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PSYCHIATRIST ADMINISTRATOR

NewsJournal of the
American Association of Psychiatric Administrators

Volume 1, Issue 2 Summer 2001

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NEWSJOURNAL OF THE AMERICAN ASSOCIATION OF PSYCHIATRIC ADMINISTRATORS

Editor Sy Saeed, M.D., MS, FRSH

Published 4 times a year
Winter • Spring • Summer • Fall

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If you don't know where you're going, will any road do?

Its estimated that the amount of time it takes today for the knowledge base to double is about ten years. There are over 2 million articles published annually in over 20 000 health related journals. This explosion of knowledge is taking place in the context of rapidly changing health care delivery systems. Pressure on health care resources has led to a demand for greater value for dollars spent. Competition of commercial forces for delivery of health care has led to a demand for value while maintaining, or improving, the quality of care being delivered and allowing for patient preferences. It would appear that the rapid advances in our knowledge base would help us in meeting these challenges. It will also be reasonable to expect that the clinical practice be longer based on opinion, as in the past. Unfortunately, despite extensive evidence, and consensus, on effective mental health practices for persons with severe mental illness, research shows that typical mental health programs do not provide evidence-based practices to the majority of people with these illnesses. The field of mental health continues to be seen by many as an area where practices continue to have unacceptable level of variations, where outcome is not routinely measured, and the systematic use of empirically supported treatments, at best, is minimal. As psychiatrists in the field of administration and management, it appears that we have not paid enough attention to the implications of this knowledge explosion around us.

The psychiatrists in administrative roles typically bring years of clinical experience and some understanding of how systems work to their places of work. They typically apply this knowledge and experience to their new role as administrator. In a typical scenario, the solutions to their dilemmas are very individual, usually created in the image of the psychiatrist administrator responsible for solving the dilemma. There is a need to critically look at the role of psychiatrist administrator as we get into an era of significant change that is happening in the context of evidenced-based psychiatry. Although we know quite a bit today regarding which treatments work at the individual patient level, we have just started to understand what happens when we take these evidenced-based practices at a systems level. In the complex and fast moving world of health care, strategy formulation is no longer a process of executives sitting around a table to develop a policy document and then expecting others to use it. Strategy often is made on the run and in effect is built from patterns of information emerging from the clinical operational processes. The major drivers of change today appear to be the rapid advances in medical knowledge and in technology. Psychiatrist administrators face the challenge of balancing ever increasing demand against finite resources and as people who work both as clinicians and managers, this often can present an uncomfortable set of ethical dilemmas.

With this issue we start a series of articles devoted to system's level implications for providing evidence-based services to the patients and populations we serve, both as clinicians and as administrators. Dr. Sowers article makes a compelling case for not being caught over there on "the right wing!" The days have changed from the times in *Alice in Wonderland* when if we didn't know where we were going, to get somewhere all we needed to do was to keep on walking long enough! Today that would only get us on the right wing!

Sy Saeed, M.D.
Editor

TAKING THE BULL BY THE HORNS: SYSTEMS CHANGE IN BEHAVIORAL HEALTH MANAGEMENT

Wesley Sowers, M.D.

Introduction

Behavioral Health Systems have undergone dramatic changes in the past ten years. For many physicians, interacting with these changing systems has become the most distasteful part of their professional lives and frustration has become a common companion. The advent of managed care has been particularly difficult to assimilate, emphasizing the cost of provided care in a manner that most physicians have not had to think about in the past. (1-4) Medical education has not provided any preparation for this shift in the treatment environment, and as a result, psychiatrists like other physicians, have been slow to adjust and have done a poor job of anticipating some of the changes which were needed to make our systems of care more efficient and effective. The lack of sophistication in the recognition of systemic issues affecting the health of persons seeking assistance has placed physicians on the margins of the change making apparatus that is radically transforming our systems. A better understanding of the evolution of mental health and addiction services and the forces shaping their future development will allow psychiatrists to interact more effectively in these systems and to advocate for their patients. It will also allow them to influence this transformation in a manner which will preserve quality while allowing greater numbers to receive this care due to efficient management of resources and effective use of appropriate services.

A story will perhaps capture this concept more clearly than the words above. A flight takes off from Kennedy Airport in New York. It is the maiden flight of Nassau Caribbean Airlines and it is bound for Antigua. Everything goes without a glitch during the first three hours of the flight, but this tranquility is interrupted by the captain about 45 minutes prior to the scheduled landing. The Captain comes on the intercom and states "This is your captain, I'm afraid I have some bad news. We have a failure in our guidance systems and we will not be able to reach our destination or a landing and we are going to have to make a sea landing. I must ask you to remain calm, it is very important that you follow the instructions of your flight attendant who will show you how to prepare for this landing. If you follow these instructions carefully there is a very good chance that we can get this plane down without any injuries. I will come back with further instructions once we are down". So, the passengers make preparations for the ditch landing and manage to remain relatively calm. The flight attendants demonstrate how to assume the proper posture prior to impact, and take their places. Shortly, the plane does descend and hits the water with a jolt, but as the captain predicted, there were no serious injuries. As promised the captain came back on the intercom. "You all did very well with the landing, now you must listen to me carefully again and we must evacuate quickly, but without panic. First, I need all of you who can swim to move out onto the left wing. Those of you who cannot swim, should move out on to the right wing. Please begin to move now and I will give further instructions once the evacuation is complete." The passengers once again manage to avoid significant panic and accomplish the captain's instructions within several minutes. Once assembled on the wings, the captain gave further instructions. "Very good everyone. Now listen carefully once again. Those of you on the left wing, please look off to the horizon and you will see a small island about two miles away. The water is warm and if you swim slowly and evenly you should be able to reach it. Once you do, help should not be far behind. You should be fine. Please jump in the water and start swimming now." The passengers began swimming as he instructed. "Now, for those of you on the right

wing, thank you so much for flying Nassau Caribbean, bye-bye now.

Clearly, the experience of those who are prepared is much different from that of those who are not. It should be clear to everyone by now that the context for treatment has been changing for some time. Physicians have two choices; they can either wait for these changes, resisting them as much as possible, and trying to adapt as best they can once they occur, or they can actively reshape their practices in a manner which anticipates the coming environment and which will preserve the quality of care provided.

Historical Context

Most would concede that physicians will probably be better off if they are prepared, so how can they do this? It probably makes some sense to think briefly about where mental health services have been to provide some context for where they should go.

We are emerging from an era where hospital based care has been predominant, this was probably most pronounced in the period around the middle of the century, when most people with mental disturbances were treated in isolated hospitals, sometimes called "asylums". This arrangement began to change for several reasons; the development of effective medications, a growing emphasis on civil rights, an awareness of the poor outcomes for these patients, and the increasing cost of maintaining these persons humanely in such institutions (if that is not an oxymoron). Care began to shift to the community although in most cases, communities were ill prepared to take on this challenge.(5)

The transition to community based care has been rather slow. For clinicians, cost was not an issue that figured strongly in treatment planning. Care was almost always paid for by some insurer, regardless of how much was provided. They were trained to think about individual care not about the welfare of the community. Quality was often equated with quantity, and a paternalistic perspective dominated the way psychiatrists were trained to provide care. (6-7)

These attitudes have grown increasingly out of sync with other viewpoints impacting our systems of care. It has also become clear that intensive and restrictive care does not necessarily provide the best outcomes. Consumers have grown impatient with paternalism and the restriction of their rights. Payers have been held to account for expenditures, and payment to providers is no longer taken for granted. The community has been drawn into the debate about what to do as well. Without complete continuums for care, communities and families have been overwhelmed by demands that they care for their own once patients leave the hospital. At the same time, community structures that support the communal well being have been weakened. As many communities have become more and more distressed and impoverished, what resources are left for them?

