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## **President's Column**

### ***"Wrong-Sizing" Treatment***

As I monitor the AACP list serve, as I read the newspaper, as I listen to TV and NPR, it is readily apparent that EVERYONE'S state budget is going down the tubes, and that one

of the first items examined to cap or shrink or delete or "right-size" (does anyone else HATE that phrase?), is the state's Medicaid budget. The first item addressed invariably is the formulary budget. And, like clockwork, the first items examined there are psychotropic medications, often the atypical antipsychotic medications, because you know, they cost too much.

They are expensive. But they are also effective. If taken appropriately and consistently patients with psychosis are less likely to relapse. Relapse into psychosis often leads to psychiatric hospitalization, which is expensive. Here in Alabama a one-day stay in a psychiatric facility can cost \$1000 (plus about \$17/day the MD is allowed to charge). I just got off the phone to my pharmacist downstairs. A month's supply of \*\*\*\* (un-named atypical antipsychotic so as not to incite a riot) costs \$1,145.88. To prescribe more than that (let's say 50% more to the tune of \$580), Medicaid has imposed a rule that states in order to prescribe more than the package insert highest dose, an MD has to complete and fax to the identified pharmacist a form asking to prescribe more, and why. The pharmacist then has to get it to Medicaid for their approval before filling the prescription. This form doesn't take much time to complete but the inconvenience may deter the MD from prescribing more than Medicaid says he/she should; or, if kept waiting at the pharmacy for a prescription, the patient may simply leave.

So we have a patient who is on a dose less than his/her doctor clinically considers appropriate, or maybe they are on nothing at all. Under treatment, or no treatment. Sounds like a recipe for relapse. Relapse always carries with it the potential for hospital admission (not to mention potential dangerousness to self or others). So, by my calculation, to "save" \$580, Medicaid is willing to risk re-hospitalization, in which just one night's stay is almost double the cost of the additional requisite medicine. What don't they get about this equation??? The literature is replete with data which reflects that restricting a psychiatric formulary incurs no long-term savings; indeed it typically costs the system considerably.

Now, I am not advocating willy-nilly prescribing. Actually, at my program, we are considering adopting TMAP (Texas Medical Algorithm Project) protocol for prescribing antipsychotic medication. I am in favor of thoughtful, responsible prescribing, in partnership with consumers, family members, and/or care-givers.

All I am advocating for is thoughtful, reasonable decision-making regarding the access to medicine that my patients need, NOT willy-nilly slashing of Medicaid payment for medicines in order to "save" money. Because it won't work.

*Jacqueline Maus Feldman, MD*

President, AACP

## **AACP Policy on Conflicts of Interest for Board Members**

*(Approved February 7, 2003)*

In order for the AACP to uphold the highest ethical standards concerning relations with corporate donors, it is important that Board members be free of actual or apparent conflicts of interest. To that end, all AACP Board members will disclose, in writing, any potential conflicts of interest, as defined below. This disclosure will be made at the time of election to the Board, and will be updated annually and at any time that there is a significant change. The declaration should also identify any individual whose financial interests could pose a conflict of interest for that individual (e.g., spouse, other family member, business partner).

The declarations will be kept on file by the Board, and will be available to all AACP members. The Board will review these declarations in detail on an annual basis, and the review will be reported in the Board minutes and summarized for the general membership.

Board members will not participate in any votes or decisions concerning donations or support from any for-profit health care entity in which the individual has a financial interest or other potential conflict of interest.

Potential conflicts of interest include:

- Specific financial interests exceeding \$500 in any for-profit health care company, or a total of \$2000 in all such companies; or lesser amounts at the individual's discretion.
- Financial interests include fees, honoraria, gifts and other emoluments for consulting or lecturing; equity interests including stock options and expectations of receiving equity interests; and directorships, executive roles, and other special relationships with companies having the potential for personal material gain.

### **FREE Resident Membership**

*The first year of AACP membership is now FREE for residents. Please pass this information on to any resident who may be interested in the benefits of joining the AACP, a dedicated and energetic group committed to promoting quality care of patients in community settings.*

## ***Regional Report***

### **Oregon's Poor Will Suffer from State Budget Crisis**

*by Kate Mulligan (Reprinted with permission from Psychiatric News)*

***Outpatient mental health services, prescription drug benefits, and substance abuse treatment are casualties in Oregon's effort to balance its budget. This article appeared as part of a special report in Psychiatric News, April 4, 2003.***

On March 1 Oregon state officials eliminated prescription drug benefits, outpatient mental health benefits, and substance abuse treatment programs for 100,000 persons who are eligible for the Oregon Health Plan (OHP) but who do not meet income eligibility criteria to be part of the "mandatory" population guaranteed coverage through the Medicaid program.

They are enrolled in OHP Standard and typically are adults whose incomes are below the federal poverty level but who do not otherwise qualify for Medicaid by fitting into a category of eligibility defined in Medicaid legislation.

The likelihood of the cuts had been discussed since November, but Oregon residents voted in January against a tax increase that would have prevented the cuts from taking place.

Legislators later announced that prescription drug benefits would be restored to those enrolled in OHP Standard until July 1. Neither outpatient mental health benefits nor substance abuse treatment benefits, however, were restored.

According to John McCulley, executive secretary of the Oregon Psychiatric Association (OPA), "We face a huge challenge to restore either benefit."

