

Response to the Presidential Address

Carolyn B. Robinowitz, M.D.

Mr. President; Mr. Speaker; members of the Board of Trustees and Assembly; distinguished guests; colleagues; family and friends. It is an honor to respond to our amazing, brilliant, and energetic President. This has been an exciting year as Dr. Ruiz led us by example in working toward his goal of "Addressing Patient Needs: Access, Parity, and Humane Care."

Querido Pedro, mi hermano
Recibes mi sincera agradecimiento por tu año fantástico que
Estuviste como Presidente
Gracias por todo lo que has hecho para nuestros pacientes y
Para nuestra profesión

I too would like to introduce my dear family: our son David, a clinician, scholar, and wonderful father; our beloved Chiara, an outstanding mother and intellectual; and my special loves, Helena, Andrea, and Alessandro, who have brought so much joy and who have been responsible for many miles on United. It is their future we want to effect. Our son Mark, who works constantly to save the environment and our world, cannot be here. And, of course, my supportive, generous, and loving husband Max, who has been the best of companions and an enthusiastic and vital partner in all my endeavors for nearly half a century.

For me, the honor continues as I prepare to assume the leadership of our wonderful organization. Most of my professional career has been devoted to psychiatric organizational life, primarily through two decades on the APA staff and my recent tenure as Secretary-Treasurer. As a clinician/educator, I have focused on promoting an infrastructure that supports scientists as well as educators and practitioners. As your President, I pledge to work to fulfill my vision of APA: a society that has available, accessible, and quality psychiatric diagnosis and treatment.

How do we continue to work to effect this vision and the marvelous goals President Ruiz has set? The answer is simple: advocacy—not just theoretically, but practically. We must be strong and effective advocates for our profession and for our patients. We as individual psychiatrists must partner with our professional Association to reach these goals. It will not happen without us!

Charles Dickens noted that "it was the best of times and the worst of times." We in psychiatry face a similar dichotomy of advances and challenges.

Let us begin with the positives.

Our field continues to grow immensely in both science and stature. Neuroscience provides an ever more intricate and complex understanding of both brain and mind function, from the molecular to genomic to behavioral levels. Sophisticated imaging techniques not only can localize functions but can demonstrate the impact of therapies, including psychotherapy and pharmacology. There is scientific recognition that physical health and mental health go hand in hand. We have a rich armamentarium of treatment possibilities that we can tailor to patients' needs. Good, careful scientific studies have confirmed the effectiveness of treatments, from pharmacological to psychotherapeutic, and verified that our outcomes compare favorably with those for illnesses such as cardiovascular disease and cancer.

Mental disorders are recognized as real illnesses. Epidemiological data confirm that some 35 million adults experience a moderate or serious mental disorder in any given year. The U.S. President's New Freedom Commission on Mental Health reported that mental illnesses constitute the leading cause of disability in the United States and other industrialized countries. Health services research has demonstrated the cost-effectiveness of treatment as related to health care expenditures and to workplace productivity. The Centers for Disease Control and Prevention noted in its initiative "Healthy People 2010" that a majority of public health concerns are dependent on behavioral issues, and the World Health Organization has recognized the impact of mental disorders on overall disability. Economic studies have estimated that the annual cost of mental disorders to the U.S. economy is \$204 billion, and other studies have shown that adding mental health/illness care to existing insurance coverage does not result in the dire expenditures predicted by naysayers, but rather less than a 1% premium increase—pennies to do the right thing. All of these provide documentation from sources outside our field of the importance and impact of mental illness for our country and for individuals and families.

We have developed strong partnerships with advocacy groups such as the National Alliance on Mental Illness, Mental Health America, the Depression and Bipolar Support Alliance, and other smaller disease- or population-oriented groups by utilizing the experience of organizations such as the American Cancer Society, which united professionals, patients, families, and the public in advocating research and care by recognizing that everyone was at risk for malignancy or heart disease. These collaborations have had mutual benefit, enhancing our strength and credibility in promoting greater research funding and adequate care. Working together has made this a patient

issue—not just self-serving guilds promoting their pocket-books—and policy makers have responded accordingly.

Psychiatry also has benefited from the disclosures of celebrities such as Tipper Gore, Art Buchwald, and Brooke Shields. Their openness has helped to diminish the stigma of mental illness and to promote valuable conversations, as almost everyone knows someone with a mental health issue. This process in part mirrors the change in attitudes toward cancer from the early 1960s, when a cancer diagnosis or treatment was hidden and secret, to recent public awareness and information campaigns, such as Katie Couric showing it all on national television to promote preventive intervention.

