This is my first column as AACP board president. I certainly have big shoes to fill, following Anita Everett who, as I’m sure you all know, will go on from president of our little organization directly to the presidency of the APA. (I can assure you, the footsteps of hers I plan to follow will stop with the AACP). It is a pleasure and an honor for me to serve in the role of president of this organization, which has been my professional “home group” for the past fifteen years or so. And for me at least, it is really important to have such a group, to know who “my people” are, and to be able connect with them, both personally and professionally. I have found that through the AACP.

We do difficult and complicated work. I’m not complaining; its good work much of the time, and relative to most jobs, we are incredibly privileged. But it can be pretty tough at times. I ran into a colleague in my department late on a Monday about a month ago. “How’s it going?” I innocently asked. “I had one of those days,” she replied with more candor than I had anticipated. “I had one of those days,” she replied with more candor than I had anticipated. She is an Assertive Community Treatment team doc (at least that’s one of her hats), and she went on to explain that she had just come from a home visit of a person she’s worked with for many years now. Lately, each time she goes, she fears she will find him dead in his apartment. She’s found him “down” several times over the past year or two, including that day, and she worries that he needs more supervision than her ACT team can provide. But he is fiercely independent. He has made it crystal clear to her and anyone who listens that his choice is to remain independent, even if it means dying prematurely. She tells me that she was more OK with this until a few months ago when she actually did find one of her patients dead at home. These days she feels the impulse to visit him with another team member, but she knows it is not the best use of limited resources, so she usually goes along. That day, she was able to arouse him, after which he sheepishly admitted that he may have drank or smoked too much. He then characteristically minimized the whole incident and wouldn’t think about coming to the hospital to get checked out. “I’ll be fine…thanks.” She was shaken. At what point does she call in her outpatient commitment and have the sheriffs bring him to the hospital against his will? At what point does she tell him they can’t in good conscience work with him anymore, knowing full well that probably no one else would?

I cannot remember all the other things that she told me happened that day. I think one may have involved a troubled resident that, in her role as associate residency director, she has to find the balance between assuring good patient care and supporting trainees. Another may have involved a technical assistance conference call with a well-meaning but fairly clueless bureaucrat who is trying to understand what she is supposed to be doing with a SAMSHA planning grant they just received, but doesn’t even know what she doesn’t know. Etc., etc., etc. Just one of those days.

Both she and I are lucky to have the peer support that comes with being a part of an academic department of psychiatry. But her office neighbor on one side spent the day in his lab with his post-docs working on their new knock-out mouse model, while the neighbor on the other side was busy negotiating a pharmaceutical contract to see if the latest SNRI can help with compulsive shopping. Psychiatrists do all kinds of things, and as I look around at faculty meetings, the number of people who actually understand what I do – what I care about and what I see as my job – is often more limited than outsiders might expect. Not so when I sit in the AACP membership forum, or at board meetings, or as I read the exchanges on our listserv. As community psychiatrists, we work in many

Continued on Page 2
different settings and do a wide variety of activities. We seem to do so with a common spirit and a shared set of core values, and maybe that’s what makes it feel like a more meaningful peer group.

I feel frustrated that there are many psychiatrists out there who could really use such a peer group but don’t know where to look. The membership of the AACP represents less than one percent of currently active psychiatrists in the United States. It appears that the large majority of people I would consider community psychiatrists don’t identify as such, and may not even know what the term community psychiatry means. Community psychiatry has seemed like something of a fringe group within mainstream psychiatry, however, I sense this is changing before our eyes. I would suggest that Anita’s path from the AACP to APA may be emblematic of this change. While it is certainly the case that community psychiatry was relegated to the fringes of mainstream psychiatry throughout much of the 80’s, 90’s and into the 2000’s, its status seems very different over the past five to ten years. It no longer feels like we are the radical contingent grabbing at the lapels of leadership in a desperate effort to get their attention focused on what we think is important.

Rather, there is a growing consensus that the issues community psychiatrists have prioritized for years are the priorities of the day and very much within the mainstream of psychiatry. It is heartening to see that Tom Insel, the most recent director of the NIMH, published an editorial about the RAISE study this month’s American Journal of Psychiatry, correcting the media’s simplistic view of psychiatric treatment. When the major results of the RAISE (Recovery After an Initial Schizophrenia Episode) study were published last year, it got some attention in the lay press – indeed, it was the “most e-mailed” article in the New York Times for a few days. Not surprisingly, they got the punch line wrong. They thought the news was something like “New evidence that psychotherapy is effective for early schizophrenia…” Such reductionist thinking is to be expected in the lay press, but we as a field must take some responsibility for contributing to this thinking. If medications aren’t the only answer, what is left? Psychotherapy, right? After all, that’s what psychiatrists do, right? They give meds and maybe psychotherapy? And that’s what people with serious mental illnesses need, right? Medications and maybe some psychotherapy: that’s what we mean by treatment of mental illness, right?

