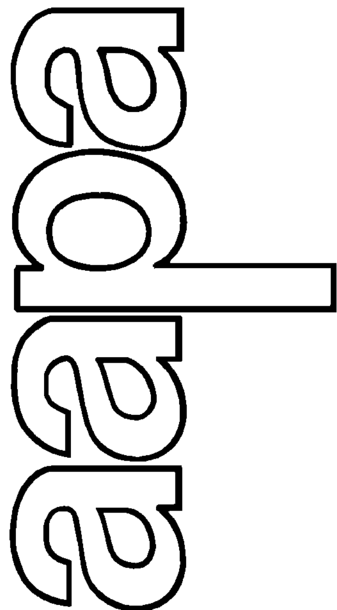

PSYCHIATRIST ADMINISTRATOR

NewsJournal of the
American Association of Psychiatric Administrators

Volume 4: 2004 Issue 2

From the Editor
Ethical Princilpes for Psychiatric Administrators
Sy Atezaz Saeed, M.D. and H. Steven Moffic, M.D. 39

President's Column
Thomas W. Hester, M.D. 40

The Americans with Disabilities Act (ADA) and the Zoning of Methadone Maintenance Treatment Facilities (MMTFs)
Judith J. Regan, M.D. M.B.A., William M. Regan, M.D., Charles E. Stephens, D.Ph., and Arvis Wright, B.S., C.P.S. 41

Ethical Principles for Psychiatric Administrators: The AMA Principles of Medical Ethics, with Annotations Especially Applicable to Psychiatric Administrators
H. Steven Moffic, M.D. 47

Revisiting the "Career Administrative Psychiatry Award" And other Reports from the APA Committee on Psychiatric Administration & Management
Stuart B. Silver, M.D. 52

Literature Scan
Josephine L. Dorsch, M.A.L.S., A.H.I.P. 54

Instructions for Authors 57

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

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

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ETHICAL PRINCIPLES FOR PSYCHIATRIC ADMINISTRATORS

Sy Atezaz Saeed, M.D. and H. Steven Moffic, M.D.

The ethical challenge for a psychiatric administrator is to help optimize the potential benefits and reduce risks of treatment and/or rehabilitation, all the while considering the costs, likely outcome, and alternatives unique to psychiatry.

Psychiatric administrators have had some particular ethical challenges as compared to other medical administrators.

- Unique organizational settings have included state hospitals and community mental health centers.
- Stigma has influenced the willingness of patients to come for and stay in treatment.
- Confidentiality has needed more stringent vigilance.
- Greater prominence of other mental health disciplines has posed problems in role definition and use of funds for staffing.
- A more recent challenge for medical administrators has been managed care. Here too, psychiatry has been particularly affected with the decrease in funding and an increase in carved out services and organizations.

When functioning as a psychiatric administrator, what ethical principles, if any, does one follow?

- Does one keep the mission statement of their organization in mind and does what he or she can do to meet that?
- Or does one always keep the needs of an individual patient primary?
- Or does one try to do some combination of both? If so, which principle may dominate in a given situation?

While different approaches could be taken, a time tested one would be to use the principles of medical ethics[1]. Just as the American Psychiatric Association added annotations to these principles[2], especially applicable to psychiatric clinicians, the American Association of Psychiatric Administrators has suggested annotations especially applicable to psychiatric administrators[3]. These annotations for the psychiatric administrators are now 4 years old. During these last 4 years we have published an ongoing column to illustrate these principles through case scenarios. We have also presented several workshops at IPS to publicize and promulgate these principles. It seems to us that these annotations may have reached a time where we need to review them to see whether they need to be updated or expanded. In this issue, we are reprinting these Principles to seek input from our readership. I hope you'll indulge and send your comments or suggestions on these principles that will help AAPA to update these annotations. Please direct your comments to Steve Moffic, Ethics Column Editor, and [smoffic@mail.mcw.edu].

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PRESIDENT'S COLUMN - FALL 2004

THOMAS W. HESTER, M.D.

Aloha, fellow members and friends of the American Association of Psychiatric Administrators (AAPA). In my last column, I noted that our Executive Council meeting held in conjunction with the American Psychiatric Association Annual Meeting on May 4, 2004 would be dedicated to strategic planning. I am pleased to report that 14 members of the AAPA Executive Council actively participated in a productive three-hour work session following our Annual Membership Luncheon. It was agreed that the primary strategic goals to strengthen the AAPA are: Increase Visibility and Value; Improve Fiscal Status; and Expand Membership. Here are some of the actions that were developed at the May 4, 2004 meeting and refined in conference calls on June 24 and August 5, 2004.

1. Increase Visibility and Value:
   - Increase publication of the AAPA NewsJournal from two to four issues annually. Dr. Sy Saeed, the editor of Psychiatrist Administrator, has reported that he has sufficient numbers of high quality submissions to support four annual issues.
   - Re-institute an improved AAPA CME course at the May 2005 APA meeting which assists members and other interested psychiatrists in attaining certification in administrative psychiatry. Dr. Shiv Hatti has taken the lead and is assembling excellent faculty.
   - Sponsor APA workshops and symposia. Dr. Jeanne Steiner has developed a proposal for a AAPA sponsored workshop at the May 2005 APA meeting entitled, "Women as Leaders: Opportunities and Strategies for Success." The presenters include Drs. Page Burkholder, Mary Ellen Foti, Elisabeth Kunkel, June Powell, and Rose Yu-Chin.
2. Improve Fiscal Status
   - Drs. Doug Brandt, Barry Herman, and Shiv Hatti are actively pursuing grants to support the more frequent publication of the NewsJournal.
3. Expand Membership
   - Dr. Doug Brandt has drafted a letter to be sent to all psychiatric chief residents with an offer of free AAPA membership for one year.
   - Frances Roton will provide copies of the AAPA NewsJournal to all attendees of the psychiatric residents leadership conference that is held in conjunction with the 2005 Annual APA Institute of Psychiatric Service Conference.

The AAPA Executive Council will soon take steps to develop focused charges for each of our standing committees. This will ensure that all components of our organization have clear work plans that align with the AAPA's strategic goals.

I have made the following Council appointments:
Dr. Doug Brandt, Secretary/Membership Chair
Dr. June Powell, Councilor
Dr. Larry Goldberg, Chair, Managed Care/Private Practice Committee
Dr. Michael Vergare, Chair, Academic Education Committee
Dr. Chris Fichtner, Liaison, APA Committee on Psychiatric Administration and Management (CPAM)

As you can see, the commitment and strategic work of AAPA Executive Council has begun to take shape. We are moving closer towards becoming recognized a major force in the development of impactful psychiatric leadership.

