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TRANSFORMING AMERICA'S MENTAL HEALTH CARE SYSTEM:
Recommendations of the New Freedom Commission on Mental Health

Sy Atezaz Saeed, M.D.

The New Freedom Commission on Mental Health recently presented its final report *Achieving the Promise: Transforming Mental Health Care in America* to the President. The product of a year of study, the report builds on research literature and comments from more than 2,300 consumers, family members, providers, administrators, researchers, government officials, and others. Commission concludes that traditional reform measures are not enough to meet the expectations of consumers and families. To improve access to quality care and services, the Commission recommends fundamentally transforming how mental health care is delivered in America, a transformation that involves consumers and providers, policymakers at all levels of government, and both the public and private sectors.

In his charge to the Commission, President Bush directed its members to study the problems and gaps in the mental health system and make concrete recommendations for immediate improvements that could be implemented by the Federal government, State governments, local agencies, as well as public and private health care providers.

In its final report, the commission found that the current system was unintentionally focused on managing the disabilities associated with mental illness rather than promoting recovery, and that this limited approach was due to fragmentation, gaps in care, and uneven quality. Recognizing that thousands of dedicated, caring, skilled providers staff and manage the service delivery system, the Commission did not attribute the shortcomings and failings of the contemporary system to a lack of professionalism or compassion of mental health care workers. Rather, it attributed the problem to the manner in which the Nation's community-based mental health system had evolved over the past four to five decades.

The report maintains that the Nation must replace unnecessary institutional care with efficient, effective community services that people can count on. It further states that there is a need to integrate programs that are fragmented across levels of government and among many agencies.

The Goal of a Transformed System: Recovery

The commission recommends a focus on promoting recovery and building resilience. The report offers the following definitions for recovery and resilience:

> ***Recovery:*** the process in which people are able to live, work, learn, and participate fully in their communities. For some individuals, recovery is the ability to live a fulfilling and productive life despite a disability. For others, recovery implies the reduction or complete remission of symptoms.
>
> ***Resilience:*** the personal and community qualities that enable us to rebound from adversity, trauma, tragedy, threats, or other stresses - and to go on with life with a sense of mastery, competence, and hope.

The Commission identified six goals as the foundation for transforming mental health care in America as listed in Table 1. The goals are intertwined. No single step can achieve the fundamental restructuring that is needed to transform the mental health care delivery system.

Throughout the report, the commission has identified private and public-sector model programs that provide examples of how aspects of mental health care have been transformed in selected communities. Commission's findings, goals and recommendations are designed to be assessed and carried forward not only by federal agencies and offices, but also by states and communities, and public and private providers, nationwide. The commission urges all shareholders in mental health to work together to make recovery from mental illness the expected outcome.

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http://www.mentalhealthcommission.gov/reports/FinalReport/toc.html. ACCESSED August 19, 2003.

Additional information about the commission and both its Interim and Final Reports are available on the Internet at www.MentalHealthCommission.gov. Print copies of the commission's final report can be obtained by calling the Substance Abuse and Mental Health Services Administration's National Mental Health Information Center at 1-800-662-4357 or 1-800-228-0427 (TTD).

Table 1: Goals and Recommendations In a Transformed Mental Health System...

Goal 1	**Americans Understand that Mental Health is Essential to Overall Health.**	
	Recommendations	1.1 Advance and implement a national campaign to reduce the stigma of seeking care and a national strategy for suicide prevention. 1.2 Address mental health with the same urgency as physical health.
Goal 2	**Mental Health Care Is Consumer and Family Driven.**	
	Recommendations	2.1 Develop an individualized plan of care for every adult with a serious mental illness and child with a serious emotional disturbance. 2.2 Involve consumers and families fully in orienting the mental health system toward recovery. 2.3 Align relevant Federal programs to improve access and account ability for mental health services. 2.4 Create a Comprehensive State Mental Health Plan. 2.5 Protect and enhance the rights of people with mental illnesses.
Goal 3	**Disparities in Mental Health Services Are Eliminated.**	
	Recommendations	3.1 Improve access to quality care that is culturally competent. 3.2 Improve access to quality care in rural and geographically remote areas.
Goal 4	**Early Mental Health Screening, Assessment, and Referral to Services Are Common Practice.**	
	Recommendations	4.1 Promote the mental health of young children. 4.2 Improve and expand school mental health programs. 4.3 Screen for co-occurring mental and substance use disorders and link with integrated treatment strategies. 4.4 Screen for mental disorders in primary health care, across the life span, and connect to treatment and supports.
Goal 5	**Excellent Mental Health Care Is Delivered and Research Is Accelerated.**	
	Recommendations	5.1 Accelerate research to promote recovery and resilience, and ultimately to cure and prevent mental illnesses. 5.2 Advance evidence-based practices using dissemination and demonstration projects and create a public-private partnership to guide their implementation. 5.3 Improve and expand the workforce providing evidence-based mental health services and supports. 5.4 Develop the knowledge base in four understudied areas: mental health disparities, long-term effects of medications, trauma, and acute care.
Goal 6	**Technology Is Used to Access Mental Health Care and Information.**	
	Recommendations	6.1 Use health technology and telehealth to improve access and coordination of mental health care, especially for Americans in remote areas or in underserved populations. 6.2 Develop and implement integrated electronic health record and personal health information systems.

PRESIDENT'S COLUMN - FALL 2003

THOMAS W. HESTER, M.D.

Aloha, fellow members of the American Association of Psychiatric Administrators (AAPA). I want to welcome you to my inaugural AAPA President's Column from my home – Hawai'i. I look forward to communicating with you, through this column, in each edition of the Psychiatrist Administrator during my two-year tenure as your President. This will give me an opportunity to inform all members of major issues and initiatives of the AAPA.

Our organization has a rich history. The American Association of Psychiatric Administrators was founded in 1961 and was originally named Medical Superintendents of Mental Hospitals. One of its early goals was to increase the number of psychiatric hospitals that were accredited by the Joint Commission on Accreditation of Hospitals. When Dr. Chris Fichtner completed his presidential term, this year, he joined the 35 other psychiatrists who have provided leadership to our organization. The Council members who are listed on page 2 of this publication now guide the AAPA.

Currently, AAPA has 165 dues-paying members. Our members range from trainees to internationally recognized experts who are involved in the administration of organizations that range from solo practice to large health care systems and represent public, private, and academic settings. Despite this diversity, we share a common mission – to promote medical leadership that enhances the effectiveness, efficiency, and humanity in service delivery.

To achieve this mission, the AAPA supports several major activities:

- ❖ The NewsJournal which is published at least twice a year;
- ❖ The Annual Membership Luncheon at the APA meeting;
- ❖ The APA CME Course on Administrative Psychiatry;
- ❖ Several symposia at APA meetings;
- ❖ The Web site, www.psychiatricadministrators.org; and
- ❖ Liaison with APA Committee on Management and Administration.

