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President's Column

What's Leadership Anyway?

What follows is a revision of a letter I sent out recently (possibly to some of you, although by the end of 400 letters, with my husband stuffing envelopes and my kids bribed into sealing them, I'm not quite sure who received the last set, hopefully not everyone on my holiday card list....).

It's that time of year again, time to elect APA leadership. Ready yourself for the avalanche of uninvited endorsement letters. Do these letters even matter? I think they can, but only if they inspire us to do some thinking, and maybe even gig us into some action! Even if you are not an APA member, read on. Leadership issues are hardly the purview of the APA alone. Y'all can read the candidates' issue statements in Psychiatric News, or go to the website (www.psych.org). I won't be giving you a synopsis of those, or a copy of their respective CVs. And I won't use this space to endorse any candidate in particular.

What I will ask is that you ponder the role of the APA (or whichever organization) and what it should be doing for us (oh-ok, and what we could be doing for the APA and our District Branch), for the front-line-in-the-trenches community and public psychiatrists. You know who you are: those of us who struggle with very sick patients, demanding schedules (how many patients can we see in an hour given a certain collection rate vs how satisfied are we with the care we are giving?), and imperfect systems of care that are often formulated by harried bureaucrats and/or politicians who are ill-informed, and shaped by economics and not by evidence based standards of care. What do we need in our leaders?

We need people who are moral and ethical, who will listen to the entire membership, while utilizing the extant organizational structure (Assembly/components/councils/task forces/APA staff) in an efficient/cost-effective manner, and who will partner with existing mental health organizations to be more productive. We need people who will revel in the rich diversity and varied talents found in our organization. We need people with proven histories of working and advocating for psychiatric patients and their family members. We need people who are grounded in clinical practice, who can advocate for mental health care providers. We need people who have been up to their elbows in current mental health issues like ____________ (you fill in the blank, you know what you are up to your elbows in). We need people who are bright, energetic, articulate, and passionate.

And we need people who can inspire us to become involved, who by their actions and words can elucidate and clarify issues, who can mobilize our affect, and make it feel worth our while to pay dues, and to go to meetings and be productive, and to write letters to the editor or emails to our legislators, and to speak up in forums with our churches or temples, civic leaders, schools, the judiciary, or law enforcement.

Vote early. Vote often (well, ok, don't vote often). But vote.

Jacqueline Maus Feldman, MD

President, AACP

Statements from the Candidates:

APA President-Elect

Fred Gottlieb, MD

Recently I wrote a candidacy statement for posting on our AACP listserve. And a few days ago Dr. Faison requested a 500-750 word statement on 'any topic of interest' for the Newsletter and our Website. In the press of time, I've decided primarily to edit aspects of what I wrote in the earlier listserve statement as well as to then append several additional thoughts. I've worked long and hard for the profession and within many areas of APA, as

you know if you've read my earlier PsychNews statements (12/6 and 12/20). Moreover, as I noted on our AACP listserve, my most "germane" AACP work has tended to be, perhaps as it should be, "in the trenches" as it were.

For example, I:

- worked for more than a decade in a half-time psychiatrist position within a small-sized, rurally situated but programmatically large Community Mental Health Center in Mono County, California;

- initiated psychiatry's involvement with the Family Medicine program at UCLA;

- founded a community program (the Family Therapy Institute of Southern California) in Los Angeles and Santa Monica, which has provided, for hundreds of professionals in the community, across many disciplines, both theoretical information and also intensive, experiential, live supervised family-focused treatment;

- stimulated the processes (and helped achieve a needed 2/3 vote) to democratize representation in APA's Assembly relative to DB size.; fought successfully to actually initiate minority representation within the Assembly; and (as Assembly Speaker) then promoted sub-specialty representation;

- sought and, to some extent, achieved (as APA Treasurer) increased openness about APA's top staff salaries and arcane budgeting processes;

- consistently argued (on the APA Board as Area VI Trustee and then as Vice-President) that many aspects of APA's overly cozy relationship and increasingly financially dependent relationship with the pharmaceutical industry poses a danger: to our integrity as professionals, to APA as an organization, and to our patients, both because of excessive costs of medication in this society and to the negative pressure it explicitly and implicitly imposes on providing truly comprehensive care.

These days I:

- teach (as USC Clinical Professor) weekly at L.A. County General Hospital, interviewing families and supervising treatment provided by Fellows in Child Psychiatry;

- try to be sure that patients are seen and understood viewed within the realities of their social and familial contexts when I teach (as UCLA Clinical Professor) Psychiatric Residents regularly at the Sepulveda VA hospital;

- have a "private practice" of psychiatry (as a breadwinner) that implements context-based approaches: I work predominantly with couples and families even for nearly all "individual" problems that present.

To the extent that my conceptual/organizational hat still is situated in public psychiatry, I have sought your vote as an AACP colleague. By virtue of my experience, I know an enormous amount about the inner workings of APA. Furthermore I have a very clear and sometimes rather feisty view that APA needs to be much more potent in protecting our *patients* and *all* who help treat them.