Other mental health and substance abuse treatment cuts have been taking place since. The state faces an estimated \$2.5 billion budget shortfall for Fiscal 2003 through 2005.

Hundreds of people with disabilities rallied on the steps of the capitol in Salem, after the announcement of the temporary restoration of prescription drug benefits to describe the damage that had been done.

Justin Taylor, who takes medication for bipolar disorder, told of people who had committed suicide after learning that their medications would be cut, according to the March 6 *Oregonian*.

A story in the March 7 *Oregonian* reported that state officials had investigated five suicides of clients of community mental health centers thought to be linked to service cuts. Three remain under investigation, and two were dismissed.

Patients who were cut from the rolls had to wait 14 days or more for reinstatement. The computers of both the state government and First Health, the company that manages the interface with pharmacies, had to be reprogrammed when prescription drug benefits were restored.

Michael Reaves, M.D., medical director of Lane County Mental Health in Eugene, said that doctors had moved quickly to enroll patients in free or low-cost programs run by pharmaceutical companies.

David Pollack, M.D., medical director of the Office of Mental Health and Addiction Services in the Oregon Department of Human Services, told *Psychiatric News* that the elimination of reimbursement for methadone is a particularly good example of the fact that many of the cuts are "penny wise, but pound foolish."

Approximately 3,000 people with OHP Standard benefits lost funding for methadone on March 1. "It's a reasonable estimate that 80 percent of them will relapse," Pollack said.

The state spent between \$3 million and \$4 million last year on methadone. The costs of an illegal substance such as heroin could climb as high as \$300 million for the same population. Criminal activity is often the source of funds for that drug. He pointed out that medical costs for that group would also increase without methadone.

On February 1 the state cut one-quarter of the inpatient alcohol treatment beds, including the state's only inpatient treatment facility for Native Americans. In March it cut funding for 70 percent of the 500 outpatient counseling clients at a center in Portland.

Pollack said that the dollars cut understate the impact on treatment because many treatment centers have closed down, rendering access impossible, even if a person is eligible for substance abuse benefits or can pay for them.

### **Impact of Cuts Compounded**

Threats to the mental health system are being exacerbated by cuts in other health and social services areas. On March 3 the *Oregonian* reported that hospitals were preparing for the onslaught of uninsured, low-income patients, who had been eliminated from the rolls of the Oregon Health Plan. And Medicaid already had been underpaying Oregon hospitals for a decade, according to a study by the Lewin Group commissioned by the Oregon Association of Hospitals and Health Systems. The state announced plans to reduce reimbursement rates to urban hospitals by another \$31 million a year, which would raise the hospitals' losses on care of health plan patients to \$162 million a year.

Charity care at Oregon hospitals increased 39 percent last year to \$108 million, while losses due to "bad debt" increased 17 percent, to a total of \$158 million.

The Oregon Health and Science University announced a second set of job cuts because of declining reimbursements for uninsured hospital patients, according to a separate story in the *Oregonian* on March 3.

In Fiscal 2002 the university's hospital received \$2 million less than it cost to treat patients for whom it receives government reimbursement. The hospital projects it will lose \$24 million on those patients in 2003. An early projection for 2004 forecasts a loss of \$45 million.

According to the March 3 *New York Times*, Oregon prisons have released some people early. Prosecutions of people arrested for theft and drug crimes are being delayed or voided because of underfunding in the legal system.

### **How Could It Happen?**

Reaves warned, "The changes that have taken place in Oregon could happen anywhere in the United States. Two years ago, I could not have conceived of them occurring. Now they are a reality".

Oregon, however, has been subjected to a particularly damaging convergence of economic and political factors.

Outgoing Gov. John Kitzhaber (D) pronounced the state "ungovernable," according to an article in the January 12 *Oregonian*, which traces the factors that led to the current crisis.

The state was hit hard by the recession of the 1980s. The timber industry crashed, but the Portland area boomed with high-tech microchip and other "new economy" businesses, until those enterprises also began to falter.

Rapid growth during the boom years led to an increase in property taxes. In 1990 residents passed Measure 5, a citizen initiative that limited property taxes for schools and had the effect of forcing them to rely on the state legislature for funding.

Oregon's economy was shattered by the bust of the high-tech ventures and had already been weakened by the decline of the timber industry. Per capita income now is 31st in the country. The state vies with Washington state for top ranking in terms of its unemployment rate.

Concurrent with these economic changes has been an increasing polarization between rural and urban sections of the state and between political parties.

"The centrist voices are harder to hear in both political parties," said David Frohnmayer, the last "moderate" Republican chosen by his party to run for governor, according to the *Oregonian*.

Kitzhaber concurred, according to the story. "Money and special interests have moved in to fill the vacuum left by a disengaged and disenchanted electorate. The result is a state fragmented by ideology and partisanship, unable to take effective action on any front. . . ."

Reaves said, "Many of us are trying to envision how we can help a reorganized system rise from the ashes of this major conflagration."

## **AACP Position Statement**

### **for the President's New Freedom Commission**

*(This document was submitted to members of the New Freedom Commission and to a White House representative*

*accompanied by a number of AACP's position statements on related issues)*

The American Association of Community Psychiatrists (AACCP) is an organization dedicated to the principle that services for individuals with mental illness must be planned and delivered in the context of real world community systems, with attention to the needs of the population as a whole, and with specific priority given to those individuals and families with the most severe illnesses, the most complex problems, and the least ability to pay for services.