As these perspectives became more divergent and as the costs of providing care became more difficult to provide, ideas for reform of the systems of care were considered.(2) Since these problems extended across all parts of country, national solutions were first considered. Single Payor National Health Insurance or some variation on that theme was considered as a simple solution to this problem. This approach was offensive to many, however, as it was commonly perceived to limit consumer choice and clearly threatened the economic interests of insurers and some providers. A more complex solution, designed to avoid some of these criticisms also failed. The Clinton Plan seemed to please no one and was difficult to understand. Strong opposition developed among some crucial stakeholders, ultimately leading to its demise. In this context of failed national reform, the solution to rising costs was left to employers in private sector and to the states in the public sector. Private enterprise and reliance on market forces was the solution that most frequently materialized.(8-9)

As a result, the cost of care has become a major determinant of how care is managed and we have

entered an era in which health care has become a business. The problem is that profit has often been realized only by limiting the quantity and quality of care, rather than by eliminating inefficiencies in our systems. Fragmented and limited continuums, administrative waste, inequalities in the care provided for various population groups, consumer insensitivity, and outcome insensitivity have not been eliminated by the advent of managed care.(10-11)

The counter force to the drive for cost containment by paying entities has been providers' resistance to change. This has been the backdrop for the adversarial relationships that currently exist between payers and providers, and in many cases, between providers themselves, resulting in the loss of collaborative relationships that were enjoyed by providers in the past. This dichotomous arrangement for care management has created gross inefficiencies in administration of mental health services resulting from the lack of trust between these two entities. It has become clear that if providers do not develop systems which will address the issues that profit driven, paying entities have neglected there is little chance of correcting the flaws of the current structure. Direct service providers need to be aggressive advocates and engineers of quality and efficiency if these shortcomings are to be transcended.(12)

Principles for Rational Care (Systems) Management The arrival of resource management businesses (managed care) has created moral dilemmas for many providers. They often feel as if their principles or standards of care are being compromised by the demands of cost reduction. Many have charged that the quality of care has deteriorated in this context. (11, 13) If providers are to be successful in their attempts to shape systems that meet the demands of resource conservation, they must make these efforts in the context of guidelines which allow them to preserve their values in the provision of care. Four such principles are discussed below.

· **Maintain Integrity:** As systems are reconstructed and the treatments and resources that will be used to address patient's problems are reconsidered it needs to be clear that what ever is chosen is chosen because it makes the most sense for the patient and the community. This implies consideration of both clinical needs and wise use of resources so that there will be enough for everyone in need. It will be critical to develop standards defining the minimum level of service which should be available to everyone, and which will meet the demands of the organizational or personal mission. This may be particularly difficult for charitable institutions.

In a financially threatening environment, how is it possible to fulfill a charitable mission and survive? The wise management of those resources which are freely given is of paramount importance. Everyone might like a Cadillac, but in most cases a Volkswagen will do. This practical concept must be considered when determinations regarding service provision are made. It does not preclude the possibility that there will be those with additional resources who may want to purchase additional services beyond this minimum standard, and a charitable mission does not prevent the provision of these services when they are requested. Integrity will only be compromised with a failure to provide services required by the organizational standards selected.

· **Outcome Driven Treatment Planning** - The services and treatments that are determined to be in the best interests of clients must ultimately be accountable to the outcomes of their treatment experiences. Quality must be determined in this way, rather than reliance on intuition and anecdote. Objectification and quantification of indicators of success must be part of the system's transformation.

Whether or not psychiatrists like or agree with this is really beside the point, it is the reality that is approaching, and if they are not prepared to engage in evidence based services, they are going to be out there on the right wing with the non

swimmers.

· **Efficiency** - Whatever the shape of the structures that are developed, they must be streamlined in their administration and operation. This will often require the integration of the many elements of extended service systems. Redundant or idiosyncratic procedures must be eliminated, flexibility in staffing and in disciplinary roles must be accomplished, team perspectives on service delivery should be developed, and universality and uniformity in information gathering systems must occur to facilitate the transfer of information. All of these processes must take place in the context of an expanded treatment array that meet the needs of clients rather than those of institutions.

· **Comprehensive, Integrated Continuums** - Care cannot be provided efficiently in the absence of a complete and integrated continuum of care. This must go beyond purely clinical constructs to include prevention, supportive services, and multi-systems collaborative approaches to complex psychosocial problems. Artificial divisions must be eliminated and political barriers must be overcome. There must be an adequate number of elements available in the resource array to meet the specific needs of an individual consumer.

Changing the Institutional Culture for Efficiency

Most providers have struggled to stay ahead of the wave of change that has swept across the country. Some have been able to stay out in front of that wave, others have had to labor to keep pace or to avoid being left behind altogether. Those who have been successful have been able to look objectively at their inefficiencies and structural redundancies and have eliminated them. They have created administrative structures that are versatile and progressive, empowering employees at all levels of the organization. They have elaborated visions of how their systems should work and how they can accommodate the demands of the principles just discussed. To achieve this magnitude of change, they have had to make their whole organizations aware of and invested in their vision of the future and enable them to work collaboratively to accomplish it.

Care Management

The implementation of level of care determination criteria have been critical to these efforts. They set consistent clinical standards for meeting client's service needs in a reliable and equitable manner. The Level of Care Utilization System (LOCUS) and the ASAM PPC-2R are examples of instruments which have been developed nationally to assist in that process(14). Instruments like these have provided much needed structure and uniformity to what was formerly an ill defined process. When used properly, these instruments allow us to assure quality while using resources efficiently and consistently. Both of these systems assess clients in 6-7 dimensions and use the dimensional ratings as criteria for matching client needs to the intensity of services which should be provided to meet them. When extended to their full potential, these tools will provide the organizational structure for the entire treatment delivery process. They will be used in conjunction with clinical pathways which provide time related guidelines for implementing interventions. They can form the backbone for treatment planning and the identification of clinical objectives.

Information Systems

Technology has created opportunities to increase the efficiency and comprehensiveness of documentation in ways that we would not have thought possible in the past. As the cost of technological hardware decreases, the major obstacle to employing it to its potential will be our work forces ability to use it. The advantages of an integrated information system to large behavioral health systems hardly need to be reviewed. The development of the computerized record will allow movement toward the ideal world of smooth transitions between levels of care in a "seamless" continuum of care. Regardless

of where or when a client presented in the system,a complete set of information would be readily available for use. As clinicians gain proficiency in using these systems, more time will be available for clinical interaction rather than pencil pushing.

