



# PSYCHIATRIST ADMINISTRATOR

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## TRANSFORMING MENTAL HEALTH CARE IN AMERICA THE FEDERAL ACTION AGENDA

Sy Atezaz Saeed, M.D.

In its final report to the President, the *New Freedom Commission on Mental Health* called for a fundamental transformation of the mental health care delivery system in the United States, a system that focused on building resilience and facilitating recovery<sup>1</sup>. The Commission described this transformed system as one in which:

- Americans understand that mental health is essential to overall health
- Mental health care is consumer and family driven
- Disparities in mental health services are eliminated
- Appropriate and early mental health screening, assessment, and referral to services occurs
- Excellent mental health care is delivered and research is accelerated
- Technology is used to access mental health care and information.

Mental Health transformation is now being taken from this “vision” to a strategy. In June of this year the Substance Abuse and Mental Health Services Administration (SAMHSA), in collaboration with seven cabinet level federal agencies, released an Action Plan that describes initial steps that will be taken as part of a multi-year effort to transform America’s mental health system<sup>2</sup>. The plan, entitled “*Transforming Mental Health Care in America: the Federal Action Agenda*”, articulates the role of the federal government in implementing the recommendations of the New Freedom Commission and describes steps that will be taken to improve collaboration and coordination between various federal agencies responsible for services to children and adults with mental illnesses.

The *Federal Agenda* articulates specific, actionable objectives for the initiation of a long-term strategy designed to move the Nation’s public and private mental health service delivery systems toward this transformed mental health system focused on building resilience and facilitating recovery.

The goals of this initiative, as described in the *Federal Action Agenda*, are as follows:

- Send the message that mental illnesses and emotional disturbances are treatable and that recovery is possible.
- Act immediately to reduce the number of suicides in the Nation through full implementation of the National Strategy for Suicide Prevention.

- Help States develop the infrastructure necessary to formulate and implement Comprehensive State Mental Health Plans that include the capacity to create individualized plans of care that promote resilience and recovery.
- Develop a plan to promote a mental health workforce better qualified to practice culturally competent mental health care based on evidence-based practices.
- Improve the interface of primary care and mental health services.
- Initiate a national effort focused on the mental health needs of children and promote early intervention for children identified to be at risk for mental disorders. Prevention and early intervention can help forestall or prevent disease and disability.
- Expand the “Science-to-Services” agenda and develop new evidence-based practices toolkits.
- Increase the employment of people with psychiatric disabilities.
- Design and initiate an electronic health record and information system that will help providers and consumers better manage mental health care and that will protect the privacy and confidentiality of consumers’ health information.

The Federal role in the *Federal Action Agenda* is described as a leader and a facilitator to promote shared responsibility for change at the Federal, State, and local levels, including the private sector.

### Highlights of the Federal Action Agenda

**Principle A:** *Focus on the desired outcomes of mental health care, which are to attain each individual’s maximum level of employment, self-care, interpersonal relationships, and community participation.*

1. Initiate a national public education campaign.
2. Launch the national action alliance for suicide prevention.
3. Educate the public about men and depression.
4. Develop prototype individualized plans of care that promote resilience and recovery.
5. Promote quality services in the workforce development system for people with psychiatric disabilities.
6. Initiate a national effort focused on meeting the

mental health needs of children as part of overall health care.

7. Launch a user-friendly, consumer-oriented web site.
8. Protect and enhance the rights of people with mental illnesses.

**Principle B:** *Focus on community-level models of care that effectively coordinate the multiple health and human service providers and public and private payers involved in mental health treatment and delivery of services.*

1. Launch the Federal Executive Steering Committee on Mental Health.
2. Include eliminating disparities in mental health services as part of the HHS “Close the Gap Initiative.”
3. Create a national strategic workforce development plan to reduce mental health disparities.
4. Initiate a project to examine cultural competence in behavioral health care education and training programs
5. Develop a national rural mental health plan.
6. Promote strategies to appropriately serve children with mental health problems in relevant service systems.
7. Include mental health in community health center consumer assessment tools.

**Principle C:** *Focus on those policies that maximize the utility of existing resources by increasing cost-effectiveness and reducing unnecessary and burdensome regulatory barriers.*

1. Initiate Medicaid demonstration projects.
2. Help parents avoid relinquishing custody and obtain mental health services for their children.
3. Support the Ticket to Work Program.
4. Educate employers and benefits managers on the practicability of paying for mental health services.
5. Develop a strategy to implement innovative technology in the mental health field.
6. Explore creation of a capital investment fund for technology.

**Principle D:** *Consider how mental health research findings can be used most effectively to influence the delivery of services.*

1. Accelerate research to reduce the burden of mental illnesses.
2. Expand the National Registry of Evidence-Based

Programs and Practices to include mental health.

3. Develop new toolkits on specific evidence-based mental health practices.
4. Expand the “Science-to-Services” agenda.
5. Conduct research to reduce mental health disparities.

**Principle E:** *Follow the principles of Federalism, and ensure that [the Commission’s] recommendations promote innovation, flexibility, and accountability at all levels of government and respect the constitutional role of the States and Indian tribes.*

1. Award state mental health transformation grants.
2. Award child and adolescent state infrastructure grants.
3. Establish a foundation for the Samaritan initiative.
4. Initiative for ex-prisoners with psychiatric disabilities.
5. Award seclusion and restraint state incentive grants.

As NAMI Executive Director, Michael Fitzpatrick, described it, the plan is “an important first step in defining the role that the federal government can play, in partnership with states and communities, in establishing a coherent and cohesive mental health system in America.”<sup>3</sup> The American Psychiatric Association President Steven S. Sharfstein, M.D. described the action plan very much in keeping with recommendations articulated in APA’s Vision Statement for a transformed mental health system. He described the action agenda as one that “offers tremendous promise for a public-private partnership as we seek to transform the nation’s mental health system.”<sup>4</sup>

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## SHIV HATTI, M.D., MBA

Hello Friends:

The APA had another great meeting on Tuesday, May 24th. The presentation "Administrative Psychiatrists in the 21<sup>st</sup> Century: Challenges and Opportunities", was given by Dr. Altha Stewart, President of the American Psychiatric Foundation. This was followed by an enthusiastic question and answer session that went well beyond its allotted time. Sixty members of our organization attended the luncheon presentation.

The Nominating Committee, chaired by Dr. Christopher Fichtner, presented a slate of officers. This slate was unanimously approved. Dr. Art Lazarus will serve as our President-Elect and also serves as the Associate Editor of the NewsJournal. Dr. Doug Brandt will fill the position of Secretary-Treasurer and is very busy obtaining financial support of our organization's various projects. We are also excited to welcome Dr. Ann Sullivan to the Council. Sadly, due to other commitments Dr. David Fassler has decided not to renew his council position and he will indeed be missed. We thank Dr. Fassler for his many years of service to AAPA and wish him good luck in his future activities. I want to thank Dr. Tom Hester for his leadership for the last two years and look forward to his ongoing guidance. I also want to thank our Executive Director, Frances Bell, who goes above and beyond to allow our organization to function as smoothly as it does.