Consequently, we are strongly supportive of the mandate of the President's New Freedom Commission to look at the needs of persons with mental illness from the perspective of the service system, and to make recommendations to the President on strategies to address system level inequities and inefficiencies that create significant barriers to proper treatment. We would like to offer our assistance in any way we can.

This position statement is intended to identify major issues which need to be addressed by policy directive. In most instances, each issue we identify is accompanied by a position paper that we have already developed, consistent with our longstanding advocacy efforts within organized psychiatry and within public behavioral health delivery systems. We hope you find these helpful, and we welcome your feedback or questions.

1. This nation needs a comprehensive national plan for the delivery of mental health services to its population, a plan that ensures appropriate access to effective treatment regardless of state, insurance status, income level, cultural background, population density (rural vs. urban), type of diagnosis, involvement of other service systems, or level of disability. This plan must require that each state ensure minimum levels of service, which is culturally competent, to all residents of that state, regardless of funding stream, as well as adequate levels of effective best practice treatment to those individuals identified as having serious and persistent mental illnesses. Medicaid waiver policies to expand access must not

do so by reducing benefits to persons with serious mental illnesses below a level needed to provide necessary services according to best practice standards.

2. Persons with SPMI require services that meet best practice standards of access, psychopharmacology, outreach, housing, rehabilitation, and recovery. We support the Principles of Treatment for SPMI articulated by the APA.
3. Persons with mental illness have co-occurring substance use disorders with sufficient frequency that it is an expectation that the system of care should be designed to provide welcoming, accessible, integrated, continuous, and comprehensive services to this population.
4. Persons with mental illness have high prevalence of co-occurring medical problems, and frequently present in primary health care settings. Consequently, the system of care must incorporate specific mechanisms to promote effective collaboration between primary health care and behavioral health care providers and settings.
5. Persons with serious mental illness deserve to participate in recovery-oriented treatment services and systems that promote access to rehabilitative services as an integral part of treatment.
6. Persons with mental illness and substance disorders are highly prevalent in criminal justice settings. There should be adequate policy direction to ensure that adequate services are provided within those settings, as well as adequate linkage to the community both to promote diversion from incarceration, and to promote successful community tenure after release.
7. Persons with mental illness require access to the full range of effective psychopharmacologic best practice interventions, regardless of payment source.
8. Persons with mental illness must be treated in systems that have formally empowered medical leadership to ensure that clinical values balance fiscal and administrative concerns.
9. Persons with mental illness require active and timely level of care assessments and seamless continuity of care as they move through multiple programs and levels of care in complex delivery systems. The system must address this issue through formal policy directives and quality management initiatives.
10. Persons with mental illness must be served in systems and settings that demonstrate principles of quality management and accountability to consumers and stakeholders for meeting the above standards.

We are hopeful that these ten items, and the accompanying position statements, will assist the Commission in developing their recommendations to the President. We believe our recommendations are both consistent with and add substance to those from other public sector oriented mental health provider and advocacy organizations. We are very committed to the values that the Commission represents, and we welcome any further opportunity to be of assistance.

## ***"The Infinite Mind"* Public Radio Program Puts Face to**

### **National Mental Health Funding Crisis;**

### **Pollack, AACP Board Member, Invited to Speak**

*(New York, Atlanta)* An exceptional line-up of mental health experts and performers will explore critical mental health issues as part of the second annual "State of Mind", to air on the award-winning public radio series "The Infinite Mind". The one-hour program, taped in front of an audience of 400 people from around the country, emanated from The Carter Center in Atlanta, GA. The program, produced by Peabody Award-winning Lichtenstein Creative Media, will air on public radio stations across the country beginning Wednesday, May 7, 2003, for national Mental Health Month (check local listings).

The program will focus on the burgeoning national crisis in community mental health care. This urgent situation in public care for mental illness has received scant attention by national media. Already, scores of mentally ill people are being dumped into jails, hospital emergency rooms and onto streets across the country in a manner eerily reminiscent of the mass deinstitutionalization of the 1970s and 1980s. Consider: Maine just slashed \$14 million in mental health services for children; Oregon ran out of funding for psychiatric medications; and Connecticut, without notice, terminated health care for 30,000 people – including 7,000 children. The public mental health system represents half of all dollars spent on treatment, and cares for some of the most vulnerable, psychologically and medically fragile Americans. Reporter Rebecca Roberts of public radio's *The World* offers a news-breaking report on this national crisis in care. "State of Mind: America 2003" will also examine mental health care among minorities, and investigate the unprecedented number of people receiving psychiatric care from general practitioners and internists.

The program will feature numerous mental health experts, including former First Lady Mrs. Rosalynn Carter; Dr. David Satcher, the 16th U.S. Surgeon General; and a reading by acclaimed writer Meri Nana-Ama Danquah from her moving memoir about depression, *Willow Weep for Me*.

Mrs. Carter, a life-long advocate for people with mental illness, will introduce the program. The nation, she warns, "is facing a crisis where states across our country are cutting mental health budget and denying much needed services to some of their most vulnerable citizens. I'm especially concerned about the effects budget cuts will have on

historically underserved populations, especially children and racial and ethnic minority groups."