THE AMERICANS WITH DISABILITIES ACT AND THE ZONING OF METHADONE MAINTENANCE TREATMENT FACILITIES

Judith J. Regan, MD, MBA; William M. Regan, MD; Charles E. Stephens, DPh; and Arvis Wright, BS, CPS

Methadone Maintenance Treatment Facilities (MMTFs) are nonresidential drug treatment programs that assist individuals addicted to opiates, such as morphine, heroin and oxycodone, in leading productive lives. At MMTFs, the treatment programs substitute a synthetic opiate (methadone) in place of the drug of abuse and provide an ongoing program of administering methadone. The treatment program includes oversight by a physician as well as intensive drug counseling services. The model for methadone maintenance treatment (MMT), as well as the location of the facilities that provide the treatment, remains controversial. This controversy has led to changes in zoning laws that affect the ability for individuals seeking treatment to access services. The concept of preventing treatment facilities, such as MMTFs from locating in certain areas, through unique zoning ordinances, is referred to as exclusionary zoning.[1]

Many of the individuals receiving MMT are considered to have a disability, and are provided some protection under the Americans with Disabilities Act (ADA) as well as its predecessor, the Rehabilitation Act. When individuals are protected by a federal law, the state statutes found to discriminate in violation of this Act would be preempted by federal law, therefore, struck down. The application of the ADA to zoning laws in general has not been clear. As a result, litigation has occurred when zoning laws were established to prevent methadone clinics from operating in certain areas.[1]

This paper examines the impact the ADA and the Rehabilitation Act have had on the zoning laws involving MMTFs by reviewing statutes, regulations and court decisions.

Overview of MMT

The National Institutes of Health (NIH) has stated that opiate dependence is a medical disorder and has repudiated the theory that opiate dependence is a problem of poor motivation, lack of will power or inadequate strength of character. Studies have shown that opiate dependence can be effectively treated with medication, and that medication is most effective when used in combination with regular psychosocial treatment.[2]

Regardless of these studies, arguments persist about whether opiate dependence is a medical disorder or a character flaw. The predominant view of opiate dependence in the past is that it results from a lack of will power due to a character disorder. These individuals are not seen as persons with a disease, but with a lack of will power. Apprehensions and stereotypes derived from beliefs and attitudes about the unworthiness of a group of people or a type of treatment are difficult to dislodge.[2], [3]

The stigmatized view of people with opiate dependence as having a weak character has followed them into treatment. Many individuals receiving treatment are afraid that others will find out and thus, their jobs and social life will be affected. This associated stigma has affected MMTFs themselves. The stigma has prevented programs from opening when community opposition develops through the process of exclusionary zoning.[1] Battles over zoning arise from residents' fears about declining property values, merchant's concerns about increased crime or general concerns that methadone will bring about increased crime.[3],[4]

Thus, public policy often seems to place greater emphasis on protecting society from MMTFs than on the epidemics of dependence, violence and infectious disease that MMT can help reduce. The cost effectiveness of MMT in communities is often overlooked. A recent study completed by the California Department of Alcohol and Drug Programs found that, for each day of MMT, the benefits to taxpayers equaled or exceeded the cost

primarily through an avoidance of crime.[5]

The 1997 NIH Consensus Statement reported that from an estimated total of 600,000 opiate dependent persons in the United States, there were 115,000 in MMT programs. The Consensus Statement also reported that "MMT is effective in reducing illicit opiate drug use, in reducing crime, in enhancing social productivity and in reducing the spread of viral disease such as AIDS and hepatitis." Although abstinence from illicit drug use would be ideal, most persons dependent on opiates are unable to stay drug free. MMT in this population has been shown to reduce the use of illegal drugs as well as other criminal activity, provide an opportunity for employment and significantly improve the quality of their lives.[2]

In spite of the need and proven efficacy, both placement and existence of methadone clinics remain controversial. It is difficult to find acceptable locations for the physical grounds of MMTFs. Although attitudes may be shifting and some enlightened individuals are not opposed to these facilities near their homes and businesses, the "NIMBY' (not-in-my-backyard) syndrome has been well described in relation to the efforts of surrounding neighbors opposing the development and placement of these facilities. Consequently, numerous municipalities have made changes to their zoning laws pertaining to MMTFs.[6]

ADA and MMT Programs

An individual is considered to have a disability under the ADA, if he or she "has a physical or mental impairment that substantially limits one or more major life activities of such individual, a record of such an impairment, or being regarded as having such an impairment." Individuals who receive MMT often meet this disability classification. While laws affecting the disabled have progressed, vague areas remain. One of these laws is the application of the ADA and its effect on those individuals seeking zoning for the establishment of MMTFs.[7] Different federal acts, such as the Fair Housing Act (FHA) and the Rehabilitation Act, address zoning for group homes.[8] An outpatient treatment center, as with a methadone clinic, is unable to use the FHA and can only use the Rehabilitation Act and the ADA as a basis for legal action.[4]

The Rehabilitation Act covers recovering alcohol and substance dependent persons under their definition of handicapped:

1. The term "individual with a disability" does not include an individual who is currently engaging in the illegal use of drugs, when a covered entity acts on the basis of such use.
2. Nothing in clause shall: be construed to exclude as an individual with a disability an individual who —
   a has successfully completed a supervised drug rehabilitation program and is no longer engaging in the illegal use of drugs or has otherwise been rehabilitated successfully and is no longer engaging in such use;
   b is participating in a supervised rehabilitation program and is no longer engaging in such use; or is erroneously regarded as engaging in such use but is not engaging in such use...[8]

Under the ADA, "No qualified individual with a disability shall, by reason of such disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any such entity."[7]

Individuals receiving methadone services may be considered "qualified individuals" and thus protected under the Americans with Disabilities Act (ADA). Under the ADA, the intent of Congress was to prohibit outright discrimination as well as discrimination which denies to disabled persons public services in a disproportionate manner due to their disability. When a state's "services, programs or activities," such as zoning laws, discriminate against disabled individuals in violation of the ADA, "reasonable modifications" are required in such "services, programs or activities." However, a defense to an ADA violation "...may include a requirement that an individual shall not pose a direct threat to the health or safety of other individuals." An individual who does pose a direct threat that cannot be remedied by a "reasonable modification"

is not a “qualified individual” under the ADA.[7]