The AAPA Council has recently launched three (3) new initiatives in order to continue our revitalization. The first initiative is an effort to improve communication and coordination of the AAPA Council throughout the year by convening three (3) conference calls in addition to the annual face-to-face meeting in May at the APA Conference. Twelve (12) council members participated in the first conference call on August 8, 2003. Minutes of this active and productive teleconference will be posted on our web site. The next call is scheduled on October 31, 2003 at 1:00 p.m. Eastern Standard Time. The second initiative is to increase AAPA revenues by seeking sponsors for our NewsJournal. Early results have been encouraging. The third initiative is to recruit new AAPA members by letters targeted to members of other organizations that include significant numbers of psychiatrist administrators. These organizations include the American College of Physician Executives; the APA Caucus of State Hospital Psychiatrists; and the National Association of State Mental Health Program Directors, Medical Directors Council.

As you can see from this brief overview, AAPA is an organization with a rich history and an array of valuable activities. We are now taking steps to make AAPA even stronger by improving planning and communication, enhancing revenues, and expanding our membership. As we grow stronger, we will be recognized as being a major force in the development of impactful psychiatric leadership. I will keep you informed of our challenges and progress.

MAXIMIZING THE BENEFITS OF PEER REVIEW

Malini Patel, M.D., Daniel W. Hardy, M.D., J.D., Pankaj H. Patel, M.D., M.Sc., Carol Black, M.D., Randy Thompson, M.D., Dan Giffort, Ph.D., Thomas M. O'Brien, J.D.

Peer review is an essential component in the evaluation process of physician performance in hospital and outpatient treatment settings (1). At it's best, peer review has been called a "valued collegial process within medicine" (2). At worst, it serves as an ineffective mechanism for monitoring ill-defined standards of care and is met with resistance or indifference. We suggest that an equitable peer review process which interfaces with and augments other established review procedures can generate enthusiasm and effect positive changes in practice.

THE CONCEPT

The reader is referred to the above Figure for a diagrammatic representation of the following discussion (3).

The most obvious interface for peer review is with the credentialing and privileging process. If peer review is accomplished on an ongoing basis and not simply as a substitute for a mortality and morbidity review in bad outcomes, and if it demonstrably incorporates objective measures and processes, peer review will form the foundation for clinician reprivileging, performance measurement, and necessary corrective action.

The interface between peer review and competency assessments and performance evaluations is less obvious, but perhaps more important. An appreciation of these relationships requires an understanding of the difference between competency and performance. An assessment of competency focuses on the question: Does the clinician have the skills to do the job? A performance evaluation asks: How well was the job done?

If an individual clinician consistently scores poorly on a particular peer review item, he or she may not have been adequately trained on the matter, or may be in need of a refresher course. If a clinician scores poorly in several areas during his or her probationary hiring period a reconsideration of the employment offer may be in order. If a number of clinicians are achieving negative scores on the same peer review item, a discipline-wide, or even hospital-wide, training program may be needed. These are competency issues. If, on the other hand, a clinician scores poorly in a number of areas where previous scores were acceptable, one might well consider the possibility of an impairment—a performance issue.

It is important to note that peer review information in our state is treated as non-discoverable in legal actions. For this reason we do not directly reference peer review findings in performance evaluations but use the findings as a starting point for further inquiries. The reader is advised to consult with hospital legal counsel regarding this issue, as laws may vary in other jurisdictions.

In some cases a systems review extending beyond the clinical area may be warranted. Peer review at the hospital of the senior authors (MP, DH) disclosed that a significant number of patient charts did not contain written consents for medication, a statutory requirement in our state. Ultimately, we were able to establish that the cause lay not with our psychiatrists but with the flimsy paper on which the forms were printed which resulted in the consents falling out of many of the charts. We now utilize plastic binders for our consents.

Thus, peer review data can be appropriately utilized to drive such diverse improvement efforts as EAP referrals and materials reviews.

THE IMPLEMENTATION

Not unlike the competency/performance dichotomy, a comprehensive peer review process measures both whether and how well certain identified tasks are done. The psychiatric peer review process developed by the senior authors begins as a chart review conducted by any one of several of our attending staff whom we have assigned to this duty. Such assignment involves a brief orientation regarding our expectation of timeliness, and an assessment of inter-rater reliability whereby a newly recruited peer reviewer and two seasoned "pros" are asked to review the same two charts with the expectation that results will be substantially equivalent.

Every attending psychiatrist at our hospital has a minimum of four of his or her patients' charts reviewed each year. These charts are not chosen at random. Instead, we intentionally identify charts of patients whose profiles or demographics suggest potential problems based on past Sentinel Events or critical case reviews. Thus, charts of geriatric patients and patients readmitted within 30 days are among those regularly reviewed at our hospital.

The assessment tool we presently use includes 32 questions created by our Peer Review Committee which range from the clearly objective —Do all mental status exams address homicidal and suicidal ideation? —to the primarily subjective —If the patient was on special precautions, were orders and documentation acceptable? Items for review are added as exigencies change. In this manner peer review serves to define the standard of care for our physicians. A question regarding pain management was added as a result of JCAHO's recent focus on that subject (4). Non-critical items where the aggregated "all doctor" scores are consistently 100% are deleted.

The peer reviewer also rates the psychiatrist's overall work as reflected in the chart on a scale of 1 to 5 and forwards the report to the Medical Directors' office for

review. Charts rated 1 (unacceptable) or 2 (follow-up needed) require a response from the clinician and may generate a corrective action plan. Feedback is given on all reviews from the Medical Directors. The identity of the person who reviewed the chart is not disclosed. Any clinician wishing to challenge the peer reviewer's findings may do so, with one of the Medical Directors being the final arbiter.

"All doctor" results are periodically distributed and reviewed at meetings of the Medical Staff Organization. Medical staff input is regularly solicited as to the items assessed and the conduct of the peer reviews.

Figure 1:

CONCLUSION

Peer review can be approached in either of two mutually exclusive ways by hospital administration and clinical staff. It can be seen as a necessary evil or as an opportunity for improving clinical competency and performance. In our experience how it is viewed by administration will frequently determine how it is viewed by staff. Embracing the latter approach, and involving psychiatric staff as well as other disciplines at all levels of planning and execution will, we suggest, maximize the benefits of this otherwise routine hospital function.

Dr. M. Patel is Metro Suburban Network Medical Director at Elgin Mental Health Center, Elgin, IL, and Clinical Assoc. Professor of Psychiatry at Chicago Medical School, North Chicago, IL. Dr. Hardy is Forensic Medical Director at Elgin Mental Health Center, and Clinical Professor of Psychiatry at Loyola/Stritch School of Medicine, Maywood, IL. Dr. P. Patel is Medical Director Quality Improvement, Advocate Health Center, Chicago, IL. Dr. Black is Associate Medical Director, Chicago Read Mental Health Center, Chicago, IL, and Asst. Clinical Professor of Psychiatry, University of Illinois at Chicago. Dr. Thompson and Dr. Giffort were formerly with the State of Illinois, Office of Mental Health. Mr. O'Brien is Asst. General Counsel, State of Illinois, Dept. of Human Services.

