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Editor Sy Atezaz Saeed, MD, MS

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Executive Director:
Frances M. Bell
P.O. Box 570218
Dallas, Texas 75357-0218
Ph.: (972) 613-0985
Fax.: (972) 613-5532
Email: frda1@airmail.net

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THE DSM REVISION PROCESS AND THE FUTURE DIRECTIONS FOR PSYCHIATRIC DIAGNOSIS

Sy Atezaz Saeed, M.D.

In this issue we have, I hope, start of an interesting discussion regarding DSM and its use. This may be a very timely discussion given that DSM-V is on the horizon. I thought it may be relevant to summarize the DSM revision process to set the stage for our starting discussion.

Although the DSM-V is not scheduled for publication until 2011 (or later), a multiphase effort to provide an enhanced research base in support of the next DSM is well underway. Last year the APA President Steven S. Sharfstein, M.D., and Medical Director James H. Scully, Jr., M.D. appointed David J. Kupfer, M.D. and Darrel A. Regier, M.D., M.P.H. to serve as the Chair and vice chair respectively, of the Task Force that will oversee the upcoming fifth revision[1]. Dr. Kupfer is Professor and Chairman, Department of Psychiatry, University of Pittsburgh Medical Center and Medical Director and Director of Research at Pittsburgh's Western Psychiatric Institute and Clinic. Dr. Regier is the Director of the APA Division of Research and Executive Director of the American Psychiatric Institute for Research and Education (APIRE). The joint appointments are aimed to closely link the professional psychiatric and academic research communities in the development of DSM-V. Under Kupfer's and Regier's leadership, the DSM-V Task Force will establish approximately 20 – 25 Workgroups, each consisting of 8 – 15 members with research and clinical expertise in a given disorder or group of disorders. These work groups will review scientific progress and examine the extent to which new research-based information warrants modifying the current organization or descriptions of disorders, or the diagnostic criteria. The Task Force will also have representation from national and international mental health professional and scientific bodies, National Institutes of Health (NIH), World Health Organization (WHO), and patient and family groups. WHO administers the International Classification of Diseases (ICD), which is the official medical coding system in the U.S. The WHO working closely with the APA on the DSM-V revision will ensure compatibility between successive editions of both the DSM and ICD which in turn will facilitate establishing a common international language for scientists and clinicians to communicate about mental disorders.

The following table summarizes the DSM-V revision process along with the respective timelines:

DSM-V Timeline*

Timeline	Goal/Outcome	Process
1999-2005	Development of DSM-V Preplanning White Papers	In a partnership between APA and the NIMH, a series of "white papers" was commissioned. The goal of the white papers was to incorporate state of the art concepts and technologies into the planning process. They were intended to trigger a paradigm shift away from a classification based on refining the current DSM-defined syndromes and to move the field toward underlying etiologies. Instead of focusing on specific diagnostic areas, the white papers focused on topics that reached across diagnostic boundaries.
2002	Publication of "*A Research Agenda for DSM-V.*"	Six white papers produced were published by American Psychiatric Publishing Inc. as a monograph entitled, *A Research Agenda for DSM-V*[2], *(*Kupfer and Regier, editors). The papers focused on basic nomenclature; neuroscience; developmental science; personality disorders and relational disorders; mental disorders and disability; and culture and psychiatric diagnosis.

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2004-5	Publication of additional DSM-V White Papers	Three additional white papers have been developed and are currently in press. These papers cover diagnostic issues related to gender, geriatric populations, and infants and young children.
2004-2007	Review data from the APA/NIH-sponsored conferences on "*The Future of Psychiatric Diagnosis: Refining the Research Agenda*"	A series of twelve research planning conferences launched in 2004 under the collective rubric, *"The Future of Psychiatric Diagnosis: Refining the Research Agenda."* Nine of the conferences focus on specific diagnostic topics. The remaining three include a methods conference, a conference on public health issues, and a conference to look at the benefits of adding a dimensional component to diagnoses. The conferences have been designed to address a range of nosological topics considered to be either particularly problematic in the current classification or most likely to benefit from new and emerging research capabilities. A summary of the papers presented during the conference is posted on the *DSM-V Prelude* site immediately following each conference. To date, five conferences have been completed[3]. Summaries of each can be found at www.dsm5.org.
2006-	Publication of a monograph series from the proceedings of the APA/NIH-sponsored conferences	The papers from the APA/NIH-sponsored conferences are revised and transcripts of the group discussions are developed into manuscript form. These proceedings of each conference will appear in a monograph series to be published by American Psychiatric Press Inc. The first monograph, *Dimensional Models of Personality Disorders*[4], was originally scheduled to be published in summer 2006. It is now available through APPI.
2007**	Appointment of DSM-V Workgroups	The APA President will appoint a *DSM-V* Task Force charged with laying the groundwork for and overseeing the activities of the *DSM-V* Work Groups. These Work Groups will form the organizational structure designed to assure maximum participation of experts representing a wide range of perspectives and experiences in each of the diagnostic and structural areas covered by the manual. They will continue the *DSM-V* process by examining the accumulated research evidence and making recommendations for criteria changes, additions, and deletions of disorders.
2011**	Publication of DSM-V	

**Source of Information: http:// www.dsm5.org[3]. Accessed April 16, 2007*

** These dates are tentative. Although these events will not occur any earlier, they could occur later.*

More information about the DSM revision process and the current activities are available on the DSM-V Prelude Project Web Site. www.dsm5.org.

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SHIV HATTI, M.D., MBA

Hello Friends,

As I write this, my final President's Column, I want to take this opportunity to reflect on the two years of my presidency. I have truly appreciated your giving me this opportunity to serve as your President, and have enjoyed working with you and my executive team.

In my acceptance speech, I said a goal we should set is to promote medical leadership in the behavioral health care system by educating psychiatrists in administrative issues, and publishing appropriate papers in Psychiatrist Administrator. I also claimed we needed to improve our financial situation by increasing membership and financial support. With the help of my executive team, we have been able to achieve three of the four goals we laid out two years ago.

After a two-year hiatus, we were able to restart the two-day Administrative Course at APA. This will be the second consecutive year the Course is offered and accepted by APA for presentation at our Annual Meeting. Last year the courses were well attended and received very favorable reviews. We must make efforts to continue to offer these courses. Several of our members are also offering workshops and symposia at the Institute and the Annual Meeting, and we should encourage them to continue to do so.

Our editor of Psychiatrist Administrator, Sy Saeed, M.D., and the entire editorial team have done a very impressive job keeping the quality of articles at the high standard we have come to expect. I eagerly look forward to receiving and reading through our journal.

Our treasurer, Douglas Brandt, M.D., has done a superb job improving the financial situation of AAPA by obtaining several grants for the organization. Due to our financial team's efforts, we find ourselves in decidedly better financial shape today than two years ago.