The afternoon began with a meeting of the AAPA Council. I am pleased with the good, active team that we have working towards our goals as an organization.

I wanted to reiterate some of the points that I covered in my acceptance speech at the APA.

- AAPA's goal is "to promote medical leadership in the Behavioral Health Care System". At the AAPA we train future leaders in our field by educating

psychiatrists about administrative issues. We have achieved that goal through courses and symposia at the APA and by publishing papers in our journal, *Psychiatrist Administrator*. Our editor, Dr. Sy Syeed along with his editorial board, has done an excellent job of improving the quality of our journal by attracting new authors to write thought-provoking articles. Through these articles we tackle issues of ethics, advocacy, guidance, and professional development pertinent to leaders in the field of psychiatry.

- We need ongoing financial support for the healthy functioning of our organization. The AAPA Council has determined that we can achieve these goals by seeking appropriate support from the pharmaceutical industry, and also by increasing our membership. If any of you have a contact with a pharmaceutical company that will be able to obtain some grants for our organization, please contact Frances or Dr. Doug Brandt. The Council decided during their last conference call to restrict publication of the *Psychiatrist Administrator* to the internet unless we get funding. We can tremendously help our bottom line by increasing our membership. Our membership stands at around 300 at this time. We all know at least ten psychiatric leaders we work with regularly who are not members of the AAPA. We all need to encourage more leaders in our respective communities to join our organization. Towards this end we strive to continuously improve our organization, such that we attract and are able to serve many more members. Any comments and suggestions are always welcome and in fact are earnestly solicited.

## THE NEED FOR TELEPSYCHIATRY AND E-MENTAL HEALTH IN PUBLICLY-FUNDED MENTAL HEALTH SYSTEMS

Scott C. Simmon, M.S., Art Eccleston, Psy.D., Sy Atezaz Saeed, M.D.,  
Gary G. Leonhardt, M.D., Michael Lancaster, M.D.

### INTRODUCTION

Many states have extreme disparities in population density and resource distribution, with substantial health and human service resources in urban centers and relative scarcity in many rural areas. Such disparities are particularly evident in the area of mental health, developmental disabilities, and substance abuse (MH/DD/SA) services (New Freedom Commission on Mental Health, Subcommittee on Rural Issues; 2004). The scarcity of MH/DD/SA service resources has been further amplified as a result of the ongoing “reforms” in these publicly-funded service systems in many of these states. For example, the North Carolina system has been undergoing a major transformation since 2001. Among multiple substantial changes, this system reform has included:

- reduction and eventual elimination of service delivery from the function of the Area MH/DD/SA Authority, and the corresponding divestment of clinical staff from employment with those agencies;
- provision of services by a range of private providers, under the management of newly transformed Area Authorities, which are referred to as Local Management Entities (LMEs);
- a concomitant need for state-wide training of LMEs and service providers on a host of new requirements and practices related to the reform.

Many states have employed telehealth to improve mental health services’ cost, quality, and access. The use of telehealth to provide psychiatric services (especially consultation) is often referred to as *telepsychiatry*, and other telehealth applications in mental health are often referred to as *e-mental health*. Regardless of how these applications are defined, telepsychiatry and e-mental health comprise one of the largest uses of telehealth nationwide (Krupinski, 2002; Grigsby, *et al.*, 2002).

The President’s New Freedom Commission on Mental Health recognized the critical role of telehealth in reforming the nation’s mental health systems (New Freedom Commission; 2003), stating that “*telehealth and*

*e-health technologies hold great promise for improving access to mental health care in many rural, remote, and other underserved areas (p. 81)*”. The commission also addressed telehealth in its series of recommendations:

*Recommendation 6.1 Use health technology and telehealth to improve access and coordination of mental health care, especially for Americans in remote areas or in underserved populations (p. 79)*

Telehealth can be crucial to enhancement of MH/DD/SA systems. This paper will identify the applications and benefits of telepsychiatry and e-mental health, address potential barriers to its use, and recommend steps for moving forward.

### TECHNOLOGY BASICS

Telepsychiatry and e-mental health services primarily involve videoconferencing over high speed (broadband) networks to enable natural interactions between patients and providers. Traditionally, this has required leasing specialized high speed telephone circuits (either T-1 or ISDN) that were dedicated for videoconferencing. However, the rapid growth of Internet and Worldwide Web (WWW) applications and corporate local- and wide-area (i.e. Ethernet) networks has catalyzed the development of Internet Protocol (IP) videoconferencing systems. IP networks offered the advantage of serving multiple concurrent applications, such as printing, e-mail, WWW browsing, and medical records in addition to videoconferencing.

Since videoconferencing is quite bandwidth-intensive, audio and video compression methods must be employed. This is accomplished via a coder-decoder, or codec, which can be implemented in hardware and/or software. In telehealth videoconferencing applications, a codec is usually a standalone device, or appliance, that performs all of the requisite compression, decompression, and synchronization of audio and video signals. However, continued developments in signal processing, microprocessors and compression algorithms, coupled with

increasing penetration of affordable broadband network services, will soon enable high-quality videoconferencing from personal computers and consumer-priced devices. This will likely result in increased availability and use of videoconferencing and concomitantly enable the diffusion of telepsychiatry and e-mental health applications.

## **THE PROMISE OF TELEPSYCHIATRY AND E-MENTAL HEALTH**

Telehealth use is growing annually in the U.S. The diffusion of telehealth in clinical practice is further evidenced by professional organizations' development of policies, standards, and guidelines for telehealth — the American Psychiatric Association (1998) has developed guidelines for using videoconferencing technologies for telepsychiatry. The evidence suggests telehealth's efficacy in many clinical applications, including mental health. Generally, consumer satisfaction with telehealth is high (Gustke, *et al.*, 2000; Brown-Connolly, 2002). Telehealth can make a significant impact on the delivery of health care services to those who have usually received less than adequate care. The following benefits have been demonstrated or could be expected to result from implementing telepsychiatry and e-mental health services:

- Reduction of stigma associated with receiving mental health services, including individual (self) stigma and stigma by others (Farrell and McKinnon, 2003).
- Reduction in professional isolation and concomitant improvement in recruiting and retaining mental health professionals to live and work in underserved or rural areas (Haythornthwaite, 2002; Redford and Parkins, 1997; Stamm, 1998; D'Souza, 2000).
- Reduction in geographic and socioeconomic health disparities, by improving access to mental health services.
- Improved consumer convenience by reducing the time and expenses associated with travel.
- Improved consumer compliance.
- Improved education of mental health professionals.
- Improved coordination of care across mental health system.