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COMMENTARY ON "MAXIMIZING THE BENEFITS OF PEER REVIEW"

by Alan D. Schmetzer, M.D.[1] and John J. Wernert, III, M.D., M.H.A.[2]

Peer review has been used for many purposes, including not only those higher ideals discussed by the authors of this article, but also for managing care for third party payers (1). Both authors of this commentary have served as chairs of the credentials committees for their local hospitals. We concur completely with the authors' assessment of the challenges involved in integrating peer review into the re-credentialing and privileging process. Indeed, most hospitals continue to utilize the same assessment tools that were developed in the 1980s when the Joint Committee on Accreditation of Healthcare Organizations (JCAHO) (2) concentrated their review focus on physician credentialing and handling of poor outcomes.

Peer review has long held a negative connotation in the physician community and was sometimes viewed as a "witch hunt" that could rarely have a good outcome for the examined doctor. After two decades of focus on "enhancing quality" and casting the peer review process as "an opportunity for learning," we believe physicians are now more accepting of the fact that peer review, in some form, is here to stay.

The tool developed and reported by the authors sounds comprehensive and fair. Little detail is given as to the full range of review items and questions asked. However it is clear that such items could be refined easily to reflect an individual institution, priority for a group of doctors, or a particular quality improvement problem area. Nothing is reported as to the "reviewed physicians" feedback or response to the quality record review. We believe that a follow-up article discussing in detail how negative reviews are handled or noncompliant physicians are disciplined would be very helpful to most clinician administrators.

Overall we would have to say that much of what is reported in this article may well already be done in some form at most hospitals and insurance plans. As a behavioral health medical director of a local insurance plan (65,000 members), one of the authors (JJW) has developed and approved such review tools for several years. National Committee for Quality Assurance (NCQA) guidelines insist upon a similar process (3). The real challenge would be to apply such quality reviews to the licensing process!

Nonetheless, the authors of this article discuss not only a process, but also an attitude with which they would like to see peer review pursued. The process is outlined clearly in their article and the accompanying diagram. It is the attitude about which more comment might be useful.

Peer review is one of a number of "paperwork" issues to which physicians are required to attend as part of "good citizenship" within the hospital(s) in which they practice. But "most professional education does not include training in administration" (4) and this can lead to a devaluation of such duties. Patel and colleagues argue that peer review may be seen as a way of identifying specific problems in, and improving upon, clinical competence and performance, hopefully also improving mental health status and quality of life for those served in such care systems. This is, indeed, a mandate for all psychiatric administrators and managers, according to Dr. Michael Freeman in his introduction to the Textbook of Administrative Psychiatry (5). While we agree with the values espoused by Patel et al, we believe that it will take more than a good process, or even a buy-in from current leaders, to bring about such a shift in values. We would say that this is far too late. Instead, we would argue that residents in psychiatry and other clinical trainees must have course work specific to the theories and benefits of administrative activities such as peer review built into their training. Involvement in peer review is mandated by the Residency Review Committee in Psychiatry (6), but our program has also initiated an Administrative Psychiatry course for senior residents. This was begun some five years ago, but we cannot as yet provide any data on whether this attitude shift will be one of the benefits derived from such an educational experience.

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The AAPA on line . . .

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If you have suggestions, we would like to hear from you!
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PSYCHIATRIST ADMINISTRATOR WELCOMES ITS NEW ASSOCIATE EDITOR, **Arthur Lazarus, M.D., M.B.A.**

Dr. Arthur Lazarus is senior director of clinical research for AstraZeneca Pharmaceuticals, based in Wilmington, Delaware. Dr. Lazarus has responsibility for establishing AstraZeneca as the gold standard for medical research by developing and managing strategic clinical trials for pharmaceutical products and ensuring their successful deployment in the United States.

Dr. Lazarus has more than 20 years of experience in health care practice and administration. Before joining AstraZeneca, Dr. Lazarus served as director and medical research specialist for Pfizer Inc. He earlier had led quality management and care delivery programs at Humana, Prudential Health Care and Independence Blue Cross. Dr. Lazarus also has administered community and academic hospital and institutional programs.

Dr. Lazarus received his medical and business degrees from Temple University in Philadelphia, Pennsylvania. He is one of only a handful of physicians in the United States to have been inducted into both the Alpha Omega Alpha medical honor society and the Beta Gamma Sigma honor society of collegiate schools of business. Dr. Lazarus is an active member of several professional and medical organizations and currently holds academic appointments at Temple University School of Medicine and Drexel University College of Medicine.

A Fellow of the American College of Physician Executives, Dr. Lazarus has published over 100 articles in scientific and professional journals and has co-authored or edited four books.

Dr. Lazarus resides in Chadds Ford, Pennsylvania, with his wife and four children.

NEGOTIATION IN MENTAL HEALTH SYSTEMS[1]

Daniel J. Reid, D.P.P., M.B.A.[2]
William H. Reid, M.D., M.P.H.[3]

Some people hate the thought of negotiating anything. They get sweaty palms when it's time to buy a new car. They turn down free trips to any country with street vendors and open-air markets. *These people equate negotiation with confrontation.* There is some confrontation in negotiation, but serious, successful negotiating in the management environment is much more than simple haggling.

Negotiation is part of successful management. This article will help you to get more than you *need* from other people. It will introduce you to the principles of getting what you *want* from them. It will show you that getting the best deal for yourself or your organization is not always the same as defeating the other party, nor are the two mutually-exclusive.[4] We'll discuss multi-party negotiations, coalitions, optimizing, negotiating your own salary and perks and, of course, hostage situations.

Hostage Situations?

What better place to start our discussion than with life-or-death scenarios, bristling with weapons and words like "Get me a helicopter and five million dollars or the old lady gets it in the belly!"

> A New York man who had just committed armed robbery ran from police and barricaded himself in a small apartment with a woman, threatening to kill her. He demanded a number of things, including safe passage from the scene. Reinforcements were called, and soon the building was surrounded.
>
> Instead of rushing in with guns blazing, the police called a specially-trained negotiator. He began to talk with the perpetrator, gaining his confidence and even promising him a ride through Central Park in a patrol car. No shots were fired and after several hours, the man surrendered.
>
> Although the local officers wanted to take him directly to jail, the negotiator insisted that the perpetrator be given his ride through the park. When asked why the city should waste good gasoline on a criminal, the negotiator replied that he had made a promise, in the name of the city, and that it should be kept.
>
> The criminal must have talked about the episode in jail, because several months later, another hostage situation arose, with the same negotiator. The new perpetrator recognized the negotiator's name and, after some acceptable compromise, gave himself up. He later told the negotiator "I knew I could trust you; you kept your promise about the ride through the park."

The vignette above is based on a true story. The negotiator was then-detective Frank Bolz of the New York City Police Department, who developed many of the hostage negotiation techniques now used by law enforcement agencies across the country. Those techniques are based on the premise that the best way to get what you want is not just to flex your muscles, but to *understand the opponent's interests and be sure everyone comes out alive*. Let's take a look at what happened.