Those of us who call ourselves community psychiatrists know deep in our bones that there is much more to the treatment of serious mental illness than medications and maybe a little psychotherapy. Treatment involves helping people find ways to make their lives optimally meaningful, gratifying and productive in ways that they choose. We know that this outcome usually involves a lot of effort to elicit and evoke from them what such a life might actually look like, especially as so many of our patients have been acculturated to accept that their identity is that of a psychiatric patient – and that their job is to sit at home, watch TV, drink Mountain Dew, take their meds, and show up for their 15 minute appointments every 3 months. We know we must strategize with them about steps to take to get there, identifying and bringing together their natural and professional supports into a functional network. We recognize that physical health is a core part of mental health, not just as a nice soundbyte, but as a clinical priority. And we recognize that making and maintaining an interpersonal connection is the vehicle that drives all of this work.

We also recognize that our patients are part of a variety of systems and communities (whether they choose to be or not) including family and friends, neighborhood, financial, legal, housing, vocational, as well as on-line networks among others, all of which may impact their capacity to thrive. Even if we are not be able to do much to change these systems, we know that understanding them is key, and treating people as if in a vacuum is not an option. Indeed, we accept the role of advocacy and systems change as an inherent part of our job and skill set.

It’s not an easy job, but it’s certainly one I can get behind. It’s a job that I can, in good conscience, recommend to the best and the brightest medical students and residents as the future of mainstream psychiatry.

Who knew? The mainstream has come to us. Buckle up.

Michael Flaum, MD
President, AACP

Welcome to Atlanta for the APA Annual Meeting! Hotlanta, ATL. Home of Dr. Martin Luther King, Jr., Elton John, and Tyler Perry; home of Morehouse, Spellman, Georgia Tech and Emory; and the (former) home of the Atlanta Braves. Home of Delta, CNN, Coca-Cola and the Fabulous Fox Theater. Home to hundreds of amazing restaurants: Ponce City Market, 246 and Victory (for their Jack and Coke slushies) in Decatur, Gunshow, Bacchanalia, Sweet Auburn Curb Market, The Varsity, and Mary Mac’s Tea Room. Home to your new AACP Newsletter Editor (the undersigned) and home to over a thousand (or more) unsheltered homeless individuals on any given night. To many, this last statistic sounds odd in conjunction with all the other reasons for which Atlanta is known. To me, this number is the biggest reason I love to live and work in Atlanta. For all the great experiences Atlanta has to offer, the experience of working on the streets with people who live almost solely outdoors has given my life and work deeper meaning. It is the reason I went into medicine and the reason I call myself a Community Psychiatrist.

I first started working with homeless people – in their environment – during my second year of residency at Emory University. I chose an elective rotation with a newly-formed PATH team (Projects for the Assistance in Transition from Homelessness). I did very little of what I thought of as psychiatry during the month-long experience. Mostly, I rode around in a van with two team members, stopping at food pantries, soup kitchens, and park benches along the way. I distinctly remember the first time the team asked me to engage a man sitting on a bench in downtown. Fear of not knowing what to say (and a healthy dose of anxiety at approaching a random stranger) gripped me as I exited the van. But as I tentatively struck up a conversation with the man, I felt the streets take hold of my heart. In these streets of Atlanta, I found the essence of what it is to be a psychiatrist. There, I learned to engage as one human being to another human being, to build trust first and foremost, and to slowly, gently introduce the idea that psychiatrists aren’t so scary. It is this ability to be present with my street friends that is both fundamental to treatment and the most important lesson I learned in residency.

Two years later, I started the Community Psychiatry and Public Health Fellowship at Emory, a Fellowship that unfortunately no longer exists. The only requirement of my fellowship, aside from getting a Masters in Public Health, was to work with a United Way program to bring psychiatric treatment to chronically homeless people. I was able to design a program to figure out the best way to reach people who were deemed “the most difficult.” Working with several different PATH teams that identified these individuals for me, I began with sitting on street corners, taking homeless men to lunch, and filling out all that damned paperwork people need to actually exit homelessness. Admittedly, I had no idea what I was doing, but it seemed to be working. I was practicing street medicine before I even knew what Street Medicine was.