Even though we have increased our membership numbers over the last two years, I still have concerns. One out of five psychiatrists is in some sort of leadership/ administrative position, generally as a medical director. Our membership numbers need to be much higher than they are today. This is a challenge for the new leadership team that will take over in May.

In summary, I can report that our organization is in better shape than it was two years ago. This improvement would not have been possible without my great team of Arthur Lazarus, M.D., MBA, who was available at all times to assist; Douglas Brandt, M.D., who tirelessly worked to get us on solid financial footing; and Sy Saeed, M.D., who worked tirelessly as an editor. Lastly, I would like to thank Frances Bell, our Executive Director, who kept everything on track and moving smoothly, making our job much easier.

My thanks again for the opportunity to serve as your President.

The AAPA on line . . .

Visit our new website: **www.psychiatricadministrators.org**
and let us know what you think.
If you have suggestions, we would like to hear from you!
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A CONCEPTUAL APPROACH TO NEEDS ASSESSMENT IN MENTAL HEALTH SERVICES

Yilmaz Yildirim, M.D.

Introduction

Despite significant improvements in their diagnosis, treatment, promotion, and prevention, mental disorders remain one of the leading causes of disability, in most of the developed as well as in developing countries. In 1990, global burden of disease study showed that depression itself caused Disability-Adjusted Life Year (DALY) second to ischemic heart diseases in developed countries and it was expected to be the second leading cause of disability worldwide in 2020 (1). In the United States, mental disorders account for more than 15% of overall burden of diseases and in the15-44 years age group, it is a leading cause of disability(2). Approximately one in five adults suffers from a diagnosable mental disorder in a given year and only about one third of them get treatment. For children and adolescents, only half of the 21% of population that has diagnosable mental disorders get some treatment from the de facto mental health system (3). Besides emotional and social consequences, both direct and indirect costs of mental disorders have increased steadily through the years. For example, in 1996, $99 billion were spent for treatment which is about 7% of overall health expenditures. (4) Similarly in European Union, 27% of population experience at least one form of mental illness and cost about 3- 4% of gross domestic products mainly due to loss of productivity.(5)

Since it is well-known that mental illnesses affect the well-being of individuals and societies, it is very important to establish promotion and prevention services besides diagnosis and treatment. Establishing these services at community, organization, and individual level requires a thorough needs assessment (NA) that includes identification of problem(s), obtaining necessary information, prioritization of use of resources, and making decisions for policies and services that would be implemented and monitored. In this article, we approach NA as a more comprehensive concept not only towards the community but also towards organizations and individuals. Each level of NA, necessary data sources and importance of sociocultural variables, stakeholders and organization theory in the context of mental health services will be discussed.

Definition of Needs Assessment

In the medical literature NA mainly has been described as either gathering of information or establishing of a service for a target population (6). On the other hand, economists have approached NA in the context of supply-demand, cost-effectiveness, or cost-efficiency. (7) The Institute of Medicine describes health as a combined product of biomedical sciences, public health, psychology, statistics, epidemiology, economics, sociology, education, and other related sciences (8). Therefore it requires a multidisciplinary approach to determine what a community, organization, or individual needs and how these needs will be met and monitored. Keeping this in mind, NA can be defined as a systematic set of procedures to reach the desired state of affair. (9) The set of procedures tries to answer the discrepancy between "what is" and "what should be" at a target population level, at organizational level as health provider, or at individual level. This description encompasses more than obtaining information or allocation of resources. NA should answer the following questions:

i) What is (are) the problem(s) and who are the stakeholders in NA
ii) Who is (are) the target of the intervention(s)
iii) What kind of information is required
iv) How much information is required
v) What kind of resources are required and how they can be used most efficiently
vi) What would be the product of NA
vii) How NA product will be implemented and who is going to be responsible
viii) Who will monitor the implementation and how it will be monitored to provide feedback for continuous quality improvement and cost-effectiveness

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Traditionally epidemiological approaches have been the main method of NA where morbidity and mortality data is used as source of information to identify priorities and to allocate resources. (7) Even though demographic and other socioeconomic variables have been used in NA as necessary, rarely target groups, patients/individuals, and provider preferences and values are included in the procedures. In daily practice, unfortunately, these services have been deficient in meeting the needs of communities and individuals due to various reasons.

The definition and guidelines provided above try to ensure to involve all stakeholders in NA and to have their voices in the process and the product of NA and to make services and policies most cost-effectively and to provide continuous feedback information to make necessary changes as soon as possible.

The Nature and Purpose of Needs Assessment

NA can be done for various reasons and for different levels. Identification and scope of NA and potential uses of the NA findings should be the first step before any further procedures. (9) For instance, developing a promotion and prevention program for depression requires different sets of procedures according to target population and geographic location.

We would like to approach NA in two domains. The first domain encompasses the target population of NA and second domain the purpose of NA. The target population can further be subdivided into three:

i) A whole community itself or a specific group such as child and adolescent population, homeless population, chronically severe mentally ill population and so on.
ii) An organization or group of organizations that provides mental health services. At this level, NA can be done for administration, for human and technological resources, for cooperation and collaboration with other organizations, for staffing and for many other reasons.
iii) NA can also be done at individual level. It is well known that a small portion of sick people utilizes the major portion of the resources. At this level, assessment can be done by involving individuals themselves, families, other important agencies and people in the individuals' life to produce best possible solutions.

Second domain of NA is related to the purpose of needs assessment that can be summarized as follows:

i) At community level: to establish new policies or services or revising existing ones; to reach a specific group of community with a specific reason; to involve all stakeholders in the community for mental health services; to provide human and technological resources that are necessary for communities; to ensure appropriate inpatient and outpatient services for both adult and child & adolescent population and so on (10,11,12)
ii) At organization level: NA can be done at local, regional or national level depending on the purpose of NA such as to make necessary changes at administrative level; to recruit and train staff; to determine human and technological necessities; to cooperate and collaborate with other organizations for the same purpose; to motivate and educate staff for the NA product; to make changes in organizational structure, as necessary.
iii) At individual level: the purpose of NA is to provide best services as much as possible to provide dignified living conditions; to be supportive in individual's social relationships; to coordinate individual's both mental and physical health services; to involve individual's family and other important person in his/her life to provide a support system in the community. Usually individual level of NA is provided by case management or care management.