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[1]This article is taken from the manuscript *Tech To Exec* by William H. Reid and Daniel J. Reid, and includes material reprinted in WH Reid and SB Silver (eds.): *Handbook of Mental Health Administration and Management* (New York: Brunner-Routledge, 2003).

[2]President and CEO, Paladin International, LLC and its subsidiaries Paladin Negotiations and Paladin Special Operations (www.paladinnegotiations.com).

[3]Clinical and forensic psychiatrist, mental health management consultant, Horseshoe Bay, Texas (www.psychandlaw.org). Address comments and reprint requests to reidw@psychandlaw.org.

[4]Getting what you want can, and often should, actually benefit the other side.

First, law enforcement agencies have learned the hard way that deadly force should usually take a back seat in situations in which the other person has something you really want. Wading in with guns blazing can hurt a lot of innocent people, and almost always hurts the agency's reputation.[5] The order of the day is "Calm down and examine the situation."

Second, the negotiator is specially trained and usually *not* empowered to make big decisions (such as ordering a helicopter and $5 million). This person is responsible for the negotiating process, and will try to develop an outcome that will be *optimal for his organization* (in this case law enforcement and local citizens) and *acceptable for the other party*. In the hostage example, that means everyone comes out unhurt and the perpetrator ends up in custody. The idea that everyone can come out of the situation unhurt is communicated to the perpetrator, while keeping in mind (but not usually revealing) the things the police are willing — and not willing — to offer as bargaining chips. They will not, for example, trade weapons for hostages, and it is very unusual for a policeman to take the place of a hostage, no matter what one sees in the movies.

Third, *honesty is surprisingly important in negotiation*. Credibility can go a long way if one should have to restart failed negotiations, deal with the same person at some future time, or deal later with someone who has heard about the current negotiation.

Finally, the negotiator is aware of his organization's absolute limits for negotiation, the "choke point" beyond which he will not go. If the choke point is reached, negotiations cease (one way or another). Many law enforcement agencies have a policy that "deadly force" will be strongly considered if the perpetrator injures a hostage after negotiations begin. In the world of health care organizations, the offended party usually just leaves the table.

Non-lethal Applications of Negotiation

You have probably already guessed that we will use the above example to illustrate some tenets of successful business negotiation.

- A little fear can be a good motivator, but regularly flexing your (or your organization's) muscles is a poor way to get what you want. It may work if you're the only game in town, but it irritates and sometimes frightens the other players. You probably will have to work with those people in the near future. Why would you want to irritate or frighten them? For example, if a health care organization can purchase supplies or rent office space from any of several local vendors, it may be tempting to say to one of them "Shave your profit to the bone to please us, or we'll take our huge order to your competition." But business relationships built on cutthroat tactics don't last long. The vendor may desert you at the first opportunity, or join your competition. Don't be a tyrant.

- The negotiator should be experienced. If the deal is really important, organizations often use professional negotiators. Sometimes they are internal (such as buyers or lawyers) and sometimes they are hired for a specific arbitration (such as those chosen for major labor contract negotiations[6]). The professional takes his or her basic orders from the organization, including specifics about what is or is not acceptable and where the choke point lies. The negotiator should not usually be empowered to change these basic policies on his own, nor to accept any unplanned agreement on behalf of the organization.

- The negotiator should look for areas of *optimization*, often by learning what is important to the other party(ies). Let's consider a classic labor-management situation:

[5]A decade or so ago, Philadelphia police confronted members of a radical militant group who had barricaded themselves in a row house. In a tragic mistake of negotiation and confrontation, the city used its heavy artillery. The resulting conflagration, seen on nationwide television, turned public opinion away from the police and caused far more damage — physical and political — than it was worth.
[6]In a 1992 national railroad strike, as in several similar major conflicts, accord was reached by having each side choose a lead negotiator, then the lead negotiators jointly chose a single arbitrator. Finally, when at an *impasse*, each side submitted its "final" offer and the arbitrator was empowered to bind both parties to either of them.

The members of Texas Widget Makers' Local 102 have had it up to here with management that doesn't respect their skills and compensate them accordingly. Furthermore, a number of the members are worried about the dangers of widget making and fear disability and medical bills. There's not much call for widgets in Texas at the moment, and management has threatened either to train its own, non-union, widget makers or to move the factory to Florida. The national union is supporting Local 102 in its demands for salary increases of 50% over three years, special disability insurance, and a guarantee that all widget makers hired will be union members.

Management has been having a tough time selling widgets. There's not much market in Texas, and shipping costs to that great Florida market are so high that manufacturing costs simply must be controlled. The company is the main employer in Niederwald, Texas,[7] and it would be a shame to relocate. They can't afford more than a 10% salary increase right now, but there are good indications that Texas business will pick up during the next two or three years (another reason not to relocate to Florida). They have just discovered that if they can keep a workforce of over 100 people, they are eligible for an excellent, cost-effective, medical benefit plan. If they have to close a widget division because of the threatened strike, the number of employees will dip below 100. To make matters worse, Niederwald just raised its city corporate taxes in order to finance subdivision utilities.

What are some of the issues relevant to the negotiation, and what is their relative importance to each side? Let's outline a few and assign some priorities.

For the **union**, salary is important but the critical thing is keeping the company (and thus jobs) in Niederwald. Union strength is also a priority in this small town, where some feel that labor is at the mercy of management. Health care isn't an overriding concern to the relatively young workforce, and takes a back seat to workplace safety.

Management has to place its highest priorities on operating costs and proximity to a good widget market. Moving would be a lot of trouble, but could be readily accomplished if local costs threaten to drive the company out of business. Safety and health care expenses are moderate concerns, and the company wants to do the right thing for workers and their families. Union strength is a factor, but the company is fairly mobile and is not worried about labor having a stranglehold on operations.

A chart of the each group's relative priorities might look something like this:

	LABOR	MANAGEMENT	CITY
Top Priorities	Jobs Union strength Location	Salaries Market	Tax base Jobs
Mid – Priorities	Salaries Safety	Health care costs Local taxes Safety	
Lower Priorities	Health care	Location Union strength	

The chart suggests two things. First, there are areas in which the two sides' priorities are different, which invites compromise. Later, we'll refer to this as optimization of the system at the expense of some of its parts. Second, there aren't just two

[7]Actually, the largest business in Niederwald, so far as we know, is the Linnaeus Medicine Ball Company. Honest.

sides: At least one outside party (the City of Niederwald) has a stake in the outcome.

What happened? The company and the union realized their mutual interdependence. The union, faced with a glut of members with little other employment opportunity, accepted a one-time 10% salary increase along with a guarantee that if the Texas market indeed improves, salaries will be renegotiated. This allowed the workforce to remain above 100 and medical benefits to be improved**.** Management agreed to 100% union employment in the widget division, since training is expensive and there are plenty of good union workers. Management and labor agreed to develop a joint injury-prevention program, with funding and consultants to come from the national union.