What has made this possible? Not only are the diseases and the people who suffer from them real and tangible, but there are more effective means to intervene. Cancer is highly treatable and can be cured. We are experiencing similar success in psychiatry, although there is still quite a way to go.

Yet there are many challenges and negatives; for example, access to care is limited. Almost 45 million Americans have no health insurance and another 25 million are severely underinsured by virtue of discriminatory coverage for the treatment of mental illness. Coverage, when it exists, tends to favor interventions such as medications, limiting the possibilities of care.

Far too many psychiatric patients are in our jails and prisons, incarcerated by virtue of their illness. States are having difficulty funding community services and especially meeting the needs of those on Medicaid. In May 2007 *The American Journal of Psychiatry* published a report from the American Psychiatric Institute for Research and Education (APIRE) documenting the negative impact of Medicare D on those most vulnerable in our psychiatric population.

The fragility of the system is especially demonstrated during catastrophes, such as Hurricane Katrina, from which New Orleans has still not recovered the mental health services needed. Another flood is the returning casualties from service in Iraq and Afghanistan. Both the military and the U.S. Department of Veterans Affairs are overwhelmed by the number of service men and women suffering from depression, traumatic brain injury, and posttraumatic stress disorder (and related substance use) and must deal not only with limited resources but with a culture that discourages seeking mental care and that often excludes treatment for substance abuse.

Violence remains a challenge. We are limited in predicting it, especially when there is no previous indications. Fear-driven responses and overreactions reawaken partially resolved stereotypes about persons with mental illness without necessarily supporting the services that could provide their needed care.

Risk aversion can lead to unanticipated negative consequences, as we saw after the Food and Drug Administration's black box warnings on selective serotonin reuptake

inhibitors (SSRIs) in 2004. Not only were there fewer prescriptions for antidepressants, but we saw an increase in suicide rates (not just suicidality, but death), reversing a decade of decline. Ironically, states are not risk averse enough and are putting patients at risk by awarding prescribing privileges as if they were rights or rewards to those insufficiently educated in the appropriate use of medication.

The negative impact of managed care continues. Short-term savings lead to long-term costs and patient distress. And once again, insufficiently trained people are practicing medicine by fiat, with decisions based on finances and not patients' needs. Actually, the term should be managed cost. True managed care would determine what is in the patient's best interest, but like communism (to each according to their need, from each according to their ability), this exists only in theory; once translated into reality, it is about control and not the greater good.

And groups such as Scientologists, fueled by funds from the entertainment industry, attack our science, gaining public prominence and even credibility by virtue of their celebrity visibility. While they are entitled to their beliefs, they are not entitled to replace science with those beliefs.

Sadly, we contribute to the problem. How often and how loudly do we speak, and do we speak effectively with one voice? We are too often silent. The good news clearly stated by Dr. Jack McIntyre in his sesquicentennial address—that we can effectively diagnose, that treatment works, and that it is affordable—sometimes resembles a well-kept secret.

We as psychiatrists are the only profession that can integrate the needs of patients into our systems of care. We are the only people who can provide access to care, assess the care, and ensure its quality. We are the only professionals trained in both the biological *and* psychological workings of the brain, mind, and body. Thus we have an intellectual as well as a moral responsibility to commit to our core professional values and protect our patients, without being paternalistic or maternalistic.

How do we do this? I know well from my years in solo practice that we need to utilize our Association. Its role is to help us so we can help our patients. But APA, even with the greatest staff and resources, needs our strength and contributions to succeed. We must contribute work, wealth, and wisdom.

We must **be** members. Not all members share the same priorities. There are differences in our area of responsibility or clinical expertise, in our subspecialty focus, and even in our governance, and pursuing these differences consumes energy, lowers morale, and impedes function. Dissatisfaction with outcome (neither we nor any other medical organization has been successful in stopping the abuses of managed care), internal disagreements, or focusing too much on subspecialty interests (priorities may be more easily set, but the small organizations look to the strength of APA to represent them) can lead members to

leave, in spite of a decade-long freeze on dues. APA still continues its work helping nonmembers, as well as those who pay. Are there free lunches? Should not all the beneficiaries of APA's efforts contribute?

Wealth may be as simple as paying dues, or it may represent greater expenditures, such as contributing to the public information campaigns of the American Psychiatric Foundation or to the research efforts of the National Alliance for Research on Schizophrenia and Depression (NARSAD), where 100% of all contributions are used for research, or by promoting specific APA activities, such as support for colleagues devastated by Hurricane Katrina.

