Response to the Presidential Address

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It is an honor and privilege to stand before you as your President-Elect. I am grateful for this opportunity and humbled by your confidence in me and the challenges ahead. Alan, your leadership continues to inspire me. It has been great fun to work with you and to benefit from your vision and expertise. I will certainly rely on your wisdom in the year ahead as we continue to strengthen our pride in our profession and our Association.

No event is complete without the chance to thank those who have helped make it possible. First and foremost, my husband Arthur Meyerson, a renowned psychiatrist who has taught me much about leadership and who has made it possible for me to have a rich career while still providing his love and support. And of course, my daughter Samantha, who came to her first APA meeting at the tender age of 6 weeks. She plans on a career in veterinary medicine not psychiatry, but I trust her presence with me at most of my APA events has convinced the next generation that a work-life balance really is possible. I also want to thank my father, Stanley, who had wanted to be here to celebrate with me but who could not. He never quite got over the fact that I chose psychiatry over cardiology. (Don't worry, I cured him of his biases.) But he has always been proud that I chose to follow in his footsteps as a physician. My brother Michael, sister-in-law Patti, and my niece Ele are in the audience as well. New Orleans has been their home for the past 3 years, and they are living proof that this wonderful city will rise again in spite of Katrina and oil spills.

I also must thank the women leaders who came before me, especially "the Carols," for their mentorship and guidance. I recently read a book entitled *Closing the Leadership Gap: Why Women Can and Must Help Run the World*. These women certainly have, and sometimes I think I wouldn't be standing here if my name weren't Carol!

My theme is "transforming mental health through leadership, discovery, and collaboration." American psychiatry is at a pivotal point as we enter the second decade of the 21st century. With the passage of a healthcare reform bill and parity legislation, we are positioned to help assure that our patients are fully integrated into the house of medicine.

The culture of discrimination against the mentally ill is continuing to change, although there is no question that this will continue to take a great deal of hard work and vigilance. Stigma has always been a powerful enemy in our fight to ensure access and treatment for our patients. As psychiatrists, we have been stigmatized by our medical colleagues, just as our patients have been stigmatized in the world at large. How many of you were told that you were "too smart" or "too normal" to be a psychiatrist? How many of you were advised by your medical school deans to go into surgery, medicine, or orthopedics rather than psychiatry?

As psychiatrists, we know how hard it is to change beliefs, especially when they are motivated by fear and mistrust, so we must use law and government to help us prevent discrimination against those with mental illness, just as the Civil Rights Movement did for the African American community 50 years ago. We have been and must continue to be leaders in educating our policy makers. Without these efforts, parity will not become a reality.

As you all know, the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 was passed in the fall of 2008. The law is not perfect.

Many fear that since parity is only required if mental health and substance abuse services are offered in an insurance plan, insurance companies will no longer offer coverage. There is also concern that if reporting requirements are too onerous, psychiatrists and other mental health professionals will not participate in these plans. Still others are concerned about the lawsuits that have been filed by managed care companies opposing implementation of parity on regulatory grounds. Nevertheless, I cannot begin to describe the unprecedented consequence of the parity law, coming as it does with the initiation of real healthcare reform for the first time in this country's history. Because of the parity law, insurance programs must manage mental illness and substance abuse disorders the same way that other medical disorders are managed. No discriminatory lifetime limits, no higher copays, no pre-existing conditions. This is a real way to ensure equal access to treatment even if we have not fully eradicated stigma. Our psychiatric leadership is essential to this process.

The first part of my theme is about leadership. I have devoted my career to the education and

training of the next generation of psychiatrists. I am committed to assuring that both the profession and the APA continue to nurture the next generation of clinical and scientific leaders. Why is this particularly significant now? From a sociological perspective, for the first time, there are four generations in the workplace in the United States: the World War II generation (aka the veterans/geezers/radio babies), born between 1925 and 1945; the baby boomers, born between 1946 and 1964; the gen Xers, born between 1964 and 1982; and finally, the millennials, almost as large in number as the boomers, born between 1982 and 2000. Generation Z, born after 2001, is as yet nameless. The Generation Xers and the millennials are our field's future leaders, educators, researchers, and clinicians. The communication and technological changes they have witnessed and are part of will radically alter the way in which they live their lives. They are the most racially and ethnically diverse in our nation's history.