Since company employees were the main prospects for the new subdivision, and company relocation to Florida would cripple the town's growth, the City of Niederwald agreed to delay any tax increase that would affect the company for at least two years.

Good negotiators look for areas of optimization, in which all parties can realize some benefit.

Who did the negotiating? Local 102 hired a professional recommended by the national union. The company decided against an outside negotiator, in part because they wanted to convey a friendly, local image, and chose a team consisting of one of its lawyers and a personnel manager with negotiating experience.

Can You Negotiate Everything?

Some people (and one popular book) say you can; a few even say you should. We once heard a speaker boast that she negotiated the price of her dry cleaning. The cleaners, a small mom-and-pop operation, needed consistent customers and she wanted a single, reliable supplier. She firmly reminded them that she could take her business elsewhere, and believes she got a good deal.

This example raises other issue as well. On the one hand, it is a micro-example of a single-supplier economy (see another case later in this article). On the other, it is kind of silly unless the customer considers services, and not just price. Neighborhood businesses usually can't beat chain-store prices, but may be able to offer special amenities. One might also question the ethics of pushing a neighborhood business (and thus a neighbor) toward insolvency by forcing them to set their prices below those of larger organizations.

Large purchasers, like managed care organizations, medical centers, and government agencies, routinely negotiate deep discounts.

Why a Relationship Is Important

The "single-supplier" concept is a good example of balancing priorities and working together for common goals and mutual benefit rather than simple immediate gain. This concept is not necessarily "win-win" (a vastly overused term which makes little sense in many negotiating situations) or compromise. It is an exercise in efficiency and maximizing long-term gains for your organization. Benefit for the other guy is necessary but irrelevant, in the sense that your (and your organization's) interests are what count. That sounds tough, and politically incorrect, but negotiation is not about being nice for nice's sake. We advocate helping your opponent to the extent that it somehow benefits *you* in the long run (and good will often has significant value), or is at least irrelevant to your success. If the other side gets a lot from the deal — even if they get more than you — you should not care. The point is not to compare benefits, but to get as much as possible of what you want.

Okra Delite, a profitable fast-food chain with about $20 million in annual sales, had reached a plateau in its

growth. For some reason, none of the big investors on Wall Street wanted to capitalize the expansion of the company at acceptable interest rates. The owners decided to talk with their suppliers about discounts, based upon their prediction that the chain would expand and the suppliers would enjoy bigger and bigger orders for raw okra, okra fixins, alcoholic beverages[8] and the like. (We'll use one supplier as an example.)

Sweet Home Okra Farms saw an opportunity to stabilize its own market as well. Okra Delite generally purchased about 20% of the Sweet Home crop, but in some years Sweet Home was outbid by other farms and had lots of okra left over. Moreover, Okra Delite was the only customer that paid Sweet Home close to top dollar (some 80% of the crop usually going to animal feed companies in the Outer Hebrides at great discounts, with attendant shipping costs and export hassles).

Sweet Home agreed to sell okra to Okra Delite at half their current U.S. price, provided the price would be allowed to rise and fall with the consumer price index and provided Okra Delite promised to buy at least 75% of its crop or 100,000 bushels per year, whichever was less, for twenty years. Sweet Home would guarantee safe delivery of high-quality raw okra to all Okra Delite processing plants. If Sweet Home could not grow enough raw okra for Okra Delite's needs, it would locate and deliver additional product, any way it could, at the agreed price plus reasonable shipping costs.

What happened? Okra Delite got a heck of a deal on okra, a dedicated and reliable supplier, and a partner in its future. Sweet Home Okra Farms gained a guaranteed market for its product, a steady stream of revenue, and a partner in its future. The okra industry in general got a boost and help with price stability without government price supports.

A few years later, when okra became one of our most popular vegetables, seed prices skyrocketed. At Sweet Home's request, Okra Delite agreed to help Sweet Home by paying a bit more per bushel than was originally promised. Some time after that, Okra Delite suffered a bad year because of rumors of okra-related baldness. Sweet Home, investing in their long-term, mutually beneficial relationship, allowed Okra Delite to purchase only half of the agreed-upon amount.

This kind of negotiation can have many advantages. A buyer who is willing to guarantee purchases of goods or services for many years can often negotiate excellent long-term discounts, dictate product and service specifications, lower inventory and warehousing expenses, predict costs far into the future, and expect priority treatment in time of need. There is another advantage as well: the buyer has fewer suppliers to deal with and worry about.

The long-range success of the negotiated arrangement depends upon the relationship that forms between purchaser and supplier. If the relationship is built on mutual needs, trust, and respect, either party will probably be willing to change the agreement a bit if necessary. Each knows that the enduring benefits of the business relationship often transcend short-term gains or losses. Such a relationship helps the agreement to last because it fosters good communication, and therefore allows flexibility, or even renegotiation, when needed.

One-Sided Negotiations

Before going any further, we need to warn you: We'll stress mutual satisfaction in negotiation, but don't be so naive that you believe every negotiation can have mutually-optimal (we dislike the term "win-win") results. However, if the parties don't create a relationship for future dealings, the chances of the deal falling through or not remaining optimized increase greatly. If the playing field isn't level, the other guy may not do you any favors. Consider the hapless automobile buyer below (and apply the following to health care, as appropriate).

---

[8]*It is very hard to enjoy okra in any form without an alcoholic beverage.*

One reason most of us don't like to negotiate automobile purchases is that losing isn't any fun. We are in the dealer's and salesperson's arena. They negotiate car sales every day. Only they know the real price of the car, and only they know the dealer's choke point (the lowest acceptable price). You may be satisfied with the deal you get (which is, of course, a measure of success), but unless you are an excellent negotiator, the probability is overwhelming that you won't get the best price the dealer could allow.

Can one make the circumstances close to optimal? Probably not, unless you're buying a fleet of cars. But there may be some things in the negotiating process that can make the outcome better for the buyer.

Certain parts of the deal, such as selling price, accessory markup, inventory cost, and (often) local reputation, are more important to the dealership than others. For example, the dealer would rather sell a car from stock, where it is devouring finance and storage dollars, than order one from the factory. The salesperson's priorities, on the other hand, are often limited to a quickly-consummated sale and an acceptable commission.

By the same token, certain parts of the deal are more important than others to you, the buyer. Perhaps you are very interested in service after the sale, with a loaner car for every tune-up and a promise that if the transmission falls out, they'll take the whole car back. Maybe you need the car delivered to a special place on a special day, with a big sign that reads "Welcome Home, Shirley."

The point is to try to learn the other person's priorities, then work on those areas in which you don't mind attending to his priorities and *vice versa.* In this example, try telling the dealer that you're willing to take a car from existing stock, provided you pay less for it and get a special deal on service. The dealer might go for it, since his service costs will not change much in any event, to get you to sign on the dotted line.