I have been carefully following many discussion threads on our listserve in recent months, with much interest and pleasure. It seems to me that the kind of interchange our members have provides a model for APA and moreover should help stimulate APA action. I believe I would be particularly sensitive to such issues and to pressing for apt action in that regard. Addressing the issues of adequate energy in prevention, increasing outreach/wrap-around services, psychiatrist shortages/credentialing and special C/A needs, work in/with primary care, and (what should be additional critical examination of) our profession's role *vis a vis* the pharmaceutical industry, are part and parcel of the strong stances I have taken over the years and, within the word count constraints of PsychNews, mentioned as well in previously published candidacy statements therein. Once again, it seems straightforward to suggest that AACP members support my candidacy now ***by outreach to other colleagues*****, as well as when you cast your ballot for APA President-elect.**

I look forward to seeing you in Charlottesville in a few weeks.

Fred Gottlieb, MD

Michelle Riba, MD

As a long standing member of AACP, I am very honored to have been part of this wonderful organization for so many years. I have also very much appreciated the support of AACP in serving as APA Trustee at Large, Secretary and Senior Vice President. I am now running for APA President-Elect and would very much again appreciate your support and vote. I have served as Scientific Program Chair of the APA's Institute on Psychiatric Services, and 5 years on the IPS SPC Program Committee. I am also on the Editorial Board of *Psychiatric Services* and have served as a trustee of the American Association for Emergency Psychiatry (AAEP). I am a consultation-liaison psychiatrist at the University of Michigan and serve as Associate Chair for Education and Academic Affairs as well as Director of the Psycho-Oncology Program at the University of Michigan Comprehensive Cancer Center. My commitment to community psychiatrists and to ourpatients is strong. The recent issues that have been discussed on our list serve: generics versus trade meds; samples; not enough child psychiatrists and options for training changes; role of drug reps in clinical and academic sites; etc are all important to

AACP and APA. I find the discussions on the AACP list serve the best -well informed, knowledgeable, and patient oriented... I will continue to be an active member of AACP, will listen to the concerns that are raised by our membership, and will do my best to help serve our patients. Thank you for your help and support.

Michelle Riba, MD

American Association of Community Psychiatrists

Position Paper on

Interface and Integration with Primary Care Providers

(Approved October 10, 2002)

Introduction.

For a variety of reasons, too numerous to enumerate in this document, primary care providers can and should play a significant role in the care of persons with a wide range of psychiatric disorders. This especially pertains to the provision of mental health services for persons with less severe psychiatric disorders and appropriate medical-surgical services for the co-morbid non-psychiatric conditions that affect adults with severe and persistent mental illnesses and children with severe emotional disorders. It is essential and efficacious for community based mental health providers to participate in improving access and quality of care for patients who have psychiatric disorders who get some or all of their health care services from primary care providers. The importance of such integration efforts has been endorsed and emphasized by a wide range of national organizations and authorities, including three recent Surgeon General's Reports, the Healthy People 2010 campaign, and national initiatives led by the Health Resources Services Administration (HRSA) and the Substance Abuse and Mental Health Services Administration (SAMHSA).

At an organizational level, administrators of community based behavioral health programs should incorporate a more systematic program for interfacing or integrating with primary care provider organizations in their communities. This includes provision of sufficient budget, training, and staff to accommodate the primary care interface initiatives. The consequences of not being proactive and assertive in developing improved relationships with primary care providers are poor communications and the likelihood that the primary care organizations will develop behavioral health projects on their own, thus fragmenting the array of behavioral health services in the community.

The following training, organizational, and quality improvement principles provide guidance for how to achieve these goals.

Training Issues.

1. Psychiatrists and other mental health professionals who work in community based settings must become aware of the clinical culture of primary care and the types of psychiatric disorders that are encountered in those settings.

2. Behavioral health programs need to train most of their providers to understand how to most effectively collaborate and communicate with their primary care colleagues, especially in the care of persons with severe and persistent mental illness.

3. These same programs should identify and train specific clinicians who can be used to more directly collaborate and consult with primary care providers, either through a co-location consultation model or in a more systematic behavioral health integration program (e.g., HRSA's Health Disparities Depression Collaborative and grants for community health clinics to develop integrated behavioral health care services).

Organizational Issues.

It is essential to work closely with local primary care provider organizations to help them determine the types of interface or integration initiatives that make the best sense for them.

Improving access to and quality of primary health care services for adults with severe and persistent mental illness and children with serious emotional disturbances may include the provision of effective communication and consultation with PCPs. These interface initiatives, at a minimum, require behavioral health providers to:

- Establish effective means of bi-directional communications with local PCPs.

- Determine what information is most essential to share on mutually served patients, e.g., diagnostic, lab, medication, and treatment planning information.

- Develop appropriate confidentiality and consent protocols.

Integration and co-location models.