Data sources in Needs Assessment

Because of comprehensiveness, NA cannot be based only on traditional data sources such as epidemiological findings and surveys. According to the nature and purpose of NA, the data sources and quantity and quality of information should be customized. Practically we can categorize necessary information into three according to the purpose of NA.

i) Data for Community Level NA: Besides traditional data sources each NA should use necessary information according to purpose. This information

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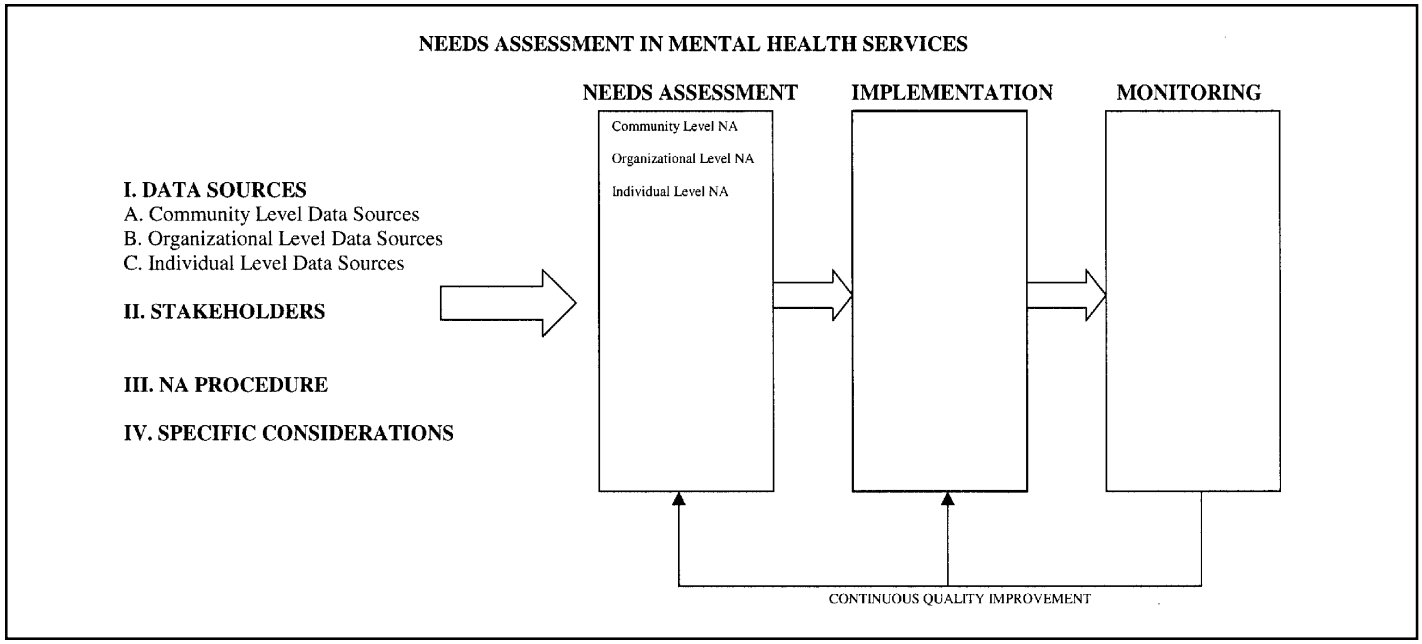
could be census data; hospitalization records; outpatient follow-up records; list of mental health providers such as number of psychiatrists, psychologists, therapists, case managers; social indicators such as level of education, divorce rates, crime rates, substance abuse rates; economic indicators such as poverty level, employment rate, and per capita income. According to the purpose of NA, information can be obtained by special surveys such as from schools, institutionalized population, prisons. Many studies have used both quantitative and qualitative survey methods such as Camberwell Assessment of Need (CAN) and General Health Questionnaire to assess mental health of the communities and individuals and to determine needs for services. (13,14,15,) Importance of culture and ethnicity has been noted in some studies and interventions, which is going to be discussed as separate topic in article further.

ii) Data for organization level NA: Each organization has been built on a specific mission and has created its own unique culture. It is important to know organization evolution, its values and norms shared by its employees and weaknesses and strengths. For this level of NA, information can be obtained from many existing resources such as organization old records, media or employees. It is also possible to obtain information with specific techniques such as basic group process, strategic planning, and causal analysis according to purpose of NA.

iii) Data for Individual level NA: Probably individual level NA is most difficult and challenging for health providers since most of the time, providers have limited time and resources to gather necessary information about the individual. Traditionally, case managers have been the main person for mentally ill patient to coordinate necessary medical services. Individual NA should be therapeutic rather than administrative. It has been shown that any type of case management when executed well had significant outcomes such as decreased symptoms, hospitalization rates, increased social contact and leisure time. Ideally case managers should have core functions of case assessment, psycho education, crisis intervention, monitoring daily living skills, monitoring medications, building daily living skills and liaison with other care agencies.(16) Information for individual NA can be gathered from families, friends, hospital records, clinic records, employers, social services and other important persons and agencies in individuals' life.

Social and Cultural Aspect of Needs Assessment

Since cultural factors play an important role in symptom formation, diagnosis and treatment of mental disorders, it is imperative to understand and incorporate social, ethnical and cultural variables in NA. (17,18). At individual level a



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misdiagnosis can occur due to cultural interpretation of perception, experimentation, and presentation of the problem. The culture-bound syndromes have unique features that are distinct from DSM criteria. Also it is known that there are differences to respond to same psychotropic medication in different ethnicities. (19) Research has shown that the prevalence and symptomatology of mental disorders can be different in various ethnic groups as well as their help seeking behaviors and utilization of mental services. (19, 20, 21) For instance, it was found that Korean immigrants to the United States experience higher depressive symptoms compared to other Asian groups. (21) Similarly, it was found out that Ethiopian immigrants in Toronto have lower mental health service utilization rate although they have higher need of mental health care compared to majority population. (20)

Stakeholders and Needs Assessment

In market economies, customer preferences have always been one of the main sources for production and consumption of goods. The medical field, especially mental health services, did not respond to this principle till the second half of the 20th century. Even though health providers are trying to implement consumer-led services, it falls short to meet the individuals' or communities' needs. Stakeholders are the sum of organizations and individuals who have an interest in the health of targeted population. (8) A wide range of individuals, organizations, and agencies may play important roles such as members of individual or families of targeted groups, health care providers, public health agencies, researchers, schools, businesses, faith communities and other community groups. We can classify stakeholders into four groups; members of target population, service providers, researchers and community leaders. (22) There can be major discrepancies between health provider and customer perspectives about the quality and quantity of mental health services provided such as treatment, crisis services, rehabilitation services, information about medications, and amount of information being given to individuals (23, 24).

One way to overcome or minimize the problem is to involve all stakeholders in NA. For instance, New York State Department initiated a strategy called Assets Coming Together (ACT) for Youth to address violence, abuse, and high risk sexual behaviors in Youth aged 10-19 years by establishing effective community partnerships by developing a vision, establishing partnership structure, leadership and membership, developing an effective collaboration process and sustaining momentum (25). In Harris County, Texas, Mental Health Needs Council for the last 25 years identified mental health service problems and provided solutions by forming close alliances between major mental health providers, professional organizations and advocates. (26) They have addressed service needs for children and adults, drug issues, crisis services and criminal justice problems.

At organization level NA, stakeholders usually include individuals from service receivers, service providers and interested community members and may also include people who have specialized knowledge about NA. (9) At individual level NA, stakeholders may include patient himself or herself, family members, other people important in individuals' life, case managers, health care providers, social services and other people and organizations that has an interest in individuals.