Host Dr. Fred Goodwin's notable guests include: Dr. Benjamin Druss, Emory University's Rollins School of Public Health; Dr. Quentin Ted Smith, clinical professor of psychiatry and behavioral sciences at Morehouse School of Medicine; Mrs. Doris Smith, co-founder of the National Organization of People of Color Against Suicide; Dr. Thomas Bornemann, director of the Mental Health Program at The Carter Center; and **Dr. David Pollack**, medical director for mental health services for the Oregon Department of Human Services.

According to Bill Lichtenstein, senior executive producer of the program and president of Lichtenstein Creative Media, which produces "The Infinite Mind": "This program represents the first in-depth examination of severe cutbacks in public mental health coverage occurring throughout the country, from Maine to California. Experts tell us the effects will be devastating ... as serious as the closing of the psychiatric hospitals 30 years ago. The end result? Dramatic increases of homeless people and overflowing emergency rooms and jails, where many untreated people with mental illness end up when they don't have private insurance.

## CALENDAR

*May 17-22, 2003*

**APA Annual Meeting**, *The Promise of Science, The Power of Healing*, San Francisco, CA.  
[www.psych.org](http://www.psych.org)

*AACP Events:*

Saturday, May 17

Board Meeting, 12 noon - 8 pm

Pan Pacific Hotel - Terrace Room

Sunday, May 18

Board Meeting, 8 am - 4:30 pm

Pan Pacific Hotel - Terrace Room

Sunday, May 18

Membership Forum, 6:30 pm - 8 pm, Olympic Ballroom

Sunday, May 18

Membership Reception, 8 pm - 10 pm, Olympic Ballroom

*June 28-July 1, 2003*

**National Alliance for the Mentally Ill (NAMI)**, 2003 Annual Convention, *Partnerships for Recovery: Confronting the Mental Health Crisis in Our Communities*, Minneapolis, MN. [www.nami.org](http://www.nami.org)

*October 29 - November 2, 2003*

**55th Institute on Psychiatric Services**, *Access to Integrated Mental Health Services*, Boston, MA. [www.psych.org](http://www.psych.org)

*May 1-6, 2004*

**APA Annual Meeting**, Javits Center, New York, NY. [www.psych.org](http://www.psych.org).

## **Board of Directors' Report**

The AACP Winter Board Meeting was held February 7-8, 2003 in Charlottesville, Virginia in conjunction with a statewide meeting of community mental health and primary care providers. Dr. Anita Everett organized a fabulous conference, Board meeting and introduction to historic Charlottesville.

### **Announcements**

Dr. Steven Karp announced that the National Executive Training Institute has prepared manuals detailing training and resources for reducing use of seclusion and restraint. These will be web-accessible. Dr. Karp will notify members by e-mail of details.

### **Treasurer's Report**

Dr. McQuiston circulated the budget report. He highlighted concerns about decreasing net worth over the last 12 months due to a combination of increased expenses and decreased income. Projected loss could be as high as \$25,000 by June, 2003. Specific sources of variance included a drop in dues income (possibly an artificial drop as the income 'bubble' from the initiation of multi-year memberships now contracts), a significant drop in corporate donations, a drop in LOCUS revenues, and increased expenses for the Journal and the website.

The Board analyzed and discussed a variety of short and long term solutions to address potential shortfalls. The shift away from dependence on corporate donations was applauded. Proposals were made to substitute other types of donations, including donations from Board members such as voluntary self pay of meeting and travel expenses. Dr. Sowers reported there are two major sales pending for LOCUS.

In order to address the impending deficit the Board took several actions including: 1) Dr. Sowers will invite Rick Seeger of Deerfield to attend a portion of the board meeting in San Francisco to discuss projected LOCUS income and to clarify several issues related to income sharing between AACP and AACAP; 2) The Finance Committee will meet electronically to develop short term contingency plans for dealing with the \$25,000 short fall anticipated this spring; 3) A special financial workgroup including Drs. Cruz, Sowers, McQuiston, Pumariega, Ng and Faison, was appointed to plot long range strategies to diversify our funding base. A long term plan will be developed and presented at the May 2003 Meeting

### **Guests**

*Mike Hogan, PhD, Ohio Commissioner of Mental Health and Chair of New Freedom Committee*, attended the Board Meeting to provide an update on the President's New Freedom Commission. The Commission is expected to publish its report in April 2003. He stated that the report represents an "opportunity to build on what has been done already, and to provide a stepping stone for the future". Two issues that will be emphasized in the opening paragraphs of the Report are 1) the concept of recovery; and 2) that cultural competence is inextricable from quality. He added that time and space considerations will limit the detail and depth of the main report. Forty to fifty sub-committee reports will expand on issues that cannot appear in the main report, and may be the source of the Report's lasting impact. Dr. Hogan entertained discussion with Board members and addressed issues such as the Commission's attention to children's services, prevention services, cultural competence, and relationship to the Surgeon General's report. He states that the Commission was directed to 'first look at things that don't cost'. Its report will therefore emphasize 'small things that add up to a lot', eg. inequities in Medicare. Dr. Pollack presented to Dr Hogan the AACP position statement to the Commission. Dr. Pollack observed that AACP's work has already influenced Commission sub-committees. Dr. Hogan also suggested that AACP perhaps has its greatest influence at the State level and that AACP documents should be used as appropriate with State legislatures.

