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President's Column

The Future…*y El Futuro*

As my four years of being AACP President now closes, I want to use this final Presidential Column to look ahead and recruit you into a process of critically reviewing where the organization needs to go over the next phase of its existence.

In last issue's Column, "Reconciling Opposites" (Vol. 25, No. 2, October 2011), I pointed to the next few years as a paradoxical period – one of critical opportunity for community psychiatrists to be identified as important advocates and negotiators of systems integration –relying on our professional identity as adaptable, forward thinking, and above all, systems-savvy. Regardless of fiscal belt-tightening and Supreme Court decisions concerning the federal Patient Protection and Affordable Care Act, or ACA, most states' healthcare policy is on the move to align with ACA principles. In my view, many localities are already promoting initiatives that expand health coverage, encourage services integration, re-define clinical populations and how they are served, and focus on less expensive community-based interventions.

So, where does all this place the American Association of Community Psychiatrists? Many in our general membership and on our Board of Directors have been keenly focused not only on adapting to these changes but in taking on the challenge of leadership to influence the process. We have an obligation to membership, and the entire profession, to continually evaluate what "community psychiatry" is and to be poised as authoritative in policy and in our practices.

To this end, and with the help and encouragement of Emeritus Board Member Ken Minkoff, we have launched a project called *El Futuro*. During the April AACP Winter Meeting that was held in Phoenix in conjunction with Recovery Innovations, Inc. (which member Ken Thompson orchestrated with energy and great success) and at Philadelphia's May meeting, the Board has been drilling down into the issues concerning the AACP's future, convening a process covering these 6 key areas:

• Who is our population and where do we work?: defining the populations we serve and organizing delivery systems to address behavioral health needs.
• Community behavioral health is part of health: visibly positioning within integrated health systems and working on this issue with other groups
• Citizens of the world: overcoming US-centricAmericentric pull and not ignoring what can be learned from community systems globally
• Children's systems of care: representing psychiatrists working in resiliency-oriented services
• Getting real about recovery: If we are recovery-oriented, then demonstrating that we regard consumers as true partners
• Promoting partnerships: working collaboratively with other healthcare professionals and policymakers on implementation of access to psychiatric services.

We will continue to work on these issues at least through the Fall Board meeting at the APA Institute for Psychiatric Services in New York City. These 6 topics might not even be a fully comprehensive set of challenges and–if we are to be succeed in organizational strategizing –your active contribution to the discussion and planning is indispensable. The Board reported progress on these areas at the Membership Forum in Philadelphia and will be reaching out for your involvement as we begin to move this process to concrete steps that will transform important aspects of the organization's identity. We really can't afford to miss this leadership opportunity – both within our profession and the broader public behavioral health care system – advocating for the wellness of people we serve every single day.

Finally, please join in our appreciation of the dedicated service of members who are now leaving the Board: Peter Chien, Michelle Clark, Charlotte Hutton, Beatrice Kovasznay, Brinda Krishnan, Mark Ragins, and Erik Vanderlip. Special thanks go to Wes Sowers, who is leaving his role as Immediate Past President. I can't tip my own hat and exit the stage without expressing appreciation to you for your trust and support over the past four years. Being

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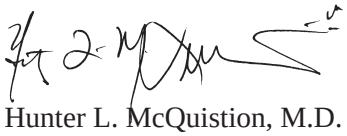
In this Issue:

President has been fun, fascinating, and a learning experience in its best sense: a true honor to serve. I have been proud of the accomplishments we've made in solidifying the organization and advancing the AACP's visibility, particularly as a beacon for recovery-oriented services. As the organization moves to its next developmental challenge, please also join in offering enthusiastic support to the Presidential stewardship of Anita Everett who, with the help of our next AACP Board team --a group of exceptionally energetic and committed people --who, with you, will take us into the future.



Hunter L. McQuistion, M.D.
President, AACP

Editor's Brief

Margaret Balfour, M.D., Ph.D.

I am honored and excited to begin my term as Editor of the Community Psychiatrist! My first contact with the American Association of Community Psychiatrists was when I began my APA Public Psychiatry Fellowship several years ago. Longtime AACP member Ken Thompson gave the opening address at the Institute for Psychiatric Services meeting that year. In it, he talked about how Pennsylvania had eliminated the use of seclusion and restraint from their state hospital system. Being a naïve resident from Texas, at the time I thought that sounded pretty cool, but impossible.