Organizations and Needs Assessment

In real life, service providers or organizational aspects of NA don't get the necessary attention. Rarely organizational structure, governance, mission, culture, ethics, technology, or staffing are part of or target of NA process. A good NA requires well functioning organization(s) to implement and to obtain the desired outcomes. A good NA without well functioning organization is similar to a good warrior without weapons. An organization can be defined as two or more people working together cooperatively within identifiable boundaries to accomplish a common goal or objective (27). Every organization has its unique structure where labor is being divided into distinct tasks and being coordinated among them. Governance mechanism is used to maintain goal directed behaviors inside the organization. Technology of an organization refers to productive power that includes knowledge, tools, information, skills and materials used to complete tasks within organization as well as the nature of the outputs of the organization. On the other hand, organizational culture is composed of shared values, beliefs, norms of the members as well as behavior patterns, rules, language and ceremonies.(27)

Every aspect of organization can be part of or target of

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NA as required. For instance, human resources have always been very important for mental health services. It has long been recognized that employee resistance can be a serious constraint on the success of organizational performance. Furthermore high staff turnover has negative impact on effectiveness and productivity of care and resulting in higher labor costs for organizations. (28, 29) As in other service providers, mental health providers also can deal with this problem if they include Strategic Human Resource Management in their NA. The organization should have right number of and kinds of people at right place, at the right time to help the organization to achieve its overall objectives. (30) Motivating and evaluating employee performance is as important as selecting and training process.

Conclusion:

A well-planned and executed NA is vital to establish mental health services in most cost-effective way to promote both individuals' and communities' quality of life. NA is not only important to prioritize the needs but also for implementation and monitoring phases of the services and policies. NA procedures should include all stakeholders who have an interest in the subject and should use all available information sources. Every step of NA has to be planned before starting. Since there is no rule of thumb for NA, each procedure should be customized according to uniqueness of the community, individual and organization. Socio-cultural variables of individuals and communities and traditional values of organizations should always be considered in each NA. Even though mental health services have shown significant improvements, further research is necessary to investigate in many aspects of NA such as multidisciplinary cooperation, NA techniques, organizational behaviors, individual and societal preferences, motivation and training of health providers.

Dr. Yildirim is a first year Fellow in Child and Adolescent Psychiatry, University of East Carolina, Greenville, North Carolina where he completed his Adult Psychiatry Residency in 2006. He obtained his Master of Public Health Degree in 2000 from Department of Policy and Administration, School of Public Health, University of Illinois at Chicago and he is a Doctoral Candidate in the same department.

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Dr. Micheal Vergare, M.D. to Receive - 2007 Bell of Hope Award on May 15th

The Award recognizes an individual, organization, foundation or corporation for significant contributions benefiting those facing the challenge of mental illness. The Award salutes those who bring hope to the struggle through their words, resources, products, research or advocacy efforts.

Dr. Vergare is the first psychiatrist to be honored. He is being recognized for his long-standing work in the field of mental health issues, his research, dedication and activities in the mental health community. In selecting nominees, the Mental Health Association of Southeastern Pennsylvania considers people, actions and events that have made a great impact on the mental health community.

Some past recipients include the late Governor of Pennsylvania Bob Casey, former New Jersey Senator Richard Codey and his wife Mary Jo Codey, cable show host Susanne Roberts, author of *The Outsider* Nathaniel Lachenmeyer and Secretary of the Pennsylvania Department of Public Welfare, Estelle Richman.

COLUMN EDITOR: H. Steven Moffic, M.D.

ETHICS COLUMN

Who Should be Able to Use DSM-V?

*This is the second in a projected series "**A Day in the Ethical Life of a Psychiatrist Administrator**", designed to highlight ethical challenges which may arise at any time and/or can be often ignored. It is based on Aristotle's recommendation for virtuous ethical choices that need to be made for specific situations (the Nicomachean Ethics). This situation, oddly enough, has to do with an after-work dinner with friends.*

At a dinner not long ago with another couple, the wife of another physician was discussing her son's career plans. He's started on a PhD Psychology path. She said he was interested in therapy and families, but not diagnosis. She reported that he said that diagnosis is just "superficial" stuff. "But psychologists can't diagnose anyways, can they?" she asked me in a statement sort of way, before ending with a questioning tone as my face must have lit up. "Only physicians diagnose, right?" Her husband, a former emergency room doctor, kept silent. I explained, somewhat apologetically, how and why psychologists can indeed diagnose. I could only fantasize that maybe things would change for our next *Diagnostic and Statistical Manual* (DSM), DSM-V.

Psychiatric administrators have long been in the best position to assess and determine how the Diagnostic and Statistical Manuals are actually used in practice. If you lead an organization that provides clinical care, who, i.e., which discipline, does the initial evaluation? Is it a psychiatrist? A psychologist? A social worker? A nurse practitioner? All of the above? If you are a psychiatrist administrator who is now leading the new DSM Task Force or any of its components, what changes are important to consider for the next edition?

Already, we are hearing of advocacy for new diagnoses, different criteria, and better incorporation of cultural sensitivity. The American Journal of Psychiatry has begun an intermittent column "on issues that should be considered in its formulation." However, there has apparently not been any publicized discussion as to who DSM-V should be for. Will it continue to be readily used by all disciplines or should it be geared to use by psychiatrists? The check-list format of DSM-IV has certainly helped it to be used by all the disciplines, and thereby helped it become a best-selling publication world-wide (as there are many more mental health clinicians of other disciplines than there are psychiatrists). This has led to companion books such as *DSM-IV Made Easy* and *Diagnosis Made Easier*. However, in being able to be used by others, it seems that it has diminished the role and prominence of psychiatrists. I also wonder whether, in part, it paved the way for psychologists to apply for prescription privileges. After all, if they could learn easily enough to diagnose psychiatric disorders, and could do psychotherapy and psychoanalysis treatments, what could be so hard about medication treatment?

The only comment in DSM-IV about who should use it comes in its brief "Cautionary Statement", where it says that "the proper use of these criteria requires specialized clinical training that provides both a body of knowledge and clinical skills". So what comprises that specialized training and what is the necessary ensuing knowledge and skills? Given that various other medical conditions can produce so many psychiatric symptoms, and that many of the major disorders, i.e., Mood Disorder, Anxiety Disorder, and Psychotic Disorder, have a diagnosis listed under them predicated on "Due to a Specific Medical Condition", is not medical training crucial to use the manual competently? Our diagnostic skills are important enough to psychiatrists that they are the essence of our live Board Certification examination process.

Unfortunately, there are no studies that I am aware of that adequately compare the diagnostic skills and outcomes of psychiatrists to other disciplines. One of the great regrets of my career as an academic psychiatrist administrator was missing an opportunity to do just that in our managed care contracts. We seemed to get too wrapped up in everyday demands and challenges to set up a proper comparison study. The easy way out was to have our social worker do a brief triage evaluation for most situations.