## **TELEPSYCHIATRY AND E-MENTAL HEALTH APPLICATIONS**

There are a myriad of potential applications of telepsychiatry and e-Mental Health:

***Training and education*** – Telehealth technologies can streamline the implementation of training efforts, allowing the learning activity to originate from a variety of possible locations inside or outside the state. Designated trainers would not have to travel to multiple sites in order to deliver the desired training to multiple audiences. The provision of telehealth-facilitated training would also allow broader access to the training by the myriad of staff from mental health centers, hospitals, and private providers and minimize training related travel. Furthermore, telehealth-facilitated training will ensure that the subject matter is conveyed consistently from site to site, and questions and comments of the participants and their responses will be communicated simultaneously to multiple audiences at the different training sites.

***Support of State mental health, developmental disabilities, and substance abuse facilities with other clinical needs*** – The MH/DD/SA primary service needs of inpatients in these facilities are usually met by facility staff. However, these patients often have co-morbidities or other health conditions that become manifest during their inpatient stay. It is often problematic, costly, and inefficient to provide other clinical services in a timely manner, either on site or by offsite transport. Many specialty consultation services are possible by telehealth/telemedicine. For example, the East Carolina University (ECU) Brody School of Medicine (BSOM) currently provides these types of services for two state-operated facilities in North Carolina. ECU psychiatrists use the link with these Hospitals to consult with inpatient treatment teams regarding selected patients at these hospitals.

***E-Mental Health/telepsychiatry and other clinical telehealth services for other state institutions*** – Other state institutions, such as correctional facilities or special needs schools, require mental health and other health services. Telepsychiatry can be quite helpful in providing such services. For example, the ECU BSOM has provided this type of service for the Eastern North Carolina School for the Deaf for nearly five years, allowing consultation and primary care delivery via a telehealth connection to the school's infirmary during normal office hours. Other clinical services have included child and adolescent psychiatry and dermatology. This has been proven to be cost effective and educationally beneficial, as it has resulted in students remaining at the school and spending more time in the classroom, as they would have otherwise returned home. Although geared toward a special

population, this type of service could be extended to many other institutions.

***Mental Health Centers and private providers*** – Consumer access to MH/DD/SAS professionals in rural areas has typically been much more limited than in urban areas. Mental Health Centers and private providers could improve access to their services in their rural catchment areas by utilizing telepsychiatry/e-mental health as a vehicle to extend the professional MH/DD/SA services to locales that have few or no such professionals. Telehealth networks could also provide coverage or oversight by psychiatrists from the major academic medical centers or other sites.

***Assessment/committal for law enforcement/emergency departments*** – For the current system to work properly and efficiently there is a requirement for a seamless interface between the mental health professional, law enforcement and the judicial system. Commonly, law enforcement officials are responsible for the safety, care and sustenance of consumers in crisis, who often must be transported over great distances to facilities with receiving clinicians who have little or no information on the consumer in route. Other variables such as the changing mental status of the consumer, attitudes and cultural beliefs of the care givers and drugs and/or alcohol consumed prior to the crisis further complicate the situation. Similar complications arise when law enforcement must interface with rural emergency departments when accompanying those recently apprehended or otherwise in custody that might have significant mental illness. Telepsychiatry and e-mental health systems could greatly improve the efficiency of these situations and improve public safety.

***Educational facilities*** – Students in K-12 schools, community colleges, colleges and universities could also benefit from telepsychiatry and e-mental health services. Fortunately, much of the high-speed networking and videoconferencing infrastructure is already in place in many states to support education. However, most of these capabilities use public (i.e. Internet) connectivity, and additional security measures would need to be implemented.

***Nursing homes/extended care facilities*** – There is a great need to improve the quality of and access to mental health services in nursing homes and other extended care facilities. Residents' mental health conditions are often

misdiagnosed (or underdiagnosed) and nursing staff are increasingly overburdened and inadequately trained to deal with mental health issues. Telepsychiatry and e-mental health services could improve the quality and efficiency of mental health services delivery. Furthermore, other clinical needs could be addressed by telehealth using the same infrastructure.

***Primary care and community health settings*** – The primary care physician is the principal gatekeeper for accessing the health care system. Many of the patients seen in the primary care setting have mental disorders, psychiatric co-morbidities, or psychogenic symptoms. Further confounding the problem are the primary care physician's limited mental health training and difficulty in referring patients for mental health services (Trude and Stoddard, 2003). Therefore, primary care physicians often under diagnose mental health conditions, are unaware of developments in and protocols for pharmacotherapy, and struggle to appropriately refer their patients for external mental health services. There are several primary care applications for telepsychiatry and e-mental health, including training, tele-mentoring, teleconsultation, and care coordination.

## POTENTIAL BARRIERS

There can be several potential barriers to the diffusion of telepsychiatry and e-mental health. Some of these are concomitant with the adoption of any new technologies and practices in health care. Natural impediments include inherent personal or organizational resistance to change, technological illiteracy, and cost. Several legal, regulatory, and technical factors complicate the telehealth landscape. Over the last several years, some legislative and regulatory improvements have been made, but these issues still are a barrier to more widespread diffusion of telehealth.

## Reimbursement

Medicare reimbursement for telemedicine started in 1999, and the payment model has evolved to address some initial limitations (Coleman, 2002; Puskin, 2001). To be reimbursed, telemedicine encounters must be interactive (i.e. bi-directional videoconferencing), with both the (consulting) provider and the patient present. Generally, reimbursement in mental telehealth is provided for diagnostic interview (CPT code 90801), individual psychotherapy (CPT codes 90804-90809), and

pharmacologic management (90862) that is provided by psychiatrists and clinical psychologists (American Telemedicine Association, 2003). Services provided by other mental health providers are not currently covered.

In addition, nearly half of State Medicaid programs, and many third-party payors, provide reimbursement for telehealth services, with similar caveats as Medicare. All payment is based on a “fee-for-service” approach that reimburses the consulting physician or other health professional for their time. However, technology and personnel infrastructure costs are not reimbursed.

### **Licensure**

Currently, physicians are required to possess a medical license in each state in which they practice medicine. Therefore, for a physician to conduct a telemedicine consultation with a facility in another state, that physician must be licensed by both states’ licensing boards. Nursing and other allied health professions are subject to similar state licensing constraints. Sanders (1993) suggests three potential solutions to the licensure problem: (1) establishing a national licensing system, (2) assigning the responsibility of care to the referring physician, with the consulting physician’s opinions as “recommendations only,” or (3) determining that the patient is being “electronically transmitted” to the consultant’s state.