The oldest millennials are approaching age 30; the youngest, like my daughter, are approaching adolescence. Ninety percent say they are close to their parents; 78% believe spirituality is important, but they are the least religious in our nation's history. They have suffered from nature deficit disorder and kiddie migraines. They have been raised by "helicopter parents" and have been overparented, overindulged, and overprotected. But, they are digital natives and have been using computers since prekindergarten. They are e-learners and are frequently "in a state of continuous partial attention." They are accustomed to giving feedback and getting feedback, to instant communication, and to speed. They are optimistic and oriented toward collective action. They value volunteerism—very evident in New Orleans. There are more than 700 chapters of Habitat for Humanity in American high schools.

Generation X is moving into its peak family raising years, and previous census data show an increase in stay-at-home Gen X moms. Many are looking for a less "frazzled" lifestyle. Most of them have no intention of having one job throughout their lives. Their view of authority is based on competence, not how many years someone has worked, and most of all, they believe that we have gotten it all wrong about work-life balance. In the world in which they grew up, the Kennedy tragedy was a plane crash, not an assassination; a "45" is a gun, not a record with a large hole in the center. They have probably never lost anything in shag carpeting, and M*A*S*H and The Muppet Show have always been in reruns. There have always been automated teller machines, and bottle caps have always been screw-off. They have never watched a black and white TV or used a bottle of white-out except to paint with, and "google" has always been a verb.

Why am I telling you all of this? Because fundamentally, wishing people were more like you is not a strategy. We must build communities and build bridges across our generations. We must redefine important concepts such as work-life balance and view this not as either/or but as a dynamic interplay that redefines who we are and what we do.

I have been holding a series of town hall meetings with our members-in-training and early career psychiatrists. The most recent of which was held just last night here in New Orleans. These gatherings have been enormously helpful to me in beginning to understand some of the vital issues that are of concern to our younger colleagues. We must look to them to help us figure out how to redefine and reconfigure our Association so that it can be the most effective and efficient as possible in confronting the issues which we and our patients face.

The second part of my theme is about discovery. Through scientific discoveries, research, excellence, and quality outcomes are revolutionizing medical care. The patient safety movement has transformed the way many of our hospitals operate. Standardization and quality metrics will be the benchmarks of the practice patterns of the future. We will be held accountable both individually and collectively for the care our patients receive and their ability to contribute to society while living with chronic illnesses. This is a challenge for those of us who grew up when the practice of medicine was focused on the individual physician. We must work hard to preserve the significance and uniqueness of the doctor-patient relationship at the same time that we embrace the long overdue call for evidence-based practice and measurable outcomes.

The DSM-5 is a major undertaking for our Association in advancing our research agenda and in helping us move toward integrating discovery with the clinical care of patients. First, a huge thank you to the dedicated researchers and clinicians from all over the world who are donating their time and energy to this critical process. Field trials will begin this summer across the country for which the APA has received more than 70 applications from the academic community. The DSM-5 draft criteria have already had more input from clinicians, patients, researchers, and the general public than any other document in our history. Draft criteria were posted on our public website for 60 days and received more than 8,500 comments on proposed diagnostic criteria. The website itself has received more than 700,000 unique visitors and more than 44 million

hits. Comments have come from all over the world and are now being reviewed by each of the work groups. In addition to academic research centers, DSM-5 field trials will include individual practitioners to assure that potential changes in diagnosis have both clinical relevance and practical utility. It has been an extraordinary opportunity for me to be part of this research and educational process. DSM-5 is slated for publication in 2013 and will be a "living document," one that can be modified in an ongoing way as research advances define the causes of psychiatric disorders and guide the way to new and more effective treatments.

The third part of my theme is about collaboration—collaboration across generations, collaboration with our patients, within all of medicine, and across the disciplines that provide treatment and services to our patients. Community mental health centers and programs, great events in the history of the treatment of the mentally ill, arose out of the deinstitutionalization effort of the 1950s and 1960s. While this provided a way to assure full treatment for patients who had been disenfranchised from the healthcare system, an unintended consequence has been the fragmentation of good medical care and continued discrimination.