It would seem that psychiatrist administrators now have the opportunity and challenge to advance not only diagnostic criteria in the new manual, but determine who and how it should be used. The ethical priorities, per our

Continued on next page

Ethical Principles for Psychiatrist Administrators, include benefiting patients, the proper role of psychiatrists, and organizational success. In the meantime, any data we psychiatrists might provide on who has been using DSM-IV, how well its criteria were followed, how accurate diagnoses turned out to be, etc, should be invaluable for the DSM-V Task Force.

I, for one, would make a tentative recommendation that our next DSM, in all its likely medical sophistication, should be solely for psychiatrists. That means finishing psychiatric residency training or its equivalent. If we think that our medical training is essential to prescribe medication, why is it not essential for the prior step, establishing a diagnosis, which in turn influences medication choice? Other disciplines should have an adjunctive role in its usage or develop their own manuals geared to their own training and skills. A consortium of psychoanalytic groups has indeed done so with their *Psychodynamic Diagnostic Manual*. One model for making a diagnosis dependent on psychiatrists could be based on TeenScreen, a large school-based screening program for mental illness. The first stage is for students to fill out a short questionnaire. If results are positive, they are interviewed by a social worker or psychologist to see if it seems clinically significant. If it seems significant, then a psychiatrist could do a more comprehensive and definitive evaluation. This is not to say that individual psychiatrists might differ in their diagnostic skills; rather, it is considering the presumed skills of a class of clinicians.

What do you think?

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:

Sy Atezaz Saeed, M.D., Editor
Professor and Chairman
Department of Psychiatric Medicine
The Brody School of Medicine at ECU
Brody 4E-100
600 Moye Boulevard
Greenville, NC 27834
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FAX: 252-744-3815
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WHO SHOULD BE ABLE TO USE DSM-V?

Arthur Lazarus, M.D., MBA

Dr. Moffic's ethics editorial invites debate, which a good editorial should do. But I find myself in disagreement with the suggestion that only psychiatrists should use the DSM.

In my opinion, the DSM is for patients. Clinicians may be the end-users, but patients are the beneficiaries of the information contained in the DSM. Furthermore, it is elitist to reserve the DSM for psychiatrists and to think that psychiatrists will do a better job, across the board, diagnosing patients compared with all other disciplines. Should primary care physicians also be banned from using the DSM?

The editorial assumes that users of the DSM will be involved directly or indirectly in patient care, which simply isn't the case. Attorneys, educators, and billing and coding specialists, for example, often use the DSM for litigation, teaching, and reimbursement purposes. I believe Dr. Moffic also confounds the use of the DSM with the competency of practitioners: the more important issue is how to ensure competent practice (diagnosis), not whether non-psychiatrists should be prevented from using the DSM.

I agree that empirical research is needed to assess the diagnostic acumen of the various disciplines that use the DSM. But even if psychiatrists prove to be superior diagnosticians, should clinicians from other disciplines be precluded from making diagnoses? Ultimately the public must be made aware of any differences in competencies between disciplines and make their choices on a "buyer beware" basis.

The idea that lesser trained individuals can screen and refer patients to psychiatrists is problematic. It runs counter to the argument that such individuals should refrain from making diagnoses (screening patients for psychiatric disorders is one step short of making a diagnosis). And because all screening instruments can yield false negative results, screening should never be a substitute for a clinical diagnosis based on a comprehensive face-to-face evaluation of the patient.

The question of whether psychiatrists and allied mental health professionals can peacefully coexist parallels a development in several other medical disciplines. Chiropractors, nurses, dentists, optometrists, and podiatrists are invading many fields of medicine, and professional licensing boards appear to be pushing the envelope to allow non-physicians to stray into areas beyond their qualifications. All incursions into the practice of medicine are a serious problem. Any attempt to sidestep the criteria of nationally established medical requirements threatens the safety of patients.

The hot topic du jour regarding the DSM is how to manage conflicts of interest involving the many DSM contributors. The contributors to DSM are potentially influenced by a bias toward a particular theory, a bias against other contributors or perspectives, and a desire for career advancement. Close ties between the DSM contributors and the pharmaceutical industry and the NIMH are also potential sources of bias. Recommendations on how to manage these conflicts of interest are certainly worthy of a future column.

Arthur Lazarus, MD, MBA, is senior director of clinical research for AstraZeneca Pharmaceuticals in Wilmington, Delaware. He is associate editor of Psychiatrist Administrator and President-Elect of AAPA. His opinions are not necessarily those of AstraZeneca, its management, agents, or employees.

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WHO SHOULD BE ABLE TO USE DSM-V?

L. Mark Russakoff, M.D.

What ethical principles are involved with the use of a diagnostic manual?

The most prominent issue is that of competent practice. The principles of beneficence and non-malfeasance apply. The "cautionary statement" regarding training is relevant here. The question of whether psychiatrists alone are adequately trained in order to properly apply the criteria is testable. I am aware of no data that suggests that well-trained psychiatric social workers or clinical psychologists cannot properly apply the criteria. In fact, a number of nonpsychiatrists were involved performing interviews in the development of the DSM-III. However, that does not address the issue of whether the modal nonpsychiatrist is sufficiently well trained to apply the criteria competently. We rely on epidemiological studies that involve trained interviewers who are not psychiatrists. These researchers use structured interviews with concomitant scoring of all the elements that go into making a diagnosis. Algorithms are then applied to make the diagnoses. It would seem hypocritical to accept data from those studies as being valid and then insist that only a psychiatrist is sufficiently skilled to perform a diagnostic assessment.

The principle of autonomy also applies here. Informed consent is linked to autonomy. In clinical circumstances, the patient should know what the educational background of the diagnostician is. A person who presents to a mental health professional with adjustment issues might feel more comfortable seeing a nonpsychiatrist. In fact, this interaction occurs daily throughout the country without much controversy. If either party is dissatisfied with the results, then consultation with other professionals, including psychiatrists, may be initiated. Misdiagnosis may occur, but it remains to be studied whether any group of professionals is more likely to make errors. It is not uncommon for bipolar patients to be misdiagnosed by psychiatrists early in the course of their illness.

Diagnoses of cardiac conditions, arthritic conditions or endocrinological conditions are not made solely by cardiologists, rheumatologists or endocrinologists. Primary care physicians and many specialists use the current criteria and make their best assessments. These patients are often diagnosed and treated by non-specialists without oversight by specialists. This is true in psychiatry where many primary care doctors initiate treatment of depressive disorders and anxiety disorders. When situations seem more complicated or severe, referral to a specialist typically occurs.