Through my experience with the AACP, I have since come to learn that the elimination of seclusion and restraint is very much possible. We recently held our Winter Meeting in Tempe, Arizona where we had the opportunity to visit Recovery Innovations' Crisis Response Center – another program I would have considered impossible until I actually saw it. This is a psychiatric emergency facility that receives people in all states of crisis and substance intoxication, often brought by police in handcuffs. Yet it's unlocked, and after demonstrating over 10 years of restraint-free care, they advocated for and were given special permission by licensing agencies to remove their seclusion rooms altogether.

Other AACP members are at the forefront of this important issue, which is so fundamental to building recovery-oriented services. AACP member Scott Zeller also serves as the President of the American Association for Emergency Psychiatry and was instrumental in developing their new guidelines for the treatment of agitation – Project BETA (Best Practices in the Evaluation and Treatment of Agitation, http://tinyurl.com/AAEP-Project-BETA). The guidelines emphasize more humane and person-centered approaches such as de-escalation, shared decision-making, and reduction of seclusion and restraint. Project BETA makes a compelling case that this approach is not only more humane, but also more effective.

Most of our members already practice these principles, but it's very helpful to have the backing of our professional organizations, especially when working and advocating in systems that are still on the way to becoming fully recovery-oriented. Using what I've learned from my fellow AACP members, I am very proud to be part of a team that has reduced seclusions in our own ER by 98%. Three years ago I would have considered this an impossible feat.

All of our members are doing similarly impossible things every day. The IPS and Winter Meetings, the newsletter, and the listserv provide opportunities to share our innovations and challenges. We encourage you to submit an article for the next edition of the newsletter so that others can gain inspiration from the great work that our AACP members do each day.

Margaret Balfour, MD, PhD
Associate Medical Director for Performance Improvement in Behavioral Health at Parkland Health and Hospital System; Assistant Professor in Psychiatry at University of Texas Southwestern Medical Center at Dallas.

AACP has major presence at this year's Institute on Psychiatric Services

by David Pollack, M.D.

I have been privileged to serve as the chair of the Scientific Program Committee that has put together the great array of sessions that make up this year's Institute on Psychiatric Services, in New York City, October 4 –7. Several other AACP members are also on the SPC and have represented the values and ideas of our organization in creating a marvelous program that all who attend will find quite impressive. The conference, whose theme this year is *Pursuing Wellness through Recovery and Integration*, will be innovative, diverse, comprehensive, and professionally fulfilling.

The IPS, an inter-professional meeting with a predominant focus on community and public mental health and substance use issues, provides top-notch scientific and policy presentations. It is an excellent one-stop resource for those who need to satisfy professional CME requirements. An additional popular bonus is the opportunity for attendees to network with experts, colleagues, advocates, and peers.

Numerous workshops, lectures, symposia and discussion groups are planned as well as half- and full-day courses. The courses will help attendees master important new material in depth, and will cover diverse topics, such as: Integrated Care, Emergency Psychiatry, Psychopharmacology for Primary Care Providers, Finding Ideal Jobs in Psychiatry, Clinical Work with Persons who are Homeless, Cultural Psychiatry, Essential Psychopharmacology, Buprenorphine Training and Geriatric Psychiatry.

This year's IPS will have some special features:

- An expanded track on integration of behavioral health and primary care. There will be numerous interactive sessions in which psychiatrists, other BH professionals, and primary care providers can learn and talk about our different clinical cultures and how to effectively collaborate/integrate.
- Emphasis on mental health recovery: what it is, how psychiatrists can be involved, and the perspectives of persons who have been recipients of mental health services. The Opening Session keynote will be provided by Dr. Elyn Saks, a prominent advocate and recipient of mental health services. Additional lectures and discussion sessions with prominent consumer advocates will also be featured.
- In commemoration of the birth of community-based health movements in the United States, there will be an exciting special session with Leonard Stein, Joel Feiner, and Matthew Dumont, three pioneering psychiatric leaders who will look back at the first 50 years of the community mental health era.
- OMNA (APA's Office of Minority/National Affairs) on Tour has organized a special track on the impact of psychological trauma on minority and underserved communities and families.

Featured presenters include:

➢Prominent clinical leaders, such as Judith Beck on CBT, Joseph Parks on CMHC-based health homes, Danny Carlat on conflicts of interest in psychiatry, Ron Diamond on recovery oriented prescribing, Patrick McGorry on early psychosis intervention, and Jurgen Unutzer on integrated care.

➢Policy experts, such as Linda Rosenberg from the National Council, Harvard health economist Thomas McGuire, international socio-epidemiologist Richard Wilkinson, New York State MH Commissioner Michael Hogan, Health Disparities expert Camara Jones, and former APA Presidents Paul Appelbaum and Pedro Ruiz.