Continuum Development

As time goes on, hospitalization will play a smaller and smaller role in the treatment process. There has already been a reduction in lengths of stay to an extent that would not have been imagined just a few years ago. There is an obvious logic to this process, and in most cases we can take care of people in less restrictive settings than we have in the past. Eventually, hospital care will be available only to those who have psychiatric disorders which absolutely need intensive monitoring and those who pose a threat to themselves or others. In response to these changes, alternatives to inpatient treatment must be developed. The development of crisis intervention services, extended observation facilities, subacute and residential services will allow diversion of admission for many of those clients currently being admitted to the hospital. Intensive outpatient services and partial hospitalization programs will also play an important role in this respect, and ancillary social services to support them will be critical. Unique programming for special populations will add additional capacity to the treatment array. Significant expansion of the current continuum will be required as time goes on, with the capacity for flexibility and evolution as the changing environment dictates.

Staffing Flexibility and Productivity

Maintaining the quality and flexibility of the behavioral health staff is an essential piece of a well functioning system. Cross training and experience will allow staff to move from one setting to another with minimal loss of efficiency. In this way, they can be concentrated where needs are the greatest at any particular point in time. It will be important to maximize the amount of time that staff can devote to clinical treatment activities as opposed to clerical/ documentation activity to achieve high quality care. Elimination of redundancy in documentation requirements and development of the computerized record as discussed above will of course contribute to a system's ability to maximize the productivity and efficiency of its staff.

Continuous Quality Improvement

Solving problems pro-actively will be the key to maintaining quality, and in some cases, survival in a very difficult and ever changing environment. In order for this to occur, a process in which all staff members are involved should be in place. A problem solving structure which is simple but useful will help move quality improvement initiatives forward. As with the treatment planning process, clear objectives should be established which have measurable indicators. This will allow objective evaluation of the solutions proposed to address identified improvement opportunities.

Outcomes

Intimately connected with quality improvement is outcome measurement. There are a variety of ways that outcomes can be measured, one of the most accessible is satisfaction monitoring. It is important to identify all of the groups which the system is trying to satisfy. The client's perception of change and well being following an episode of treatment can be an important indicator of the effectiveness of the services provided. It is also possible to independently monitor function during and after treatment exposure using objective indicators. These measurements may help clarify whether certain types of treatment or the use of particular levels of care contribute to differences in function or well being over time. The use of this latter process is much more complex and expensive than self report methods, however. Whatever the methods which are employed, outcome driven treatment planning will clearly be a prominent feature of successful service systems in the future.

Consolidation of Resource Management and Care Management Functions

One key element of a system that preserves quality while providing efficient care is the ability to control both of these elements. This eliminates the need for micro management and the considerable expense associated with it, and allows those resources to be devoted to clinical services. Current fee for service arrangements have not been very successful in maintaining balance between quality and efficiency. Moving toward more creative payment systems such as risk bearing/sharing capitated relationships will eliminate some of these inefficiencies. With these types of payment systems in place, providers would truly be in control of their resources, eliminating the copious administrative waste inherent under the present arrangements. When liberated from the constraints of over-regulation and when allowed to implement innovative solutions needed to overcome difficult clinical problems, service providers can rise to the challenge, providing higher quality and less costly services to a greater number of people.

Conclusion

Systems need to continue to evolve in response to quality concerns and outcomes of provided services. Efficiency and the wise use of resources will allow services to be extended to a greater number of people and will allow the minimum standards for health care to rise over time. An understanding of the forces shaping and driving current systems will allow providers of mental health and addiction services to contribute to the redesign of systems of care. A failure to achieve this understanding or stubborn resistance to it will likely result in a swift demise as the wave of change passes over. It is best not to be caught over there on the right wing!

Dr. Sowers is the Medical Director of the Allegheny County Office of Behavioral Health in Pittsburgh, Pennsylvania.

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PERSPECTIVE ON PARITY: PART I

Steven Kouris, DO, MS, MPH

INTRODUCTION

The desirability of non-discriminatory mental health coverage has received increasing attention over recent years. This recognition garnered support in part due to advances in neuroscience with concomitant treatment refinements, but also because of the relentless efforts of advocacy groups and political champions for improved mental health coverage. Disparities in insurance coverage between mental illness and other medical illnesses have been in place since contemporary health insurance first developed in this country. An embedded public-private split in coverage, poor public understanding of mental illness, a persistent social stigma, and ineffective advocacy in the past have all contributed to the evolution of an insurance system with marked differences in coverage between mental and other medical illnesses. During the past decade, a quest for parity has emerged, on both the state and federal levels. Part I of this review will briefly chronicle the history behind efforts at the federal level, with an overview of the Mental Health Parity Act of 1996. Part II examines the state of parity since the bill's implementation and takes a look at more recent initiatives.

BACKGROUND

The Role of Government

Before the 19th century, insanity was not defined medically; care of "lunatics" was given informally by relatives or by community networks through charity and poor laws. In the early 19th century, reformers spearheaded the creation of asylums, the premise being that acute mental illness could be cured if humane treatment was delivered. A public asylum system was created, with shared responsibility between the state and local government. Gradually, as an increasing number of patients were shifted from almshouses to asylums, the ranks of those requiring long-term care steadily grew. Though some, like Dorothea Dix, championed a shift in fiscal responsibility for care of the insane to the federal government, the prevalent belief that health and welfare issues were the responsibility of the states remained intact through the 19th century and into mid- 20th century. The mental hygiene movement of the early 20th century led to the insane being treated as wards of the state. In the 1950's, another shift began, this time towards community-based programs via state-local partnerships.

The passage of the National Mental Health Act in 1946 ushered in a federal presence in mental health policy, and included authorizing the creation of the National Institute of Mental Health. The Community Mental Health Centers Act of 1963 increased the role of the federal government, but with a focus on community driven agendas and consequentially an emphasis on lower acuity mental health issues than the historic focus on the severely mentally ill. The role of the federal government significantly increased with the passage of the Social Security Act in the 1960's, which introduced Medicare and Medicaid. As noted in the Surgeon General Report on Mental Health, federally funded public sector programs have served as the 'catastrophic insurer' for those citizens with the most severe problems and the fewest resources in the United States. As part of the movement to a new federalism beginning in the 1980's, the Omnibus Budget Reconciliation Act reduced the role of the federal government in mental health funding, In 1996, of $69 billion spent on diagnosis and treatment of mental illness, 53% came from public payers, including state and local (18%), Medicaid (19%), Medicare (14%), and other federal sources (2%).

The Role of Insurance

A significant public mental health care system was essentially in place as contemporary health insurance began to take root in the 1930's. Consequently, a split in responsibility between

private and public funding for coverage of mental illness was woven into the fabric of health insurance as a result. With private insurers generally providing more restrictive benefits than for other illnesses, and designing benefit plans to cover only time-limited mental conditions, responsibility fell disproportionately to the public sector to serve those with more persistent and severe needs.