Unfortunately, I also reinvented the wheel during this time. I had no idea that there were others out there, psychiatrists even, doing similar work but with more resources and a lot more experience. I was able to connect with people at The Street Medicine Institute and some psychiatrists both in Atlanta and through the AACP, but I still did not meet many people practicing psychiatry literally on the streets. I mostly made it up as I went along, but I also earned a lot of “street cred” (an important level of respect from people living on the streets and from clinicians who work on the streets). I continued some of this work for several months after my fellowship ended, but my newborn son and my “real” job working on an Assertive Community Treatment team drew me away.

ACT was satisfying, but we did not spend much time on the streets. Those Atlanta streets called and after two years I took a job where I could create a Street Medicine program. Though I spend most of my time in clinic, on Wednesday nights I take to the streets with a nurse, a primary care provider, a formerly homeless peer specialist, and a couple of students. We drive to nooks and crannies of the city to bring primary care, wound care, and psychiatric treatment to people who are often reticent to receive it. We make friendships, give hugs and socks and sometimes meds, and we re-establish broken bonds of trust. We make ourselves at home in Atlanta among the homeless.

When you come to Atlanta for the Annual Meeting, go out and enjoy all that Atlanta has to offer. And know that as you walk the streets of this city, you are walking through the vessels of my heart.

Liz Frye, M.D., M.P.H.
Director of Psychiatry and Street Medicine
Mercy Care, Inc
Atlanta, GA
lefrye@gmail.com
AACP@APA AACP Events at the
American Psychiatric Association Annual Meeting

Receive updates in real-time via Twitter @AACP123 and Facebook.

All events are in the Atlanta Marriott Marquis Hotel, International Level, International B Room
265 Peachtree Center Avenue
Atlanta, GA 30303

**Board Meeting**: All members are welcome to attend the AACP Board Meeting
Saturday, May 14 from 1-7PM
Sunday, May 15 from 8AM-4:30PM

**Membership Forum**
Monday, May 16 from 5-7PM

**Fellowships@APA: Public Psychiatry Fellowship Events at APA**

**APA Fellow Presentations:**
The APA Public Psychiatry Fellows present workshops at the APA annual meeting each year. Please support our future leaders in Community Psychiatry with a big AACP presence!

*Saturday May 14th, 1:30PM*
Financing the Future of Psychiatry: Financing the Addiction Treatment System

*Sunday May 15th, 8AM – 11AM*
Autism symposium: Revisiting Risperidal in Autism

*Monday May 16th, 1PM – 4PM*
APA on Tour: Human Trafficking

*Tuesday May 17th, 9AM – 12PM*
Sexuality and Psychiatry: Ethical & Policy Dilemmas
Reporting Child Pornography Use: Psychiatrists as Police

**AACP Updates**
A Facelift for Our Website and Listserv!

We are developing a new and improved web presence. Soon we will be unveiling an updated website. We will then begin to improve our Listserv. Instead of one Listserv that captures all topics, each topic will have its own thread. That change will allow for threads to be searchable long after they are established. All of these changes will enhance our ability to communicate with one another.
American Psychiatric Association (APA) to Offer Training!

APA is pleased to announce a new opportunity for psychiatrists interested in opportunities to advance integrated care. In September, the Centers for Medicare and Medicaid Services (CMS) launched the Transforming Clinical Practice Initiative (TCPI) and awarded $685 million to 39 national and regional healthcare transformation networks and supporting organizations to support practice transformation through nationwide, collaborative, and peer-based learning networks.

As a TCPI Support and Alignment Network (SAN), APA received $2.9 million over four years to partner with the AIMS Center at the University of Washington and train 3,500 psychiatrists in the clinical and leadership skills needed to support primary care practices that are implementing integrated behavioral health programs. Once psychiatrists are trained (see below), APA will work to connect them with local Practice Transformation Networks (PTNs) participating in TCPI.

***Free training is available to psychiatrists through online modules and live trainings. CME credit is also offered. Content is similar for both training sessions so you may choose to participate in one or the other based on your learning preferences and availability.

- **Online Modules** - [Click here to get started!](#) There are two parts to the training containing seven modules in all. It is recommended that participants complete both parts 1 and 2.

- **IPS: The Mental Health Services Conference** – Registration opens Spring 2016. Check back at [www.psychiatry.org](http://www.psychiatry.org) for meeting information.