Come to New York, join us and take advantage of the enormous educational and professional opportunities that await you as an attendee at the APA's 2012 Institute on Psychiatric Services.

AACP Calendar

October 17 -21, 2012 World Psychiatric Association Thematic Conference – Czech Republic / Prague

October 23-28, 2012 American Academy Of Child & Adolescent Psychiatry Meeting – San Francisco, CA

Nov 8-11, 2012 25th Annual U.S. Psychiatric and Mental Health Congress Meeting – San Diego, CA

March 23-24, 2013 American Society for Adolescent Psychiatry Annual Meeting – Charleston, SC

May 3 -5, 2013 Society for the Study of Psychiatry & Culture Annual Meeting – "Stigma" Toronto, Canada

May 18-22, 2013 166th Annual Meeting of the American Psychiatric Association – San Francisco, CA

Telepsychiatry: A Decade Later

by Satya Chandragiri, M.D.
President, Oregon Psychiatric Association
www.psychospitalredesign.com

"The difference between what we do and what we are capable of doing would suffice to solve most of the world's problems"

Mahatma Gandhi

It was a big relief when I told my patient that there was no need to be restrained and sit in the back of the Sheriff's car to be returned to the county court for his civil commitment hearing. We now have Videoconference equipment and the courts can conduct the hearing via video. This was my introduction to using Telepsychiatry as a tool to support the recovery of those we serve.

We all recognize that the person's we serve have experienced trauma, challenges with attachment, have been re traumatized several times in the course of their life, have significant problems with establishing trust, battle with stigma and shame and are frightened with the experience of their mental illness. In order to support their recovery, it is critical that we provide the conditions that can nurture and heal the damages due to the trauma and attachment deficits and engage them in their recovery.

While serving as the Chief Medical Officer of a state Hospital in Rural Eastern Oregon, I got to use the Telepsychiatric equipment for a wide variety of activities. What initially started as a means to connect with our state capital for administrative meetings, became a medium for us to not only hold civil commitment hearings but later we started using it for team meetings and invite the family and county case manager and teams to join the treatment planning meetings in real time. The families and the community mental health teams could appreciate the progress made by the patient and it reduced the length of stay in the hospital. The families appreciated this opportunity to remain connected with their loved ones thus help repair any broken bridges. Soon we extended this to group home interviews and they started accepting the patients after interviewing them via videoconference.

When I left the state Hospital in 2005, I continued the practice of Telepsychiatry and started serving a frontier County nearly 250 miles away in Eastern Oregon. Harney County is nearly 10180 square miles and has a small population of 7500. We have an active caseload of nearly 300 patients. In addition to group home which serves former patients from State Hospitals, I serve the outpatient mental health clinic, provide support to the local Primary care group and the Local Emergency room. By providing a real time availability and accessibility of psychiatric care, we have a very small psychiatric hospitalization rate of between 5-8 per year. I am able to provide psychiatric evaluations, treatment planning, medication reviews, psychotherapy and coordination of care with the staff.

Over the last three years we have been able to extend similar telepsychiatric services to two group homes in Springfield, Oregon which serves forensic, adult and Geriatric, Voluntary and civilly committed persons with psychiatric and neuropsychiatric problems with dual eligibility under Senior and persons with disability services and mental health services.

It is reassuring to know that the cost of the equipment has decreased over time. I started with a Polycom videoconference equipment and a T1 line. I became eligible for energy tax credit as it reduced my driving by 60%. Recently I started using ichat with a business DSL line and recently I switched to Webex as I can now provide services from my tablet computer and yet it gives me the necessary encryption to meet the HIPPA standard. This also allows me to invite family and other members, share my screen thus allowing me collaborative charting and have the patients provide additional input, use it for patient and staff education while allowing me the flexibility to serve even when I am away from my office.

Ultimately it is essential to remember, Telepsychiatric equipment is a tool and a medium for us to connect. In our field of work, nothing can replace the therapeutic relationship, providing a safe atmosphere where the person served feels comfortable to share and heal. If used wisely Telepsychiatry can be an instrument to provide timely access to care in real time, reduce cost, and bring down the global burden due to mental illnesses and other health problems. The potential is endless. We are only limited by our own constraints. In this era 'where the world is flat', waiting for psychiatric access is unacceptable!

A Client's Perspective....

by Brinda Krishnan, M.D.

As Community Psychiatrists it is imperative to include the feedback of our clients when evaluating and creating service models. We can increase our understanding of their individuality and the multidimensional components of their recovery, such as creative expression. The following is an interview with Eddie Lin, a client working with the Green Door ACT team.