In order to improve the behavioral health treatment provided in primary care settings, integration of behavioral health providers may be the preferred approach. The first steps of this process include:

1. Complete an environmental scan. The environmental scan should examine three key areas: resources, capacity of local behavioral health services, local and federal regulations. At a minimum, this should involve identifying who the local behavioral health providers are, what capacity for service they currently provide, what potential exists for collaboration or conflict, and how the former can be

enhanced and the latter minimized as the primary care organization develops integrated behavioral health services.

2. Determine the primary care program's "capacity filter" based on information gathered in the environmental scan. Who should be eligible for the on-site integrated services and what level of care is to be provided? Should the pathway of care require prior primary care assessment and referral or allow for direct access to the on-site behavioral health provider and, if the latter, under what circumstances?

3. Establish buy-in that is systemic. It is essential to secure the understanding and support of both administrative and clinical leadership within the primary care organization in order to proceed with planning and implementation.

4. Make an initial decision about renting and/or owning behavioral health staff. This refers to whether the behavioral health staff are employed by the primary care organization or are contracted from the behavioral health organization. There is no one right answer to this question. Rather, it is dependent on the answers to the environmental scan and the philosophical and regulatory factors specific to the primary care organization and the local community. The implications of the rent/buy decision have significant implications for record keeping, enrollment and billing, communications, and referral processes. Effective operational integration can be achieved via both methods of staffing.

Components of the integrated model.

An integrated program may provide any or all of the following functions:

- Behavioral Health Triage. This is a quick and efficient, but comprehensive enough assessment to identify generally what the patient's presenting concerns are, sufficient to lead to one of the following provisional disposition recommendations.

- Comprehensive Behavioral Health Assessment. This should be reserved for those patients for whom the triage assessment is insufficient to make a relatively confident disposition recommendation.

- On-site Behavioral Health Treatment. This may include an array of services, the breadth of which is determined by the environmental scan, and clinical/budgetary capacity of the primary care facility based behavioral health staffing. It can include brief individual, group, and family counseling or psychotherapy as well as psychopharmacological assessment and treatment.

- Referral. This includes internal referral back to the primary care provider or other staff with behavioral management/treatment recommendations. It also

includes external referral to specialty behavioral health providers or other social service supports (e.g., entitlements, housing, employment).

- Consultation. This includes ad hoc and ongoing medical/psychiatric and behavioral management consultation support and in-service training for primary care providers and other staff within the primary care facility.

- Care monitoring and chronic disease management protocols. This should be applied to chronic psychiatric conditions that can be effectively managed in the primary care setting, such as less complicated cases of depression. It is also for those patients who have other chronic health problems whose co-morbid psychiatric conditions result from, complicate, or interfere with the other health problems or their treatment, e.g., difficult adjustment to diabetes or somatoform disorder in persons with or without other "physical" illnesses. The care monitoring function is comparable to care monitoring for other chronic conditions, i.e., disease registry data management, periodic screening and outcomes assessment, supportive counseling, patient education, self-management support, facilitation of treatment adherence (e.g., checking in with patient between appointments, prompting, assisting in tasks associated with adherence to medications, lab work support, etc.).

The staffing for the above functions can be quite variable, but should at least include:

- Masters or higher-level mental health professional, preferably capable of assessing persons from adolescence to older age for mental health and addictions disorders. This same person can provide the triage, comprehensive assessment, on-site psychotherapy, and some of the consultation and care monitoring support. This professional should also have a good working knowledge of and relationship with the specialty behavioral health providers in the community in order to manage the external referral process. Depending on the size of the facility and the resources available, more than one person can be utilized to perform these functions, thus allowing increased flexibility and accommodation of differing areas of expertise (child vs. adult, mental health vs. addictions). The prototypical position would encompass most or all of these functions, but must do so in such a way as to effectively manage the flow of patients and balance the various functions without reducing access to triage and assessment, i.e., they cannot develop too large an on-site treatment caseload.

- Mental health professional with prescribing privileges (preferably a psychiatrist). This function can be provided on-site or distance-based (via telephone, e-mail, or telemedicine link) and can provide some of the comprehensive (including medication) assessment, consultation, and back-up support to the on-site mental health professional.

- Nursing or other non-mental health staff trained to provide some or all of the care monitoring and chronic disease management protocol support services.

After establishing the functions and staffing patterns for the integration project, appropriate process flow diagrams, treatment algorithms, and other system supports can be designed and implemented.

Quality Improvement Issues.

It is essential to develop ongoing methods for evaluating interface or integration initiatives to demonstrate their effectiveness and to provide guidance for progressive improvement in increasing access and quality of care. Community based psychiatric providers should be involved in the development and implementation of these evaluation and improvement activities. The following principles are specific to improving quality in the area of primary care interface:

- It is essential to demonstrate whether the project has an impact on increasing the frequency and accuracy of recognition of psychiatric disorders of persons seen in primary care settings.

- It is essential to demonstrate that more effective and cost-effective services and provided and unnecessary health care interventions are avoided for persons with psychiatric disorders seen in primary care settings.