It is possible to hide behind the need for specialized training as a way to maintain a guild, that is, protect the economic interests of those with specialized training. This stance would be unethical if it would unnecessarily limit access to care. It would be ethical if it protected patients from incompetent practitioners. Not all mental health disciplines have been authorized by licensure to make a diagnosis. There are many dimensions to this complex issue. Being licensed to diagnose typically permits the initiation of treatment with its concomitant costs. Limits on the scope of practice effects cost-containment, through a gatekeeper, as well as assigns economic and political advantage to those who have the authority to make diagnoses. If the costs of treatment were not a concern of legislatures, would the legislatures be more willing to authorize more disciplines to make diagnoses?

"The question may not be money but the answer often is."

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

COLUMN EDITOR: Kathy Cable, MLS

LITERATURE SCAN

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

Ammen S, Arstein-Kerslake C, Poulsen MK, Mastergeorge A. Feasibility of Expanding Services for Very Young Children in the Public Mental Health Setting. *Journal of the American Academy of Child & Adolescent Psychiatry.* 2007 Feb; 46(2): 152-61. (Study)

This study evaluated the feasibility of training mental health providers to provide mental health screening and relationship-based intervention to expand services for children 0 to 5 years of age in eight California county mental health systems from November 2002 to June 2003. State-level training was provided to more than 582 participants and county-level training to more than 5425 participants, including ongoing supervision. Based on the results the authors advised that training mental health staff to provide treatment to infants, preschool children and families in public mental health settings is feasible and leads to an increase in numbers of children served.

Bloch RM, Saeed SA, Rivard JC, Rausch. Lessons Learned in Implementing Evidence-Based Practices: Implications for Psychiatric Administrators. *Psychiatric Quarterly*. 2006 Winter; 77(4):309-18.

The authors of this article discuss factors related to the dissemination and implementation of evidence-based practices (EBPs). They explain how extensive effort is required to successfully implement and sustain EBPs that improve clinical outcomes. In addition, examples of large-scale implementations of EBPs in mental health are described with emphasis on the factors thought critical for success and how the need for designing systems can cost-effectively be implemented for new EBPs. As a final point, the implications for psychiatric administrators are discussed.

Cohen D. Should the Use of Selective Serotonin Reuptake Inhibitors in Child and Adolescent Depression be Banned? *Psychotherapy and Psychosomatics*. 2007; 76(1):5-14.

The author states that European and US pharmaceutical agencies have recently warned against the use of selective serotonin reuptake inhibitors (SSRIs) in child and adolescent depression. Given these facts the author adds that this came as a surprise to many practitioners who had made treatment decisions based on data from pharmaceutical trials using adult samples. The author reviewed the latest literature relevant to the use of SSRIs in youth depression, including psychiatric-clinical trials, pharmacology and drug safety data and concluded that an SSRI prescription is still a second-line option in severe and resistant forms of youth depression. It is also recommended that specialists well-trained in child and adolescent psychiatry should prescribe treatments.

Fava M, Graves LM, Benazzi F, Scalia MJ, Iosifescu DV, Alpert JE, Papakostas GI. A Cross-sectional Study of the Prevalence of Cognitive and Physical Symptoms During Long-Term Antidepressant Treatment. *Journal of Clinical Psychiatry.* 2006 Nov; 67(11) :1754-9.

The purpose of this article is to examine the prevalence of cognitive and physical side effects of antidepressants during long-term treatment of depression. A study was performed consisting of patients at least 18 years of age who were deemed responders to antidepressant therapy following at least three months of treatment for major depressive disorder (MDD) (diagnosed according to DSM-IV criteria) and whose MDD was considered to be in partial or full remission were eligible. Based on results, physical and cognitive symptoms are frequently reported by MDD patients who have responded to antidepressants and are treated in the long term with these agents. The study indicates that it is likely that these symptoms are both side

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effects of the antidepressants as well as residual symptoms of MDD.

Harrison JP, Lee A. The Role of e-Health in the Changing Health Care Environment.
Nurse Economics. 2006 Dec; 24(6):283-8. (Study)
This article discusses how health care organizations spent 2.3% of total operating expenses on information technology in 2005. It is stated that health care organizations are slowly developing the infrastructure necessary to expand e-Health capabilities. In addition, the article focuses on how e-Health is being recognized as a method to improve the overall health status of the population and how important it is to build partnerships among health care providers, local community organizations, and national health care associations to ensure the continued development of e-Health initiatives.

Heres S, Hamann J, Kissling W, Leucht S. Attitudes of Psychiatrists Toward Antipsychotic Depot Medication. *The Journal of Clinical Psychiatry.* 2006 Dec; 67(12): 1498-53.
The authors discuss how a second-generation depot antipsychotic has been available since 2002, which combines the advantages of depot administration and aspects of the so-called "atypical" antipsychotic. Despite that, the authors state that long-acting injectable formulations are seldom prescribed in the treatment of schizophrenia. They surveyed 350 psychiatrists at an international conference to determine reasons for not prescribing a first- or second-generation depot antipsychotic for their patients diagnosed with schizophrenia or schizoaffective disorder. The authors concluded that aversions to prescribing depot treatment are frequent among psychiatrists and appear to be unrelated to the antipsychotic class. In addition, the stated reasons for not prescribing depots are generally not supported by the current evidence. They recommend that further studies are urgently needed to clarify the advantages of depot treatment.

Hipwell AE, Loeber R. Do We Know Which Interventions Are Effective for Disruptive and Delinquent Girls? *Clinical Child and Family Psychology Review.* 2006 Dec; 9(3-4):441-55.
This article examines the issue of how disruptive and delinquent girls are not well served by the mental health and juvenile justice systems. It goes on to discuss that interventions that have been developed for the behavior problems of boys are frequently applied to girls despite growing evidence for a female-specific phenotype, developmental course, and set of risk factors from middle childhood onwards. Current literature proves that evidence of the effectiveness of treatments for girls with disruptive and delinquent behaviors is limited. Nevertheless, some evidence suggests that interventions specifically designed to address female behavior problems or risk factors can be effective in improving disruptive and delinquent behaviors in both pre-adolescence and adolescence. Multi-modal interventions and methodological issues are discussed with recommendations for development and evaluation of future interventions to prevent and reduce girls' disruptive and delinquent behavior.

Knapp PK, Ammen S, Arstein-Kerslake C, Poulsen MK, Mastergeorge A. Feasibility of Expanding Services for Very Young Children in the Public Mental Health Setting. *Journal of American Academy of Child & Adolescent Psychiatry.* 2007 Feb; 46(2):152-61.
The purpose of this study was to evaluate the feasibility of training mental health providers to provide mental health screening and relationship-based intervention to expand services for children 0 to 5 years of age. From November of 2002 to June 2003, eight California county mental health systems provided state-level training to more than 582 participants and county-level training to more than 5425 participants, including ongoing supervision. Direct services and use of collateral services were tracked. Additionally, psychiatric symptoms were screened with new Mental Health Screening and Risk Assessment tools for 388 children (mean age, 34 months). At intake and after intervention (mean of 22 visits), an index sample (93 children) was further characterized by the Diagnostic Classification for Zero to Three and DSM-IV, and parent-child relationship was characterized by the Diagnostic Classification for Zero to Three Parent-Infant Relationship Global Assessment Scale. The results conclude that training mental health staff to provide treatment to infants and preschool children and families in public mental health settings is feasible and leads to an increase in numbers of

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children served.