The intent of Congress was to give the ADA significant latitude in granting autonomy to the disabled and restoring full participation in society. In the area of zoning, however, the actual breadth of the ADA has not been clearly established. Court rulings are divided on the application of the ADA to zoning for the disabled. It remains unclear as to whether the ADA or its predecessor, the Rehabilitation Act, works to address a zoning dispute concerning a substance abuse treatment center such as methadone. The ADA does not explicitly cover discrimination against outpatient treatment centers for the disabled trying to obtain zoning.[4]

Federal and State Regulatory Oversight

The federal and state governments have responded to the methadone controversy through the passage of extensive regulations. Methadone use in treating opiate dependence has been subjected to extensive Federal, State and local regulations for over thirty years. Laws limiting and controlling the availability of psychoactive drugs and their use to treat opiate dependence were enacted by Congress as far back as the early 1970s. In 2001, the Department of Health and Human Services (DHHS) and Substance Abuse and Mental Health Services Administration (SAMHSA) issued regulations governing the use of methadone. The regulations enforced by the Food and Drug Administration (FDA) in 1972 were repealed, and a new accreditation-based regulatory system was created. The new system shifted administrative responsibility and oversight from the FDA to SAMHSA. The new regulations (42 CFR part 8) acknowledge that opiate dependence is a medical condition that cannot be reduced to a one size fits all treatment. The regulation recognizes that individual patients may need vastly different services. Essentially the regulations establish a different regulatory and oversight structure for medication-assisted treatment (MAT) for opiate addiction. The Drug Enforcement Agency (DEA) role remains the same, but the FDA’s authority to approve and monitor programs has been moved to SAMHSA.[9]

The new Federal regulations do not override the authority of the states to regulate MMT programs. State regulation of methadone programs adds another layer to the operation of these programs. States monitor the same areas as the Federal agencies; however, the state rules do not exactly follow the Federal regulations. Other State and local regulatory requirements such as Certificates of Need (CON), as well as zoning and licensure might affect the number, size and locations of MMTFs.[9]

State/Circuit Cases

MX Group Inc. v City of Covington

MX attempted to open a MMT clinic in the City of Covington. After finding a suitable location, MX went to the City’s zoning office in order to receive the required permit for operation of the clinic. A determination was made by the City that the clinic was appropriate for the zone where it would be located. However, once the zoning permit was granted, the residents expressed their disapproval to the City. At a public hearing community members testified on the negative effects of having methadone clients in their residential area. These effects included murders, robberies, drug use and other antisocial acts. After the hearing, an appeal was filed, which resulted in overruling of the permit. Although MX appealed, the Circuit Court dismissed their case due to lack of a necessary party. MX began to look for another site for their clinic. In the meantime, the Council began working on a modification to the City’s ordinance to prohibit methadone clinics. An amendment to the zoning ordinance was made that provided for the added qualification of a text amendment for a methadone clinic. MX again appealed, citing an ADA violation. The district court held:

- The possible clients, recovering heroin addicts, for the methadone clinic were “persons with disabilities” under the ADA.
- Addiction affects a working individual’s life activities, as well as parenting abilities.
- MX had standing to bring this action on behalf

of the addicts, and

- By barring clinics within the city limits, the ordinance violated ADA on its face.

On review, the court stated that the City could consider reasonable safety issues in its zoning decisions but should not base its decisions on alleged harm that results from stereotypes and generalized fears as in this case.[(10)]

Bay Area Addiction Research and Treatment Inc. v City of Antioch

The patients and owners of a methadone clinic sued the City stating that the zoning ordinance adopted by the city, barring methadone clinics from within 500 feet of a residential area, violated the ADA and the Rehabilitation Act. The court found that both Acts applied to zoning ordinances. However, the court stated that the "reasonable modification test" under the ADA and the Rehabilitation Act requiring a public entity to make "reasonable modification" in "policies, practices or procedures" in order to avoid discrimination, was not applicable to this case. Here the ordinance was discriminatory on its face. The court also stated that the plaintiffs must show that clinic patients were "qualified individuals" under the "significant risk test." The "significant risk test" under the ADA and the Rehabilitation Act provides that "public entities have the ability to craft programs or statutes to respond to serious threats to the public health and safety while making sure that these uncommon distinctions are based on thorough policy grounds instead of on fear and prejudice." Under the ADA and Rehabilitation Act, one is not a "qualified individual" if they create a "significant risk to the health or safety of others" that a "reasonable modification" cannot resolve.[(11)]

Innovative Health Systems, Inc. v City of White Plains

Innovative Health Systems, Inc. (IHS) was a rehabilitative treatment program for individuals recovering from drugs and alcohol dependency. Several clients of IHS brought an action against the city, the Planning Board, and the Zoning Board of Appeals. The clients claimed the city violated the ADA and Rehabilitation Act by refusing to allow IHS to operate their treatment program in the downtown area. The city and boards argued that the clients' claim did not fall under either the ADA or the Rehabilitation Act because it was based on zoning. The Court found that the clients did have a claim under the ADA and the Rehabilitation Act. The court concluded that the clients must show that similarly situated groups were treated differently.

The court acknowledged that the ADA case law was ambiguous concerning zoning issues. They analyzed the term zoning as a part of a "service, program or activity" under the ADA. The court ruled that the ADA protected zoning as an activity of a public entity by drawing on literature from the DOJ. The court held:

- Both the ADA and Rehabilitation Act apply to zoning decisions,
- The Center and clients showed "requisite irreparable harm,"
- The Center had standing to bring an action under the ADA and the Rehabilitation Act, and
- The Center and clients stated "cognizable claims" under both Acts.[(12)]

Oak Ridge Care Center, Inc. v. Racine County, Wisconsin

Oak Ridge, the operator of an elder care facility, attempted to sell its property. Oak Ridge eventually found a buyer, a Christian growth and development center (Teen Challenge). Teen Challenge intended to use the property and facility as a residential drug and alcohol rehabilitation center. Teen Challenge agreed to purchase Oak Ridge's property contingent upon obtaining a conditional use permit from the county. An application was completed; however, in a public hearing, numerous residents urged rejection of the conditional use permit. The residents were opposed to the rehabilitation center because they felt it would be a security risk to neighborhood schools, attract criminal activity, bring too much traffic, cause sewage problems and diminish property values. After the public hearing, the county denied the conditional use permit. Oak Ridge was unable, after this, to sell the property and claimed economic damages as a result. Oak Ridge claimed the county denied the permit based on stereotypical attitudes that were discriminatory towards alcoholics and drug

addicts.

Oak Ridge brought this action under Title VIII of the FHA and Title III of the Americans with Disabilities Act (ADA). The court held:

- The elder care facility had standing to bring this action under Article III of the ADA.
- The facility had a cause of action under the ADA based on its association with disabled individuals.[13]

Village of Maywood v. Health, Inc.