Stay up-to-date on TCPI and APA’s Support and Alignment Network at [www.psychiatry.org/sansgrant](http://www.psychiatry.org/sansgrant). If you have questions, contact [SAN@psych.org](mailto:SAN@psych.org).

Perspectives:

News of the Opiate Epidemic in Maine

As I write this article the legislature is about to enact specific restrictions on the prescribing of opiates, including dosage and time limits, as well as requirements that our Prescription Monitoring Program be used for benzodiazepines in addition to opiates. There are concerns that these limits will have the unintended consequence of increasing the use of street opiates when patients are cut off from prescribing; the management of exception requests will probably be important.

Maine, as well as the rest of New England, has seen a large increase in the amount of fentanyl being sold as heroin, thus dramatically increasing overdoses and deaths since last summer. Distribution of Narcan is also increasing, but it is not available over the counter. The only inpatient substance abuse detox facility in Southern Maine closed in the summer and only one nonprofit methadone program in Maine, at Acadia Hospital in Bangor. Coordination between nonprofit health and mental health systems and the other methadone programs has been variable, leading to at least one psychiatrist being disciplined by the board of medicine. Maine Medicare lowered the rates for methadone treatment to the point that at least one provider went out of business, though the rate is now being raised slightly. Maine Department of Health and Human Services has been hostile to methadone, which is not available in large geographic areas of the state. Many of our state legislators believe that extended residential treatment is effective for opiate dependence and have voted for modest state grants for it, but not for medical treatment of substance use disorders. One highly publicized law enforcement program in a suburb of the Maine metropolis links people with opiate dependence to out-of-state residential treatment programs that seem, at times, to offer free services. No reports of outcomes there.

The explosion of overdoses has led to a doubling of the street price of buprenorphine as people seek alternatives to “heroin.” Most of the larger nonprofit hospitals have limited opiate addiction services, very few traditional CMHC’s do, and there are a variety of relatively new for-profit outpatient services that mostly take Medicaid. These for-profit services tend to want to mostly treat people who are willing to come to IOP level services initially. However, Medicaid was not
expanded in Maine and in fact it has significantly contracted under the current administration so that a large segment of the population with opiate use disorder has no insurance. The largest hospital in the state, Maine Medical Center, is moving to support buprenorphine prescribing in its primary care clinics, as have some smaller hospitals such as Maine General in Kennebec County. Maine Behavioral Health Care, the community mental health arm of Maine Medical Centers parent corporation, is starting an initiative in the Rockland-Belfast area. The recent federal initiative to support opiate use disorder treatment in FQHC’s will engage several of these in the effort.

As in red states generally, especially across southern Appalachia, venture capital is setting up cash only addiction treatment services to respond to demand for outpatient treatment by the uninsured or in some instances residential programs for people who cannot get insurance coverage for residential services. In some cases, this requires more frequent contact and monitoring than occur with the scattering of private physicians who take cash and may involve some group work. As health insurance for outpatient services effectively ceases with ever increasing insurance deductibles, we may wonder if “patient choice” will lead to the development of a broader spectrum of cash only health services that does not involve the significant overhead of regulatory compliance, billing, and “quality” related documentation: my guess is that this is why venture capital is interested in this model.

The regulatory restrictions on the treatment of opiate dependence, which still significantly reflect the Harrison Act of 1914, have once again created market failure, especially in states that have been unwilling to attempt health finance reform. Governmental attempts to intervene with even more restrictions may create a second chance for medicine to protest this governmental practice of medicine. In 1914, the allopaths had just recently claimed the leadership of medicine with the help of state governments, the Flexner Report was still news, and in the years immediately following the passage of the Harrison Act, it was interpreted in an atmosphere of growing Federal assumption of power over markets, be these for drugs, labor, or alcohol. Insurance and Medicare had not made physicians prosperous yet. Opposition to the Harrison Act faded in the face of threats of federal prosecution, and opiate dependence put in a ghetto that was formalized 50 years later by the legalization of methadone treatment.

Now physicians are frustrated by the strictures of multipayor billing and “quality” requirements and increasingly facing competition from NPP’s; our power will most likely fade back to where it was in the 19th century soon. Supposedly the Federal rules will be modified soon regarding buprenorphine restrictions; rarely is the limited availability of methadone discussed, though this is a treatment of choice for many people. Now is our chance to advocate that patients with treatable life threatening disorders have at least the choice of getting whatever the most effective treatment is without delay.