- Access to data on access to services, encounter information, and service utilization is required in order to accomplish the above evaluation goals. Therefore, behavioral health and primary care programs should design and, when feasible, integrate their information systems to allow access to such information.

- Direct and indirect clinical outcomes indicators should be identified, which are correlated with improvement in the psychiatric conditions that are encountered in primary care settings.

- Satisfaction of all participants in the interface or integration efforts must be included in the evaluation process.

- Organizations involved in interface or integration initiatives must develop ongoing processes for incorporating the findings of these evaluations into the continuing improvement of clinical and logistical processes.

Implementation Issues

In order to accomplish any of the above goals, several generic issues must be addressed:

- First and foremost, the various barriers to financing programs or reimbursing providers for consultation or direct services (such as payer rules which prohibit billing for activities by two different providers on the same day or provider to provider consultations in which a patient is not directly seen) must be identified and corrected.

- Cultural sensitivity and competence issues regarding both patients and providers must be identified and addressed.

- In order to assure broader awareness, increased clinical competence, and a sustainable supply of well-trained clinicians, any behavioral health consultation or integration initiatives should be linked to appropriate local professional training programs (e.g., psychiatry and family medicine residency programs and social work graduate schools).

Board of Directors' Report

The AACP Board Meeting was held on October 9-10, 2002 at the elegant Palmer House Hilton in Chicago, Illinois during the Institute on Psychiatric Services Meeting.

The following announcements were made at the Board meeting:

- The Board welcomed several new members including Drs. Satya Chandrigiri, Paulette Gillig, Tony Ng, and Pamela Weinberg.

- Sue Bailey, MD, the first Early Career Psychiatrist Representative to the Board, was acknowledged and thanked for her service and commitment to the Board . Her appointment lasted for a duration of two years and concluded at the IPS Meeting.

- David Pollack, MD has been recently appointed Oregon State Medical Director for Mental Health. In this capacity, he will join the National Association of State Mental Health Program Directors (NASMHPD) Council of Medical Directors and will act as an AACP liaison to that organization.

- Robert Ronis, MD has recently been awarded the LW Lenkowski Endowed Chair in Community and Addiction Psychiatry at Case Western Reserve University.

Paul Appelbaum, MD, President of the APA; Prakash Desai, MD, Speaker of the APA Assembly; and Paula Panzer, MD, IPS Scientific Program Committee Chair, participated in the Board Meeting. Dr. Applebaum noted APA's commitment to the IPS Meeting and the need to find a liaison to work with AACP to ensure the viability of IPS. Dr. Feldman commented that gains have been made with the assistance of Dr. Paula Panzer. Dr. Panzer stated that a proposal is being made to the APA Board of Trustees to outline the following regarding the future of the IPS Meeting:

1) To officially affiliate with AACP for IPS planning

2) To create a joint planning committee with AACP for years 2004-2006

She hopes that IPS will become a more affordable, accessible, and multidisciplinary meeting in the future.

Dr. Appelbaum shared APA's political and advocacy efforts, including working with Senator Wellstone on parity. There is concern that the first casualty of the Iraq conflict may be the mental illness parity legislation. He also discussed that a number of states will be pursuing psychologist prescribing legislation. The APA is working to help District Branches with their strategy. Further, he emphasized that the APA will be addressing the potential effects of state budget shortfalls on public mental health services. Dr. Appelbaum also noted that the APA is exploring how to be involved with the President's New Freedom

Commission. Carl Bell, MD, also a participant in the Board meeting, shared information regarding the New Freedom Commission's visit to his agency. Dr. Bell stated that he advocated to the Commission the need for linking community based organizations with universities to develop and disseminate treatment approaches with "real world effectiveness," as is being attempted in Chicago.

The APA has appointed a steering committee on the Surgeon General's Report with no funding. Altha Stewart, MD is in charge of this committee.

Several members of the NASMHPD Medical Directors Council including Drs. Steve Karp, Alan Radke, Steve Sterry, Lisa Hovermale who is standing in for Dr. Burt Pepper from Maryland and Joe Parks, also joined the meeting. Current foci of interest for the Council include integrated MI/MR services, disaster planning, and seclusion and restraint. Their most recent paper is the restraint and seclusion paper for deaf and hearing impaired individuals.

A recently added area of interest for the Council is the new cost saving trend among states to abolish or marginalize state medical directorships. Only approximately 30 states have medical directors, and a number of these are directors in name only. The council is undertaking a national survey on state medical directors' leadership practices.

Highlights of Board Member Reports

APA Assembly

Dr. Everett reported on the progress of the SPMI Assembly Task Force appointed by APA Speaker Dr. Nada Stotland. The task force has ten action items that have been reshaped into five action papers.

APA Council on Advocacy and Public Policy (CAPP)

Dr. Pollack has been appointed to the APA Council for Advocacy and Public Policy. This Council oversees three committees that used to be joint commissions. CAPP reports to the Joint Reference Committee, which in turn reports to the Board of Trustees. Of note, CAPP has concentrated most of its efforts on psychologists' prescribing privileges.