The Village of Maywood sought to prevent Health, Inc. from operating a methadone clinic. They alleged that the clinic was in violation of the village-zoning ordinance. The trial court had found that the methadone clinic was a permitted use under the ordinance Section 8.4. This section read: "Offices of professional persons such as physicians, dentists, health practitioners, attorneys, architects and engineers, and including out-patient medical and dental clinics, but not hospitals" are a permitted use.

The appellate court stated that the methadone clinic could qualify as a permitted use under the zoning ordinance, and the clinic's existence was advocated by Illinois' public policy. This policy stated that the "human suffering and socioeconomic loss caused by addiction to controlled substances was of grave concern to the people of Illinois."[14]

Smith Berch Inc. v Baltimore County (1999)

White Marsh Institute (WMI) was formed by Mr. Smith for the purpose of providing MMT services to individuals with opiate addiction living in the White Marsh areas. Mr. Smith, after finding a location for WMI, applied to the permit department to open a center. Due to a denial, Mr. Smith sued the county and their officials alleging a violation of the applicant's rights under the ADA and Due Process Clause of the Fourteenth Amendment. Smith Berch sought declaratory and injunctive relief, monetary damages and costs. In 1999, the district court found:

- WMI had the "constitutional and prudential" standing to bring this action on behalf of their potential clients,
- The county and its officials were not immune to a cause of action brought under the ADA, and
- The unwritten zoning policies that applied only to methadone clinics forced a "disproportionate burden upon persons disabled by opiate addiction who required methadone therapy."[15]

On further review in 2000, the Court held that the zoning permit did violate the ADA because it required an applicant for a methadone clinic to undergo a public hearing prior to obtaining a zoning permit.[16]

Habit Management Inc. v. City of Lynn

Habit Management, the operator of a drug and alcohol treatment facility, alleged that the City ordinance regarding methadone clinics violated the ADA. The operator filed this action after applying, and being denied, a permit for a methadone clinic. The ordinance stated that methadone clinics within two miles of a school were prohibited in the City. The Court found the ordinance was a violation of the anti-discriminatory provision of the ADA. The court stated that the two-mile prohibition completely prohibited methadone clinics from operating anywhere in the city.[17]

Conclusion

Methadone Maintenance Therapy (MMT) is a highly cost effective treatment in terms of preventing complicated healthcare costs (HIV, hepatitis and others), crime and the impaired social functioning resulting from untreated opiate dependence. However, public concerns persist regarding the lack of an absolute cure, as well as the stigma that surrounds those in need of this form of treatment.[2] This Not-In-My-Back-Yard (NIMBY) syndrome has prevented some methadone maintenance facilities from being established and hampered individuals from receiving appropriate treatment.[6]

The federal and state governments have responded to both these issues with complex regulations. The courts have become involved in a dispute interpreting the Rehabilitation Act, and the ADA as it relates to zoning and those "qualified individuals" receiving MMT.[4]

While the Rehabilitation Act has always supported the disability rights movement and its quest for

autonomy, Congress has indicated "that the ADA has wide breadth and grants the disabled autonomy and a chance to fully participate in society." In the area of zoning, the breadth of the ADA has been uncertain.[4] In addition, exclusionary zoning claims require that discrimination be shown to "qualified individuals" under the ADA. Courts have been reluctant to become involved in defining federal acts, and thus dictating policy to state and local government.[18]

After a stage of transition, the public can begin to assess how the lives of disabled individuals receiving methadone have been effected by the ADA. Congress may need to clarify the Act and specifically provide that zoning is a "service, program or activity" of a public entity and that the ADA protects the disabled from discrimination in the area of zoning. Further education of the public on the model of MMT as well as the benefits of treatment on disabled individuals and communities will be essential. While the zoning of methadone maintenance treatment facilities remains controversial, the treatment of opiate dependence remains essential in improving the quality of life for both the addicted individual as well as society at large.[4]

Dr. Judith J. Regan is the Medical Director of the Department of Mental Health and Developmental Disabilities for the State of Tennessee; Dr. William M. Regan is an Associate Professor at Vanderbilt Medical Center; Charles E. Stephens is with Department of Health for the State of Tennessee; Arvis Wright is Administrative Assistant with the Department of Mental Health and Developmental Disabilities for the State of Tennessee.

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ETHICAL PRINCIPLES FOR PSYCHIATRIC ADMINISTRATORS:

The AMA Principles of Medical Ethics, with Annotations Especially Applicable to Psychiatric Administrators

The American Association of Psychiatric Administrators Ethics Committee,
H. Steven Moffic, M.D., Chair

INTRODUCTION

Off and on, but especially in the recent managed care era, the question has arisen as to what ethical principles psychiatric administrators should follow. To be sure, psychiatrists have "The Principles of Medical Ethics, With Annotations Especially Applicable to Psychiatry" (1998) to follow potentially. These principles were developed by the American Medical Association, with annotations developed by the Ethics Committee of the American Psychiatric Association. However, these principles and annotations primarily address the clinician, and there is little in the annotations, which relates to the responsibilities of psychiatric administrators. Even the new Addendum 1, "Guidelines for Ethical Practice in Organized Settings", is geared to clinicians, save for some comments on doing utilization review. There is also a related publication by the American Psychiatric Association, "Opinions of the Ethics Committee on the Principles Medical Ethics" (1995), which consists of questions and answers on examples relating to the Principles. Although some of these questions relate to managed care settings, they also are mainly presented from a clinical point of view. Similarly, the American Medical Associations' Council on Ethical and Judicial Affairs has published over 150 ethical opinions, but only one of them emphasizes administrators, that being 8.02, "Ethical Guidelines for Physicians in Management Positions and Other Non-Clinical Roles". This opinion simply states that "physicians in administrative and other non-clinical roles must put the needs of patients first", but does not comment on other, or more specific, administrative ethical issues.

One possible reason for the lack of defined ethical principles for psychiatric (and other medical) administrators is that they are not needed. This sort of question goes back at least as far as the philosophy of Plato and his student Aristotle. Plato advocated for ideal philosophical principles, which could then be applied to real life political situations in Greece. Aristotle, on the other hand, felt that such general principles would not be of much use, because real life would always necessitate selecting the best available compromise out of various alternatives. In medical ethics, we seem to have chosen the path of Plato for clinicians, by developing the clinically based "Principles of Medical Ethics", but the path of Aristotle for administrators, by leaving them to address any ethical dilemma by a subjective analysis of the circumstances involved.

