Nominations for Board Members of the American Board of Adolescent Psychiatry

Any psychiatrist who is certified by ABAP or by ABPN in child and adolescent psychiatry is eligible to be nominated by ASAP for consideration for appointment to the Board of Directors of ABAP. All interested, qualified persons should send a copy of their curriculum vitae to Stephen Billick, 11 East 68 St., #1-B, New York, NY 10021

Council on Programs and Meetings Report

The fall business meeting will be held October 1, 2005 in Dallas, TX.
Plans are being made for the annual meeting to be held in Miami Beach in 2006. Dominic Ferro will be responsible for organizing the conference. Fabian Saleh will be Dr. Ferro's co-chair. We discussed many ideas for the meeting and we also recommend that the Executive Committee consider going back to our prior format when the Annual Meeting was held before APA's annual meeting. Dr. Saleh plans to conduct a survey of APA members to see if we can discover which are interested in adolescent psychiatry. Hopefully, we canencourage them join us. The Council recommends we look at the west coast for our 2007 meeting. Dr. Gilfoil will be resigning his position as chair of this Council.

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assess possible savings in our expenses. This will be specifically reviewed as part of the budget discussions at the October 2005 Governing Board meetings.

Bylaws: The new Bylaws were approved during the last year. With the new structure, some items, (e.g., specifying which officers need to be on specific Councils) may no longer be needed. Otherwise, there are only three items that need to be clarified.

The Nominating Committee for next year will be chaired by Robert Weinstock, MD, as the immediate past president.

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Dismounting by Gregory P. Barclay

There is a Dakota tribal saying: "When you discover you are riding a dead horse, the best strategy is to dismount" (O'Hanlon, 1999). Several years ago, I left the organizational practice of medical model psychiatry to start my own solo practice. The opportunity presented itself because of a downsizing undertaken by the multi-specialty medical clinic where I had worked. My position and eventually the clinic's entire mental health program were eliminated. I was 43 years of age, with teenagers at home, established community ties, an active caseload, and the distinguished title of "mid-career psychiatrist". Circumstances now required that I make changes and choices. I could relocate to another administrative or clinical organizational practice position, or stay in Ames and open a solo practice. It really meant choosing to continue doing the same thing somewhere else, or to stay here and do something different.

As a young psychiatrist starting off in a CMHC, I accepted the medication management role organizational practice required of me. Several years later, thinking private practice would be different, I joined a multi-specialty group practice. I soon learned that the economics and organizational forces in any multi-disciplinary program created the same expectations and patterns. As the years went by, I grew more uncomfortable and troubled in the split-treatment model of practice. Not only did I find it confining, but also I did not support the notion that unhappiness, attention difficulties, daytime sleepiness, and disruptive behavior problems were now presumably brain disorders requiring medication. I had trained in a 1980's residency program that stressed the biopsychosocial model and a thorough grounding in human development and psychotherapy. Therefore, I knew that many of these problems were learned and not the result of disordered neurochemistry.

I was further troubled that increasing numbers of my non-medical colleagues embraced the chemical imbalance explanation for almost all problems of living. Many were awestruck by the seeming legitimacy of a brain disorder diagnosis and believed their role was to provide nominal supportive measures while facilitating a referral for medication. Essentially, organizational practice required that I prescribe on demand and be comfortable limiting my scope of practice to neuropharmacology. These unwritten reciprocal referral patterns and expectations invariably contributed to the rapid increase in psychotropic medication use among adults and children.

When I opened my solo practice, my new philosophy was to conduct a practice more compatible with my beliefs and values that permitted me the freedom to utilize my entire range of skills in my clinical work. Although I still utilized medications to some degree, I immediately eliminated the 15-minute "med check". Instead, I phased in the 45-minute appointment. I explained to patients that I needed to spend sufficient time with them to reasonably understand their problems. I informed parents that in order to thoroughly evaluate their child or adolescent, I would need to conduct several individual interviews and possibly a school visit. Only then would I be willing to discuss medications with them. I educated patients that I could do more than simply prescribe drugs. I started seeing some patients twice a week, sometimes for 75-minute appointments if necessary.