APA Council on Minority Mental Health and Health Disparities

Dr. Russell Lim reported that several committees previously under this council were transformed into corresponding committees and reassigned to the Council of Psychiatric Services. The Committee on Minorities and Under-represented Groups has been downsized to 5 members. Dr. Lim plans to improve the collaboration between the Council and AACP.

AACP/APA IPS Collaboration

The AACP was invited to become more involved with IPS Meeting planning. Dr. Feldman met with the APA Scientific Program Committee about how to enhance the quality of IPS in orderto attract a larger target audience and to meet the needs of community psychiatrists. Three recommendations resulting from this collaborative effort included the following: 1) Develop a formal relationship between the AACP and the IPS meeting planning committee; 2) Develop a formal relationship between Presidents of AACP and APA; and 3) Develop a task force composed of four members, including the current and future Scientific Program Chair and two members of the AACP Board.

Amicus Brief for New York City (NYC) Homeless

Dr. McQuistion had previously presented a request (via email) that AACP serve as Amicus Curiae to the New York Supreme Court opposing attempts by NYC to deny shelter to homeless individuals with mental or social dysfunction who were unable to comply with bureaucratic requirements. The request was presented formally to the Board and it was approved that AACP sign on as Amicus Curiae.

Committee Reports

AACP Child/Adolescent Committee

Dr. Huffine reported on several issues the committee will be focusing on in the future including: 1) Consent for treatment laws (around the country age of consent varies from 13 — 18); and 2) Developing new articles on system of care reform for a new child psychiatry column in Psychiatric Services.

AACP CME Program Development Subcommittee

This is a new subcommittee under the Training Committee. Drs. Gibson and Forster shared that the focus of the subcommittee will be on developing CME specifically relevant to community psychiatrists. They discussed possible venues for their first CME event, including traveling educational events, courses at IPS or APA, and web-based offerings. Committee members will examine funding and participant arrangements used by institutions and global/regional financial resources. Content of initial CME offerings will derive from the AACP membership survey. The next step will be to develop a specific curriculum.

AACP Disaster Committee

Dr. Ng provided follow-up to the AACP/CMS community disaster response meeting held in DC in July. A steering committee will be writing the proceedings from the meeting and developing curricula that were outlined in the meeting. There is a Substance Abuse and Mental Health Services Administration (SAMHSA) disaster response preparedness grant available for each state for $100,000.

AACP Diversity Committee

Dr. Lim reported that the committee is working on the ten nominees for next year's free membership. The committee plans to involve local diversity training professionals in Boston with the IPS meeting/presentations. Dr. Ng will be developing modules in the CMS disaster response curriculum for working the minorities during disaster.

AACP Formulary Management Committee

Dr. Everett noted that the document, *Principles of Formulary Management*, is expected to be completed by February and will highlight the relationship between provider and consumer.

AACP Membership Committee

Dr. Primm reported that there are 602 paid members. The committee has been considering strategies for increasing membership further. They will be working on developing a list of 'WhyJoin?' bullets for recruitment purposes. The committee is also considering rewriting the statement in the application brochure to better include state hospital psychiatrists.

Drs. Goldfinger and Ronis stressed the importance of recruiting residents early in their career. Subsequently, the Board approved offering residents a one-year free membership without the journal.

AACP Committee on Persons with Mental Illness Behind Bars (MIBB)

Dr. Moltz reported that AACP has been asked to endorse a powerful document on policy statement and recommendations, "Criminal Justice/Mental Health Consensus Project " (www.consensusproject.org) The document was subsequently endorsed by the Board. Further, the committee is working on a position paper that emphasizes the impact of psychiatry becoming more involved in long-term incarceration. Dr. Osher is working on a presentation for IPS on "Integrating Offenders with Chronic Mental Illness into the Community Mental Health System."

AACP Primary Care Committee

Dr. Pollack reported that: 1) AACP's letter has been sent to APA leadership commending their work on fostering integrated primary care/mental health care delivery and offering the help of AACP in APA's endeavors; and 2) the Board reviewed the most recent edits of the proposed position paper, "Principles for Working Effectively with Primary Care." The position paper will be included with the AACP's report to the New Freedom Commission. Of note, Dr. Weinberg will take over as Chair of the Primary Care Committee.

AACP Publications/Communications Committee

Dr. Oudens reported that the website is currently receiving 41,000 hits per month. Dr. Cutler reported that the CMJH publisher has given permission for placement of articles on the website for an online journal club. Dr. Thompson plans to initiate a separate AACP listserve for social issues (. Dr. Cutler reported that CMHJ is planning a 25th anniversary issue for October 2003. The journal is still soliciting articles for this commemorative issue.

AACP Quality Management

Dr. Sowers circulated a revised draft of the AACP paper, "Quality Management Guidelines for Incorporating Recovery Oriented Principles in Mental Health Treatment Systems." The Board recommended an improved description of the Recovery Model and summary statement. The committee plans to incorporate these suggestions, add quality indicators, and re-circulate the document to the Board.