The 1970's and 80's exacerbated the situation as employers noted rising health care costs. Mental illness and substance abuse treatment rates were climbing faster than treatment costs of other conditions, almost double the rate according to some. The principle sources of this rise seemed to be long-term psychotherapy and inpatient substance abuse treatment, but employers and insurers tended to respond with broad reductions in benefits rather than more targeted responses. The RAND Health Insurance Experiment of the 1970's, showed a significantly greater induced demand for outpatient mental health services compared with other ambulatory health services when out-of-pocket expenses were decreased. It is important to note that due to the sample used in the RAND study, the effects of price on inpatient or outpatient mental health treatment by individuals with more severe mental disorders was not examined. Regardless of the restricted sample and the advances in mental health since the 1970's, the RAND study continues to be cited as justification for limiting mental health benefits.

The response of insurers and employers was predictable. Some private insurers offered no mental illness coverage. Those offering coverage typically included restrictions such as lower annual and lifetime benefit limits, higher deductibles and co-pays than for other medical conditions. By the early 1990's, insurance typically included an annual inpatient benefit of 120- 365 days for medical illnesses, but only 30 days per year for mental illness; whereas unlimited outpatient visits were included for medical illnesses, mental illness outpatient visits were limited to 20 per year. A lifetime ceiling for mental illness coverage might be $50,000 when no ceiling or $1 million ceiling would be in place for other illnesses. As of 1996, private payers accounted for 47% of mental health expenditures, with private insurance picking up 27% of costs, out-of-pocket costs 17%, and other private sources, 3%.

PROBLEM RECOGNITION

By 1990, advances in the understanding of mental illness helped challenge the mind-body dualism so prevalent for the past centuries. Diagnosis became more standardized and reliable; and awareness of highly prevalent psychiatric conditions such as depressive and anxiety disorders increased. Refinement of pharmacological interventions transformed mental illness from conditions having little hope to chronic illnesses that could be effectively managed. The scientific evidence equating psychiatric disorders with brain disease mounted, and in recognition and furtherance of this increasing science, the 1990's were dubbed the Decade of the Brain by Congress.

Concurrently, key stakeholders began expressing a louder voice. The National Alliance for the Mentally Ill (NAMI) developed into an effective and powerful advocacy group. NAMI championed the prioritization of severe mental illness, supporting increased research related to biological underpinnings and improved treatments. NAMI effectively developed grass roots chapters locally while also establishing a strong Washington presence and successfully partnering with key legislators, such as Senators Domenici (R- NM) and Wellstone (D- MN). Other groups, such as the National Mental Health Association, community mental health centers, and the professional associations of psychiatrists, psychologists, and social workers criticized the unfair nature of mental health coverage and pushed for reform. The demand for parity legislation was finally gaining momentum. A notable feature of political champions for mental health parity has been a family history of mental

illness. This association between political championing and personal exposure to mental illness has been an important dynamic contributing to the momentum of the parity effort on both the federal and state levels.

During this phase, some large employers recognized that mental illness and substance abuse produced high indirect costs via absenteeism, reduced productivity, and disability. Digital Equipment Company was a leader in redesigning its health care benefits to expand mental health benefits and introduce performance standards. A few other large employers also began increasing benefits by more tightly managing the care. It was during this time that managed behavioral care companies, specializing in mental illness and substance abuse, appeared on the scene; and employers and insurers began subcontracting out the behavioral health benefit.

States began passing parity legislation in the early 1990's. Some states, such as Texas, North Carolina, Ohio, and Massachusetts focused on public employees. Others, such as Maryland, Minnesota, Maine, New Hampshire, and Rhode Island enacted full parity for employers subject to state regulation. The passage of ERISA in 1974, however, greatly limited the scope of the state parity efforts, as the number of companies that chose to self-insure steadily increased during this time.

There were other stakeholders who opposed parity. Major employer and small business groups focused on the direct costs of providing coverage, fearing rising premiums if benefits were expanded. Insurance companies and HMO's opposed any mandates for parity, claiming significant associated increases in premiums if passed. Political conservatives in Congress and state legislatures opposed increased mandates for parity viewing it as further government intrusion into health care benefits. The public, with the exception of those affected by mental illness in their families, remained largely quiet about the need for parity mental health coverage.

Enter the 104th Congress. By the 1995-1996 session, national health care reform had failed, Senators Domenici and Wellstone were staunch advocates for mental health legislation, and Tipper Gore was a prominent public voice supporting parity.

POLICY AND POLITICS

The health care debate resumed when Senator Daschle introduced a bill considering parity for mental illness and substance abuse services with respect to cost sharing and duration of treatment. His bill offered a plan, modeled after the congressional health plan offered by Blue Cross and Blue Shield. Soon after, the Judge David L. Bazelon Center for Mental Health Law released their report, *Turning the Corner: New Ways to Integrate Mental Health and Substance Abuse in Health Care Policy.* The report suggested that reform legislation include a comprehensive mental health and substance abuse benefit with coverage of services normally funded though the public system. It urged that the benefit be incorporated into basic health care to facilitate an integrated health system with no arbitrary restrictions on outpatient and community services.

1996 brought considerably more debate on health care reform. The Health Insurance Reform Act sponsored by Senators Kassebaum and Kennedy (SB 1171) did not actually include mental health when first drafted. The original intent of this bill was simply to establish portability so workers could keep their insurance coverage if they lost or changed jobs, and to place limits on denial of coverage by health insurance companies because of pre-existing conditions.

Senators Domenici and Wellstone truly believed the time had come to eliminate discriminatory mental health coverage. They introduced, as an amendment to SB 1171, full parity coverage for all mental illnesses. This consisted of provisions requiring that annual inpatient and outpatient benefits be the same as for physical illness; co-payments and deductibles

be the same as for physical illness; annual and lifetime financial caps, and stop loss all be the same as for physical illness. Additionally, services may be limited to those that are deemed "medically necessary," and lastly, it stated that managed care is indeed allowed, i.e. plans are not in any way prevented from managing mental illness treatment services, from requiring preauthorization for treatment, or from negotiating discounts with providers.

In April, the amendment passed the Senate. Shortly thereafter, a report issued by the American Academy of Actuaries concluded that private-sector parity for mental health could save the public sector up to $16.6 billion a year. In an attempt to rally support, Representatives Roukema, Wise, and Fox secured signatures from 101 members of the House supporting the concept of full parity. Representative Roukema cited treatment statistics for bipolar disorder, which had a higher success rate (80%) than commonly accepted medical procedures, such as angioplasty (40%).

In June, Senators Domenici and Wellstone offered a compromise, which attempted to allay persistent fears of uncontrolled costs still held by some opponents. This more limited proposal required parity coverage only for aggregate lifetime and annual payment limits and allowed mental health care to be managed at the discretion of the health plan. This compromise measure sharply lowered the projected cost to the federal government from $16.7 billion to $1.8 billion, according to the Congressional Budget Office (1996). It was projected to increase premiums 0.4 percent; however, employers would likely only see a 0.16 percent increase in premium costs. Importantly, the compromise did not determine what a plan must charge; nor did it require parity for copays or deductibles, for inpatient days or outpatient limits. It excluded substance abuse and chemical dependency, excluded Medicare and Medicaid, but did include the Federal Employee Health Benefits Program. It allowed for managed care and mental health carve-outs, did not apply to individual coverage, and exempted businesses with 25 or less employees.