*Charlie Curie, Director of SAMHSA and Mark Webber, Director of Communications for SAMHSA* joined the AACP Board. Dr. Feldman asked Mr. Currie if there were ways in which the AACP could be helpful to his agency or mental health issues at large. Mr. Currie commented that the AACP represents psychiatry and recovery in a way that is not represented in any other organization. He felt that AACP can particularly help by articulating concepts of recovery and resilience. He emphasized the importance of outcomes as a way to help educate the public at large and to challenge us to put our resources where we can see outcomes in people's lives. This is an extremely important leadership role for the federal government, and one that SAMHSA embraces. It is now using a Matrix format to develop partnerships around priority and program agendas.

He addressed the general concern about continued funding reporting that SAMHSA has received a 6% increase in budget for the coming year. Most of this increase is for substance abuse programs (\$200M). Children's Systems of Care will receive \$10M of the increase. In response to the issue of mental health /primary care interface he acknowledged lack of coordination between HRSA and SAMHSA on plans to improve mental health capacity in primary care, but hopes to see this change. In addressing the problem of implementation of research Mr. Currie responded that SAMHSA's "Science to Service" agenda should help set the implementation agenda in partnership with CMHS. He envisions SAMHSA's role as evaluation rather than research. He added that SAMHSA is developing an improved partnership with NIH.

## **Liaison Reports**

*APA/IPS Task Force:* AACP representatives met with APA representatives to discuss the IPS Program. The AACP has been allowed to be the controlling force with the Program Committee which is made up of all AACP members. Almost 30% of IPS attendees are AACP members. At this time a meeting for 2006 is being planned. Dr. Goldfinger noted that the IPS has to be profitable in order to survive, and this past year was the first year in several years to be profitable. The fee schedule has been reviewed and the APA is working to keep the higher fees for physicians but lower fees for other disciplines and public sector employees to the lowest possible fee. The Board voted that Dr. Feldman will contact leaders of related professional organizations to discuss their interest in participating in a reformatted IPS.

*AACAP/CALOCUS:* There have been two conference calls since the IPS Meeting regarding CALOCUS. Agreement between the AACP and AACAP has been achieved. Dr. Huffine noted that both organizations have some autonomy in handling the instrument. Rick Seeger from Deerfield and Kristen Kroger from AACAP are working together on marketing issues. The Board recommended that the LOCUS/CALOCUS committee work on a memorandum of understanding.

*NAMI:* Drs. Goldfinger and Forster will attend the NAMI meeting in Minneapolis in June.

*NASMHPD:* The state medical directors who attended the AACP May meeting have continued to work with the AACP in a collaborative way. NASMHPD Medical Directors are developing a collaborative survey of State Medical Director positions. Another current focus of the Medical Directors Council is developing training for restraint and seclusion. The medical directors will be invited to attend the Board meeting at the APA.

*National Council of Community Behavioral Health:* Executive Director Charley Ray was disappointed that the AACP newsletter is no longer able to be sent to all their members. Dr. Feldman and Pollack will meet with Mr. Ray to discuss other ways to continue collaboration between the two organizations.

## **Old Business**

*Winter Meeting 2004:* A number of meeting sites were nominated including Hawaii, Pittsburgh, New Mexico, Charleston, Asheville, and Brooklyn. The Board voted that Dr. Forster will explore the possibility of a meeting in Hawaii. If Hawaii is not feasible for 2004, Drs. Thompson, and Cruz will begin preliminary planning to hold the meeting in Pittsburgh. Tennessee/North Carolina will serve as a back up for 2004, and will likely be in rotation for the 2006 meeting. Brooklyn will be a likely site for the 2005 meeting.

*Board Position for Early Career Psychiatrist:* Dr. Huffine does not yet have a nominee, though he has a list of possible people recommended by the Board. (Note: Subsequent to the February meeting the position was offered and accepted by Dr. Cynthia Major. *See article page 8*)

*Email voting procedure:* Dr. Moltz reviewed the Board's new email voting policy which was approved prior to the Winter Meeting. This allows the Board to act more quickly on pressing matters.

*Netiquette:* In response to recent heavy and passionate listserv dialogue on war related issues, Dr. Feldman asked the Board to review basic listserv netiquette and expectations regarding discussion of social issues. Some AACP members were bothered by war dialogue that was not directly related to community psychiatry. Some members removed themselves from the listserv. Concern was expressed that unbalanced political expression might drive away members with different political viewpoints who share an equally deep commitment to community psychiatry. Dr. Feldman agreed to send a message monthly that listserv postings are not the official position of the AACP. If problems persist, the mission of the organization should be published and members asked to keep the discussions in these areas.

*J-1 Visa:* This issue now appears resolved by the increase of Conrad program positions for physicians in underserved areas from 20 to 30 per state.

*Letter to APA Board of Trustees:* Dr. Feldman sent a letter to the APA Board of Trustees commending the work of the Assembly SPMI task force.

*Bazzetta v. McGinnis Amicus Brief vote:* Dr. Moltz reviewed this class action law suit affecting prisoners rights.. Dr. Moltz asked that AACP participate as *amicus curia*. The Board voted to sign on to the *amicus* brief.