AACP Training Committee

Dr. Haggerty reported on multiple issues being tracked by the Training Committee: 1) The curriculum project is progressing. Curricula and training programs are now being collected in a new training section on the AACP website for public access; 2) The Committee will work toward a presentation on the status of community psychiatry training for a future IPS meeting; 3) The Committee will explore the feasibility of a national summit on community psychiatry training; 4) The Committee will work to improve community psychiatrist representation on the Residency Review Committee (RRC); 5) The Committee will work on developing strategies for using consumers as consultants to training programs.

Task Force on Strategies to Fight State Mental Health Budget Cuts

Dr. Foster updated the Board on his efforts to organize a broad based response strategy against cuts in state funding for mental health services. He hopes to have a strategy (advocacy) "toolkit" on the AACP website following the 2003 AACP Winter meeting.

Task Force on Consumer and Family Participation in AACP

Dr. Sowers discussed various ways AACP could obtain input from consumer and family partners: 1) A hybrid advisory group could be formed from existing advocacy groups; 2) AACP products might include

input from either local or national groups with whom AACP Board members already have liaison relationships; and 3) An official policy to obtain feedback from consumer and advocacy groups could be developed.

Other Business

J-1 Visas

The Board resumed discussion of post-September 11 restrictions affecting availability and maintenance of J-1 visas (and job placements in underserved areas) for FMG psychiatrists. Dr. Chandrigiri will take the lead in developing an AACP position statement and will present it at the next Board meeting. He would like to develop liaisons in each state to work on the project. Several Board members suggested that our response can best approach the J-1 issue through discussion of its impact on access to care.

New Freedon Commission

Dr. Minkoff circulated the draft of an AACP statement to the New Freedom Commission. The statement contains 10 bullets, each referring to existing AACP position papers. A general discussion of items that needed to be added occurred. Among the pertinent items, the importance of culturally competent care, the need for housing, and government responsibilities were highlighted.

Pfizer's Collaboration with Coporations to Address Health Issues

Dr. Primm shared that Pfizer would like to talk with AACP about employee initiatives. Pfizer has a division for employee health and they have linkages with corporations. Pfizer is working with Sara Lee, a company based in Chicago. Employees of Sara Lee have a high incidence of diabetes and mental health issues. Pfizer is looking for psychiatrists to make presentations to their employees. These efforts are educational and Pfizer is hoping for outcome demonstrations.

Netiquette

Dr. Feldman offered guidance on email etiquette. It was reiterated that email responses are preferably directed, when applicable, to the initial sender rather than the entire group. It was also recommended that the subject line needs to be very clear.

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AACP WELCOMES

THESE NEW MEMBERS

Area 1

Gwendolyn Barros

Leslie Finn

Jeanne Greenblatt

Thomas Pizor

Area 2

Christine Lim

Derek Tate

Area 3

Lidia Carnota

Brenda Freeman

Debra Hales

Lawrence Real

Steven Steury

Area 4

Lauren Bern

Surjeet Bhangoo

Mark Johnson

Shahm Martini

Steven Mays

Alan Radke

Area 5

Joseph Battaile

Cathleen Harrison

Manuel Mota

Joe Thornton

Area 6

Michelle Clark

Monika DoValle

Katherine Mellott

Tina Tonnu

Area 7

Charlotte Grant

Disaster Preparedness: A Brief History of The American Red Cross,

The Role of Women and Psychological Issues

"To be calm, when others were distracted, to be sure, when others were uncertain, to be brave, when most of us would have been timid, and above all, to be generous, when most of us would have been selfish, was her practice", said of Jane Delano, founder of the American Red Cross Nursing Service, by her colleague Ruth Morgan.

As we reflect on the history of healing we find women played a big role. In *Witches Midwives and Nurses*, Barbara Ehrenreich traced the role of women in medicine. As we start the 21st century, we are confronting terrorism and must continue the work of women who came before us in dealing with disaster. One year after the terror attacks in New York, Washington and Pennsylvania, many still feel numb. Others experience symptoms which may be normal. Emotions may be closer to the surface. Still others feel that they are not themselves, mistreat others or increased their use of drugs and alcohol. Some may feel hopeless or despondent, wish they were dead or think about doing something to hurt or kill themselves. They need help. Almost everyone was affected in some way.

Women and nurses played an important role in the history of disaster response in the United States. Clara Barton founded the American Association of the Red Cross in 1881. Jane Delano founded the American Red Cross Nursing Corps in 1909.