Green Door (http://www.greendoor.org) is a core service agency serving the mental health needs of over 1,800 residents of Washington, DC. In addition to other core services, 2 ACT (Assertive Community Treatment) teams have recently developed to serve the needs of the SPMI population.

Please tell me about yourself Eddie

I was born in Taiwan and stayed there for 22 years. At age 27 I moved to the US. I am 54 years old. I moved here because my mom is here.

How long have you been working with Green Door?

Since 1992. I have been on the ACT team for 1.5 years.

What do you like about working with the ACT team?

The ACT team talks to me and helps me adjust to my daily life and activities. They help me get a creative activity. Sometimes the situation you are in needs to be watched and how it develops. Look at the medications and how they work. They make sure I am OK.

What is your mental health diagnosis?

Schizo... Skinnage. I hear the voice. I have had this since age 27.

How has the hearing the voices affected your life?

Since I took the medication I am doing better. I didn't go to the hospital in many years. I didn't hear the voice but sometimes I feel depression, anxiety and feel impatient. My diagnosis is an anger problem. I hear the voices of people are arguing with me. My brain can't concentrate.

What are your strengths or what things do you feel successful doing?

I don't know… I draw pictures but I copy pictures. Before, I drew a lot of pictures and cooking. I played the guitar on the streets but couldn't make money. I was dancing on the street and I was happy. I spent a lot of time playing guitar. I haven't done it in a year because my guitar is broken and I played the whole day but didn't make any money.

What could we do better on the ACT team?

Sometimes the community people didn't share the message of how many medications I'm taking. On the weekends they didn't bring the correct medication for me. I had a stomach problem and didn't get any medications. Maybe in the meeting they can open up my case and discuss how many medications I have.

Do you have health insurance?

I have Medicaid and Medicare.

Do you understand how your health insurance works?

No but they team helps me understand.

Where do you live right now?

I live in an apartment in NW. It is a section 8 house. I have lived there since 1992. My mom helps me pay the rent.

What do you like about living in Washington, DC?

I just watch my mom and my sister. I like the Potomac River and the view. I like fishing there but I need a license. I can take the bus or walk. I feel comfortable living in the city because there a lot of people to watch on you. I feel secure.

You are from Taiwan. Do you think the team understands your cultural background? Do they talk to you about it?

I don't know. Not really. I would like them to. My father gave me a deep sense of my culture. He was very close to the culture and really believed in it. I like being Taiwanese. I miss Taiwan. I miss my friends and the food.

Who is your family support in this area?

My mom, my sister and my family. My mom lives in China town. I see her every few days. My mother looks old like a senior citizen [smiles]. I was thinking that if I didn't have mental illness my mother would still look young. There was too much pressure and trouble due to my mental problem and she worried. My family accepts my mental problems. My brother and sister also have mental problems.

What are your strengths or what things do you feel successful doing?

I don't know… I draw and copy pictures. Before, I drew a lot of pictures and cooking. I played the guitar on the streets but couldn't make money.

Please tell me about your art

I draw anything. I have drawn buildings, animals, and humans. I am self-taught. I was in 4th grade and I drew a Tower and my teacher told me to go to art school but it was too expensive and I didn't want to affect my family finances. I usually draw in Chinese ink or fountain pens.

Thank you so much for your time and allowing us to share your story and art in this newsletter.

No problem. I will come back next week.

Book Review

by Bernadette Grosjean MD. Associate Professor Harbor UCLA

Pharmageddon by David Healy
University of California Press. March 2012

Working as a psychiatrist in different countries, systems and settings as I did during the last 25 years has taught me that nothing is ever written in stone. What is considered safe and effective in one place may be looked at as harmful or useless in another. Psychiatry is definitively not an exact science and working with human beings' sufferings often needs more creativity than rigid guidelines. When working as a community psychiatrist we learn very rapidly the limits of what we were taught in academic forums and research literature. Reading David Healy's book comforted me in something that patients (our co-partners in the difficult business of healing bruised souls) had convinced me of a long time ago: how much they know and how carefully we need to listen to them …

David Healy is a serious man. As a caring clinician and internationally recognized expert in pharmacology, epidemiology and the history of psychiatry, this Irish professor may be reminiscent of both Sherlock Holmes and Atticus Finch.[1]

His latest book, *Pharmageddon***,** is a riveting detective story, a meticulous account of the troubling evolution of the practice of medicine and a compelling plea for a better protection of those that medicine is supposed to serve. It is a must-read for all of us. Beware though, that, as a physician or as someone who will sooner or later be a client of the healthcare system, you may be in for a painful ride. It takes only a few pages to realize that, if you are a health care provider, you may already have become, willingly of not, an accomplice of a system that has slowly but surely drifted from the shores of a "First do no harm" philosophy to shores covered by a growing number of victims of poorly or overly prescribed medications. Adverse drug events are currently the fourth leading cause of death in the US and Europe [2], [3] and possibly the leading cause of death within the mental health domain.