The Senate's health insurance reform bill was negotiated in a joint House-Senate conference committee. Senator Kassebaum wanted to drop parity and instead include a provision for a study. Several days later she changed her position and agreed to bar lifetime and annual limits for coverage but allow discriminatory co payments. A report, *Paying for Parity*, released by the Bazelon Center (1996), indicated that the price of parity would not come at as high a cost as its detractors had argued.

In July, mental health parity won approval from the Senate for a third time when the Finance Committee approved a mental health parity amendment in its Medicaid reform bill. The amendment was sponsored by Senators Simpson and Conrad. It included mental health parity, a more flexible definition of community-based services, and an easing of the Institution of Mental Diseases (IMD) exclusion which prevents facilities that use more than 50 percent of their available psychiatric beds from receiving Medicaid reimbursement for adults aged 22-64 years. Unfortunately, the months of intense debate and presentation of conflicting statistics finally concluded with the removal of the mental health parity amendment by the House-Senate conference committee negotiating the health insurance reform bill. Undaunted, Senators Domenici and Wellstone on August 1 introduced the Mental Health Parity Act of 1996, S. 2031. This revived the mental health parity compromise offered in July. The bill was referred to the Senate Labor and Human Resources Committee where it died.

In September, Senators Domenici and Wellstone tried again by drafting a compromise amendment which prohibited insurers from setting lifetime and annual caps for mental illnesses. This amendment, worked out between Senator Domenici, Tipper Gore and a small group of

advocates, was attached to HR 3666, the Veterans Administration and Housing and Urban Development appropriations bill. A related amendment, sponsored by Senator Gramm, allowed businesses to drop mental health parity if their insurance costs rose more than 1%. Support for the latter bill came from the American Managed Behavioral Health Care Association. The amendments were passed in the House and the Senate on a non-binding "motion to instruct" to vote favorably on the health measures.

On September 26, 1996, President Clinton signed into law the compromise parity amendment attached to the VA/HUD appropriations bill for fiscal year 1997. It eliminated lifetime and annual caps for coverage of mental illness but left in place the ability of insurance plans to impose discriminatory benefit limits and co payments. Businesses with less than fifty employees are exempt from the law. H.R. 3666, Dept. Of Veterans Affairs and HUD, & Independent Agencies Appropriations Act, 1997, eventually became PL 104-204. Title VII of the Act covered Parity in the Application of Certain Limits to Mental Health Benefits.

Dr. Kouris is with the Department of Psychiatry, University of Illinois College of Medicine at Rockford, Illinois

Welcome! New Members

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July 2001
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CALL FOR PAPERS

The ***Psychiatrist Administrator*** invites articles on all areas of paychiatric 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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Administrative Certification Now Faster, Simpler, Less Expensive

William H. Reid, M.D., M.P.H.

The APA Committee on Psychiatric Administration and Management recently changed the application and examination processes for APA certification. The examination process is now shorter; the oral examination has been eliminated; and application prerequisites now allow many young and early career psychiatrists to pursue certification. Elimination of the oral examination means that candidates could be certified just a few months after applying, assuming they pass the written test.

The new, single written examination will be more comprehensive than the old one, probably a combination of multiple choice and brief essay questions. It will be given for the first time in May, 2002, probably just before the Annual Meeting. The application deadline for the May, 2002, test is February 1, 2002. Earlier applications are encouraged in order to allow candidates more time to prepare.

AAPA is developing an administrative psychiatry course which would be given just before or during each APA meeting and could serve as a comprehensive review for candidates preparing to take the exam. The course would not be limited to certification candidates, nor would it be required or recommended by the APA for the examination itself.

Prospective candidates must be certified in general psychiatry by the ABPN or an equivalent body, and must have some experience in general or clinical administration (verified by letters of reference). The experience need not be extensive, but should provide some 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.

Persons currently engaged in the certification process who have completed the written examination but not the orals will probably have the option of taking an oral examination or taking the essay portion of the new written one. Those who applied and were accepted when the orals were required, but who have not completed the written test, will only be required to take the new, broader written exam.

APA Certification in psychiatric administration and management is designed to establish 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 illustrates those qualifications. In addition, certification is a visible demonstration of knowledge and skills which 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.

Further information, application materials, and study recommendations can be obtained from Kristen Moeller, APA Department of Continuing Medical Education, (202) 682-6109 (e-mail kmoeller@psych.org).

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

Pharmaceutical Industry Sponsorship: Guidelines for Ethical Practice

Kenneth C. Casimir, M.D.

The psychiatrist administrator occupies an important point of influence in the relationship between a staff psychiatrist and pharmaceutical representatives. With the progressive increase in marketing toward physicians by drug companies, articles began to emerge pertaining to the controversial topic of gifts from industry (1-3), and a heated dialogue has continued in recent publications (4-6). The literature has primarily focused on the ethical implications of accepting gifts, effects of corporate sponsorship on medical education, and the relationship between marketing and the prescribing practices of physicians.

Wazana (5) has published an extensive review of 29 studies performed between 1982 and 1998 having to do with attitudes toward the relationship between physicians and the pharmaceutical industry, and its impact on the knowledge, attitudes, and behavior of physicians. The author concludes that the present extent of physician-industry interaction appears to affect prescribing and professional behavior, and should be further addressed at the level of policy and education. This critical review of the data clearly identifies the need for administrators and educators to consider the implementation of guidelines within their institutions to facilitate ethical practice. However, the literature appears to have done little to clarify the place of organizational ethics in the generation of institutional policy to help regulate interactions between staff physicians and pharmaceutical representatives.

The purpose of this article will be (1) to distill from the current literature some of the operative ethical principles in this area, (2) to undertake a brief survey of guidelines drafted by professional societies concerning CME sponsorship and gifts from the pharmaceutical industry, and (3) to provide an example of an institutional policy which has been drafted by the author to serve as a framework for ethical practice.

Ethical Principles

Despite the controversy surrounding the gift relationship between pharmaceutical companies and physicians, a careful survey of the literature does not demonstrate this relationship to be inherently unethical. A conflict of interest occurs in any situation in which professional judgement regarding a primary interest, such as research, education, or patient care, may be unduly influenced by a secondary interest, such as profit or prestige . Lemmens and Singer remind us that conflicts of interest exist in every field, including science and medicine (7). There is nothing inherently unethical in experiencing a conflict of interest.

Rather, the key issues are whether the conflict is recognized, and how the conflict is dealt with. Important strategies include (a) disclosing the conflict, (b) establishing a system of review and authorization, and (c) prohibiting activities which might exacerbate the conflict.

In an effort to logically examine the interrelated issues involved in this debate, Peppin (8) uses a philosophical framework argued for by H. Tristram Engelhardt. This framework would consider interactions between pharmaceutical sales representatives (PSRs) and physicians to be acceptable as long as such relationships are free from coercion. The author identifies four common criticisms which have claimed that PSR-physician interactions are morally undesirable: (a) influence, (b) “patients do not choose, but they pay,” (c) violation of ethical principles, and (d) erosion of the physician-patient relationship. Each of these criticisms was shown to be unfounded within Engelhardt’s philosophical framework. As long as the principles of permission and informed consent obtain without coercion, interactions between PSRs and physicians can be considered morally permissible.