The reason for this dichotomy may reside in the differing roles of the clinician and administrator. The main ethical principle for clinicians has generally been to respond primarily to the needs of an individual patient; other considerations were secondary. However, the medical administrator has always been precariously poised between two primary needs, those of individual patients, and those of the organization. In ethical terms, this dilemma often reflects the demands of business ethics versus those of medical ethics. Business ethics generally are concerned with making a profit and/or providing a reimbursable service to customers and society in an honorable manner, whereas medical ethics developed primarily for the benefit of individual patients. Although psychiatric administration is generally deemed to occur in an organizational setting, using these ethical principles implies that an "organization" can be as small as a solo private practice office.

Occasionally, the values of the larger society further complicate the interaction of medical and business

ethics, are the values of the larger society. At its extreme, one example is how the values of Nazi Germany adversely affected medical ethics in general, and psychiatric patients in particular. Similarly, until recent years, some psychiatric administrators and clinicians in communist USSR succumbed to state demands to "treat" political dissidents. In the United States, societal values about psychiatric treatment have been reflected in relative under-funding and a lack of parity with the rest of medicine. How to balance such competing values and loyalties can at times be very painful and appear unsolvable to the medical administrator.

Psychiatric administrators have also had some particular ethical challenges as compared to other medical administrators. Unique organizational settings have included state hospitals and community mental health centers. Stigma has influenced the willingness of patients to come for and stay in treatment. Confidentiality has needed more stringent vigilance. Greater prominence of other mental health disciplines has posed problems in role definition and use of funds for staffing.

A most recent challenge for medical administrators has been managed care. In fact, managed care has led to new organizations and more medical administrators. Here, too, psychiatry has been particularly affected, with a decrease in funding and an increase in carved-out services and organizations. Psychiatric administrators in managed care organizations have often played a key role. Whether in the role of managed care CEO or medical director, these psychiatric administrators have had major responsibility for such areas as profit goals, cost savings, administrative costs, definition of medical necessity, the utilization review process, and treatment guidelines. Managed care companies have been increasingly criticized for putting business ethics, in terms of profits and organizational growth, before medical ethics, in terms of the well being of individual patients. A recent APA President, Herbert Sacks, M.D., expressed the concern that psychiatric administrators in managed care settings were too concerned with business priorities, "ideologies dis-identified from patient care, imperatives that were overriding at another moment in their professional lives." Although psychiatric administrators in other times and other settings have been challenged with similar dilemmas, managed care has affected many more administrators, psychiatrists, and patients.

The latest ethical challenge for medical administrators is on-line. When the medical administrator is involved with providing information to the public or colleagues, the lack of ethical standards for health information sites has contributed to the blurring of the line between content and advertising that has been previously seen at times with managed care companies, hospitals, and individual practitioners. When some medical evaluation and treatment is provided on-line, medical administration would seem to have some responsibility to ensure that quality of care would be equivalent to or better than that which would be provided by more traditional processes.

At times, other healthcare organizations, such as hospitals, or professional societies, especially the American Association of Community Psychiatrists, have tried to address some of these ethical administrative dilemmas. However, none has clearly resolved the ethical dilemma of when duty to the patient should supercede loyalty to the organization. Moreover, the particular codes or model job descriptions developed by these organizations did not necessarily generalize to all other healthcare or psychiatric organizations.

Therefore, given the increasing ethical concerns for psychiatric administrators, are there any ethical principles, which could guide psychiatric administrators in an organizational setting? While different approaches could be taken, a time-tested one would be to use the aforementioned "Principles of Medical Ethics". Just as the American Psychiatric Association added annotations to these principles especially applicable to psychiatric clinicians, the American Association of Psychiatric Administrators now adds other annotations especially applicable to psychiatric administrators. The following does this by providing the original AMA "Principles" in the format of a "Preamble" and Sections 1-7, and

adding relevant annotations for psychiatric administrators (and possibly administrators from other mental health disciplines).

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 1

"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.

Annotation (2). Whenever competing ethical needs, such as under-funding or the survival of the organization, jeopardize the provision of competent medical services, the psychiatric administrator will strive to have the organization still provide the best possible services with compassion and respect for patients.

Annotation (3). Given the targeted patient population of the organization, the psychiatric administrator should not allow discrimination of patients based on race, religion, or other socio-cultural characteristics. Likewise, staff discrimination should not be tolerated.

Annotation (4). To substantiate that competent psychiatric services are being provided, the psychiatric administrator should support and/or foster the development of relevant outcome studies and strive for continuous quality improvement.

SECTION 2

"A physician shall deal honestly with patients and colleagues, and strive to expose those physicians deficient in character or competence, or who engage in fraud or deception."

Annotation (1) for Psychiatric Administrators. To deal honestly with patients and colleagues, the administrator needs to try to be aware of the psychological factors that may prevent that. Such factors may include dependency, narcissism, and guilt. To monitor and help maintain such honesty, advisory committees and consultation with more senior administrators in other settings is advisable.

Annotation (2). The role of the psychiatric administrator in a system of care should be explicit to the public, patients, and clinicians. Effort should be made, via newsletters, meetings, or other mechanisms, to make the administrator known and visible.

Annotation (3). When an administrator who is a psychiatrist decides or chooses not to follow these ethical principles, an ethical course would be to try to make that publicly obvious in one way or another, such as not using "Doctor" or "M.D." as part of their administrative title.

Annotation (4). Whenever incompetent or inappropriate behavior on the part of the clinicians or other administrators comes to the attention of administrators, the administrator must intervene.

SECTION 3

"A physician shall respect the law and also recognize a responsibility to seek changes in those requirements which are contrary to the best interest of the patient."

Annotation (1) for Psychiatric Administrators. A psychiatric administrator should know and follow the laws relevant to the healthcare system, and strive to advocate for new laws that may improve or develop healthcare systems that can provide cost-effective, quality care.
Annotation (2). The psychiatric administrator should not support policies, nor receive financial benefits based on such policies, that compromise quality of care.

SECTION 4

"A physician shall respect the rights of patients, of colleagues, and shall safeguard patient confidences within the constraints of the law."

Annotation (1) for Psychiatric Administrators. While psychiatric administrators may have an ethical right to obtain patient information that, in its aggregate, will help to monitor and improve outcomes, every effort should be made to inform patients and clinicians as to why and how such clinical information will be used. It must be clear that appropriate safeguards for the confidentiality of the information are in place, including the use of coding whenever possible. Especially given the importance of confidentiality for psychiatric patients, the potential benefits must outweigh the risks of less confidentiality.
Annotation (2). Aggregate patient data may be shared within the healthcare institution and publicly, but any presentation of a specific patient must protect confidentiality unless the patient willingly provides informed consent in writing.

