containment, fiscal challenges are not surprisingly perceived to be the major challenge, regardless of experience, followed by quality of care, monitoring of outcomes, and recruitment. The lowest ranked challenges are physical plant, legal and ethical issues. Given the challenges of various administrative priorities, and as reflected in the administrative ethical principles [8], it is surprising that ethics is ranked so low. Here, we have administrators who must balance the needs of the organization, finances, staff, and, of course, patients, yet they do not seem to see the ethical challenges in doing so. Even naming an organization can be an ethical issue [11]. However, in the oldest age group, with the most administrative experience, ethics did rate rather highly. (Figure 9)

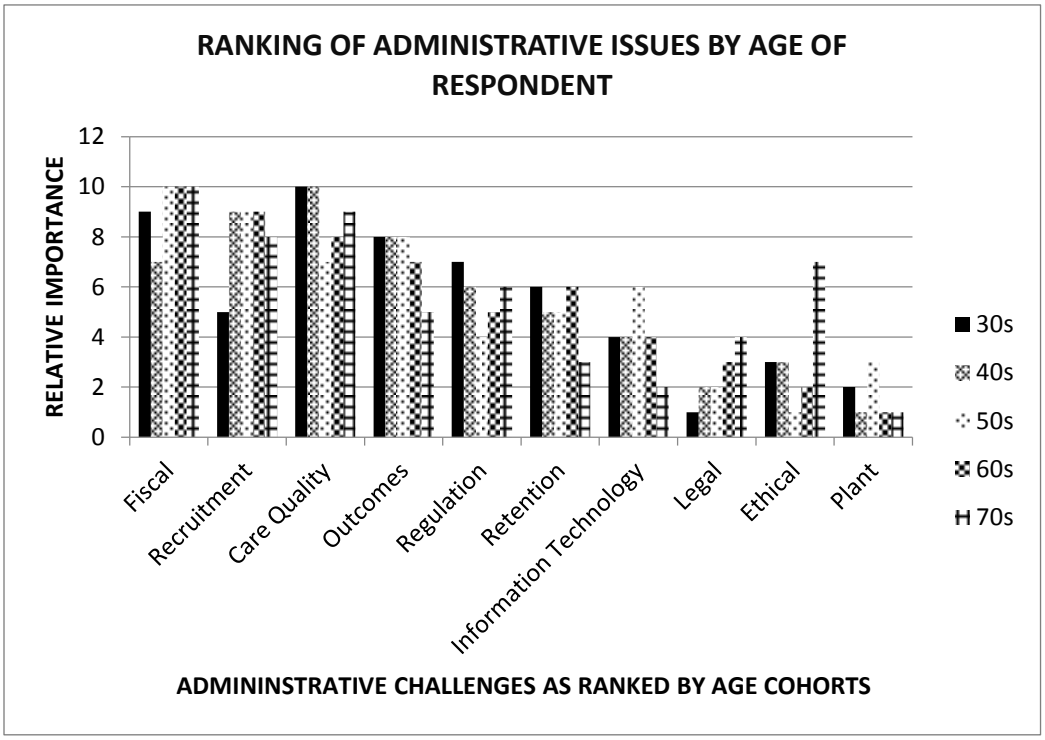


Figure 9. Age Differences in Ranking Administrative Challenges.

Certainly, the ordering of the topics could influence the response tendencies and/or cause answering fatigue for those items on the bottom of the list like ethics. In the space left for writing in other responses, some of those specific ethical challenges are spelled out, such as: struggles with non-physician leadership; managing people issues; no clear priority of challenges; current political leadership brought by lobbyists overriding any ethical concerns; and negotiating personnel resource allocation internally. As such, many of these "other" comments reflect leadership or the art of doing administration when encountering such ethical challenges. See Appendix B for other category text responses. As noted earlier, the differences in the ranking of administrative challenges between genders did not appear significant.