Some people buy new cars by soliciting written bids for a very specific model from several area dealerships. This can be a good strategy when one sticks to the original game plan, but it falls apart if one allows the model to change, accessories to be added, or salespeople to call.

Here's a critical point for all negotiations: *If you are not prepared to establish your choke point and "deal breakers," and then walk away if your terms aren't met, your "negotiation" is probably a waste of time*. It is pointless to tell the salesperson you won't budge if you really will; any experienced negotiator (or salesperson) will sense your lack of commitment. That's why car dealers invented those magic words, "this special price is only good if you buy right now."

> ***The ease with which you can walk away and not look back is one of your biggest assets. The absence of that asset is a serious liability.***

As in the Niederwald example, it is often useful to actually list the issues to be negotiated and their respective priorities. Is price your first priority? Location a distant third? How much would one priority item have to change, positively or negatively, before it offset other considerations of the deal? Where do you think the other side's priorities lie? How might you get information that could help level the playing field? In some negotiations, one can literally run the numbers and priorities by formula, and thus be prepared to respond quickly to the other party's offers.

What Does Your Side Have to Offer?

To succeed in any negotiation, one must have something to offer *and must be able to describe it convincingly.*

> ***Successful negotiation depends on having something to offer.***

You or your organization may have more to offer than you think. In the car-buying scenario above, you have money and little else. That's not much clout. But in other negotiations the things you bring to the table can be significant.

> Nancy never thought much about asking for a raise until she turned 40 and realized her retirement plan was woefully underfunded. She had been a psychologist with the same managed behavioral health care organization for years and, given problems in the managed care industry, felt lucky just to have a job. Nevertheless, it was clear that she had to do something if she expected to support herself and her husband in the years ahead. She talked with Fred, another psychologist, just after the boss turned down his request for a similar raise. "Psychologists are a dime a dozen," Fred had reflected, "and the company knows it."
>
> A couple of months later, Nancy got her raise, along with a promotion to a supervisory position. She had successfully convinced her boss to go to bat for her with upper management by reminding him that she was not only an excellent psychologist, but that she made him (her immediate superior) look good as well. Her professional track record was very good, and she helped others to perform at their best. She showcased her skills as a team player, letting management know she had studied the company goals and objectives and was ready to do what it took for both the company and herself to succeed. She did not threaten to quit, but she knew that they knew she was serious about advancement, and that training another person with her qualifications would be expensive. She showed management that she had much more to offer than her clinical skills.[9]

Try to Reach the Person Who Can Say Yes

Many interactions that sound like negotiations are really mere discussions. Lots of people are authorized to turn down requests, suggestions, and offers of negotiation; far fewer are empowered to say "yes." Most of the former don't know what you want or what you have to offer, can't act on anything without someone else's permission and, no matter what they tell you, won't take your offer or idea to upper management. You may feel you are getting somewhere when talking with peers or middle managers about some conflict or concept, but that alone rarely leads to a decision in your favor. Similarly, an important-sounding committee may have a worthy topic to explore, but unless the result goes to someone who is authorized to act, its time has largely been wasted. Lots of ideas that are important to you never reach the real decision-makers.

What can you do? We suggest you respect your organization's chain of command, but try to do your negotiating with people who have the power to act.

> ***Communicate with the person who can say "yes." Don't spend too much energy on those who have only enough authority to say "no."***

Complex Negotiations and Coalitions

Complex Projects. Large projects involve several important parties or groups directly, and many more that are less important but should be considered. Public agency projects, for example, usually require approval by many people and entities before they may proceed. Similarly, starting or changing a complex service line often means negotiating with new suppliers, staff candidates, and financing resources, all of whom must arrive at acceptable agreements at about the same time.

The negotiating principles are similar to the concepts we've discussed, but the complexity of the process increases almost

[9]She had also read this article, but putting that into the example would be tawdry and self-serving.

exponentially with the number of parties to be satisfied. Recruited clinicians want job and salary guarantees. Existing staff need interim plans for patient referral and care (as well as reassurance about their jobs). Unions want a fair balance of compensation and job security. In really big projects, suppliers want purchase guarantees before tooling up to provide bulk materials. The community wants to increase its tax base, maintain service levels, and keep new traffic to a minimum. Venture capitalists want control over the business plan. The list goes on, depending on the undertaking.

Some of the interest groups will collaborate; others will play off each other. City government, for example, may not be able to offer local tax relief because federal loan guarantees are linked to a certain level of taxation. The unions may be torn between local jobs and the competition the new project will mean for other health care employers. Bankers and other capitalists may use fears of labor unrest to demand higher interest or a greater voice in organization affairs.

Coalitions. Smaller groups can get pushed around in the struggle. Their best bet is often to try to align themselves, in official or unofficial "coalitions" with one or more other groups with whom they can find some common ground. Thus a small advocacy group, for example, in an effort to gain support from a regional chapter of the National Alliance for the Mentally Ill (NAMI), may loudly proclaim that the new clinical service will discriminate against some people with mental illness. The NAMI chapter, on the other hand, may not wish such a coalition (or may unexpectedly dissolve it later in the negotiations) if they perceive a conflict between the small group's concerns and those of NAMI constituents.

Some coalitions are more effective than others, and all are targets for efforts to split them apart. In the long run, small groups benefit most from coalitions with other small groups. They are usually not very valuable to larger groups, and are thus vulnerable to being sacrificed when the going gets tough. Large, influential groups need good reasons before they will go to the trouble of allying themselves with disparate small groups.

Let's pause a moment and apply what we've just described to the structure of a single organization, such as your own. Do you see different internal factions? Conflict among strong and weak interests? Compromise and coalition? As you recognize these and try to get what you want, you should slowly become aware that resolution of conflict and *optimizing overall system interests and resources* is one of the organization's overriding goals. Senior management must not allow any part of the system to flourish at the expense of the whole (i.e., the organization mission and goals).

> ***When negotiating within your organization, be able to demonstrate that your position helps optimize the system, not merely a part of it.***

Negotiating Emotional Issues

In the real world, the heat of conflict often ignites even cool business heads; polite demeanor can go south in a hurry. Dr. John Sheridan, L.R. Jordan Professor of Health Services Administration at the University of Alabama, listed a number of "conflict management" principles which are particularly applicable to negotiations in which the parties are highly sensitive or emotionally involved:

- **Separate the *people* from the *problem*.**[10] A negotiation is not about friendship, but it is about relationship. Liking or disliking the other people is irrelevant, but you will probably have to work with them in the future. Listen actively to the other person. When you do speak, express regard for him or her and keep the topic on the issues. Avoid wording that is likely to worsen the conflict.

- **Focus on the interests being negotiated, not on "position" or "posturing."** The word "position" implies

[10]This concept was developed earlier by Professor Roger Fisher, emeritus of Harvard Law School, and is one of the seven elements of a successful negotiation highlighted in the Harvard negotiation program.

something stationary. Negotiation is *fluid*. Stationary people have to defend their positions. Even worse, you may end up becoming an attacker. Optimization and interests are often lost. When someone states a position, look for the needs that lie behind it. Search for common ground, perhaps even rewording the issue being negotiated in a way that lends itself to optimization for all parties.
Try taking the word "position" out of your vocabulary for a week and see what happens. Look for other ways to describe where you are and what you want. If someone uses the p-word, tell him or her that it implies a rigid, take-it-or-leave-it attitude that creates a barrier to getting the deal consummated.