Lopez-Munoz F, Alamo C, Dudley M, Rubio G, Garcia-Garcia P, Molina JD, Okasha A. Psychiatry and Political-Institutional Abuse from the Historical Perspective: The Ethical Lessons of the Nuremberg Trial on their 60th Anniversary. *Progress in Neuro-Psychopharmacology & Biological Psychiatry.* Dec 15; [Epub ahead of print]. The authors of this article explore the Nuremberg Trials and how this trial exposed a perverse system of the criminal use of medicine in the fields of public health and human research. The aim of their article is to review, from the historical perspective, the antecedents of the euthanasia programs for the mentally ill, the procedures involved in their implementation and the use of mentally ill people as research material. The authors explain that the Nuremberg Code, a direct consequence of the Doctors' Trial, is considered to be the first international code of ethics for research with human beings, and represented an attempt to prevent any repeat of the tragedy that occurred under Nazism. However, the authors go on to elucidate that the last 60 years have seen continued government-endorsed psychiatric abuse and illegitimate use of psychoactive drugs in countries such as the Soviet Union or China, and even in some with a long democratic tradition, such as the United States. They explain that even today, the improper use of psychiatry on behalf of governments is seen to be occurring in numerous parts of the globe: examples given are religious repression in China, enforced hospitalization in Russia, administration of psychoactive drugs in immigrant detention centers in Australia, and the application of the death penalty by lethal injection and psychiatric participation in coercive interrogation at military prisons, in relation to the USA. The authors go on to explain The Declaration of Madrid in 1996 constituted the most recent attempt to eradicate, from the ethical point of view, these practices. Nevertheless, the authors stress that even though various strategies can be used to combat such abuses, it is uncertain how effective they are in preventing them.

Martin RD, Cohen MA, Weiss Roberts L, Batista SM, Hicks D, Bourgeois J. DNR versus DNT: Clinical Implications of a Conceptual Ambiguity: A Case Analysis. *Psychosomatics.* 2007 Jan.-Feb; 48(1):10-5.
The authors examine psychiatrists who practice psychosomatic medicine and are routinely called upon to help resolve ethical dilemmas that arise in the care of patients near the end of their lives. Additionally, the authors discuss how psychosomatic-medicine psychiatrists may be of unique value in these situations because of the clinical insights that they bring to the care of the dying patient. They indicate that these psychiatrists bring expertise related to the evaluation of decisional capacity of patients who are faced with accepting or declining end-of-life decisions. The authors specify that in this first entry in a new bioethics case series in *Psychosomatics*, they will lay the groundwork for examining a complex patient case and provide an illustrative analysis of end-of-life care issues that may be addressed by psychiatrists who practice psychosomatic medicine.

McCay RN, Daylo AA, Hammer PS. No Effect of Lunar cycle on Psychiatric Admissions or Emergency Evaluations. *Military Times.* 2006 Dec; 171(12):1239-42.
The authors look at the popularly held belief that psychiatric behavior worsens during a full moon. The authors examined records from Naval Medical Center San Diego for the years 1993-2001. The records showed whether there were higher rates of psychiatric admission associated with particular phases of the moon. Records from 8,473 admissions revealed that there were no more admissions on days with a full moon, a new moon, any quarter of the moon, a waxing moon, or a waning moon. This held true for psychiatric patients as a whole, as well as for individuals with particular diagnoses, such as those with a mood disorder or psychotic disorder. Records from 1,909 emergency psychiatric evaluations that occurred between 2002 and 2003 were also examined to see whether a higher percentage of patients might present, but not require hospitalization, during a particular phase of the moon. The authors summarized that the lunar phase was not associated in any significant way with psychiatric admissions or emergency presentation.

McGinty KL, Saeed SA, Simmons SC, Yildirim Y. Telepsychiatry and E-Mental Health Services: Potential for Improving Access to Mental Health Care. *Psychiatric Quarterly.* 2006 Winter; 77(4):335-42.
This study provides information about how mental-health-

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reform is a focus of many ongoing initiatives in the United States, both at the national and state levels. One of the problems identified is access to adequate mental health care services. The authors of this study explain how telepsychiatry and e-mental health services could improve access to mental health care in rural, remote and underserved areas. In conclusion, the authors discuss the required technology, common applications and barriers associated with the implementation of telepsychiatry and e-mental health services.

Moulding R, Kyrios M. Anxiety Disorders and Control Related Beliefs: The Exemplar of Obsessive-Compulsive Disorder (OCD). *Clinical Psychology Review.* 2006 Sept; 26(5):573-83.
The authors found that beliefs about control are important to anxiety and mood disorders. Based on the phenomenology of Obsessive-Compulsive Disorder (OCD), the article suggests that it may be an example of an anxiety disorder where control issues related to the self (behavior and thoughts) and world (the external environment) are important. The authors summarize that the theoretical and empirical research are relevant to control-related beliefs. They suggest that those discrepancies between an individual's desired level of control and their perceived level of control could contribute to OCD symptoms. On the whole the authors' review demonstrates how consideration of control cognitions could enhance understanding of OCD and improve its treatment.

Sar V, Koyuncu A, Ozturk E, Yargic LI, Kundakci T, Yazici A, Kuskonmaz E, Aksut D. Dissociative Disorders in the Psychiatric Emergency Ward. *General Hospital Psychiatry.* 2007 Jan-Feb; 29(1):45-50.
The purpose of this study was to determine the prevalence of dissociative disorders among emergency psychiatric admissions. Data was analyzed from forty-three of the ninety-seven consecutive outpatients admitted to the psychiatric emergency unit of a university hospital and were screened using the Dissociative Experiences Scale (DES). Results from the study ranged from patients having dissociative disorder, to dissociative identity disorder, to dissociative disorder not otherwise specified, and to patients having dissociative amnesia. In addition, a majority of them had comorbid major depression, somatization disorder, and borderline personality disorder. The authors of this article concluded that dissociative disorders constitute one of the diagnostic groups with high relevance in emergency psychiatry.

Silver, Eric. Understanding the Relationship Between Mental Disorder and Violence: The Need for a Criminological Perspective. *Law & Human Behavior.* 2006 Dec; 30(6): 685-706. (Review).
The author offers a criminologically informed framework to guide research on the relationship between mental disorder and violence. Criminological theories examined include social learning, social stress, social control, rational choice, and social disorganization. In addition, the "criminal careers" and "local life circumstance" methodologies are reviewed. The author argues that adopting a criminologically informed framework that takes into account within-person changes over time will contribute to understanding of the factors that affect violence among people with mental disorders living in the community, and enhance the capacity of research to support effective evidenced-based case management programs aimed at reducing violence.

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

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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.