### **Privacy, security, and HIPAA**

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) has raised the awareness of the need to protect patient privacy and secure individually identifiable patient data, i.e. protected health information (PHI). Certainly, HIPAA’s impact is not unique to telehealth as the entire clinical enterprise has been affected. Kumekawa (2001) identifies privacy considerations that are unique to telehealth, including the potential for non-clinical technical and administrative personnel to view telehealth transactions and the off-camera presence of other clinical personnel (i.e. not seen by patient). Telehealth transactions have traditionally occurred over private circuits; however, the increased use of IP videoconferencing over public networks creates the potential for unauthorized access to PHI. Therefore, technology solutions, such as in-codec encryption and virtual private networks, will need to be implemented.

### **Infrastructure**

The cost of telehealth network connections can be reduced via the U.S. Federal Communications Commission’s (FCC) Universal Service Fund (USF) subsidies, which resulted from the Telecommunications Act of 1996. The USF was set up to increase the diffusion of high bandwidth telecommunications to rural schools, libraries, and health care providers. The fund comes from fees paid by telecommunications providers, and is supposed to make telecommunications services available at the same price in rural areas as charged in urban areas. Actually, the fund pays the price difference to the eligible telecommunications provider. However, the USF mechanism is not being widely used for several reasons, including an overly cumbersome application process, limitations on eligible facilities and locations, and the formula used for calculating the discount rate, which can actually be higher than the rates otherwise available (Puskin, 1999).

Several states have developed other mechanisms to support telemedicine. Texas has one of the largest programs and uses funds obtained from telecommunications companies, in lieu of taxes. Kentucky has appropriated state funds to cover telemedicine. Georgia has used funds returned to the state after telecommunications companies overcharged their customers. California has established an organization to distribute funds for telemedicine that come from a foundation established after the state’s Blue Cross/Blue Shield plan was privatized. Long-term, alternative support appears to have enabled these states to develop sound statewide telemedicine systems.

### **OPPORTUNITIES FOR PUBLIC MENTAL HEALTH SYSTEMS**

Telepsychiatry and e-mental health offers several opportunities for public mental health systems. Although these opportunities can be of interest in any organized public mental health systems, several could be of benefit to states’ mental health authorities. State Government Mental Health Agencies (SGMHAs) should actively engage in diffusing telepsychiatry and e-mental health principles, practices, and technologies across their states in collaboration with their academic medical centers, mental health centers, and private providers. SGMHAs should also take the leadership role, to ensure consistency,

foster collaboration, minimize duplication of effort, and coordinate with other health and human service agencies within state governments. The following recommendations are under consideration by North Carolina's system and should be contemplated for other SGMHAs:

**1.) *Aggressively pursue tele-training, leveraging existing resources to the greatest practical extent.*** As previously described, extensive high-speed networking and videoconferencing resources may already be in place. Additional videoconferencing resources may be available through public and private higher education institutions, Area Health Education Center (AHEC) offices, and Public Health systems. These existing resources could be quickly brought to bear for MH/DD/SA training and reach a large portion of the population that needs such training. The SGMHAs should seek out other options for areas not adequately covered by existing resources.

**2.) *Foster pilot projects in mental telehealth.*** The SGMHAs should foster pilot projects that demonstrate different aspects of telepsychiatry and e-mental health, e.g. innovative service delivery, cost, efficiency, efficacy and effectiveness, or new technology. The SGMHAs should establish key objectives, performance metrics, and exit criteria to ensure that these projects produce tangible results that can be used to advance the use of mental telehealth.

**3.) *Work to remove barriers to mental telehealth utilization.*** The SGMHAs should develop a plan to mitigate the barriers to the use of telepsychiatry and e-mental health, starting with those that have been identified earlier in the paper. Additionally, the SGMHAs should look to professional societies, and other states mental telehealth programs to develop guidelines and best practices for telepsychiatry and e-mental health.

**4.) *Promote collaborative mental telehealth research.*** In today's increasingly competitive research funding environment, grant applications that have multi-site or multi-institutional collaboration have a distinct advantage. The SGMHAs should promote research projects that include such collaboration between research institutions, through bringing together researchers from different institutions, providing letters of support (and/or SGMHA

co-investigators) for collaborative applications, and identifying key research needs in mental telehealth. The SGMHAs should also consider developing a set of key data elements that might be included in mental telehealth research that could be used to develop a registry or large data set for subsequent evaluation.

**5.) *Identify technology infrastructure needs.*** The SGMHAs should look across the MH/DD/SA system to identify technology infrastructure needs, and then implement a plan for meeting these needs. There are many Federal programs that can assist with infrastructure, including the previously described FCC Universal Services Fund (communications subsidies) and the U.S. Department of Agriculture/Rural Utility Service's Telemedicine and Distance Learning grant and loan program (equipment purchases). Furthermore, many private foundations will fund infrastructure purchases. The SGMHAs could play an important role in coordinating grant applications and technical compatibility.

**6.) *Improve awareness of telepsychiatry and e-mental health.*** Awareness of, and attitudes about telehealth are influential factors in the success of telehealth programs. The SGMHAs should reach out to potential constituencies, including users and consumers, to promote mental telehealth concepts, technologies, and practices. Potential mechanisms to accomplish this goal include meetings/forums, lectures, printed promotional materials, and Web resources.

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## PUBLIC MENTAL HEALTH ADMINISTRATOR'S GLOSSARY OF TERMS

Daniel J. Luchins

**Anecdote(s):** An untoward event not yet publicized (see expose) which requires the collection of additional data.

**Collaborative Agreement:** An agreement between two public agencies that have inadequate resources. It will either have no consequence or increase services for one group with a corresponding decrease for another.

**Competition:** Although officially a virtue, the private sector avoids it through public appeals for community control, and cultural sensitivity. If detected in the public sector it is condemned as evidence of bureaucratic waste.

**Confidentiality:** What allows you to not have to disclose what you would rather not disclose (see expose).

**Consumer:** A person in need of services who has no money to purchase them.

**Continuous Quality Improvement:** Continuously changing documents to keep abreast of changes in JCAHCO.

**Data point:** What is collected in response to an anecdote to establish benchmarks. When there is subsequent change in the data point, it is explained by reference to a new anecdote or leads to collection of more data points.

**Demonstration Project:** A program funded through non-annualized monies that will be discontinued after it succeeds.

**Empowerment:** What you give to consumers when you have no money to provide services.

**Expose:** Publicity that excoriated the mental health system (usually alternatively) for not containing, committing or restraining an individual so as to prevent injuries or death; or for containing, committing or restraining an individual, thus violating their rights.

**Free enterprise:** An activity that is never free. It requires money to begin, money to continue and has as a goal the making of more money.