David Healy is a courageous man. Twenty years ago, when psychiatrists, like everybody else, wanted so much to believe in the quasi miraculous and purely benevolent powers of new and heavily marketed drugs, he was among the first to take the risky and unpopular position of pointing out the emperor new clothes. He cautioned us that the same pills that may relieve severe depression and save lives may also, occasionally, be the cause of suicidal thoughts and sometimes of suicide itself. By doing this, he saved lives, while compromising his own academic career in a world where academia and research have become increasingly and, in some places, totally dependent upon the financial support of the for-profit pharmaceutical industry.

In *Pharmaggedon*, the author expands his observations from psychiatry to the entire field of medicine. With carefully documented evidence, he brings us on a journey to observe the worrisome directions taken by medicine, which went from a cautious use of potentially poisonous substances and a denunciation of charlatanism to a profession hijacked by the greed of the Pharmaco-Industrial Complex and the doctors who benefit from it. One of the most stunning observations is how "evidence-based medicine," which was developed initially to protect society from quackery, has become the very tool used to turn data inside out in order to "advertise" medications as *efficacious* or *totally safe* while, too often, they are neither. Again and again, Healy demonstrates how the globalization and mercantilisation of clinical trials, together with the limited access to raw data from published and unpublished studies, and the ever expanding use of ghostwriting, have often turned evidence-based research into no more than a gimmick to increase sales.

Medical ghostwriting is a practice where pharmaceutical or device companies hire medical education, marketing, or communications companies to draft articles that are presented to prominent physicians and scientists to sign on as "authors." The idea, then, is that this will increase the likelihood that the article will be published in important medical journals. The articles may be review articles, editorials, or primary research papers, and they are typically presented to physicians and scientists affiliated with academic institutions. The physicians and scientists agree to sign on even if they may not be intimately familiar with the underlying data or relevant research or provided limited input on the article. Healy estimate than over half of the current medical literature has been "ghostwritten."

This drift from science to evidence-*biased* medicine, and the latter's role in the development of rigid and sometimes inappropriate guidelines, is very disturbing and makes for a very bleak future. Trust, the cornerstone of the relationship between a patient/consumer and his or her physician, seems doomed. Similarly, the trust that a physician needs to have in academia and Pharma in order to subject those in their care to potentially dangerous substances is also highly compromised. Some may regret that, by insisting

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mostly on the dangers of medications, David Healy does not put enough emphasis on their positive and life saving properties and the true improvement that have been made in reducing side effects. Maybe Healy considered that enough literature has been (ghost) written already on these aspects of pharmacology and that his erudition would be of better use in exposing truths that the majority of us were not aware of.

But Healy is not just a spoil-sport. As a good old fashioned physician, he proposes remedies to change a self-destructive medical dynamic. One of the most feasible and important changes that he recommends is the provision of full and free access to raw research data. It is shocking that these data are not already in the public domain since the interpretation of them affects not only our health but a good part of our economy. Another point made by Healy is to challenge a "prescription-only" system because a "prescription-only arrangement means that doctors have to give us disease if they want to give us pills" (or I would add, if they want to be paid).

I may need a little more convincing from the author as to what would safely replace this system. I would hope that this problem could be addressed with the regular updating of physicians' pharmacological knowledge - one where we would be considered smart and mature enough by academia and Pharma - to be informed of the risks of a molecule as well as their vaunted benefits. Other useful changes could be made at the level of billing practices, for instance in the design of a system that does not penalize the doctor financially for not prescribing anything.

David Healy has put theory into practice by creating RxISK.org, a free website (not sponsored by Pharma or advertising) for patients and their doctors to research and report drug side effects.

There is certainly a long road between appealing ideas and their execution in a world dominated by people who may all have some short-term interest in the status quo.

Let's hope, however, that, just as Atticus Finch's words helped to transform society for the better, David's Healy's *Pharmageddon* will give us the tools, courage and strength to rethink and transform the way medicine is designed and delivered.

Finally, if there is only *one* thought you want remember from this book, it should be this almost prophetic counsel by Philippe Pinel, from two hundred years ago: "It is an art of no little importance to administer (medication) properly, but it is an art of much greater and more difficult acquisition to know when to suspend or altogether to omit them."[4]

Amen.