It all started in 1859 when Henry Dunant, a 30-year-old Swiss businessman was on his way home. He was shocked by the pitiable condition of the 40,000 dead and wounded soldiers he saw on the bloody battlefield in Solferino, in Northern Italy after the French victory over the Austrians. The horror of the carnage was surpassed only by the wounded being left to die. Dunant organized villagers to aid wounded soldiers, regardless of their nationality, "all brothers" the local women repeated as they carried the wounded seven miles to the courtyard of the cathedral. Dunant's simple idea, people looking beyond national conflict to serve humanity, started events that changed the world. He went home and wrote a book which he mailed to influential people and which became famous, *A*

Memory of Solferino (*Un Souvenir de Solferino*), published in 1862. This led to the birth of the International Committee of the Red Cross (ICRC) one year later in 1863. A red cross on a white background was adopted, the reverse of the Swiss flag and became a universal protective emblem in conflict areas. The founding of the ICRC led to the first Geneva Convention in 1864. But Dunant was not an organizer or a public figure. He was a private citizen who accidentally became acquainted with the human wreckage caused by war. He emphasized the need for trained volunteers and international cooperation and spent a great deal of strength, time and money on promoting these ideas. But amazingly, almost from the moment of his greatest success he declined. By 1867, just four years after the ICRC, Dunant was bankrupt. He resigned and wandered for 25 years without friends or work until he entered a hospital where he was rediscovered and received the first Nobel Peace Prize in 1901. In 1910, after 18 years in the hospital, he died but is considered the founder of the Red Cross and his birthday is celebrated at World Red Cross Day. Although Dunant remains a mysterious person, his craving to bring relief to humanity in pain has made itself felt throughout the world.

The Red Cross is the largest humanitarian organization in the world. The components of the Red Cross Movement are: (1) The International Committee of the Red Cross (ICRC), (2) the International Federation of Red Cross and Red Crescent Societies founded in 1919 and based in Geneva and (3) the national societies. The ICRC is an all-Swiss group of about 25 people which serves as an intermediary between belligerent countries in carrying out the terms of the Geneva Conventions.

The American Red Cross (ARC) is one of more than 145 national societies. The national society in Israel, Magen David Adom, is identified as the Red Shield (Star) of David which along with the emblems of the Red Cross and the Red Crescent identifies and protects people and facilities providing relief.

The three components of the Red Cross Movement are governed by a unity of purpose and allegiance to the seven Fundamental Principles of the International Red Cross and Red Crescent Movement:

1. *Humanity*: Our purpose is to prevent and alleviate suffering, protect life and health, and ensure respect for human beings.

2. *Impartiality*: We do not discriminate as to nationality, race, religion, class or political opinions.

3. *Neutrality*: We do not take sides in hostilities or political, racial, religious, or ideological controversies.

4. *Independence*: We must always maintain our autonomy.

5. Voluntary Service: We are not prompted by a desire for gain.

6. *Unity*: There is only one Red Cross or one Red Crescent society in any one country.

7. *Universality*: The Movement is worldwide.

There are four Geneva Conventions although the third one of 1929 is the best known for the protection of prisoners of war. These international treaties to protect the victims of war started with the first one of 1864 to deal with the humane treatment of those wounded on land. The second of 1907 protects those wounded at sea and the fourth of 1949 protects civilians and further expands these rights under international humanitarian law (IHL). The best way to get people to obey international humanitarian law is to educate them about their rights and responsibilities and the impact of world opinion can be a powerful inducement to comply.

Clara Barton, like many 19th century women who moved beyond their traditional female roles, she was plagued by self doubts. She was fearful of delegating authority, driven and often in poor health. This shy, timid, private woman battled the strong-willed humanitarian part of herself. It was a battle she would never resolve. But she was a feminist. She was a pioneer, a teacher when most teachers were men and an office worker when women worked at home. In 1861, when she was 40-years-old, she served soldiers in the Civil War, including reading to them, writing letters for them, listening to their personal problems and praying with them. In 1868, when she was 47 years old, Clara Barton had a nervous breakdown and traveled to Europe for rest. She heard of the Red Cross and helped the war-stricken in France and Germany during the Franco-Prussian War. She worked closely with many groups but never allied herself too closely with them. When she was 60-years-old in 1881 Clara Barton founded the American Red Cross. She had battled ten years of poor health, uncooperative government officials and public apathy. In 1882 the Senate ratified the Treaty of Geneva, thus establishing the Red Cross in the United States. When she was 76-years-old, she directed relief from the battlefields of Cuba during the Spanish-American War. The Red Cross needed to expand and Clara Barton was forced out. Alone and in bitterness she resigned in 1904. In 1905 Congress gave the American Red Cross the authority to provide disaster response. But Clara Barton did not stop and again, was ahead of her time. In 1905 she established the National First Aid Association of America to teach emergency preparedness in the community and five years later in 1910, the Red Cross introduced First Aid as a national program. She liked reading, gardening, writing, cats and horses and died when she was 91-years-old. She had a great talent for writing and speaking and had great charisma and she impressed her cause upon her country and the world.