Policy Implications: Professional Societies

The last decade has witnessed a notable increase in corporate sponsorship, and a concomitant increase in the systematic establishment of professional guidelines relating to this area. As recently as 1989, Chren et al. (1) lamented the fact that "medical codes of ethics in this country do not mention these subtle issues." Soon thereafter, in 1990, the American College of Physicians released a position paper entitled *Physicians and the Pharmaceutical Industry* (9) in which it was stipulated that not only real bias, but even perceived bias should be avoided. In 1991, the Council on Ethical and Judicial Affairs of the American Medical Association published guidelines relating to gifts to physicians from industry (10). In their most recent form, the AMA's recommendations consist of AMA Ethical Opinion 8.061: Gifts to Physicians from Industry, and Ethical Opinion 9.011: Continuing Medical Education. These guidelines are available online at www.ama-assn.org/cmeselec/cmeres/cme-6.htm.

The American Psychiatric Association endorses these principles through its *Principles of Medical Ethics – American Medical Association with Annotations Especially Applicable to Psychiatry* (11). The recently released Ethics Primer of the American Psychiatric Association (12) devotes the second half of Chapter 7 to the topic of gifts from industry. In summary, the acceptance of gifts from industry is described as ethical (a) if they contribute to physicians' education or care of patients, and (b) do not exceed the norms of pharmaceutical-supported gifts to physicians.

On a more regional level, some state medical societies have published guidelines to clarify standards of medical practice in their states, and to foster an ethical working relationship with the pharmaceutical industry . In our state of Wisconsin, the State Medical Society has condensed a number of relevant principles from the American Medical Association code of Medical Ethics into seven guidelines, summarized below (13). (These guidelines may be found in their entirety at: www.wismed.org/physicians/drugsigns3122001.htm.)

· Any gifts accepted by physicians individually should primarily entail a benefit to patients and should not be of substantial value.

· The compassionate use of medical samples by physicians, when freely given by pharmaceutical sales representatives, is ethical.

· Individual gifts of minimal value are permissible, as long as the gifts are related to the physician's work (e.g., pens and notepads).

· Subsidies to underwrite the costs of CME conferences or professional meetings can contribute to the improvement of patient care, and therefore are permissible. Such subsidies should be accepted by the conference's sponsor, and not by individual attendees of the conference.

· Subsidies from industry should not be accepted directly or indirectly by physicians attending conferences, to pay the costs of travel, lodging, or other personal expenses. It is ethical for faculty at conferences to accept reasonable honoraria. However, it is not considered ethical for attendees of a conference or symposium to accept financial compensation for time spent attending the conference.

· Scholarships are acceptable to allow medical students, residents, and fellows to attend educational conferences. It is not acceptable to provide similar scholarships to practicing physicians.

· No gifts should be accepted if there are strings attached. This includes any expectations regarding prescribing practices or control over choice of speakers at CME presentations.

Institutional Guidelines

Although guidelines provided by professional organizations at the national and state levels are unquestionably valuable in bridging the gap between ethical principle and behavioral imperative, they may not enter into a physician's practice on a day-to-day level. In a busy clinical environment, convenience and perceived efficiency often win out over ethical principles.

In addition, many physicians continue to believe that they are not significantly influenced by their interactions with industry (14). Another point to consider is the fact that residents in training are likely to be more impressionable than practicing physicians. One study showed that third and fourth year residents believed that pharmaceutical representatives were a better source of new drug information than the *Physician's Desk Reference.* In response to such concerns, several authors have called for formal teaching ("counterdetailing") to help residents develop the critical skills necessary to obtain useful information from pharmaceutical representatives and industry-sponsored CME programs (15).

In an effort to approach this controversial area in a systematic and ethically consistent manner, a policy was drafted to govern Industry-Sponsored CME at Mendota Mental Health Institute. MMHI is a civil and forensic state hospital in Madison, Wisconsin, with 293 inpatient beds, and approximately 150 outpatients in our seminal Assertive Community Treatment program. In crafting the policy, care was taken to incorporate the following principles essential to maintaining relations with pharmaceutical representatives in an ethical manner: (1) equal access, (2) avoidance of endorsement, (3) freedom from coercion, (4) disclosure, (5) avoidance of appearance of conflict of interest, and (6) attention to training and medical education. The policy was drafted by the author (the Institute's Medical Director), and was ratified by the Institute's Medical Executive Committee. Table-1 shows this policy in its entirety.

TABLE-1: Mendota Mental Health Institute (MMHI) POLICY 1E.10 : INDUSTRY-SPONSORED CONTINUING MEDICAL EDUCATION

As part of a comprehensive plan to provide timely and efficient access to clinical literature, research data, reference assistance, and cost information, corporate sponsorship of Continuing Medical Education activities will be permitted at MMHI within the following guidelines:

1. To assure compliance with MMHI policy, and to assure consistency with institutional ethical considerations, all corporate representatives will be required to obtain the approval of the Medical Director or his designee prior to sponsoring any program, and before visiting any clinician on the grounds of MMHI.
2. It is the policy of Mendota Mental Health Institute to allow equal access to all pharmaceutical representatives, to avoid favoring any corporate entity. To facilitate the monitoring of frequency of visits and marketing patterns, at the time of each visit, pharmaceutical representatives will be required to sign a log which will be maintained in the Medical Director's office. Entries in the log will include the date, corporate affiliation, and location/purpose of visit.
3. A Continuing Medical Education Committee will be appointed by the CEO, upon recommendation of the Medical Director. The responsibilities of the CME Committee will include, but not be confined to coordination of industry-sponsored CME programs, including audio/televised broadcasts, speakers funded by unrestricted educational grants, and co-sponsored symposia. It is expected that the CME Committee will monitor issues pertaining to disclosure of corporate affiliation, timeliness and accuracy of information presented, and encouragement of critical analysis of research data, especially in training clinicians.
4. To monitor practical pharmacologic considerations, including cost effectiveness and provision of sample medications, all corporate representatives will be required to consult with the Director of Pharmacy services before visiting any clinician on the grounds of MMHI. If necessary, the Director of Pharmacy services or his designee will be responsible for contacting a physician to sign for sample medications. Formulary status of medications will be determined by the MMHI Pharmacy

and Therapeutics Committee.

5. For resolution of questions and/or issues pertaining to side effects, drug-drug interactions, laboratory or other diagnostic testing, and other medical issues related to pharmacologic agents, MMHI physicians and pharmaceutical representatives will be expected to consult with (a) the Director of Pharmacy Services, and/or (b) the Director of the MMHI Medical Clinic.
6. MMHI seeks to provide an environment in which physicians may prescribe medications based on a critical review of the scientific literature, free from pressure or coercion. In the event of unresolved concerns regarding a potential conflict of interest, physicians will be encouraged to present their item for discussion during a regularly scheduled meeting of the MMHI Medical Staff Organization. If it is decided by a majority of the Medical Staff that there is indeed a need for further examination of the issue, it will be the prerogative of the President of the MSO to obtain a consult from the MMHI Ethics Committee. The results of this Ethics consult will be forwarded in writing to (a) the President of the Medical staff, (b) the Medical Director, and (c) the CEO.
7. MMHI does not, and will not engage in the exclusive endorsement of any product marketed for the purpose of health care delivery. In keeping with the principle of equal access, corporate representatives will be provided with similar opportunities for sponsorship of Continuing Medical Education programs. When sharing information regarding their product, it is expected that this data will be presented in a timely, accurate, and ethical manner.
8. When accepting gifts or trinkets from corporate/pharmaceutical representatives, including pens, notepads, coffee cups, or other paraphernalia, MMHI clinicians will be expected to use professionalism and discretion when bringing such material into patient care areas and/or when interacting with the public. This includes an awareness of brand names and corporate emblems/logos. MMHI clinicians are expected to avoid the display of any item whose corporate logo or emblem might foster an impression of conflict of interest.
9. MMHI clinicians are expected to abide by any other applicable departmental and professional association guidelines and/or policies regarding sponsorship of CME and corporate gifts.