*This book review was originally published in Psychiatric Services

[1] Harper Lee. To Kill a Mocking Bird. 50th Anniversary Edition Harper Collins.New York. 2010.
[2] Lazarou J, Pomeranz BH, Corey PN Incidence of adverse drug reactions in hospitalized patients: a meta-analysis of prospective studies. JAMA. 1998 Apr 15;279(15):1200-5. .
[3] Hakkarainen KM, Hedna K, Petzold M, Hägg S. Percentage of patients with preventable adverse drug reactions and preventability of adverse drug reactions - a meta-analysis. Hakkarainen PLoS One. 2012;7(3):e33236. Epub 2012 Mar 15.
[4] Philippe Pinel. A Treatise on Insanity (1809). Nabu Press 2012.

IPS Announcements

This year's 64th annual APA Institute on Psychiatric Services (IPS) will be held at the Sheraton New York and Towers, New York, NY from October 4th - 7th. The theme this year is Pursuing Wellness through Recovery and Integration. For those of you attending please note the following AACP activities taking place at the Sheraton New York and Towers.

AACP Board Meetings

Day 1 Wednesday, October 3, 12pm – 8 pm
Day 2 Thursday, October 4, 8 am – 12 pm
Riverside Ballroom, 3rd Floor

Membership Forum

Friday, October 5, 5:30 pm – 7 pm, Sheraton New York and Towers, Empire West Room, 2nd Floor

Membership Reception

Friday, October 5, 7:30 pm – 9 pm, Fountain House, 5th Floor, 425 West 47th Street, New York, NY 10036

From Generation To Generation in The American Association of Community Psychiatrists

H. Steven Moffic, M.D.

I was recruited for the Board of the American Association of Community Psychiatrists (AACP) in its earliest stages. The AACP had been established back in 1985. I had recently edited a book, "A Clinician's Manual on Mental Health Care: A Multidisciplinary Approach" (Addison-Wesley), which somehow got the attention of someone on the Board and, unbeknownst to me, seemed to fit the developing mission and vision of the AACP and its founding President, Gordon (Gordy) Clark, M.D. The book had a multidisciplinary and integrative (with primary care) approach.

These were heady times indeed. Now, as an Emeritus Founding Board Member, I just attended yet another membership business meeting at the 2011 Institute of Psychiatric Services. Nearing retirement and wondering how many more of these meetings I would attend, I gazed on the large number of attendees, seated in a wide circle. There were some still recognizable graying elders like myself sprinkled among new faces to me, mainly males and mostly light skin colored.

The Successes

Nostalgia crept in as the discussion started. Much seemed similar, but much has changed, both in the AACP and in wider psychiatric systems. And, wouldn't you know it, a new edited book on community psychiatry is about to be published! I am not one of the editors, but I did contribute the closing chapter on ethics for community psychiatrists. My co-author is the head of the Consumer Council of the Houston community mental healthcare system, and he is one indication of the changes over this generation.

As budget crises were briefly discussed, I recalled how President Reagan had demolished the principles and funding mechanisms of President Kennedy's Community Mental Health Act of 1964. Community psychiatrists began to have to try to provide competent care in less time. Gordy Clark recommended over and over that Medical Directors should not take responsibility without the accompanying authority, even if that involved being fired or resigning, as we later found out to prove true in his own case. So, mutual collegial support at meetings 2-3 times a year, for a while supplemented by lavish pharmaceutical-sponsored dinners, was an obvious immediate benefit of the AACP. But there proved to be much more.

We honed in on residency education on community psychiatry. Results included some standards and the development of Fellowships in Community Psychiatry.

To counteract the abuses of for-profit managed care, we developed Levels of Care guidelines for children and adults. To recognize those who addressed managed care most ethically, we established the Moffic Award for Ethical Practice in Public Sector Managed Behavioral Healthcare.

We took over the editorship of the Community Mental Health Journal, first under David Cutler, M.D., and now under Jacqueline Feldman, M.D. The quality and scope of the articles increased and continue to do so.

We've had this Newsletter to specifically hone in our particular challenges as community psychiatrists. The columns of our Presidents invariably boost morale, and hearing from other colleagues around the country provides new perspectives and comparisons. The list-serve of the AACP has been the day to day way of communicating and debating for those who like using it.

We've always tried to emphasize the principles of recovery. Now that the consumer and recovery movement has gained more momentum across other disciplines and administrators, we are not only most willing participants, but we wrote a position paper "on ensuring access to recovery oriented safety net psychiatric services". Some disagreement, though, exists on whether the recovery model should take priority over our medical model or to infuse the medical model.

Whether we've had a formal ethics committee or not, ethical care has always entered into the conversation. We successfully opposed an APA Task Force that was considering developing new ethical principles that did not recognize and appreciate some of the unique ethical challenges of our work. We became Pharma-sponsored free well before the APA began to do so.