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List Serve: aapa@wpaweb.com

PRESIDENT
Shivkumar Hatti, M.D., MBA (2005-2007)
107 Chesle Drive, Unit 4
Media, PA 19063
O: 610-891-9024/104
Cell: 610-389-3274
FAX: 610-891-9699
Email: shiv@suburbanpsych.com

PRESIDENT-ELECT AND BYLAWS COMMITTEE CHAIR
Arthur Lazarus, M.D., M.B.A. (2005-2007)
AstraZeneca LP
1800 Concord Pike, B3B-425
PO Box 15437
Wilmington, DE 19850-5437
O: 302-885-4542
FAX: 302-886-4990
Email: arthur.lazarus@astrazeneca.com

SECETARY & MEMBERSHIP COMMITTEE CHAIR
June A. Powell, M.D. (2005-2007)
PO Box 2519
Corinth, MS 38835
O: 662-223-9213
Email: junpow@msn.com

TREASURER & FINANCE COMMITTEE CHAIR
Douglas Brandt, M.D. (2005-2007)
82 High Meadow Lane
Mystic, CT 06355
O: 860-444-5125
FAX: 860-444-4767
Email: dbr5118925@aol.com

IMMEDIATE PAST PRESIDENT AND NOMINATING COMMITTEE CHAIR
Thomas W. Hester, M.D. (2005-2007)
1250 Punchbowl Street
Room 256
Honolulu, HI 96813
O: 808-586-4780
FAX: 808-586-4745
Email: twhester@amhd.health.state.hi.us

COUNCILORS
(including committee chairs)
Andrew Angelino, M.D.
Department of Psychiatry
Johns Hopkins Bayview Medical Center
4940 Eastern Avenue, A4C – 461A
Baltimore, MD 21224
O: 410-550-0197
FAX: 410-550-1407
Email: aangelino@jhmi.edu
Term: May 2003- May 2007

Private Practice & Managed Care Committee Chair
Lawrence Goldberg, M.D.
United Behavioral Healthcare
100 Penn Square East, Suite 400
Philadelphia, P
O: 215-557
Email: Law
Term: May

Barry K. H
277 Upper
Radnor, PA
O: 610-687
FAX: 610-
Email:
Term: Fille

Public and Forensic Psychiatry Committee Chair
Beatrice Kovasznay, M.D., MPH, Ph.D.
Capital District Psychiatric Center
75 New Scotland Avenue
Albany, NY 12203
O: 518-447-9611/6808
Email: cdfmbmk@omh.state.ny.us
Term: May 2003- May 2007

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

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

Malini Patel, M.D.
Medical Director Community Psychiatric Services/
Metro Suburban Network
Elgin Mental Health Center
750 South State Street
Elgin, IL 60123
O: 847-742-1040/Extension 2015
FAX: 847-429-4911
Email: dhs594J@dhs.state.il.us
Term: May 2003 - May 2007

APA ASSEMBLY LIAISON
Barry K. Herman, M.D., M.M.M.
Co-Representative: Arthur Lazarus, M.D., M.B.A.

Pedro Ruiz, M.D.
1300 Moursund Street
Houston, TX 77030
O: 713-500-2799
FAX: 713-500-2757
Email: pedro.ruiz@uth.tmc.edu
Term: May 2005 – May 2009

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

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

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

Academic Psychiatry Committee Chair
Michael Vergare, M.D.
Jefferson Medical College
833 Chestnut Street, #210-A
Philadelphia, PA 19107-4414
O: 215-955-6912
FAX: 215-923-8219
Email: michael.vergare@jefferson.edu
Term: May 2003 – May 2007

NewsJournal Editor
Sy Saeed, M.D., M.S., Chairman
Professor/Chairman - Department of Psychiatric Medicine
The Brody School of Medicine
Brody 4E-100
600 Moye Boulevard
Greenville, NC 27834
O: 252-744-2660
FAX: 252-744-3815
Email: saeeds@ecu.edu

NY CHAPTER PRESIDENT (ex-officio)
Rose Yu-Chin, M.D., MPH
Chief, Community Psychiatry
Cabrini Medical Center
227 East 19th Street
New York, NY 10003
O: 212-995-6000
Ryuchin@cabrininy.org

NewsJournal Associate Editor
Arthur Lazarus, M.D.

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

BMS Fellow Representative
Marcy Forgey, M.D., MPH
255 Masachusetts Avenue, Apt. 401
Boston, MA 02155
O: 617-575-5724
Email: marcyforgey@aol.com

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

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

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

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

EXECUTIVE DIRECTOR
Frances M. Bell
PO Box 570218
Dallas, TX 75357-0218
O: 800-650-5888
H: 972-613-3997
FAX: 972-613-5532
Email:

Course #8: Basic Concepts in Administrative Psychiatry-Part I, Saturday, May 19th,
9:00 am - 4:00 pm, Room 29D - Upper Level, San Diego Convention Center
Co-Directors: Arthur Lazarus, M.D. M.B.A., and Shivkumar Hatti, M.D., M.B.A.
Faculty: Barry K. Herman, M.D., L. Mark Russakoff, M.D., Stuart B. Silver, M.D., Sy A. Saeed, M.D.

Course #24: Basic Concepts in Administrative Psychiatry-Part II, Sunday, May 20th,
9:00 am - 4:00 pm, Room 29D - Upper Level, San Diego Convention Center
Co-Directors: Arthur Lazarus, M.D. M.B.A., and Shivkumar Hatti, M.D., M.B.A.

Course #CW37: Career Advancement in Administrative Psychiarty for ECPs, Wednessday, May 23rd
9:00 am - 10:30 am, Room 3 Upper Level, San Diego Convention Center
Chair: Dimitri Markov
Faculty: Barry Herman, M.D., M.M.M., Shivkumar Hatti, M.D., M.B.A., Thomas Newmark, M.D.

"Meet the Experts" Breakfast for Residents, Fellows and Medical Students. The roundtable breakfast session will be held Monday, May 21st, 7:00 am - 8:30 am, San Diego Marriott, San Diego Ballroom A, North Tower, Lobby Level

Doctors Art Lazarus and Barry Herman will be available to discuss administrative issues with Residents, Fellows and Medical Students.

Faculty experts generally facilitate discussion with small groups of residents, fellows and medical students, covering a wide range of issues related to training and career opportunities. We are particularly aware of your valuable contribution in the area of adminstrative psychiatry and are certain that sharing your expertise will be a valuable asset to this session.

Annual Membership Luncheon
Tuesday, May 22nd, 12:00 noon - 2:00 pm, Omni Hotel - Gallery Room 2
"On Being President of the APA: Some Fun and Games" - Speaker: Steven S. Sharfstein, M.D.

Executive Council Meeting
Tuesday, May 22nd, 2:00 pm - 5:00 pm, Omni Hotel - Grand Ballroom C- Level 4

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Central Office • P.O. Box 570218 • Dallas, TX 75357-0218