**Mandatory education:** mandatory penance by staff for the administrations past sins.

**Provider:** A person who makes money caring for persons who have no money (see consumer).

**Private sector:** Those who may profit from public need.

**Public sector:** Those who assure that the private sector profits from public need.

**Research:** What to do for advocates if you don't have monies to deal with a problem and need to do something. (see also mandatory education and demonstration project).

**Specialized Program:** A program that once established will insure those who receive its services will never be able to leave and those who cannot be accommodated in this program will have to do without since they can no longer be treated elsewhere.

**State Operated Hospital:** A facility that exists to employ politically connected craft workers.

**State Operated Hospital Census:** A figure determined by the number of unionized front-line workers who cannot be laid off.

**State Operated Hospital Patient:** A client whom neither private hospitals nor congregate homes can profitably house.

**Strategic Planning:** What is done while waiting for the next layer of government to tell you what you are actually going to do.

**Training:** What you do if you don't have monies to deal with a problem but funding more research will not satisfy advocates. (see also, mandatory training, research and demonstration project)

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*Dr. Luchins is the Chief of Adult Public Psychiatry and an Associate Professor of Psychiatry at the University of Chicago.*

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ETHICS COLUMN

DO OUR ETHICAL PRINCIPLES SUGGEST THAT ALL PSYCHIATRIST ADMINISTRATORS SHOULD CONTINUE TO SEE PATIENTS?

The ethics column in this issue considers the question: *Do our ethical principles suggest that all psychiatrist administrators should continue to see patients?* This question actually refers back to our column in the last issue. We posed this question to ten psychiatrists in significant administrative roles representing academia, public mental health system, managed care, research, and industry, across our nation. We obtained a response rate of 80%. The following column starts with my initial e-mail that was sent to these psychiatrists followed by a series of responses, in the order in which they arrived. It is my hope that series of these responses will stimulate a discussion that can be published in the future issues of the *Psychiatrist Administrator*.

Sy Saeed, M.D.  
 Editor

Good morning:

The Ethics Column of the *Psychiatrist Administrator*, the NewsJournal of the American Association of Psychiatric Administrator, will be focusing on the following question in its next issue:

***Do our ethical principles suggest that all psychiatrist administrators should continue to see patients? If so, should they be seeing patients in the systems they administrate? Why or why not?***

I would really appreciate it if you could consider this question and send me your response via e-mail. This response can be as long or short as you'd like.

Many thanks.

Sy Saeed, M.D.  
 Editor

**Response # 1**

The AMA Principles of Medical Ethics, and annotations to them by APA and AAPA, do not address whether psychiatrist administrators should continue to see patients, irrespective of setting. This isn't necessarily an ethical issue, especially for psychiatrists who work in corporate settings (HMOs, pharma, etc.) and don't see patients anymore. Whether a psychiatrist administrator, or any physician executive for that matter, continues to see patients speaks more to the issue of professional competency than to ethics. Historically, most physician administrators continued to practice medicine, but as the demands of

clinical medicine have become more complex, many experts believe it is more difficult for physicians to maintain knowledge and skills in both medicine and management. With the ranks of physician executives swelling, one could actually make an "ethical case" for NOT seeing patients in order to devote full-time to management to do the best possible job, without the distraction of patient care and emergencies. An exception might be a physician who desires a part-time practice as an administrator because he believes he will somehow benefit from continuing to see patients (perhaps enjoying greater job satisfaction by continuing to practice) or because the physician believes he will appear more credible to his peers if he continues to see patients.

Arthur Lazarus, MD, MBA  
 Senior Director, Clinical Research  
 AstraZeneca LP

**Response #2**

Sy –  
 I agree with Art's take on this issue.

Gordon H. Clark, Jr, MD  
 President and Medical Director  
 Integrated Behavioral Healthcare  
 Past President AAPA and AACP

**Response #3**

I agree with Art's position.

Thomas Hester, M.D.  
 Chief Adult Mental Health Division, Hawaii  
 Past President AAPA

**Response #4**

Agree too. I don't see this as an ethical issue but one of maintaining competence.

Michael J. Vergare, MD,  
 Professor and Chairman  
 Department of Psychiatry and Human Behavior  
 Jefferson Medical College of Thomas Jefferson Univ.

## Response #5

In a sense, this seems to be a trick question. In Section 6, Annotation 2 of our own AAPA Ethical Principles for Psychiatric Administrators, we have an answer of sorts:

### 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 services.”

### 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.

So there we have an answer in one of our ethical principles. Or do we? It says we ethically do not need to keep seeing patients, but also says that if we don't, then we need some other way to maintain empathy for patients (in order to balance our organizational priorities).

Probably the most standard textbook in our field, the *Textbook Of Administrative Psychiatry* (2001), edited by John Talbott and Robert Hales, doesn't say much about this issue except to further illustrate some ambiguity or ambivalence on the matter. In the chapter on Ethics, Jeremy Lazarus writes that when one administers a contract for a group of patients, this is “not obligating an individual to care directly for particular patients, . . .” (p. 384). On the other hand, David Pollack and Kenneth Minkoff, in their chapter “The Medical Director's Role in Organized Care Delivery Systems”, seem to come down on the side of seeing patients in the system when possible. They write that one way “to represent the importance of good clinical care as the organization's ultimate mission” is with the medical director “providing direct clinical care . . .” (p. 86).

My own experiences in trying to answer this question have varied. The first psychiatrist administrator I worked for did not see patients. I assumed it was because he was so busy with development of the system and related concerns. Only later did I find out that he was fearful of being a clinician, so perhaps in an ethical sense it was best he did not do so. However, he got into trouble as an

administrator leading to the demise of the whole system. In retrospect, it seems clearer that he was more concerned with facilities and finances than quality of patient care.

As I personally did more administrative work, I started to go on a similar path as far as seeing patients. The more administrative responsibility I had, the less I saw patients. As this progressed, I realized that I not only missed seeing patients, but in some way I was losing touch with understanding the entire hospital system from a patient perspective. When sometime later I assumed administrative responsibility for a full-at risk capitated system, I approached this issue differently. Not only did I think it was necessary to see patients myself in order to understand the system as best as possible, but it was a way to provide checks and balances (akin to our country's democratic system) administratively, clinically, and even financially. Financially, it was better for me personally to provide more patient care, but worse financially for the system. (If you really want a more extensive discussion of this consideration, see the book *The Ethical Way* (Jossey-Bass, 1997).

In viewing and consulting on other systems, I've generally noticed that psychiatrist administrators who do not see patients in their systems usually do a worse job in their administration. Other clinicians tend to think that the administrator does not really understand what is going on clinically and even tend to respect the psychiatrist administrator less.