In the United States, we have had separate funding streams for different types of healthcare: one stream for community health centers, another stream for community mental health centers, a third stream for the treatment of those suffering from substance abuse and other addictions, a fourth stream for the psychiatric treatment of children and adolescents, and yet another for those with intellectual and other developmental disabilities. It is past time for us to rejoin our colleagues in the rest of medicine. As we hear about the health home (formerly the medical home) and accountable care organizations, medicine is moving to integrated healthcare. This includes all medical specialties and mental health disciplines as well as nurse practitioners, physician's assistants, and other healthcare extenders. Psychiatry should be leading the way. For decades, we have utilized the team model in the treatment of our patients. We have understood the significance of disability not just diagnosis, the need to address social issues such as housing, vocational rehabilitation, and an approach called "recovery," which focuses on helping individuals with chronic illnesses to be valued members of our society. We are the "glue" for all of medicine. Without an appreciation of human behavior and the many factors that contribute to how people approach both health and illness, efforts to try to combat obesity, hypertension, diabetes, smoking, cancer—to say nothing of depression, anxiety, psychosis, and suicide—will all go for naught.

Recently, I visited the Riverdale Mental Health Association in New York, this extraordinary group of mental health professionals. Functioning collectively within their community over the past 50 years is a testament to the way in which our field can provide a treatment model for the healthcare of the future.

We must collaborate with our sister specialties and work alongside internists, pediatricians, and family practice physicians to provide psychiatric care to the general public and assure that our patients get the general medical care they need. The older generation must mentor, guide, and support our younger colleagues. Academic leadership must connect with psychiatrists in the community to translate science into clinical care and make sure that "bench to bedside" is a reality.

At a recent strategic planning meeting of APA elected and staff leadership, we talked about how the American Psychiatric Association represents a diversity of constituencies, some of which include those in solo private practice, academia, the military, rural areas, Afro Americans, Native Americans, GLBT psychiatrists, Asian and Hispanic Americans, and IMGs, the subspecialties of psychiatry, psychoanalysis, the public sector, men and women. Each of these identities brings a slightly different focus to our work in psychiatry. These categories also help define the patients whom we treat.

As an Association, we must focus on the issues that unite us, not the ones that divide us, while still valuing the diversity of background and experience. What are these important unifying issues? Education of the general public, of our legislators, and of our members; developing quality metrics and improved outcomes for patients; promoting and supporting discovery; DSM-5; studying and evaluating current psychiatric practice, and collaborating with those around us.

Many have asked me, Why should I join the APA? What can the APA do for me? I challenge all of you (to paraphrase a former president) to ask what you can and should be doing for your patients, your colleagues, your family, your friends, and your profession to help spread the word that psychiatric illnesses are treatable, just like other medical illnesses. You can help reduce stigma by talking to your neighbors and finding referrals for them. You can speak with your local congressmen and women, your state legislators, your local PTA, your church or synagogue, your book club, and your Facebook friends. One of the first talks I ever gave was to the PTA at one of the elementary schools in my hometown after I attended

a high school reunion and one of my classmates learned I was a psychiatrist.

The APA can provide you with materials to do this: slide sets on depression, on anxiety, on childhood disorders, on addiction; talking points for your legislators. You don't even have to ask. It's all on the Web. You can help in this process, and we must do this together.

My challenge to every one of you is to do your own small part in helping to ensure that those suffering from psychiatric disorders have access to the best possible psychiatric care, benefit from the most recent research and treatment strategies, and are able to live productive and useful lives as citizens. If each of us does a little bit, we can have a profound impact on our field. This isn't just about my leadership. It is about our leadership for our profession, for our patients, and for the general public. We can and we will make a difference.

Thank you.

Presented at the 163rd Annual Meeting of the American Psychiatric Association, New Orleans, May 22–26, 2010. Dr. Bernstein, 137th President of the American Psychiatric Association, is Associate Professor of Psychiatry, Vice Chair for Education, and Associate Dean for Graduate Medical Education at New York University School of Medicine. Address correspondence and reprint requests to Dr. Bernstein, Department of Psychiatry, New York University, 550 First Avenue, MSB 153, New York, N.Y. 10016; carol.bernstein@nyumc.org (e-mail).