And there were many other accomplishments. These are just my own highlights, but others can – and should – share theirs.

The Disappointments

Of course, there have been disappointments along the way. Membership numbers have dropped from its peak and never reached the goal of at least 1,000 members (and even that is likely a fraction of the community psychiatrists out there). Incorporating others in public sector communities outside of traditional community mental health, such as prisons and state hospitals, never took off much. We've never

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achieved the influence we hoped for within the American Psychiatric Association, though we did save and take over the management and planning of the APA's fall meeting, Psychiatric Services. Many of us have had to pursue other activities as national economic problems downsized our facilities and/or changed their priorities. Our authority is less. We even seem to have lost touch with some of our early leaders.

Future Challenges

As our membership meeting continued on, some of our challenges for the future became obvious. Do we stay more or less as we are, with the same name and the same core membership? How are we to address the emergence of ACOs if healthcare reform emerges as planned over the next few years and, given the omission of a public sector option, private for-profit insurance companies consolidate power and influence? How should we respond, if at all, to public issues that are effecting mental health, such as the Occupy Wall Street movement? Or, should we stay more insular and isolated? As the main theme of this meeting seemed to emphasize, how do we integrate better with primary care and medicine this time around? A similar try in the late 1970s failed over time as funding following federal grant pilot projects ended, and the programs could not be maintained and cultural gaps between psychiatry and the rest of medicine could not be closed. Since then, psychologists and social workers have been moving in. How do we attract more psychiatrists from various ethnic backgrounds, which will more mirror our patients' cultural backgrounds and values? We are moving toward a certification process for community psychiatrists, despite controversy about certification and recertification for psychiatrists under the American Board of Psychiatry and Neurology. Will this help our image, value, and quality, or be more of a surface obligation rather than substantive accountability?

Though we have supported the consumer movement in principle, and hired many peer specialists in our workplaces, why have they not been involved in any significant way on our Board? Should they have a special membership status?

Despite my tendency to be a "gadfly", I remain optimistic for our future and for our patients. Our dedication to those most in mental health care need is unlikely to significantly waver no matter the obstacles. That's just who we are at our AACP core.

Welcome New Members

Mawuena Agbonyitor
Akin Akinsanya
Brian Allender
Tichianaa Armah
Sunny Aslam
James Baker
Andres Barkil-Oteo
Paul Berkowitz
Renee Binder
Michelle Bloss
Maria Bodic
Andrea Brandon
William Bruno
Onaja Bryant
Carissa Caban-Aleman
Pat Cason
Flavio Casoy
Karen Chaney
Gil Citro
Daniel Cohen
Calvin Cruz
Ronnie Cummings
Neisha D'Souza
Papiya Das
Nicole Del Castillo
Esperanza Diaz
Jaap Doek
Chris Esquerra
Mark Everard
Toral Fadia
Sarah Falgowski
Gerard Fernandez
Carl Erik Fisher
Seth Flesher
Marshall Forstein
Andrea Fox
Richard Fragala
Kathryn Fraser
Gregory Gale
Adriel Gerard
Kristen Grable
Gregory Graves
Shawki Haffar
Jaesu Han
Helena Hansen
Sheri Hollander
Emily Gifford Holmes
Tiffany Hughes
Judith Ann Hunter
Joseph Insler
Rachna Kenia
Richard King
Noam Koengisberg
Steve Koh
Marianne Kroak
Christopher Lau
Jeffrey Lieberman
Nubia Lluberes Rincon
Mary Lutz
Tara Malekshahi
Christina Mangurian
Cecile Martineau
Elizabeth McMasters
Ashley Miller
Andrea Moore
Alisha Moreland
Shashi Motgi
Mark Nathanson
Ruth Netscher
Ikechukwu Ofomata
Terry Osborne
Paresh Pandya
Sandrine Pirard
Ellen Politi
Kaplana Raj Prasad
Todd Rankin
Naven Reddy
Cheryl Merrill Rotter
Pablo Sadler
Robert Schiller
Ruth Shim
Mel Sigman
Gagandeep Singh
Marilyn Smith
Sean Stanley
Sandra Steingard
Stephanie Stewart
April Sweeney
Nina Tioleco
Torrey Fuller
Jean Tropnas
Gary Tsai
Kristin Vanzant
Sudeept Varma
Bakari Vickerson
Ulrick Vieux
Terese Watkins
Bonnie Wright

Welcome New Board Members

The new officers of the AACP are:

President: Anita Everett
Vice President: Stephanie Le Melle
Treasurer: Eddie Maxwell
Secretary: Tony Carino