We all have wisdom through our extensive training and experience. Consequently, we are resources to policy makers and the media, as well as the public. Learning to work with the various media outlets (print, radio, television, and Internet) in how to get our message heard is a skill that can be taught by our dedicated staff in the Office of Communications and Public Affairs (who will come to your local society) and that can improve with practice.

We can meet with our federal legislators at home as well as in Washington, D.C. We can contribute to political action committees and campaigns, knowing that we need to approach legislators on their terms. Gaining access to legislators allows us to educate and inform them on issues that no other organization will address. In turn, they value our input, respect our professional expertise, and see us as community opinion leaders who vote. These interactions must be seen in their long-term context, and we must aim for a win-win situation while remembering that we cannot get everything, compromise is better than loss, and we can always live to fight again. We should remember Tip O'Neill's statement that "all politics are local" and work with our state as well as national legislators.

What should our legislative priorities be? I use the mnemonic PPASSS to address Parity, Privacy and confidentiality, (nondiscriminatory) Access, Stigma and its removal, Science and research, and Scope of practice.

I hope you are informed about these areas and the importance of current parity legislation in both houses of Congress. Neither is perfect, but perfect is the enemy of good. The coalitions that have prepared this legislation demonstrate the best of advocacy in action (for more information on advocacy, please visit the APA web site at www.psych.org).

Support for science ensures that advances persist and that our tools for diagnosis and treatment continue to improve. With the decrease in federal funding, we need to turn to public-private partnerships with foundations and industry, recognizing that "he who pays the piper calls the tune." Industry-funded research must be free of industry interference and be open and transparent. Such transparency will help mitigate the trend toward "witch hunts." Pharmaceutical industry-generated advances have helped and will continue to help our patients and our field.

In working with the business community, which plays a role in access and reimbursement, we need to recognize that their operant phrase is, "What's in it for me (or my values, or my company)?" Many in the business community are aware of the impact of mental disorders on the workforce, including absenteeism, presenteeism, and productivity loss, as well as the affordability of mental health coverage. Business representatives have signed on to Senate parity legislation, but local hesitation and/or discrimination, based on stereotypes and misinformation, continues.

Clergy of all faith are an important resource. Not only can their statements and sermons address the misconceptions about the causes of and approaches to mental illness, but they are frequently the first line of approach to potential patients and their family members.

What must APA do?

As professionals, we must ensure that new scientific knowledge becomes translated into clinical-based care, avoiding the reductionism that is divisive to our profession and to patient care. No one size fits all; treatment decisions must be made using the best knowledge available and be informed by ethics and professional values, while recalling that our constituencies are patients, psychiatrists, and our profession.

As an organization, we aim for teamwork, members and staff who can create and communicate our vision, broad-based involvement and empowerment, and delegated management (not micromanagement).

We anticipate an adaptive culture that is nonbureaucratic, candid, risk tolerant, open to input and participation, flexible in nurturing potential leaders, capable of setting priorities based on data, and emphasizes **communication**. We recognize there are many things we could or even should do, but resources are limited and we must prioritize, focusing on those things that only APA can do.

This year I will work to expand our interactions by strengthening linkages with our own subspecialty organizations and especially with other physicians. We will continue our wonderful relationships with patient advocacy groups and work appropriately with our colleagues in other mental health disciplines. We will work with legislators, other policy makers, the business community, the clergy, schools, and, of course, the media. Of great importance is communication with our members, who are not always aware of what APA is doing for them and of what they can do for their profession and their patients.

Finally, I call on you to show us your involvement in advocacy and to pledge to future efforts.

I ask all of you to join me in a commitment to advocacy, to working with colleagues in medicine, policy makers and advocacy groups, the media, the business community, the clergy, and the general public to educate, inform, and ensure that our patients no longer face discrimination and have access to appropriate care. Share your energy and expertise to promote our professional values. I ask each of

you to make that commitment to work actively in your professional life. Thank you.

I anticipate much wonderful communication on behalf of advocacy for our patients and our profession and look forward to our work together. Please plan to walk with me next year, May 4, 2008, in Washington, D.C., with our NAMI colleagues as we go to Capitol Hill to demonstrate “Our Voice in Action: Advancing Science, Care, and Our Profession.”

Presented at the 160th annual meeting of the American Psychiatric Association, San Diego, May 19–24, 2007. Dr. Robinowitz, 134th President of the American Psychiatric Association, is a former Dean of the Georgetown University School of Medicine and currently is in private practice of adult, child, and adolescent psychiatry. Address correspondence and reprint requests to Dr. Robinowitz, 5225 Connecticut Avenue, N.W., Washington, DC 20015; carolynrobinowitz@usa.net (e-mail).