In order to assure that I could offer these services, I took steps to carefully screen patients before agreeing to meet with them for a consultation. If a non-physician therapist in the area referred them, I clarified whether or not their expectation was medication prescription and management. This afforded me the opportunity to educate therapists about my practice philosophy of not limiting my clinical work to neuropharmacology. As a result, some of those referrals went elsewhere. However, new referrals came from physicians and school professionals familiar with my work. By spending more time with my patients, I was able to thoroughly understand their problems from a perspective not possible in organizational or collaborative practice. I re-trained myself to listen, clarify, confront, and interpret instead of reflexively reaching for the prescription pad whenever new problems or symptoms emerged.

Solo practice has been very liberating and meaningful in other ways. I now work 4 days per week and make a com-

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fortable living. Since I have always been interested in writing, I have begun work on a book and have completed essays and book reviews for several society newsletters. I also compose a newsletter for patients and referral sources every few months. School personnel have begun to invite me to the classroom to observe and teach them alternative, non-medical strategies for managing problem children. I am able to swim laps every day and my systolic blood pressure has dropped 30 points to where it was when I was in my 20's. While organizational medical model practice pays better, my work is so much more satisfying than my old practice that the pay cut is worth it.

I have also discovered that some of the promulgated myths are not true. For example, once nurse reviewers are educated about my practice philosophy, it has not been problematic to obtain authorization or payment for psychotherapy visits. They do not insist that I do "med checks" unless another therapist is involved, whereupon I ask the patient to make a choice if they aren't willing or able to pay the full fee with the insurance company's assent. I have been surprised to find out that many patients are willing to pay full fee and are grateful for the local service they receive in return. Contrary to what I had heard, I have yet to experience the publicized harassment and claim denials by managed care companies, and I am on all of the regional panels. Controlling overhead costs has been possible by staying out of the high rent district and limiting expensive outsourcing. In my instance, I hired a capable transcriptionist and then trained her to do insurance claim processing and all the other aspects of an office manager position.

Molly Ivins once said "The first rule of holes: When you are in one, stop digging" (O'Hanlon, 1999). Organized psychiatry, cheered on by our non-physician colleagues and the pharmaceutical industry, seems to be in a very deep one. Perhaps the recently publicized negative consequences of the widespread use of SSRI's in teenagers will lead to some necessary and overdue re-examination? One central issue is whether we should continue to encourage our non-physician colleagues to decide whether a patient should be medicated. We do this by accepting referrals for medication evaluation while simultaneously limiting our scope of practice to medication management. We perpetuate it by training residents to practice neuropharmacology while referring to non-physician colleagues for therapy. I now choose to do things quite a bit differently than in the first half of my career. Consequently, many patients tell me they had never met a psychiatrist who spent more than 10 minutes with them, knew anything about therapy, or who didn't immediately prescribe drugs. After listening and reflecting with them on their experiences, I respond by telling them I used to do my share of 10-minute med checks but lost my touch. We share a laugh and they assure me my approach works well for them or their child. I know it is better for me. Perhaps it might be so for others.

Reference: O'Hanlon, Bill H. Do One Thing Different (Morrow, 1999)

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About Our Members

Dr. Lois Flaherty was elected President-elect of the Group for The Advancement of Psychiatry of APA.