As reported in the results, about a quarter of clinician respondents who accepted increased administrative responsibilities, felt this change to be a challenge to their identity as a clinician. Nonetheless, most self-identified as both a clinician and as an administrator. One possible explanation for this may be that they were required to provide clinical care. Women were slightly more likely to feel they had lost some of their identity as a clinician by accepting administrative responsibilities. The data suggested that challenges to one's identity and priorities were part of the experience of undertaking administrative responsibilities. The theme of the potential loss of a clear professional identity continued with the question about how the respondents felt others perceived them. While nearly 70% said they were seen as clinicians and administrators, eleven percent (11%) said they were viewed as clinicians and an equal number felt they were seen as administrators.

STRENGTHS AND LIMITATIONS

Limitations of this survey begin with the sample of respondents. It is small in size and not random; those surveyed belong to professional organizations such as GAP, AAPA, and AACP. This excluded administrative psychiatrists who do not belong to one of these major administrative psychiatric organizations. Secondly, more complete demographic information would have been helpful to better understand our sample of respondents. Some demographics were missing, especially the important one of ethnicity. Given the continuing racial disparities in mental health services, whether more diversity in psychiatrist administrators would help to reduce this disparity is a crucial question [12]. Instructions and phrasing of questions could have been clearer. The survey also did not indicate the type and place of administrative work.

The strengths of the survey include the response rate. The response rate was nineteen (19%) of those surveyed, larger than the average 10-15% associated with such surveys. The survey was readily accessible to those who received it. It was brief and easy to complete and return. Although not a random sampling, the survey was distributed to prominent administrative psychiatry organizations in the field. The feedback from the survey was helpful in defining future projects regarding administrative psychiatry.

Such survey results also suggest the need to separate administrative tasks from leadership skills, at least to some extent. Administrative tasks are more clear-cut and reflected in job descriptions. Leadership can be both formal and informal, encompasses a vision besides a position, and is an art as much as a science.

Who should lead mental health organizations as our healthcare systems change is a crucial question. Right now, such administrators can come from such varying disciplines as business, social work, nursing, psychology, psychiatry, and even consumers at times. How much salary influences choice of administrators is unknown, though psychiatrists tend to expect higher salaries than non-physicians. Only in academic departments of psychiatry, and possibly pharmaceutical companies, is the top administrator expected to be a psychiatrist.

As to the skill set necessary for successful administrative leadership roles, psychiatrists should be extraordinarily well qualified. Though the education of psychiatrists is leaning more toward the biological, we still espouse the bio-psycho-social model and also have the longest, most varied training experience including the rigors of shouldering the direct medical responsibility for another person's health, well-being, and even survival. However, necessary training in management is often meager and needs extra attention early in one's career. Emotional intelligence, that skill used in the business literature to describe an essential trait for "great" leadership, seems to be a focus for psychiatrists throughout their training in most institutions [10]. We find that focus especially in supervision that discusses transference and countertransference. All physicians are trained to be in charge of clinical teams during residency training and their skills are tempered in the multidisciplinary workplace of mental health services. The future quality of care of our patients may depend on whether we can develop more administrative leaders, especially "great" ones, to lead in our new and complex healthcare systems [14].

CONCLUSION

While this survey suggests that psychiatrists are still quite involved in administration, it is a survey of a subset of psychiatrists that are more likely to be involved in administration or have leadership roles. There remains limited information on psychiatrists in leadership positions, including their roles as executives in healthcare, across the country.[1] Interestingly, psychiatrists comprise about 6% of designated institutional officials and 4.6% serve as deans of academic medical centers, roughly equivalent to their proportion of all physicians nationally (Ibid).

The process of recruiting into administrative psychiatry positions by promoting psychiatrists from within is an acceptable practice in medicine. However we need to further study if better training and preparation in administrative psychiatry during psychiatric residency or through fellowship programs will encourage early career psychiatrists to seek out these positions. This could also address the issues of gender and age disparities in the field since many of the early career psychiatrists are female and would more likely fulfill these roles.

The extent of leadership versus administration is unknown, but an important distinction to keep in mind and in practice. Though psychiatrists would seem to offer the most relevant training and development of emotional intelligence, other disciplines have been increasingly taking administrative positions. A new emphasis on grooming psychiatrists to be administrators, and marketing their unique value may be necessary.