Violation of any of the above guidelines by corporate representatives will be considered grounds for discontinuation of CME sponsorship, and may result in suspension of MMHI campus visitation privileges.

In summary, it has been shown that despite controversy in this area, the gift relationship between physicians and pharmaceutical representatives is not inherently unethical. When a conflict of interest is encountered, it is the manner in which it is confronted which determines whether the ongoing relationship is to be considered ethical or unethical. Professional societies provide one measure of assistance in this regard through their guidelines, but personal and practical realities may result in a less than optimal level of ethical behavior on the part of physicians. Psychiatric administrators occupy an important point of influence in this area, through their ability to draft policy at the institutional level. An example has been provided of one such policy, which has been embraced and supported at one hospital in the public sector as a systematic, consistent framework for coping with increased marketing pressure from pharmaceutical representatives. Further research and continued dialogue is needed among psychiatrist administrators to determine how to best maintain an objective practice environment in other settings.

The past decade has witnessed the emergence of pharmaceutical corporations as the primary crucible for the research and development of new psychotropic drugs. Given the safety and efficacy of emerging medications, this need not be viewed

as an entirely negative state of affairs. However, the commercial sector will not operate under the same ethical principles as do physicians. Thus, the role of the psychiatrist administrator will be to provide leadership in harnessing the power of the commercial infrastructure, to facilitate the utilization of effective new pharmacotherapeutic agents in an ethical manner. One set of tools to help in achieving these ends are carefully crafted policies and institutional guidelines, based on solid ethical principles and consistent with practical administrative management.

Dr. Casimir is with Mendota Mental Health Institute Madison, Wisconsin and the University of Wisconsin School of Medicine.

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Is There An Ethical Way?

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

COLUMN INTRODUCTION:

On October 28, 2000 the American Association of Psychiatric Administrators approved and adopted the "Ethical Principles for Psychiatric Administrators". These were modeled after the American Psychiatric Association's "The Principles of Medical Ethics, with Annotations Especially Applicable to Psychiatry", which were geared to psychiatrist clinicians.

There has also been a related publication by the American Psychiatric Association, "Opinions of the Ethics Committee on the Principles of Medical Ethics", which consists of questions and answers on examples relating to the Principles. These questions show how the Principles can apply to real life situations.

Since our principles have been approved, we have begun to receive some unsolicited questions concerning psychiatrist administrative ethical issues. The first example follows, with commentary from members of our Ethics Committee and the Editor.

ETHICAL QUESTION:

Dear Steven,

As the Medical Director for Marin County Division of Mental Health, I very much appreciate your work and your leadership in developing the principles. It is very helpful.

I do have a question for you. Recently we have been requested to provide funding (around $40,000 - $50,000) a year for a woman with Huntington Disease and Psychosis secondary to Huntington to live in an IMD. I think clinically it would be best for her. However,
from a financial perspective, we do not have the funding to provide expensive care for people with "organic" brain disorders with secondary psychiatric manifestations. How would you handle something like that?
Tiffany Ho, M.D.

Response 1:

Dear Steven:

I reviewed Dr. Ho's ethical question and have some difficulty responding. Huntington Disease itself would be a problem for state social services or other agencies. Psychosis, secondary to Huntington Disease, needs clarification of symptoms, duration, and length of anticipated treatment for the psychosis. It does not appear to be an indication for long-term IMD residence.

This puts us in the struggle for being humanitarians and facing some unpleasant realities. Legislative intervention will be a step in the right direction.

I trust you will be able to get feedback on other responses.
Cordially,
Gerald H. Flamm, M.D.

Response 2:

I'm having some difficulty understanding the ethical dimension of this problem; maybe there's something I am missing. Here is my response anyhow.

It should not be surprising that domiciliary/or rehab. services should NOT be funded from the budgets of public mental health authorities for mental disabilities determined by axis III brain disorders such as Huntington's, Alzheimer's, trauma, encephalitis, etc.. Generally, such patients are not even eligible for routine public mental health clinic services here in Houston;they are defined out of the priority population which is confined to the most serious functional mental disorders. Also, the $40-50K price tag seems absurd to me.
Roy Varner, M.D., Professor, U. of Texas, and Medical Director, Harris Co. Psychiatric Center Houston.

RESPONSE OF EDITOR:

Dear Tiffany,

Thank you so much for your response to the AAPA's Ethical Principles for Psychiatric Administrators. Your question is just the sort of reaction I hoped we would receive, i.e. how can these principles be applied to real administrative life? My initial reaction would be as follows. In particular, the preamble annotation and section I annotation I seem relevant.

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 professionals, 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 patients, the psychiatric administrator must be guided by an ongoing commitment to the needs of patients. If and when the psychiatric administrator can no longer follow these principles, resignation would be an ethical option.

Section I

"A physician shall be dedicated to providing competent medical service with compassion and respect for human dignity."

Annotation (1) for Psychiatric Administrators. Knowing that the quality of medical services can be affected by a wide variety of variables, including the skills of clinicians, the organization of the delivery system, and the adequacy of funding, the psychiatric administrator will strive, though may not always succeed, to do what is possible to have competent mental health services in the organization. "Competent" does not mean ideal services, but rather refers to the average expectable outcomes given the current state of psychiatric knowledge and available delivery systems.

To translate these annotations into your particular situation, the main ethical question would be centered around what is your organization funded to do and who is requesting the funding for an IMD? If your organization's funding is for "mental health", then it would seem your organization's responsibility is only to help provide "competent" care for the "psychosis" secondary to the Huntington's. Presumably, that would mean medication and possibly some sort of psychotherapy. A funding source for other medial (neurological) problems, or social problems, would seem to have the responsibility for the IMD. This sort of ethical dilemma is not uncommon when mental health is "carved out" financially from the rest of healthcare and can lead to difficult decisions as to who is responsible and where to draw the line. Politics can also blur the lines. For you as Medical Director, the ethical issue is similar. What are you supposed to be responsible for, and how do you advocate for this patient's overall needs while keeping in mind your organization's funding and priorities?

INVITATION FOR FOLLOW-UP COMMENTARY:

But what does our readership think about this ethical issue from the perspective of a psychiatrist administrator? We welcome your comments, which can be published in an upcoming issue of the *Psychiatrist Administrator*.

INVITATION FOR OTHER QUESTIONS:

Given the current ethical challenges that face psychiatrist administrators, we're quite sure there are many more questions to deliberate. Please send them to us for consideration in future columns.