## If So, Should They Be Seeing Patients In The Systems They Administrate?

Of course, in some systems that psychiatrists administrate, there may not be patients to see, such as pharmaceutical companies. In that case, how does one maintain empathy for the perspective and well-being of the patient? Can we retain that just from our training and prior role as a clinician? Perhaps in this situation, it is still best to see some number of patients, especially patients who have needs which approach that of the system the psychiatrist administrates. It probably should go without saying that to see patients in any system, the psychiatrist needs to maintain and/or develop enough clinical competence to provide “competent medical service” (Section 1 of our Ethical Principles).

## Why or Why Not?

Perhaps what at first glance seems to be a simple ethical question turns out to be more complicated. The simple answer might be to conclude that the psychiatrist administrator is free to see or not see patients themselves. Either can be ethically acceptable. However, if the primary goal of the psychiatrist administrator is “the benefit of the patient”, then also seeing patients within or outside of the organization may well enhance that as long as the psychiatrist is clinically competent.

If the psychiatrist administrator does not see patients, it may be advisable to try to keep the clinical perspective prominent in some other way, such as having an Advisory Board that includes patients and clinicians. Without keeping the needs of patients prominent, organizations and their psychiatrist administrators run the ethical risk of putting the organization first and the patients (a sometimes distant) second.

H. Steven Moffic, M.D.  
Professor of Psychiatry and Behavioral Medicine  
Medical College of Wisconsin  
Editor, Ethics Column

## Response #6

Steve:

Thanks for your very complete answer. I overlooked Section 6, Annotation 2 in our principles. It probably warrants further discussion about “mechanisms...to help maintain empathy” in cases where psychiatrist administrators choose not to see patients or are unable to see them due to the demands of their administrative positions. In the pharmaceutical industry, psychiatrists have ample opportunity to retain clinical empathy, e.g., by participating in investigator meetings, advisory board meetings, consumer marketing meetings, and many other ways. I’m not so sure that physicians in other settings have the same opportunities, but there clearly are many mechanisms for physician administrators to maintain clinical empathy other than meetings, etc. How do you think Bill Frist would respond? What about many of the other 49 physicians who made Modern Physician’s (July 2005) “most powerful list” and work in non-clinical settings?

One of the things that really bothers me about the AMA principles is that they are written for practicing physicians and do not capture the complexities of the medical/administrative interface. They are, in fact, sometimes misaligned with the ethical tenets of professional organizations and societies that represent physician executives in corporate settings. I pointed this out in my article in Physician Executive that I sent you a while back.

Arthur Lazarus, MD, MBA  
Senior Director, Clinical Research  
AstraZeneca LP

## Response #7

Art,

Thanks so much for your reply. You were right on what I was trying to get at in my lengthy comments. We (AAPA) originally did our own annotations just for the reason you mentioned, i.e. “the AMA principles . . . are written for practicing physicians and do not capture the complexities of the medical/administrative interface.” The APA had also ignored administrative ethical issues in its annotations, and although those are now being in the process of being revised, I have not noted any new material related to administrative issues so far. Back in 2000 when we produced our annotations, after much discussion, we came down to the essential principle of keeping the patient primary, which can certainly conflict with organizational priorities. My sense is that it is tempting, perhaps especially for the “most powerful” physician executives, to clearly put the organization as first priority. Whatever suggestions we can come up with for keeping clinical empathy and concern for such executives may be useful.

As to overlooking Annotation 2, I have found it very common for virtually all psychiatrists not to know or remember most of our ethical principles and annotations. Reasons may vary for this, including certain assumptions about ethics, wanting to avoid psychological discomfort, a lack of education, or the information being not easy to remember.

Steve Moffic

**Response # 8**

Sy,

I have seen the response from Art Lazarus, and I agree as I do not see this as an ethical issue either. I believe there may be potential conflicts of interest inherent in all of our work, administrative or clinical, that require us to act in an ethical fashion and exclude ourselves from the decision making or clinical process where those conflicts exist.

As for actively seeing patients in the course of work, I believe there are some advantages and disadvantages. I have found that it gives me credibility, if “it has been done to me, before I do unto others”, from a UR perspective. It has fostered a more collegial relationship and enhanced my understanding and respect for those I am working with in my UR role if I am actively involved with patients. That being said, if I am working with patients there are certain clinical responsibilities that must be respected, and may interfere with the performance of my “non-clinical” job (i.e.: possible emergency situations, distractions, etc.). The roles and expectations need to be clearly delineated for both positions, with priorities established at the outset of employment.

Michael Lancaster, M.D.  
Director of Clinical Policy  
NC Division of Mental Health, Developmental Disabilities,  
And Substance Abuse Services

**MANUSCRIPT REVIEWERS:**

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

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**Response #9**

Sy,

I think the APA Principles of Medical Ethics are silent on this question.

As others have suggested in response to your question, whether a psychiatrist/administrator continues to see patients depends on the psychiatrist/administrator and his/her employment situation. I can see the argument both ways - one is that being a psychiatrist/administrator can be a full-time occupation, with many specialized facets that need to be mastered; the other is that seeing patients keeps psychiatrist/administrators grounded in clinical reality.

Regards, Harold

Harold Carmel, MD  
Chief, Continued Care, Dorothea Dix Hospital Assoc.  
Consulting Professor of Psychiatry, Duke University

**Response # 10**

Hi Sy,

In my opinion the Psychiatrist Administrator can see patients as long as he/she recuses themselves from certain QA issues and grievances related to those specific patients. The Organization should appoint someone who does not report to the Psychiatrist Administrator to those tasks.

I think the Psychiatrist Administrator should see patients, so that he/she is aware of the effects of the organizational administrative policies on patient care.

In my opinion, the administrative brain works differently than the clinical brain. As a clinician, you are only concerned about the ONE patient in front of you. As an administrator, one needs to think not only about the patient in front of you, but many others who may come to the organization. This thinking difference may lead to a treatment that may not be the best for this patient but may be best taking into consideration resources that need to be distributed over all of the other current and future patients of this organization.

Shiv Hatti, M.D., MBA  
Current President AAPA

## LITERATURE SCAN

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

**Amering M, Stastny P, Hopper K.** Psychiatric advance directives: qualitative study of informed deliberations by mental health service users. *British Journal of Psychiatry*. 2005 Mar;186:247-52.

Standard qualitative research techniques were used to explore the interests, concerns and planning activities of informed mental health service users contemplating advance directives. Results showed that conceptualizing how a psychiatric advance directive would work, reviewing past experiences and assessing risks were labor-intensive projects. The authors concluded that legal mandates and high expectations for psychiatric advance directives are not matched by empirical evidence documenting implementation and that advance directives are best thought of as complex planning tools for future psychiatric crisis management, rather than focal interventions to enhance compliance.