*North Carolina Medical Director Position:* Following the removal of the Medical Director position from the North Carolina (NC) Division of Mental Health/Substance Abuse/Developmental Disability, the NC district branch successfully negotiated with the NC Commissioner to have the position re-established as 'Chief Clinical Officer'. The job description was rewritten to place greater emphasis on community based services. However the job has not yet been advertised, and there is concern that the position could still fall victim to NC's worsening financial state.

## **New Business**

*Amicus Curia-Grutter v. University of Michigan:* Dr. Lu, Chair of APA's Council on Minority Mental Health and Health Disparities, suggested that AACP submit an *amicus curia* brief supporting University of Michigan's diversity friendly admissions policy. The Board debated the relationship between this case and AACP's mission. Some wondered if this case dealing with universal social issues fit AACP's focus on community psychiatry. Dr. Lim argued that this case is highly relevant to our priority policy of improving minority access, since it threatens to 'throw away the pipeline' for developing minority psychiatrists. Dr. Cruz observed that research evidence clearly indicates that recruited minority health professionals subsequently work with minority populations. He advocated that it is especially important for AACP to take positions favoring affirmative action including research and cultural competence. The diversity committee subsequently suggested that AACP submit a letter to the Court, drafted by Dr. Cruz, supporting the University of Michigan's affirmative action policy. This letter will be presented to the Board electronically for formal approval by email vote.

*Complaint Investigation:* A concerned individual had identified AACP through its website and then wrote a letter suggesting that AACP investigate a practitioner in her area regarding ethical and practice standards. As a result of this unprecedented type of request, the Board discussed whether its mission includes directly responding to local complaints about programs or practitioner. The Board reached general consensus that this type of action was outside our domain, but that inquiries of this type should be referred to the MHA or NAMI.

*State Budget Cuts:* Dr. Pollack recommended that the Board respond to ubiquitous and drastic budget cuts by crafting a letter to The Mental Health Liaison Group (including the Bazelon Center, FFC, NASMHPD, NMHA, NAMI) asking about their involvement in this issue, offering AACP support, and emphasizing the long term costs of cutting money, such as increases in homelessness, drug abuse, etc. The Board agreed that Dr. Osher would draft a letter to the MHLG for Board review. Dr. Pollack will conduct a conference call with fellow members of APA's Council on Advocacy and Public Policy about crafting a similar statement from the APA.

## **Committee Reports**

*Child/Adolescent Committee (Huffine):* 1) The Committee would like to increase the presence of child psychiatrists on the AACP Board. 2) The Committee reported that AACAP will be working on statements regarding privatization of child services, practice standards for community child psychiatrists, and transition to adulthood service issues.

*Disaster Committee (Ng):* 1) Drs. Thompson and Ng are working on the report from the July 2002 CMHS sponsored meeting to develop a Community Psychiatry disaster response force. The report will provide information on short term support strategies, what is necessary for longer term disaster response, and network planning. 2) The Committee will try to improve communication with APA in this area. 3) Disaster Psychiatry Outreach has been very active with some District Branch's of the APA. The reports back from residents and attendees have been very positive about the programs. 4) AACP has been invited to join America Help Together (Chaired by Bill Bradley). Together with Robert Wood Johnson they are co-sponsoring a meeting in New York City on 'Mental Health and Privacy Concerns in a Time of Terrorism'. The Board approved writing a letter of participation and underwriting the cost for Dr. Weinberg to attend as representative of AACP.

*Diversity Committee (Lim):* 1) The Diversity Committee has submitted ten names to the membership committee for honorary membership. 2) A special issue of *Community Mental Health Journal* is planned on cultural diversity. 3) The diversity committee will develop and submit a position statement on cultural competence in psychiatry.

*Ethics Committee (Moltz):* Dr. Moltz presented a revised draft of the "Policy on Conflicts of Interest for Board Members" that modified the threshold for conflict of interest from \$5000 to \$500 in one company or \$2000 to companies in the same industry, and specified that once a year each Board member would declare

if there was a conflict of interest. After considerable discussion of whether conflicts could include work with non-profit organizations, the Board concluded that the concept of conflict would apply only to interests in profit seeking health related organizations. The Board voted to approve the document.

*International Committee (Thompson):* 1) Dr. Thompson reported that he will be attending a Carter Symposium on community mental health in the newly independent states of the Soviet Union. He hopes that this might lead to some AACP trips to that region. 2) Dr. Thompson hopes an international focus could be developed if the Winter Meeting is held in Hawaii

*LOCUS Committee (Sowers): (See New Business for Discussion of CALOCUS negotiations.)* 1) The Committee discussed the development of supplementary criteria for residential services in LOCUS. Further review is planned before changes are finalized. 2) The committee discussed the long-term revenue generating possibility of LOCUS/CALOCUS. Multiple states are interested in adopting LOCUS, but have not yet committed.

*Membership Committee (Primm):* Dr. Gibson reported that we have 600 current members. The recruitment of resident members was reviewed. The Committee recommended and the Board voted to offer a one-year free membership to residents without the journal. Subsequent years would be at the usual resident rate. This offer can be disseminated to training directors by AACP members of ADPRT. The committee proposes tracking effectiveness, with reevaluation of the policy in three years. The committee also proposes retrospective effectiveness evaluation of free memberships to BMS fellows, APIRE fellows, and honorary diversity memberships. The Committee had a request to review a retired membership category with a reduced fee. This issue was tabled for the May Meeting.