Annotation (3). The psychiatric administrator must be cautious in the use of power, so as not to take financial, social, or sexual advantage of clinicians or patients.

SECTION 5

"A physician shall continue to study, apply, and advance scientific knowledge, make relevant information available to patients, colleagues, and the public, obtain consultation, and use the talents of other health professionals when indicated."
Annotation (1) for Psychiatric Administrators. A psychiatric administrator should have appropriate training and evaluations relevant to the position.
Annotation (2). The psychiatric administrator should stay abreast not only of general psychiatric advances in knowledge, but also relevant administrative, political, and business knowledge that may influence the functioning of healthcare systems. Information relevant to others in the organization and to the public should be shared with them.
Annotation (3). In order to avoid conflicts of interest, which may compromise patient care, the psychiatric administrator should make available consultants, clinicians, or reviewers outside of the system to provide objective opinions, care, appeal, or review.
Annotation (4). Given both the unique as well as occasional overlap of skills and training of the different mental health disciplines, the psychiatric administrator should strive to make the most cost-effective use of the apparent strengths of each mental health discipline.

SECTION 6

"A physician shall, in the provision of appropriate patient care, except in emergencies, be free to choose whom to serve, with whom to associate, and the environment in which to provide medical services."

Annotation (1) for Psychiatric Administrators. When psychiatric administrators are responsible for a third-party influence on the doctor-patient relationship, such as in a community mental health center, state psychiatric hospital, or managed care system, the

administrator should strive to select the best clinicians possible for the staff or network.

Annotation (2). Although a psychiatric administrator need not continue to provide direct patient care, if one does not do so, some mechanism should be found to help maintain empathy for the perspectives of clinicians and patients.

Annotation (3). When new environments, such as telemedicine or e-mail, are used to provide treatment, the psychiatric administrator should assess whether they are at least equivalent or better, with respect to benefits and risks, to traditional environments.

SECTION 7

"A physician shall recognize a responsibility to participate in activities contributing to an improved community."

Annotation (1) for Psychiatric Administrators. Whenever and wherever possible, the psychiatric administrator should try to address and reduce the stigma associated with psychiatric patients and disorders.

Annotation (2). Psychiatric administrators should use their knowledge and management of healthcare systems to improve the well being of our communities, but when communicating on societal issues, should be careful to clarify whether he/she speaks as an individual citizen, individual physician, or as a representative of an organization.

CONCLUSION

The ethical challenge of a psychiatric administrator is to help optimize the potential benefits and reduce the risks of treatment and/or rehabilitation, all the while considering the costs, likely outcome, and alternatives unique to psychiatry. These principles and annotations should help meet that challenge.

Approved by the Association of Psychiatric Administrators
October 28, 2000

WELCOME NEW MEMBER!

May 2004
Ranga Ram, M.D., New Castle, DE
Ravindra Srivastava, M.D., Hilton Head, SC

June 2004
Nicholas Abid, M.D., Hyannis, MA
Osman Ali, M.D., New York, NY
Alfred Arensdorf, M.D., Honlulu, HI
Lupicino Bajamunde, M.D., Columbia, SC
Steven Cooper, M.D., Goshen, NY

July 2004
Page Burkholder, M.D., Brooklyn, NY
Susan Deakins, M.D., New York, NY
Richard Dyer, M.D., Larned, KS
Sara Kellerman, M.D., Riverdale, NY
Lydia Weisser, D.O., Augusta, GA

August 2004
Wendy Baer, M.D., Philadelphia, PA
Robert Bauer, M.D., S. Port Huron, MI
Mary Boyd, M.D., Cola, SC
Antonowsky Coleman, M.D., Calera, AL
Kevin Gray, M.D., Charleston, SC
Suneel Katragadda, M.D., Birmingham, AL
Alan Lynch, M.D., Nashville, TN
Hany Mekhael, M.D., Sterling Heights, MI
Ranga Ram, M.D., Hockessin, DE
Lisa Seufert, M.D., Philadelphia, PA
Craig Shoenecker, M.D., Rochester, NY
David Smith, M.D., Chapel Hill, NC
David Taylor, M.D., Philadelphia, PA

REVISITING THE "CAREER ADMINISTRATIVE PSYCHIATRY AWARD"

And other Reports from the APA Committee on Psychiatric Administration & Management

Stuart B. Silver, MD

At the May meeting of the AAPA executive council, several participants wondered whether it might be worthwhile to revisit the wording of the Career Administrative Psychiatry Award.

The APA has adopted the recommendation of the AAPA and The Committee on Psychiatric Administration and Management (CPAM) and has authorized a new award to honor gifted young administrative psychiatrists. The new award will be inaugurated in 2005 and presented for the first time at the Fall 2006 Institute for Psychiatric Services Meeting (IPS). Entitled the **Early Career Administrative Psychiatry** (ECAP) Award, it will honor an early career clinician-administrator who has: 1) demonstrated interest in psychiatric administration either by additional training, certification or publication, 2) who has contributed significantly to the field of psychiatric administration and management, and 3) whose creativity and sensitivity promote interest in improving patient care through psychiatric administration and management. To be eligible for this award, the candidate must be a member of the APA, within ten years of completion of his or her residency in psychiatry, and certified in Psychiatry by the American Board of Psychiatry and Neurology.

This new award contrasts with the well-established, but newly named **Career Administrative Psychiatry Award** that has been bestowed annually since 1983. The existing wording for this award - "honors a nationally recognized clinician -executive whose effectiveness as an administrator of a major mental health program has expanded the body of knowledge concerning management of mental health services delivery systems, and whose effectiveness has made it possible for him/her to function as a role model for other psychiatrists." The question currently posed is whether this language is contemporary and broad enough to recognize administrators in non-traditional roles or newly developed roles? Is the concept of the award to honor administrators of "major mental health programs" too narrow? These and other questions were raised.

One respondent suggested the following insertion "honors a nationally recognized clinician -executive whose effectiveness as an administrator of a major mental health program, **service delivery or management system** has expanded the body of knowledge concerning management of mental health services delivery systems, and whose effectiveness has made it possible for him/her to function as a role model for other psychiatrists."

Another member suggested the language be changed to "honors a nationally recognized psychiatrist-executive whose **leadership has expanded the application of management principles to psychiatric and/or other organized health systems**, and whose effectiveness has made it possible for him/her to function as a role model for other psychiatrists."