Our findings indicate the need for further study and discussion of the challenges of administrative psychiatry and psychiatrist leadership in the USA. How our findings related to administrative psychiatry in other countries also needs exploration. It is noteworthy that ethical challenges seem under-recognized. Follow-up studies and an updated textbook are recommended to advance the knowledge-base of and for the psychiatrist-administrator.

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APPENDIX A: C-PAL SURVEY

GAP Administration Committee

Please complete ONLY if you are/were a psychiatric administrator.

***1. Are you currently in an administrative/leadership position?**

- ◯ Yes
- ◯ No

Other (please specify)

***2. If Yes, how many years have you been in an administrative/leadership position?**

***3. What percentage of your time do you spend in the following responsibilities?**

	<25%	25-50%	50-75%	>75%
Administration	◯	◯	◯	◯
Teaching	◯	◯	◯	◯
Supervision	◯	◯	◯	◯
Research	◯	◯	◯	◯
Direct Patient Care	◯	◯	◯	◯

Other (please specify)

***4. Your Gender**

- ☐ Male
- ☐ Female

***5. In your first administrative position, were you:**

- ◯ Appointed, from within the organization, but were not actively seeking/considering the position?
- ◯ Appointed, from within the organization, and were actively seeking/considering the position?
- ◯ Appointed to the position through a job search?

Page 1

GAP Administration Committee

***6. What do you consider your most challenging issues in your role as an administrator/leader?**

	First	Second	Third	Fourth	Fifth	Sixth	Seventh	Eighth	Ninth
Fiscal Resources	◯	◯	◯	◯	◯	◯	◯	◯	◯
Recruitment	◯	◯	◯	◯	◯	◯	◯	◯	◯
Retention	◯	◯	◯	◯	◯	◯	◯	◯	◯
Health Information Technology	◯	◯	◯	◯	◯	◯	◯	◯	◯
Physical Plant	◯	◯	◯	◯	◯	◯	◯	◯	◯
Regulatory	◯	◯	◯	◯	◯	◯	◯	◯	◯
Legal	◯	◯	◯	◯	◯	◯	◯	◯	◯
Ethical	◯	◯	◯	◯	◯	◯	◯	◯	◯
Quality of Care	◯	◯	◯	◯	◯	◯	◯	◯	◯
Monitoring of Outcomes	◯	◯	◯	◯	◯	◯	◯	◯	◯

Other (please specify)

7. For some, transition from a predominantly clinical role to an administrative role can have implications for one's self-concept or identity (e.g. no longer being a clinician, giving up the "white coat", going to the "dark side", etc.). Did you have experiences/feelings like this?

◯ Yes

◯ No

Comments, if any

8. Do you see yourself as:

◯ A Clinician

◯ An Administrator

◯ Both

◯ Other

Comments (if any)

GAP Administration Committee

9. Do others, in your system, see you as:

- ◯ A Clinician
- ◯ An Administrator
- ◯ Both
- ◯ Not Sure

Comments (if any)

10. Which category below includes your age?

- ◯ 30-39
- ◯ 40-49
- ◯ 50-59
- ◯ 60-69
- ◯ 70 or older

APPENDIX B: OTHER CATEGORY TEXT RESPONSES

1. Coordinating team efforts to common goal
2. Dealing in a MHC with non-physician leadership and the struggles that occur due to this
3. Poor supervision and support from MY administrative leaders
4. Stimulating research
5. Dealing with own administration!
6. Political landscape
7. Education of residents in psychiatry
8. Managing people issues
9. Really too early to answer
10. Organizational issues- getting people to work together
11. Staying relevant as a part time medical director. There is no clear priority of challenges
12. Current political leadership bought off by lobbyists over riding any ethical concerns
13. Deadly toxic organization structure and culture
14. Monitoring outcomes is #10
15. Human resources (i.e. difficult people within the organization)
16. Inspiring the next level of leaders and employee satisfaction
17. Because my administrative duties were in an earlier era, I don't think my answers would be currently relevant
18. Negotiating personnel resource allocation internally
19. Would have to answer from my past administrative roles
20. Faculty development
21. Change in leadership

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