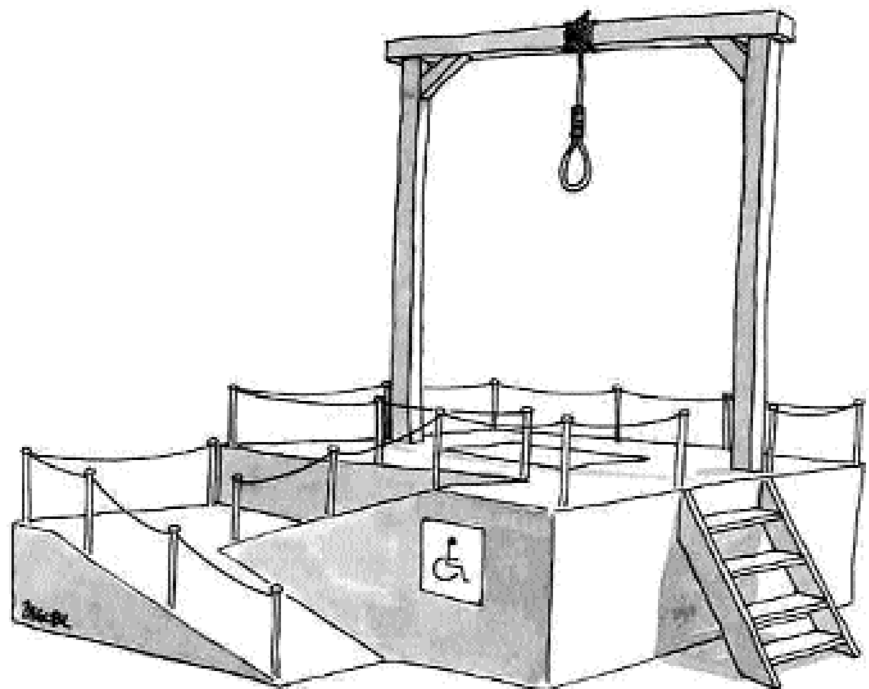
Dr. Sheldon Glass, a life fellow of ASAP, was elected president of Friends Research Institute, a non-profit that manages research grants for investigators in 22 states and overseas.

Dr. Steven L. Jaffe was appointed visiting professor at the University Of Hawaii.

Dr. Saleem A. Kahn was selected on of the top psychiatrists of America by the Consumer Research Institute of America. He also received the Lifetime Achievement Award given by the Pakistani American Society and was honored by his hospital, Rockford Center, Newark, DE, for excellent services to the community for 20 years.

Dr. Harvey Horowitz was elected a Distinguished Fellow of APA.

John Eichten co-authored a book: *Beneath the Mask: Understanding Adopted Adolescents.*



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MD, as the immediate past president. He and his committee will develop a slate of officers for next year. Anyone with suggestions for nominations should send them to Dr. Weinstock by September 1, The Membership Committee is working on two projects. As part of the recruitment program, Lois Flaherty, MD and Stephen Billick, MD, will be giving a presentation at the APA May meetings in Atlanta. The Committee will also be reviewing the names of ASAP members who may be eligible for election to Fellowship. The candidates will be notified, and will be voted on by the Governing Board at their October. meeting.

Haworth Press announces a new Journal of Dual Diagnosis. It will examine the latest research in the co-ocurrence of mental health disorders and substance abuse disorders. Case studies from intenational treatment programs, current trends in research. Also featured will be a webwatch on sites covering dual diagnosis, a journal watch will highlight publications and a funding watch providing information on current funding opportunities and resources.

IN OUR MAIL

Effects of and Interventions for Childhood trauma from Infancy through Adolescence by Sarah B. Hutchison
(from The publisher's blurb) explores an array of trauma related topics pertaining o children of all ages from a variety of cultures and countries. It covers the various ego stages of child development and addresses how each one is affected by traumatic experiences…with brief descriptions of treatments.

CLASSIFIED AND DROP-IN ADVERTISING AVAILABLE

Ads must be received at the ASAP office by the following deadlines: Spring issue — April 12; Summer issue — July 30; Fall issue — September 30. Copy should be typed and double-spaced.

For Classified ads, a check to cover the cost at $1.00 per word (minimum $25.00 per ad) must accompany the order. For an additional $12.50 an advertiser who does not desire to be publicly identified may use an ASAP "Box Number" and will be sent copies of resumes or other information sent to the box.

For drop-in ads, rates are as follows: Underwriting a complete issue, $1500. This entitles the advertiser to exclusive advertising rights in that issue, with two full pages of advertising. Full Page ad: $350; one-half page ad: $250; one-qurter page ad: $150.

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