Others on the council favored keeping the current language which has reflected the intent of the award. The council is soliciting input from the membership of AAPA with regard to this issue.

While the APA committee has not considered this issue at its meeting, I will alert them at the components meeting and we will discuss the issue. I encourage any member of the AAPA to communicate their thoughts on this subject either through the list serve or directly to me. I will seek a final recommendation from the executive council of the AAPA to bring to the committee.

The written examination combining multiple choice and brief essay questions will be administered for the fourth time in May, 2005 at the annual meeting of the APA in Atlanta. The application deadline

for the May, 2005 test is February 1, 2005. Early applications are encouraged in order to allow candidates more time to prepare. The new examination process has eliminated the oral portion of the examination; and has changed the application pre-requisites to enable young and early career psychiatrists to pursue certification. Elimination of the oral examination means that candidates could receive certification just a few months after applying, assuming they pass the written test. APA Certification in psychiatric administration and management reflects the candidate's knowledge and skills in four areas: psychiatric care management, administrative theory, budget and finance, and law and ethics, as each applies to mental health administration. APA believes the additional skills and experience found in psychiatrists who fill administrative roles, even part-time, deserve recognition through a certification that recognizes those qualifications. In addition, certification is a visible demonstration of knowledge and skills that may increase a psychiatrists opportunities for employment or promotion in some settings.

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

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

AAPA New York Chapter

The AAPA New York Chapter held its annual meeting at the New York Academy of Medicine on Friday, June 18, 2004, entitled: Personalized Recovery Oriented Services--PROS and Cons: "Medicaiding" Psychiatric Rehabilition Services. The presenters were Robert Myers, PhD and Linda Rosenberg, both of NYS Office of Mental Health, PhillipSaperia, Executive Director of The Coalition of Voluntary Mental Health Agencies, and Lloyd Sederer, M.D., Executive Deputy Commissioner of New York City Department of Health and Mental Hygiene, who was the recipient of the Distinguished Psychiatric Administrator Award.

The following officers were elected at the Business Meeting following the symposium:
Andrew J. Kolodny, M.D. - President
David Brody, M.D. - President-Elect
Jorge R. Petit, M.D. - Treasurer
Osman Ali, M.D. - Councilor

CALL FOR PAPERS

The ***Psychiatrist Administrator*** invites articles on all areas of psychiatric administration and management with a focus on the roles and perspectives of psychiatrists in leadership and management roles. Please make submissions and inquires to:

Sy Atezaz Saeed, M.D., Editor
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LITERATURE SCAN

American Psychiatric Association. Practice guidelines for the treatment of patients with schizophrenia, 2nd edition. *American Journal of Psychiatry* 2004 Feb;16(2) Supplement:1-56.

Applebaum PS. Law & Psychiatry: Psychiatric advance directives and the treatment of committed patients. *Psychiatric Services* 2004 Jul; 55(7):751-60.

Advance directives have been one of the more promising innovations in recent years to give patients a greater voice in their psychiatric treatment. However, the case of *Hargrave v. Vermont* may inhibit the use of this tool. *Hargrave* stands for the proposition that the state, having established a statutory basis for medical advance directives, cannot exclude involuntarily committed psychiatric patients from its coverage.

Bell CC, McKay MM. Constructing a children's mental health infrastructure using community psychiatry principles. *The Journal of Legal Medicine* 2004 Mar; 25(1):5-22.

Three substantive papers from the 5th Annual Southern Illinois Healthcare/Southern Illinois Health Policy Institute, *Caring for our Children: Delivery of Mental Health Services to Children and Adolescents*, appear in this special symposium issue of *The Journal of Legal Medicine*. The other two papers are: "Attention-deficit hyperactivity disorder diagnosis and treatment" by DH Barzman, L Fieler, and FR Sallee and "Encouraging a culture of caring for children with disabilities: a cooperative approach" by DE Cichon.

Burns BJ, Phillips SD, Wagner HR, Barth RP, Kolko DJ, Campbell Y, Landsverk J. Mental health need and access to mental health services by youths involved with child welfare: a national survey. *Journal of the American Academy of Child and Adolescent Psychiatry* 2004 Aug; 43(8):960-70.

Nearly half of the youths aged 2 to 14 years with completed child welfare investigations had clinically significant emotional or behavioral problems. Youths with mental health need, as defined by a clinical score on the Child Behavior Checklist, were much more likely to receive mental health services than lower scoring youth; still, only one fourth of such youths received any specialty mental health care. The authors concluded that routine screening for mental health need and increasing access to mental health professionals for further evaluation and treatment should be a priority for children early in their contact with the child welfare system.

Daniel SS, Goldston DB, Harris AE, Kelley AE, Palmes GK. Review of the literature on aftercare services among children and adolescents. *Psychiatric Services* 2004 Aug; 55(8):901-12. This review article examines the literature that pertains to the rates, effectiveness, and predictors of aftercare services for children and adolescents following psychiatric hospital stays. [Review]

Dougherty RH, American College of Mental Health Administration. Reducing disparity in behavioral health services: a report from the American College of Mental Health Administration. *Administration & Policy in Mental Health* 2004 Jan; 31(3):253-63:253-63.

The 2003 ACMHA Summit provided a foundation and framework for work to proceed at all levels of the behavioral health delivery system. A change agenda needs to include efforts at national, state, and local levels involving consumers, providers, purchasers, oversight organizations, and researchers. Examples of potential ACMHA projects in this effort include training, data collection, research, demonstrations, and coordination, particularly at the state and local levels.

Green RG, Hamlin H, Ogden V, Walters K. Some normative data on mental health professionals' attitudes about racial minorities and women. *Psychological Reports* 2004 Apr; 94(2):485-94.

This study provides some normative data, based on the responses of 705 psychologists and social workers to the Quick Discrimination Index, a 23-item self-report measure. Analysis indicated psychologists and social workers reported particularly positive attitudes toward racial minorities and women but expressed the same racial and sex contradictions, ambivalences, and vulnerabilities reported by the general public.

Himelhoch S, Weller WE, Wu AW, Anderson GF, Cooper LA. Chronic medical illness, depression, and use of acute medical services among Medicare beneficiaries. *Medical Care* 2004 Jun; 42(6):512-21.

This study assessed the relation of comorbid depressive syndrome with utilization of emergency department services and preventable inpatient hospitalizations among elderly individuals with chronic medical conditions. For elderly individuals with at least one chronic medical condition, the presence of a depressive syndrome increased the odds of acute medical service use, suggesting that improvements in clinical management, access to mental health services, and coordination of medical and mental heath services could reduce utilization.