The elected Area Representatives are:

Area 1: Jeff Geller
Area 2: Pablo Sandler
Area 3: Curtis Adams
Area 6: Alvaro Camacho
Area 7: Maggie Bennington-Davis

The elected Representatives at Large are:

Warachal Faison
Paula Panzer
Julie Ranz
Walter Rush
Ken Thompson

Our new Early Career Psychiatrist Rep is:

Marilyn Griffin

We also sincerely thank those candidates who were not elected for their willingness to serve the AACP. We look forward to their involvement in other roles:

Penny Chapman
Bernadette Grosjean
Doug Noordsy
Sonmolu Shoyinka
Mary Kay Smith

Finally, we express deep appreciation to Wes Sowers, who is completing his term as Immediate Past President and Nominations Committee Chair, and welcome Hunter McQuistion who is moving into that role.

Community Psychiatrist *is a publication of the American Association of Community Psychiatrists. The views of the editor(s) and staff are expressed only in editorials in this publication. Opinions expressed in articles, columns, and letters are those of the writer and do not necessarily represent the opinions of the AACP. Letters to the editor or other contributions should be typewritten and double-spaced if possible. Contributions by email are preferable when possible. If sending email attachments, please send them in Microsoft Word or pdf format. Articles should be 1000 words or less, and letters should be less than 350 words. We reserve the right to edit contributions to conform to space and stylistic constraints.*

Please send contributions, letters and notices to:

Margaret Balfour, M.D., Ph.D.
Medicine Administration
5201 Harry Hines Boulevard
Dallas, TX 75219
Email: Margaret.balfour@gmail.com

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MEMBERSHIP APPLICATION
AMERICAN ASSOCIATION OF COMMUNITY PSYCHIATRISTS

Please Note: The information requested on this sheet will be used to provide information for the Membership Directory. Please take a moment to fill in the form as you would like your listing to appear. Then return the form with your check to the address below. Dues include subscription to the ***Community Mental Health Journal*** and AACP's newsletter ***Community Psychiatrist.***

We now offer joint memberships with the American Association of Orthopsychiatry, American Association of Psychiatric Administrators, and American Association for Emergency Psychiatry. Take advantage of the many resources of these organizations along with those of the AACP for a reduced joint membership fee!

General Member $150
Liaison Member (non-psychiatrist) $100
International Member $150
Member-in-Training (without Journal) ..... No dues
Member-in-Training (with Journal) $40
Medical Student Membership ..... No dues
Group membership (5 or more) $75
Joint Memberships
- AACP $120
- Orthopsychiatry $120
- AAEP $100
- AAPA $60
- (Plus $25 for New York Chapter Members) ..... ($25)
- Other ..... $_____

Voluntary contribution ..... $_____
Fee Waiver Request? _____

Make check payable to: **The American Association of Community Psychiatrists**
Send to: **P.O. Box 570218, Dallas, TX 75357-0218**

Please list your name, title, address, and phone number(s) as you would like them to appear in the Membership Directory

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MEMBERSHIP APPLICATION
AMERICAN ASSOCIATION OF COMMUNITY PSYCHIATRISTS

Name: _____
Address: _____
City, State, Zip + four: _____
Phone: _____ Fax: _____ Cell: _____ Email: _____
Years Out of Training: _____ Practice Setting: _____
Reason for Joining: _____
Race/Ethnicity: _____
Special Interest: Child/Adol. _____ Geriatric _____ Other _____
Members may pay by credit card: Visa/MC# _____
Signature: _____ Expiration: _____
If we have your permission to keep this credit card on file and charge your annual dues every December 1, please sign.
Signature: _____

ABOUT THE AACP

The American Association of Community Psychiatrists (AACP) was formed in October 1984. The impetus came from a group of community psychiatrists who began sharing interests and concerns at the May 1984 American Psychiatric Association Meeting and at many local psychiatric meetings. We found that community psychiatrists are a concerned, dedicated, energetic, and underrepresented group. Our concerns had not been adequately addressed in other professional organizations, which often had other priorities.

The AACP has the following purposes:

- Promote and maintain excellence in the care of patients through the organization of psychiatrists practicing community mental health on state, regional, and national levels
- Help clarify and solve mutual problems commonly encountered by psychiatrists in community settings
- Inform and educate the public about the role of the community health system in the care of the mentally ill
- Establish liaisons with related professional organizations to advocate for relevant public policy issues
- Promote cooperation between psychiatrists and other professional, paraprofessional and consumer groups involved in mental health care
- Encourage training and research in psychiatry which will increase the number of committed psychiatrists in community settings