- **Generate several options before pronouncing what you want to do.** Divide the issue into workable problems and develop propositions to which most parties can say "yes." Make it easier for the other party(ies) to come to a decision.

> ***Try to make it easier for the other party(ies) to come to a decision.***

- **Strive to have all parties use fair and reasonable criteria in the negotiation.** Be practical and open to others' interpretations of the criteria; but yield to principle, not pressure.

Who Should Negotiate and How Much Should He or She Care About the Outcome?

Here's one last principle to put in your hat until you need it: It is difficult to negotiate matters that are crucially important to your own interests. That sounds odd, but a bit of reflection will bear it out. After all, the best lawyers don't defend their own families. The company CEO doesn't lead the negotiating team for government contracts. The chief of police doesn't negotiate directly with hostage takers or terrorists.

One reason is obvious: When it really matters, or is out of your league, one should use the best negotiator around (and sometimes hire an outsider). Few CEOs, and almost none of the readers of this article, meet that test. You know health care. You probably know enough to help set the parameters and choke points of some negotiations. But you aren't a professional negotiator.

Does this mean you should avoid negotiation? Of course not. But use good judgement and protect the resources with which you are entrusted. Know when to call for help.

> ***Know when the negotiation requires a professional.***

Finally, a professional negotiator once told us one of his secrets. He was flying to Europe with an organization CEO to negotiate a huge deal, one that could literally make or break either company.

The CEO, noting his relaxed demeanor, said "I'm paying you a king's ransom to get us what we need at the table tomorrow. You're going up against the best they have to offer. Why are you laughing at the in-flight movie while I'm doing all the worrying?"

The professional replied, in essence, "I take you and your company very seriously. You've coached me, and I've done my homework. My reputation is on the line. But it's your company, not mine. I can do what has to be done all the more effectively, all the more confidently, because *I care, but not too much.*"

> ***The person charged with negotiating should care about the outcome, "but not too much"***

Is There An Ethical Way?

Column Editor: H. Steven Moffic, M.D., Chair, Ethics Committee

COLUMN INTRODUCTION:

For the past two years, the American Association of Psychiatric Administrators has been giving a course at the annual APA meeting on "Basic Concepts in Administrative Psychiatry." I give the section on Ethics. At the course in May, we discussed an ethical dilemma, using the audience as a virtual ethics committee. The following is a summary of the discussion and outcome.

ETHICAL QUESTION:

A new Medical Director was asked by a staff psychiatrist at a public clinic whether all patients had to sign the new HIPPA form. The patient in question was bipolar, off meds, getting paranoid, had a history of risky behavior, and refused to sign the form. The Medical Director responded that the patient indeed had to sign or be discharged, per the organization's legal consultation and recommendations. Is this an ethical response on the part of this new Medical Director?

RESPONSES:

Many in the audience clearly felt like this policy would cause undue harm to the patient. They thought there should be a clause in the form allowing the patient to not sign, or in the very least, an option for the clinician to waive the signature for clinical reasons. In this case, discharging the patient would likely contribute to the patient worsening and even being at high risk. It was also pointed out that perhaps legal consultation (which was for the entire healthcare institution) did not appreciate the special needs of some psychiatric patients, and moreover that having other options need not pose more risk to the institution. The clinician was worried for her patient.

An audience member commented on another aspect of the case, which was why the new medical director may have initially just gone along with the institution's new policy. Perhaps the new medical director felt his or her position would be at jeopardy if the policy was questioned. Or perhaps, the new medical director did not understand the complexity of the ethical issues and just took what appeared to be the simple path.

RESPONSE OF EDITOR:

This case illustrates the potential conflicts of interest that is mentioned in the Preamble of our "Ethical Principles For Psychiatric Administrators"(1):

Preamble
"The medical profession has long subscribed to a body of ethical statements developed primarily for the benefit of the patient. As a member of this profession, a physician must recognize responsibility not only to patients, but also to society, to other health professional, and to self."

Annotation (1) for Psychiatric Administrators. "A psychiatric administrator will have a greater or lesser degree of responsibility for the well-being of the work setting and for the lives of those employed in that setting. 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. When conflict exists between the needs of the organization or society and the needs of the patients, the psychiatric administrator must be guided by an ongoing commitment to the needs of the patients. If and when the psychiatric administrator can no longer follow these principles, resignation would be an ethical option."

When these conflicts exist, our administrative ethical principles state the need to be "guided by an ongoing commitment to the needs of patients." In this situation, the commitment seemed to be first to the organization and self, not to the patient(s) in question or colleagues.

An additional ethical principle also seems relevant to this case, this being Section 5, Annotation 3:

"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."

Applying this annotation to the case in hand, consultation with a senior psychiatrist administrator outside of this system would have been an ethical response for the new medical director.

FOLLOW-UP:

After the APA meeting, the responses of the course attendees was relayed to the new medical director, who was not familiar with our ethical principles. Not long afterwards, the organization's policy and procedure regarding HIPPA and the requirement of the patient's signature changed. If the patient refused to sign the form, but the clinician could document that the refusal seemed to be a consequence of their psychiatric disorder, the patient would not need to be discharged.

Though only one example, this administrative case study indicates the possible real life utility of our ethical principles. If you have other examples, please send them to me. In the meanwhile, disseminating our principles to any psychiatric administrator, especially young and/or new ones, whom you know may prove to be helpful. The major ethical risk to patients for psychiatric administrators may not be concern for the organization, but rather undue concern for our own self-interest.

References:

1. Moffic, Steve (2000). Ethical principles for psychiatric administrators: The AMA priniciples of medical ethics, with annotations especially applicable to psychiatric administrators. American Association of Psychiatric Administrators Newsletter: Summer 2000, pp 5-9

MANUSCRIPT REVIEWERS:

Psychiatrist Administrator is currently seeking psychiatrists interested in serving as a manuscript reviewers for the journal. If you are interested in serving in this capacity, please contact (or send inquiries to):

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CALL FOR PAPERS

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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ELEVEN CANDIDATES PASS THE NEW STREAMLINED ADMINISTRATIVE CERTIFICATION EXAM

Stuart B. Silver, MD

The new, single written examination combining multiple choice and brief essay questions was administered for the second time in May 2003. Of the 17 candidates who sat for the examination, 11 passed (pass rate of 65%). The application deadline for the May 2004 examination is February 1, 2004. Earlier applications are encouraged in order to allow candidates more time to prepare.

We wish to recognize and congratulate the following candidates who successfully completed the examination and have received the APA certification in administrative psychiatry: Drs. Surjeet K Bagga, Jeffrey L Clothier, Lourdes J Delgado-Serrano, Edward G Gordon, Yadollah M Jabbarpour, David G Krefetz, Petros Levounis, Thomas S Newmark, Kamel K Raisani, Jeanne L Steiner, and Harold R Veits.