*Publications/Communications Committee (Thompson):* *Listserv:* has approximately 460 subscribers, and averages 58.6 messages/month. Regarding people who unsubscribe, Dr. Thompson observed it happens when there is a lot of activity on one issue. He will track the number of unsubscribers and compare that with the number of dropped AACP memberships. The social talk list serve has 32 subscribers. *Website:* is averaging 50,000 hits per month. The Board raised the question of seeking advertising revenue. Dr. Osher will check into the potential of advertising on our site. Dr. Thompson continues to work on arrangements to post an article from CMJ on the web for discussion. For those members who have books published, we could post a chapter on the site to encourage people to buy the book. *Newsletter:* now being posted more efficiently to the website. At this time we do not have enough people who only want it electronically to stop the print version. *Journal:* Dr. Cutler will check again about getting a link with Kluwer for posting articles to the website. There are two special issues coming out. The October 2003 issue will focus on the history of community psychiatry. Dr. Feldman will write the introduction. In 2004, there will be a special edition on diversity organized by the Diversity Committee. Dr. Cutler reports that while *CMJ* is doing increasingly well financially, there have been no changes in AACP's modest royalties. The Board authorized Dr. Cutler to re-negotiate royalties with Kluwer .

*Quality Management Committee (Sowers):* 1) Drs. Sowers noted that the third draft of the position paper on recovery oriented services was reviewed. There were some revisions to the seclusion and restraint section and some indicators were added. The document will be divided into administrative and clinical sections. The Committee is waiting for further edits on family oriented services, with a final draft expected by the May meeting. 2) Dr. Sowers addressed the related policy adopted by AACP of obtaining consumer input to our products. Consumer organizations need to be identified to review documents as they are developed. Dr. Sowers asked members to send the recovery oriented services draft to their contacts in consumer organizations and to ask them to review it and make recommendations. 3) The committee discussed future projects, including quality guidelines for service planning, psychiatric services, vocational planning, services for mental health and primary care, and disaster preparedness. He will be engaging other committee chairs to help develop quality indicators for emerging best practices statements.

*Training Committee (Haggerty):* 1) Dr. Gillig will be working on a position paper on training competencies for MR/DD populations. 2) The Committee will be re-working the guidelines for residency training in community psychiatry from a perspective of evidence based interventions for SPMI. 3) The Irwin

Foundation has been interested in a curriculum around the idea of recovery in training for residents. Dr. Thompson will work on this with the assistance of the Committee.

*Task Force on Long Term Financial Planning (Cruz):* Dr. Cruz outlined issues that this newly formed task force will be examining to ensure AACP's future financial viability. This will include 1) seeking contributions from organizations and individuals, 2) re-examining meeting costs, 3) member donation policies, 4) fund raising campaigns, and 5) speakers fees. The Task Force will present more detailed proposals at the May meeting.

*Workgroup on Consumer and Family Participation in AACP (Sowers):* (See Quality Management Committee Report)

## **Future Meeting**

The next Board meeting is scheduled for May 17-18, 2003, at the Pan Pacific Hotel in San Francisco, CA in conjunction with the annual APA meeting.

## **AACP WELCOMES**

### ***THESE NEW MEMBERS***

#### ***Area 1***

*Rene Mora*

*Saima Ahmad*

*Anne Bauer*

*Derri Shtasel*

#### ***Area 3***

*Jeremy Doniger*

*Spencer Kostinsky*

#### ***Area 4***

*Muhammad Munir*

*Surjeet Bagga*

#### ***Area 5***

*Harold Carmel*

*Cynthia McClure*

*Nimisha Gokaldas*

*Sara Montbomery*

***Area 6***

Joris Wiggers

Kira Williams

***Area 7***

Jackson Dempsy

**CYNTHIA MAJOR, MD. . . *New Early Career Psychiatrist Board Member***

Following the AACP Winter Board Meeting, the Nominating Committee, chaired by AACP Immediate Past President Dr. Charley Huffine appointed Dr. Cynthia Major to serve as the second Early Career Psychiatrist board member. Dr. Major will serve on the Board for two years. Her term will begin at the May meeting in San Francisco.

Dr. Major was born and raised in Nashville, TN and later went on to Howard University where she graduated *cum laude* with a B.S. in Psychology. She attended Meharry Medical College and graduated in the top five of her class. While pursuing her medical school training, she served on various community service committees. She pursued psychiatric training at the Johns Hopkins Psychiatric Residency Program and was Chief Resident during her final year. During her training, she received numerous awards including the Lange Medical Publication Award for Outstanding Achievement as a Medical Student, Dean's List at Meharry Medical College as well as Howard University, and The Raphael Hernandez, MD Award for Excellence in the Field of Psychiatry.

Since 1994 Dr. Major has served as a National Health Service Corps Scholar fulfilling her obligation in a health physician shortage area. She recently left the Regional Mid Shore Mental Health Services where she served on the psychiatric staff, in addition to providing services for the J. DeWeese Carter Center Pilot Project. At the J. DeWeese Carter Center, Dr. Major provides treatment for adolescents who are detained in the Detention Center with the hopes of showing the importance of treating juvenile offenders while detained to study the impact of treatment vs. no treatment. She recently began working at Unity Health Care in Washington, DC to complete her obligation. In this capacity, she focuses on healthcare for the homeless and indigent of Washington, DC. Dr. Major is also a consultant in the Department of Community Psychiatry at Johns Hopkins Hospital one day a week.