**Corrigan PW, Watson AC, Gracia G, Slopen N, Rasinski K, Hall LL.** Newspaper stories as measures of structural stigma. *Psychiatric Services* 2005 May; 56(5):551-6.

This study examined stories on mental illness topics in large US newspapers. All relevant stories (N=3353) were coded during six weeklong periods in 2002. The categories were: dangerousness, blame, treatment and recovery, and advocacy action. Thirty-nine percent of all stories focused on dangerousness and violence; these stories most often ended up in the front section. Only 2% placed responsibility on the person or the family, while stories about biological or environmental causation were more

common (15%). There were an equal number of stories about biological (13%) and psychosocial (14%) treatments. Twenty percent of stories fell in the broad category of advocacy action. Structural stigma and discrimination occur when an institution, such as a newspaper, promulgates stigmatizing messages about mental illness.

**Dabovsky SL.** Who is teaching psychopharmacology? Who should be teaching psychopharmacology? *Academic Psychiatry*. 2005 May-Jun;29(2):155-61.

The author's literature review revealed that the majority of psychopharmacology education for students is provided by faculty, and that the pharmaceutical industry supports a substantial amount of CME provided by psychiatrists, pharmacists, and other medical practitioners. However, office practitioners and residents receive an increasing amount of material from pharmaceutical representatives. The author concludes that this necessitates that students learn how to evaluate new research, especially if it is industry sponsored.

**Diamond G, Josephson A.** Family-based treatment research: a 10-year update. *Journal of the American Academy of Child and Adolescent Psychiatry*. 2005 Sep;44(9):872-87. (Review)

Randomized clinical trials conducted in the past 10 years that included parents as a primary participant in treatment were reviewed. The authors concluded that for many disorders, family treatments can be an effective stand-alone intervention or an augmentation to other treatments. Engaging parents contributes to better treatment engagement, retention, compliance, effectiveness, and maintenance of gains. This updated review contains an extensive bibliography.

**Harris KM, Edlund MJ, Larson S.** Racial and ethnic differences in the mental health problems and use of mental health care. *Medical Care* 2005 Aug; 43(8):775-84.

This study pooled cross-sectional data from the 2001-2003 National Surveys on Drug Use and Health to compare rates of mental health problems and use of mental health care across multiple racial and ethnic groups. The authors

found significantly higher rates of mental health problems and higher self-reported unmet need relative to whites among American Indian/Alaskan Natives and lower rates of mental health problems and use of mental health care among African American, Asian, Mexican, Central and South American, and other Hispanic-Latino groups. The results of wide variation in mental health morbidity and use of mental health care across racial and ethnic groups in the U.S. can help focus efforts aimed at understanding the underlying causes of the differences.

**Kessler RC, Demler O, Frank RG, Olfson M, Pincus HA, Walters EE, Wang P, Wells KB, Zaslavsky AM.** Prevalence and treatment of mental disorders, 1990 to 2003. *New England Journal of Medicine*. 2005 Jun 16;352(24):2515-23.

Data from the National Comorbidity Survey (NCS) were obtained in 5388 face-to-face household interview to examine trends in the prevalence and rate of treatment of mental disorders among people 18–54 years of age during the past decade. The prevalence of mental disorders did not change during the decade, but the rate of treatment increased. Although significant increases were found in the rate of treatment, data showed that most patients with a mental disorder did not receive treatment.

**March JS, Silva SG, Compton S, Shapiro M, Califf R, Krishnan R.** The case for practical clinical trials in psychiatry. *American Journal of Psychiatry*. 2005 May; 162(5):836-46. (Review)

The evidence from available clinical trials in psychiatry is often not perceived by clinicians as sufficiently relevant to clinical practice. The authors present the case for psychiatry's adoption of the practical clinical trials model, used in other areas of medicine. Practical clinical trials are intended to provide generalizable answers to important clinical question without bias. Key features including clinically relevant question, representative patient sample, sufficient power, randomization, and limited subject and investigator burden characterize them.

**Teplin LA, McClelland GM, Abram KM, Weiner DA.** Crime victimization in adults with severe mental illness. *Archives of General Psychiatry*. 2005 Aug;62(8):911-21.

A randomly selected, stratified sample of 936 patients was compared to a group comprised of 32,449 participants in the National Crime Victimization Survey. The authors found that more than one-fourth of persons with severe mental illness (SMI) had been victims of a violent crime in the past year, a rate more than 11 times higher than the general population. Depending on the type of violent crime (rape/sexual assault, robbery, assault) prevalence was 6 to 23 times greater. The authors recognized that crime victimization is a major public health problem among persons with SMI who are treated in the community and recommended further investigation.

**Young KS.** An empirical examination of client attitudes towards online counseling. *Cyberpsychology and Behavior: The Impact of the Internet, Multimedia and Virtual Reality on Behavior and Society*. 2005 Apr;8(2):172-7.

Trends over the past decade have shown that online counseling has grown in popularity. This study investigated client attitudes toward online counseling by collecting data from 48 “e-clients” who received online counseling at the Center for Online Addiction. Results suggested that Caucasian, middle-aged males, with at least a four-year bachelors degree were most likely to use online counseling. Anonymity, convenience, and counselor credentials were the most cited reasons they sought online counseling over in-office treatment.

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*Jo Dorsch is the Health Sciences Librarian at the Library of the Health Sciences-Peoria, University of Illinois at Chicago, where she is also a professor with an adjunct appointment in the College of Medicine.*

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## **MONEY AND OUTPATIENT PSYCHIATRY: PRACTICE GUIDELINES FROM ACCOUNTING TO ETHICS**

by Cecilia M. Mikalac, M.D., W. W. Norton & Company, New York,  
June 2005, 416 pages, hardbound, ISBN 0-393-70440-8, \$45.00

The author of this book teaches money management courses at the annual meeting of the American Psychiatric Association. She has divided her subject matter into fifteen chapters, evenly split among three sections. The first portion deals with managing money within a practice, including information on practice goals, ethical issues of money management, billing, payment, and taxes. The middle segment is broadly categorized as external financial influences and encompasses health insurance, managed care, the pharmaceutical industry, potential conflicts of interest, and acceptance of gifts. The final five chapters cover matters in which money directly influences the patient-doctor relationship, such as non-payment of fees, dealing with fee changes, discussion of monetary matters with patients in general, and a chapter on money as a root of transference and countertransference.

The book has a list of acronyms near the beginning, and there are various tables and figures throughout the book to simplify information or illustrate specific points. Occasional examples of practice-related business situations are used as illustrative case vignettes. Chapter 1 concludes with a worksheet for the reader to write his or her personal answers to the questions raised throughout that chapter. There are four very helpful appendices. The first is an example of a brief but very complete patient letter or "introduction" to the practice and its services. Fees, insurances, cancellations, confidentiality and HIPAA privacy regulations, patient rights, return of phone calls, coverage when the practitioner is away, and discontinuation of treatment are all discussed. The next is a simple but thorough description of insurance benefits for patients. The third is a recommended reading list, while the fourth

lists codes of conduct for various groups of mental health professionals. The appendices are followed by a list of reference citations and then an index.