The two-day comprehensive course in psychiatric administration and management was presented for the second time at the San Francisco APA convention in May, 2003 and again was well attended. Many who took the course also sat for the examination and found it a helpful review.

The APA Committee on Psychiatric Administration and Management wishes to remind potential applicants that the examination process is now shorter and less expensive. The committee has eliminated the oral portion of the examination; and has changed the application pre-requisites to enable young and early career psychiatrists to pursue certification. Elimination of the oral examination means that candidates could receive certification just a few months after applying, assuming they pass the written examination.

APA Certification in psychiatric administration and management reflects the candidate's knowledge and skills in four areas: psychiatric care management, administrative theory, budget and finance, and law and ethics, as each applies to mental health administration. APA believes the additional skills and experience found in psychiatrists who fill administrative roles, even part-time, deserve recognition through a certification that recognizes those qualifications. In addition, certification is a visible demonstration of knowledge and skills that may increase a psychiatrist's opportunities for employment or promotion in some settings.

Perhaps most important, persons preparing for the examination go through a substantial educational process which often includes studying texts and articles (some specifically recommended in the application materials), talking with professionals in other fields (e.g., an organization's human resources or budget director, attorney, or senior managers), and/or attending courses, seminars, or workshops on mental health administration.

Prospective candidates must be certified in general psychiatry by the ABPN or an equivalent body, and must have at least one year of substantial experience in general or clinical administration (verified by letters of reference). The experience need not be extensive, but should provide familiarity with general management concepts. A year as an assistant unit or program director, for example, may suffice. Applicants may substitute a year of administrative training during residency or two semesters of graduate-level management courses for the post-residency experience. APA membership is not required.

Further information, application materials, and study recommendations can be obtained from Mark Anderson, APA Department of Continuing Medical Education, (703) 907-8631 (e-mail (MAnderson@psych.org).

Dr. Silver is the Chair of the APA Committee on Psychiatric Administration and Management.

WELCOME NEW MEMBER!

March 2003

Scott McCormick, M.D.

June 2003

David Brody, M.D.
Ronald Cavanagh, M.D.
Mark Putnam, M.D.
Joseph Merlino, M.D.
Rogers Wilson, M.D.

July 2003

Samuel J. Langer, M.D.
Sara L. Stein, M.D.
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August 2003

Robert Carvalho, M.D.
Petros Levounis, M.D.

Changes in the Frequency and Format of

Psychiatrist Administrator

You probably have noticed a recent change in the frequency of how often the *Psychiatrist Administrator* is delivered to your mailbox. With this issue you probably are also noticing a change in the quality of paper and a few format changes. This is a reflection of the fiscal challenges AAPA faces today. Last year our Council decided to reduce the frequency of the Journal from 4/year to 2/year until we resolved the financial difficulties. As you know, the journal has been funded partially through an inconsistent flow of grants and partially through the membership dues. The Council continues to work on this area. I'd appreciate any suggestions that you may have for this area.

Sy Saeed, M.D.
Editor

THE DEVIL'S HANDBOOK FOR ADMINISTRATORS

Daniel W. Hardy, M.D., J.D.

Rule Number One:

Hire good people, then micromanage, them. They will appreciate your concern.

Rule Number Two:

Only associate with those at your own level or above. If you have to go down into the arena of the day-to-day activities of your organization be sure to find something to criticize. If your subordinates get the idea they are doing a good job they will begin to believe they don't need you.

Rule Number Three:

Never miss an opportunity to demonstrate your cleverness. The best way to do this is to expound at length on any subject under discussion. That always impresses people.

Rule Number Four:

Discourage independent thinking among your subordinates. If they manage to accomplish something anyway disparage it or take credit for it.

Rule Number Five:

If you have to give credit to someone else do it in a patronizing manner so others will understand that you could have done the same thing but just didn't have the time.

Rule Number Six:

The best way to stifle dissent is to immediately enunciate the definitive answer whenever an issue raises its ugly head. If that doesn't work try yawning, rolling your eyes, tapping your pencil, or looking down your nose at people when they are trying to speak. That should shut them up.

Rule Number Seven:

Your temper is your most powerful weapon. Use it frequently. Yelling at people never fails to get their attention.

Rule Number Eight:

Avoid making decisions and you will never make a mistake. You can always find something wrong with other peoples' ideas or insist that more information is needed. As a last resort, go away for a few days and delegate the decision making to a subordinate.

Rule Number Nine:

When things go wrong blame others, preferably those who work under you or were with the organization before you came. If that doesn't work blame "the powers that be." They never give you enough recognition anyway.

Rule Number Ten:

If all else fails and you actually get caught making a mistake proudly proclaim that you never make small mistakes. With a little luck you can base an entire career on making big mistakes.

Dr. Hardy is the Forensic Medical Director at Elgin Mental Health Center, Elgin, Illinois, and Clinical Professor of Psychiatry at Loyola/Stritch School of Medicine, Maywood, Illinois.

INSTRUCTION FOR AUTHORS

The *Psychiatrist Administrator* is the official publication of the American Association of Psychiatric Administrators (AAPA). Established in 1961, AAPA is the premiere educational, networking, and support resource for psychiatrists interested in administration and management. The AAPA promotes medical leadership and medical excellence in behavioral healthcare systems, including services for mental illness, substance use disorders, and developmental disabilities.

The choice of *"Psychiatrist Administrator"* is intended to distinguish the NewsJournal from other publications in mental and behavioral health administration in terms of its focus on the roles and perspectives of psychiatrists in leadership and management within evolving systems of care.

The purpose of the NewsJournal is to provide up-to-date, accurate, and easily understandable information to our readership and to contribute to the body of scholarly work in the area of psychiatric administration and management. Your article should be written in a clear, straightforward style that is pleasant to read.

PREPARATION OF MANUSCRIPT

Manuscripts should be typewritten on standard (8 1/2" x 11") white paper with 1" margins on all sides. The entire manuscript, including references and figure legends, should be double-spaced. Each element of the manuscript should begin on a new page: title page, abstract, text, references, tables (typed 1 per page), figure legends. Number pages consecutively through the manuscript. Manuscripts should be no more than 3000 words of text (not including references or tables).

A separate page should be included giving the title of the paper, the names, titles, and affiliations of each author, and the mailing address, e-mail address, and phone and fax numbers of the corresponding author. Any grant support requiring acknowledgment should be mentioned on this page. Acknowledgments other than those of grant support should be put at the end of the text.

An abstract should be provided, preferably no longer than 200 words.

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Authors will receive page proofs before publication. The author should return corrected proofs to Frances Roton, Executive Director AAPA, within three days of receipt; delays in returning proofs may result in postponement of publication.

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Manuscript submission is a representation that the manuscript has not been published previously and is not currently under consideration for publication elsewhere.

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