She has also done some work with Pfizer, Inc. in a pilot project called *Bridging the Gap* that focuses on the interrelationship between physical and mental health especially in underserved communities and populations. In addition, she participates in the Project for Depression Awareness in the community and school system and is a member of Delta Sigma Theta Sorority, Inc. She is a member of a number of organizations including the AACP, American Psychiatric Association, Maryland Black Psychiatric Association, Maryland Psychiatric Society, Alpha Omega Alpha Medical Honor Society, and the National Medical Association.

Dr. Major was asked to share some of her thoughts regarding reflections about her work experience, the status of community psychiatry, and her goals as the ECP board member:

*"I have had the fortunate experience to work in several CMHC's that are located in diverse areas, such as rural and urban settings. Both settings exhibit dysfunction but with different dynamics. In the rural setting, for example, there seem to be more dysfunctional families that stay together despite possible verbal, physical, and substance abuse. In contrast, the inner city usually has families that are broken with single mothers raising multiple children without a stable male role model around. In the rural setting, often the male role model is present, but there is often a lack of stability. Of course, this is not every situation and I don't want to generalize. It is amazing, however, to observe the different dynamics that occur with the patient presentation because of these factors.*

*There is much concern that I have regarding the current status of community psychiatry in several areas. Of most concern, there does not seem to be much enthusiasm in the newer generation of psychiatrists for entering community psychiatry. There needs to be more encouragement on behalf of residency training programs to make community psychiatry interesting enough for medical students and residents to want to pursue it.*

*Further, I think one of the biggest threats to the success of community psychiatry is patients' access to care not only for mental health, but also for physical health, labs, prescriptions, etc. Society has to recognize that health care must be made affordable to all individuals so that they can get the proper diagnosis and care. My hope is that by working on the board of AACP, I can be part of an organization that allows me to be an active voice for the underserved and working poor. Our critical work together will allow us to assist in the development of legislation that actually makes sense and to provide the best health care possible for our patients."*

### **Summer Opportunity for Medical Students**

Fun and exciting opportunity available for any medical student who has completed the first or second year. Virginia Commonwealth University School of Medicine in Richmond, Virginia will be hosting the 2nd Annual Summer Institute in Psychiatry for Medical Students from June 8-13, 2003. Each day is organized around a theme with seminars in the morning followed by clinical experiences in the afternoon. The topics for this year are:

1. *Psychoses*: Didactics on Schizophrenia, Psychosis in Medical/Surgical and Geriatric Populations and a chance to participate in a Virtual Psychosis Laboratory.

2. *Mood and Anxiety Disorders*: Didactics on Mood and Anxiety Disorders and Cognitive/Behavioral Therapy; clinical work with children, adolescents and adults with a Mood Disorder.
3. *Forensic Psychiatry*: Didactics on Competency to Stand Trial Evaluations and the Insanity Defense; tour and clinical work at a state forensic hospital.
4. *Youth Violence*: Didactics on the Development of Psychopaths and Dealing with Aggression in Youth and hands on experience in aggression management.
5. *Older and Newer Therapies*: Didactics on Acupuncture, Eye Movement Desensitization and Reprocessing, and Animal Assisted Therapy.

The Institute is free of charge to participants, including meals and housing. In addition to the above, there are plenty of opportunities for socializing. If you are interested you may get more information and an application by visiting the web site:  
[www.curriculum.som.vcu.edu/psychiatry/SummerInstitute](http://www.curriculum.som.vcu.edu/psychiatry/SummerInstitute).

*Now Available*

### **Road to Recovery**

AACP member Mark Ragins, MD completed booklet, "A Road to Recovery". Dr. Ragins has been writing and lecturing about recovery with severe mental illness for about a decade now. This booklet is a carefully edited compilation of his thoughts and best stories. A copy is available on The Village web site at [www.village-isa.org](http://www.village-isa.org). This copy can be downloaded for free. Additional printed copies can also be ordered at cost for \$5.00 each.

### **AACP MEMBERSHIP**

YES! I want to join in AACP's advocacy efforts to improve quality care for patients in community settings.

Name: \_\_\_\_\_

Title/Institutional Affiliation: \_\_\_\_\_

\_\_\_\_\_

Mailing Address: \_\_\_\_\_

\_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

email: \_\_\_\_\_

#### **DUES:**

General Member	(1 year membership)	\$100
	(2 year membership)	\$140

(3 year membership))	\$200		
(5 year membership)	\$300		
Liaison Member (non-psychiatrist)	\$100		
International Member (outsideUS, Canada, Mexico)	\$110		
Group Membership (5 or more) 1 journal+newsletter \$40 (per person)		Member-in-Training (resident)	\$40
Member-in-Training (without journal)	\$20		
Member-in-Training (first year of membership)	Free	Medical Student	Free

**Make check payable to AACP**

(Dues include subscriptions to the *Community Mental Health Journal* and to AACP's newsletter *Community Psychiatrist* )

Clip this coupon and send it with your check to:

AACP, PO Box 570218 Dallas, TX 75357-0218

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

**The AACP has the following purposes:**

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

**COMMUNITY PSYCHIATRIST**

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Dallas, TX 75357-0218

*Address Correction Requested*