Hoge CW, Castro CA, Messer SC, McGurk D, Cotting DI, Koffman RL. Combat duty in Iraq and Afghanistan, mental health problems, and barriers to care. *New England Journal of Medicine* 2004 Jul; 351(1):13-22.

The percentage of subjects whose responses met the criteria for major depression, generalized anxiety, or post-traumatic stress disorder (PTSD) was significantly higher after duty in Iraq than after duty in Afghanistan or before deployment to Iraq; the greater difference was in the rate of PTSD. Of those whose responses were positive for a mental health disorder, only 23 to 40 percent sought mental health care. Subjects reported important barriers to receiving mental health services, particularly the perception of stigma among those most in need of such care.

Kern JK, Grannemann BD, Altshuler KZ, Sunderajan P. A computerized clinical decision support system as a means of implementing depression guidelines. *Psychiatric Services* 2004 Aug; 55(8):879-95.

Although computerized decision support systems are being used in many areas of medicine, their use in psychiatric illness is limited. The authors designed and developed such a system for the treatment of major depressive disorder by using evidence-based guidelines, transferring the knowledge gained from the Texas Medication Algorithm Project (TAMP). The resulting system (CompTAMP) provides support in diagnosis, treatment, follow up, and preventive care and can be incorporated into the clinical setting.

Meredith LS. Depression: 20 years of progress. *Medical Care* 2004 Jun; 42(6):499-501.

In this editorial, the author summarizes the progress made in depression in the past 20 years, as a prelude to this special issue of *Medical Care* devoted to the topic. Articles in the issue cover arthritis and heart disease as risk factors for major depression, searching for accurate quality indicators in monitoring depression care, measuring the quality of pharmacotherapy for depression, the use of antidepressant medication in the Veterans Administration, and a longitudinal population-based study of treated and untreated major depression.

Pampallona S, Bollini P, Tibaldi G, Kupelnick B, Munizza C. Combined pharmacotherapy and psychological treatment for depression: a systematic review. *Archives of General Psychiatry* 2004 Jul; 61(7):714-9.

The authors undertook a systematic review of randomized controlled trials comparing antidepressant treatment alone with antidepressant treatment in combination with a psychological intervention in depressive disorders. They found that combination treatment is associated with a higher improvement rate. [Review]

Patel VL, Branch T, Mottur-Pilson C, Pinard G. Public awareness about depression: the effectiveness of a patient guideline. *International Journal of Psychiatry in Medicine* 2004; 34(1):1-20.

The purpose of this study was to evaluate the effectiveness of a patient guideline for educating the public in the recognition and treatment of depression. Subjects were interviewed regarding their knowledge and beliefs about depression through the use of a semi-structured questionnaire. Interviews were analyzed in the presence and absence of the guideline. In the absence of a guideline, only 50% of subjects with prior history of depression and 38% of those without prior history provided an accurate diagnosis of depression.

Shumway M, Sentell TL. An examination of leading mental health journals for evidence to inform evidence-based practice. *Psychiatric Services* 2004 Jun; 55(6):649-53.

This systematic review suggests that data needed to inform and advance evidence-based practice does not have a prominent place in leading psychiatric journals. Only a quarter of the research studies examined evaluated clinical interventions, and articles that descried pharmacological interventions were published twice as often as articles that described psychosocial or psychotherapeutic interventions. Although rigorous research designs predominated in the studies examined, sample sizes were modest.

Swartz MS, Wagner HR, Swanson JW, Elbogen EB. Consumers' perceptions of the fairness and effectiveness of mandated community treatment and related pressures. *Psychiatric Services* 2004 Jul; 55(7):780-5.

The authors interviewed mental health consumers to assess their perceptions of mandatory community treatment and other legal pressures. They concluded that consumers with schizophrenia who adopt a biopsychosocial view of their illness, who are less symptomatic, and who have better insight also tend to believe that they benefit from sanctions to adhere to treatment and believe they are imposed in their best interests and well being. In contrast, consumers who reject treatment mandates tend to have more psychotic symptoms yet are less likely to perceive themselves as ill.

Wells K, Miranda J, Bruce ML, Alegria M, Wallerstein N. Bridging community intervention and mental health services research. *American Journal of Psychiatry* 2004 Jun; 161(6):955-63.

This article explores the potential of community intervention perspectives for increasing the relevance, reach, and public health impact on mental health services research. The authors reviewed community intervention strategies and proposed a model to integrate health services and community intervention research, building on the evidence-based strength of quality improvement and participatory methods of community intervention to produce complementary functions, such as linking community-based case finding and referral with practice-based quality improvement. Despite challenges, the community intervention approach is a paradigm for affecting public health and addressing health disparities. [Review]

The WHO World Mental Health Survey Consortium. Prevalence, severity, and unmet need for treatment of mental disorders in the World Health Organization World Mental Health Surveys. *Journal of the American Medical Association* 2004 Jun 2; 291(21):2581-90.

Face-to-face household surveys of 60,463 adults in fourteen countries were conducted from 2001-03. The prevalence of having a DSM-IV disorder varied widely. Due to the high prevalence of mild and subthreshold cases, the number of those who received treatment far exceeds the number of untreated serious cases in every country. Reallocation of treatment resources could substantially decrease the problem of unmet need for treatment of mental disorders among serious cases. Careful consideration needs to be given to the value of treating some mild cases, especially those at risk for progressing to more serious disorders.

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

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

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

PREPARATION OF MANUSCRIPT

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

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

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

Tables should be typed double-spaced one per page. Provide a clear, descriptive title for each table. Tables should be numbered consecutively as they appear in the text.

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

References should be numbered consecutively as they are cited in the text, with reference numbers typed as superscripts. References should be typed double-spaced beginning on a separate page after the text and acknowledgments. The NewsJournal uses the Uniform Requirements for Manuscripts Submitted to Biomedical Journals (Vancouver group) as its guide for reference style. Abbreviations of journal names must conform to Index Medicus style; journals not listed in Index Medicus should not be abbreviated. List all authors when there are no more than six; for more than six authors, list the first three, followed by et al.

MANUSCRIPT REVIEW AND EDITING

Manuscripts are reviewed by the editor, editorial board members, or other reviewers. Manuscripts may be edited for clarity, style, conciseness, and format. The edited manuscript will be sent to the corresponding author for approval. Authors may be asked to respond to editorial queries or make revisions.

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

MANUSCRIPT SUBMISSION

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"NewsJournal is supported by a grant from GlaxoSmithKline"

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