Money and Outpatient Psychiatry is written primarily for the private practicing psychiatrist who conducts a largely or solely outpatient practice. However, other practitioners are considered throughout the book and would undoubtedly be able to glean a lot from the text. The author rightly suggests that some mental health educators may wish to use the book as the basis of a course in money and business for trainees. While it is not designed for those in the public clinic sector, everyone who deals with the business of mental health practice could learn from some part of this text. If there is a problem with this book, it is the sheer volume of material which the author tries to lay before the reader. But if it seems too detailed or lengthy, one can simply pick and choose from among the well-identified chapter and topic headings. The advice that Dr. Mikalac gives seems generally sound, she couches business terminology in phrases easily understood by the average psychiatrist, and her words will be useful counsel for anyone contemplating the start of a private practice.

*Reviewed by:*

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## APA CERTIFICATION IN PSYCHIATRIC ADMINISTRATION AND MANAGEMENT

Sy Atezaz Saeed, M.D., MS

The APA certification examination in psychiatric administration and management is offered every year in conjunction with the APA annual meeting. This certification reflects the candidate's knowledge and skills in four areas of mental health administration: psychiatric care management; administrative theory; budget and finance; and law and ethics. APA believes the additional skills and experience found in psychiatrists who fill administrative roles, even part-time, deserve recognition through a certification that recognizes those qualifications. In addition, certification is a visible demonstration of knowledge and skills that may increase a psychiatrist's opportunities for employment or promotion in some settings. Perhaps most important, persons preparing for the examination go through a substantial educational process which often includes studying texts and articles (some specifically recommended in the application materials), talking with professionals in other fields (e.g., an organization's human resources or budget director, attorney, or senior managers), and/or attending courses, seminars, or workshops on mental health administration.

The examination, first offered in 1953, currently has multiple-choice and essay portions. Applicants must be board certified in general psychiatry and must, by the time of the examination, meet at least one of the following criteria:

- An equivalent of one full year of recent experience as a psychiatrist with a substantial administrative role in a mental health program.
- Completion of two academic semesters in a recognized and accredited program of postgraduate instruction that emphasizes management or administration.
- Completion of one academic year of accredited fellowship or the equivalent in psychiatric or mental health administration, supervised by a psychiatrist.
- Completion of an accredited master's degree program in public health, business administration, or mental health administration.

The general content areas which may be examined include Administrative Theory and Human Resources; Mental Health Care Management; Revenue, Budget, and Fiscal Management; and Law and Ethics, as each is applied to mental health organizations and systems.

### *Administrative Theory and Human Resources*

This area includes the contributions of major management theorists such as Weber, McGregor, Maslow, Blake and Mouton, Deming, and Juran. Candidates are not expected to have comprehensive knowledge of any one theorist, but should be familiar with the primary contributions referred to in prominent texts, major articles, and book chapters on mental health administration. Candidates should be able to apply management theory to real life administrative situations and problems. They should be aware of the basic principles involved in such things as management styles and methods, delegation of authority, organization structure, organizational behavior, program evaluation, administrative problem solving, decision making and implementation, and human resources (including recruitment and selection, compensation, motivation, staff development, continuing education, performance evaluation, discipline, and labor management relations).

### *Psychiatric Care Management*

This area is made up of clinical program topics and principles in a variety of program settings, including (but not necessarily limited to) inpatient, outpatient, private (for profit and not for profit), public (e.g., VA, state, academic, community), special groups (e.g., people who abuse substances, children, the elderly, people with dual diagnosis), consultation services and processes, public health, program planning and implementation, accreditation and certification, utilization review, quality improvement, interaction among administrative departments, medical staff matters, clinical records, and interactions with other agencies and entities in the community (e.g., other providers, patients, government agencies, advocacy

groups). Candidates must be familiar with managed care concepts and practices and with the impact of managed mental health care on psychiatry and psychiatric patients.

### ***Revenue, Budget, and Fiscal Management***

This area includes the role and function of the financial manager, the relationship between clinical managers and budget and fiscal matters, methods and mechanisms for financing mental health care (including various sources of revenue and the general rules and ramifications of each), billing and payers (e.g., Medicaid, Medicare, managed care, capitation, fee-for-service), basic accounting principles, budgeting policies and procedures (including program budgeting, zero-based budgeting), cost-efficiency and cost-effectiveness, and fiscal controls.

### ***Law and Ethics***

This area includes legal issues as they apply to patients, staff, and the overall organization. Important topics include (but may not be limited to) commitment procedures and rights, treatment rights, other patient rights, consent, competence, criminal law as it effects the organization and its administration (e.g., billing fraud), confidentiality and privilege, record keeping, record disclosure and access, protection and advocacy, and reporting requirements (e.g., abuse and neglect, Impaired staff, communicable diseases). Candidates should have a basic understanding of employment law, facility licensure, certification and regulation, including (as they apply to mental health facilities and organizations) EEOC, ADA, COBRA, HIPAA, harassment, due process, and credentialing and privileging. They should also be able to discuss common ethical issues involved in provision of mental health care, administration and research; current major health care legislative Issues; and key judicial decisions affecting delivery of mental health care.

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.

The next exam will be offered in May 2006, at the APA annual meeting in Toronto. Completed application forms must be received by APA on or before January 31 of the year in which the examination is anticipated. Earlier applications are encouraged in order to allow candidates more time to prepare.

Application forms can be requested from APA's Web site. Information is also available from Mark Anderson by phone at (703) 907-8631 or e-mail at:

manderson@psych.org.

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

### **CALL FOR PAPERS**

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

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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.

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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

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

Three copies of the manuscript should be sent to Sy Saeed, M.D., Editor, *Professor and Chairman*, Department of Psychiatric Medicine, Brody School of Medicine at East Carolina University, Brody 4E-100, 600 Moye Boulevard, Greenville, NC 27834. The manuscript should be accompanied by a transmittal letter giving the name, address, email address, and phone numbers of the corresponding author. The letter should indicate that all authors have seen and approved the manuscript and that the manuscript has not been published or is not under consideration for publication elsewhere. A disk copy of the complete manuscript, including tables and references, should also be submitted. Please label the disk with the name of the first author and title of the article and indicate what hardware and software were used. **You can also submit the manuscript electronically by sending it as an e-mail attachment to the editor at saeeds@mail.ecu.edu.** If you have any questions about specific details not covered here, please e-mail saeeds@mail.ecu.edu.

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Other areas of interest \_\_\_\_\_  
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