NEXT ISSUE'S ETHICAL QUESTION:

Dear Dr. Moffic:

As is usually the case for Ethics Committees, there are typically more questions than answers. Please add the following one to your list.

Shouldn't Psychiatrists or Psychiatric Administrators (note which comes first in this title) not Administrators or similar non-medical regulators make decisions on clinical care?

Sincerely,
Lawrence Beasley, M.D.

PLEASE RESPOND:

For any responses to Dr. Beasley's question above, or more responses to Dr. Ho's question, or new questions for the column to consider, please communicate to:

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Thanks for your interest and participation.

Section Editor: Christopher G. Fichtner, M.D.

Book Reviewed:

Prison Masculinities. Edited by Don Sabo, Terry A. Kupers, Willie London, Temple University Press, 2001

Reviewed by:

Claudia Kachigian, M.D., J.D., Assistant Medical Director, Chester Mental Health Center, Illinois.

Assistant Professor of Clinical Psychiatry, Southern Illinois University School of Medicine.

I read most of this book on an eight-hour family trip to an amusement park. At the park, my older nephews, both fourteen years old, were prodding my younger nephew, nine years old, to go on the scarier rides. "Come on, you wimp- even little girls are riding this! Are you a girl? Are you afraid?" For most of the day, my younger nephew was sullen, angry, and felt victimized. Fortunately, one event changed the course of the day. "The Gemini". This is a roller coaster that has two trains running on parallel tracks, which "race" each other. My younger nephew and myself rode in one train, and the older men, my husband and older nephews, rode on the other. The high school aged "administrators" happened to start our train first, and changed the course of our day. We "won". The rest of the day, my little nephew gleefully shouted "Ha ha! We won!" He still did not ride the scarier rides, but he happily took on the role of "holder of the riders' stuff" the rest of the day.

Because I happened to be reading this book during the course of these events, I thought of this intrigue as "Amusement Park Masculinities". I tell this story, not to belittle or trivialize the work of the authors and editors of the book, but to show how prevalent attitudes about masculinity are. "Being a man" mentality permeates even the most superficially benign, white, middle class activity, rendering a pleasant day at the park a source of anger, persecution, and competition. An amusement park hierarchy and power struggle was created. There were the "riders" and the " holders".

Now imagine a supermax prison, filled with mostly "lower-class" African American young males. How much this amplifies feelings of anger, persecution, and competition, we can only imagine. This book, however, takes us there. I felt, through vivid descriptions by current and former prisoners, a little bit of what they feel in this environment. Other essays provided a background, politically, socially, and historically, which guided the reader to the development of the "tough on crime" mentality and the creation of the modern day prison.

After reading about this environment, where every aspect of a prisoner's life is observed and scrutinized to determine if he is a powerful man, or a "punk" (the prison term for a weak prisoner who has become the sexual slave of a dominant one); whether he plays by the "rules", or will be labeled a "snitch" and potentially slaughtered; where he must kill to prove his manhood or become a punk –a woman, or even be killed himself, even the most staunch supporter of harsh punishment for felons will reconsider his position.

Through a series of essays by sociologists, prisoners, psychiatrists, journalists and poets, among the contributors, the reader learns of historical and social underpinnings of sexuality, violence, and health in; and finally, efforts and proposals to reform, the prison environment. The editors focus on how societal views of masculinity and what it takes to be a man, fuel the prison environment with its rigid hierarchies and displays of power meant to establish who is the most manly. They try to show us that these attitudes are not restricted to a prison setting, but spill out into communities leading to domestic abuse, spread of infectious disease, and continued crime. They propose that efforts to harshly punish nonviolent criminals do not prevent crime, but

further perpetuate it. Pouring funds into building more prisons may be beneficial to those profiting from the industry of private prisons, or companies that receive cheap prison labor, but is not lowering crime rates or protecting society. They propose that funds would be better spent by reintegrating nonviolent criminals into noncorrectional settings and establishing rehabilitation programs.

Their arguments are effective, but could have been more so if there were more points of view considered. The essays in the book were authored by obviously literate, thoughtful and caring individuals, who happened to have also been felons at some point in their lives. However, are there not psychopaths who do not respond to rehabilitative efforts? Or is there any type of offender who is less likely to respond to efforts at rehabilitation , and how should they be treated in prisons? I realize that the authors are trying to tell us that we should stop thinking of offenders as "lost causes" and untreatable, but does that mean that all will respond to rehabilitative efforts, and if not, is harsh punishment appropriate for those who do not?

The book also tends to vilify correctional officers and prison administrators. The descriptions of their treatment of prisoners are horrific, and likely, accurate, but we do not see the other side at all. Prison masculinties should include correctional officers who are also on front line in the power struggle and the shows of force necessary for survival in prison. How much respect by peers and prisoners, who judge others in terms of their masculinity, would a compassionate, soft-spoken correctional officer receive? I am not condoning cruelty, but I believe the point of view of those running the prisons are conspicuously absent.

I would also liked to have learned more about the environment in an all women's correctional facility, where masculinities, presumably, are not present, as contrast. Is there an emphasis on being womanly? Is the equivalent of a "dominant" male a woman who is the most compassionate, motherly, neat?

In summary, this book was extremely effective in presenting the view from a cell, describing the various factors which have led to the prison environment as it exists today, and convincing the reader that rehabilitation (one of the keys to which is a change in societal attitudes of what it is to be a man) should be our goal, but presenting the views of those running the prisons, addressing situations in which rehabilitation efforts may not be successful, and offering a description of the environment in a women's prison for contrast, would have made the book less one sided and even more persuasive.

CERTIFICATION IN PSYCHIATRIC ADMINISTRATION AND MANAGEMENT

At its meeting of May 5, 2001, the Committee on Psychiatric Administration and Management of the American Psychitric Association and met all other requirements for certification in Psychiatric Administration and Management. They are:

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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.

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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).

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Figures should be numbered consecutively as they appear in the text. Illustrations - line drawings, graphs, or charts - should be of camera-ready quality.

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return corrected proofs to Frances Roton, Executive Director AAPA, within three days of receipt; delays in returning proofs may result in postponement of publication.

MANUSCRIPT SUBMISSION (Add electronic copy)

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

Three copies of the manuscript should be sent to Sy Saeed, M.D., Editor, *Psychiatrist Administrator*, Department of Psychiatry & Behavioral Medicine, University of Illinois College of Medicine @ Peoria, 5407 North University Street, Suite "C", Peoria, Illinois 61614-4785. The manuscript should be accompanied by a transmittal letter giving the name, address, email address, and phone numbers of the corresponding author. The letter should indicate that all authors have seen and approved the manuscript and that the manuscript has not been published or is not under consideration for publication elsewhere. A disk copy of the complete manuscript, including tables and references, should also be submitted. Please label the disk with the name of the first author and title of the article and indicate what hardware and software were used. **You can also submit the manuscript electronically by sending it as an e-mail attachment to the editor at SASaeed@UIC.Edu.**

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Participants:
Marc D. Feldman, M.D., F.A. P.A. & **Steven Moffic**, M.D.

Workshop #44 at the
53rd Institute on Psychiatric Services
Orlando, Florida
Saturday, October 13, 2001

NewsJournal is supported by a grant from Wyeth-Ayerst

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