Jane Delano, a distant relative of FDR on his mother's side, was the founder of the American Red Cross Nursing Service and a leading pioneer of modern nursing. In 1886 she graduated from Bellevue Training School for Nurses. Twelve year later, in 1898, during the Spanish-American War, she joined the New York Chapter of the American Red Cross. In 1902 she revolutionized the nursing curriculum at Bellevue by dignifying the position of nurses at a time when nurses were not recognized as full members of the medical profession. She also added cultural and recreational advantages for nurses. She

emphasized the importance of having a ready supply of nurses in case of military conflict to avoid the lack of preparation during the Civil and Spanish-American Wars. In 1909 Jane Delano founded the American Red Cross Nursing Corps. Because of her efforts, when the United States entered World War I in 1917 there were over 8000 registered nurses immediately available for duty. By the end of the war 20,000 Red Cross Nurses had volunteered. Since it started, more than 370,000 professional Red Cross nurses have enrolled in the Nursing Service. Jane Delano died in 1919 at the age of 57 and is buried in the Nurses' Corner at Arlington Cemetery.

In 1900 the US Congress granted the ARC a charter making them responsible for providing services to members of the US Armed Forces and relief to disaster victims at home and abroad.

When war broke out in Europe in 1914 one in five Americans was a member of the ARC. When the US entered the war, with the support of President Wilson, more than 30 million Americans were supporters. In addition to other services, the Red Cross pioneered the development of psychiatric nursing programs at veterans' hospitals.

The American Red Cross involvement in World War II preceded the entrance of the United States into the conflict. By the end of the war, nearly every family in America had some connection to the Red Cross. War-related services included Services to the Armed Forces (SAF) including consultation and guidance in personal and family problems, communication between service personnel and family members, recreation and medical and psychiatric social work. The Volunteer Special Services included the Motor Corps which consisted almost entirely of women who clocked over 61 million miles answering nine million calls for transport. Forty-five thousand women served in the Motor Corps, most driving their own cars, and many completing training in auto mechanics! The Specialized War-time Services included care for the 65,000 war brides who were provided an array of services. The War-Related Activities of Ongoing Red Cross Services included the Nursing Service which enrolled 212,000 nurses. Seventy-one thousand actually served, representing 90 percent of all the nurses in the military! Throughout the war years, the Red Cross continued to serve those affected by natural disasters such as the Coconut Grove Fire in Boston which killed 492. Finally, the Red Cross supplied nurses to combat the polio epidemic that lasted into the 1950s.

Today the American Red Cross has 1.2 million volunteers and administers many programs including stress management, and programs for the homeless and parenting.

Major lessons learned from September 11, 2001 include the importance of coordination with other relief organizations, focusing on providing continuity of care and personal relationships with those tended to. And we remember the women who organized and provided psychosocial services along with other help.

CALENDAR

February 7-9, 2002

AACP Winter meeting, *Journey to Recovery,* Omni Hotel, Charlottesville, VA.. For more information, please contact Anita Everett or Heather Glissman at 804-692-0276.

March 12-15, 2003

American College of Mental Health Administration (ACMHA) Santa Fe Summit, "Reducing Disparities: Achieving Equity in Mental Health Services." Hotel Santa Fe. Keynotes include: Dr. King Davis, PhD, Professor and the Robert Lee Sutherland Chair In Mental Health and Social Policy University of Texas at Austin on, "Mental health, mental illness, culture, race, and ethnicity: An overview of the data", and Dr. Norman Sartorius MD, PhD, FRC Psych, Professor of Psychiatry, Scientific Director of the WPA Global Program Against Stigma and Discrimination because of Schizophrenia, Member of Council, WPA, Immediate Past President, Association of European Psychiatrists on international efforts to reduce disparities in the field of behavioral health. As in past Summits, this will be a working conference. For more information contact ACMHA website at www.acmha.org

March 27-30, 2003

American Society for Adolescent Psychiatry 2003 Annual Meeting, *Adolescents and Their Environment,* The Roosevelt Hotel, New York, NY. For further information contact Frances Roton, Executive Director, American Society for Adolescent Psychiatry, P.O. Box 570218, Dallas, TX 75357-0218. Phone 972-686-6166. info@adolpsych.org.

May 17-22, 2003

APA Annual Meeting, *The Promise of Science, The Power of Healing*, San Francisco, CA. www.psych.org

Behavioral Health Groups Create

Seclusion/Restraint Document

In an effort to capture the good ideas that are in use throughout the country to lessen the need for restraint and seclusion with psychiatric patients, several national associations have teamed up to publish *Learning from Each Other: Success Stories and Ideas for Reducing Restraint/Seclusion in Behavioral Health.* This 42-page publication was created by the American Psychiatric Association (APA), American Psychiatric Nurses Association (APNA), and the National Association of Psychiatric Health Systems (NAPHS) with support from the American Hospital Association (AHA) Section for Psychiatric and Substance Abuse Services (SPSAS).

The document may be downloaded at no charge directly from the following website: http://www.psych.org/clin_res/learningfromeachother.cfm This document is also available by downloading the complete text at no charge on the following websites: http://www.psych.org; http://www.naphs.org; http://www.apna.org; and http://www.aha.org