Ben Crocker, M.D.
Medical Director of Partial Hospital Program, Maine Medical Center in Portland, ME
Medical Director of Woodfords’ Child and Family Services in Westbrook, ME Consultant, CORE ACT team in Brunswick, ME

Perspectives:
Prescribing Psychiatry

Psychiatry training and practice are equally adept at producing questions as they are answers. Why do the same patient and family adhere religiously to their antibiotic or antihypertensive medications but not to their antidepressants? During residency and fellowship training, and now working as a community psychiatrist in a rural county on the USA-Mexico border, I have faced this phenomenon repeatedly.

Why is this? The higher rates of non-adherence to medications among our patient population are not completely accounted for by “mental illness” or “lack of insight.” Multiple factors play a role here: differences in end goals between the psychiatrist and the patient, transferential prescribing, hesitation of the psychiatrist in discussing uncomfortable topics, and less than required attention to confounding social and economic factors; all are significant.

Upon some introspection, I concluded that I myself, a trained physician, may have some reservations in taking an antidepressant over an antibiotic. I do doubt that it is just stigma as I am convinced sufficiently by the biologic reductionstic explanations we have available for mental illness today. Mintz & Flynn’s “How (Not What) to Prescribe: Nonpharmacologic Aspects of Psychopharmacology” sheds some light on the topic.

The dynamics of a psychiatrist-patient relationship are much different from ones influencing the regular doctor-patient relationship. A psychiatrist is someone who you are [hopefully] able to talk to a little longer, tell them more than, “I am sad,” but actually why you are sad. The fact that this
relationship allows such communication itself changes the nature, the expectations, and outcomes of interventions. One of my adolescent patients said it is a “paid friendship.” Even though this seemed demeaning to me at first, given that I had undergone nearly a decade of training to get to this point, I understood where he was coming from. The relationship lends itself to a greater level of understanding of the unique circumstances that come with each patient.

Frequently, our patients have a sense that the medications control their mind and may feel, in turn, that medications will take away free will or change their personality. Parents are concerned, “Will this change my child’s personality? Will he look like a zombie?” This sense of free will is one of the basest needs of us humans. Even though other groups of medications, steroids for example, may cause changes in mental function, these are rarely questioned as the prescribing doctor is generally a non-psychiatrist physician. We have a special role to play in integrating the patient as a partner in the treatment process so that this feeling, often robbed by mental illness and medications, is restored. I recently had a patient with Obsessive Compulsive Disorder with an intense fear of incapacitating control by the medications and control by me through the medications. If I had prescribed him a medication during our first meeting and demanded adherence, the treatment would have likely failed. His collaboration and understanding were essential.

The confidence a patient feels with his doctor also greatly affects the outcome. Though it is a given that patients are supposed to talk freely and without hesitation to their psychiatrist/psychologist, a lot of this can be and is predetermined by our stance. If adherence to treatment is made a strict prerequisite, it may greatly hamper alliance. I have found that; my thinking that a patient needs a medication in many cases may be far less important than the patient’s own thoughts and those of their parents, family members, partners and friends. Our role thus incorporates including the patient as an equal partner in decision making. The fact that we use the word ‘insight’ in mental status exams, lends to our role in bringing it to the patient. Patients with poor insight may not see obvious difficulties they have in everyday life. This lack of insight needs gentle exploration and a safe space for the patient to think. “This is just me” is something I heard from a depressed patient who lies in bed all day, has poor sleep at night, isolates herself and has angry outbursts. Pointing out and educating her about these classic symptoms of depression was a start. Bringing to light, the times the patient was happier and functional in the past and uncovering a hidden desire to do better was crucial. Inability to convince her would possibly stagnate treatment. “It is not who you are – its depression,” needed conveying.

Improved alliance forms through creation of a safe space where the patient feels comfortable saying “I don’t want to take this medication,” and it is not taken as a personal rejection or question on our competency. I have frequently told my chronically non-adherent patients that “if you do not feel like taking medications, it is OK, but let me know. We will discuss other options.” I have frequently told my patients suffering from substance abuse, “relapses are a part of the illness, it is important that we discuss them earlier than later and we will work out a plan to help you.” To my chronically suicidal patients, I have frequently said, “I am not going to admit you to a psychiatric inpatient unit just because you mention the word suicide to me. We will evaluate the situation together and come up with a plan.”

Mintz and Flynn point out how reductionism is frequently used to explain all the factors involved in treatment. Though it helps in explaining how mental illness is, in part, a change in biology of the brain, it is incomplete as it ignores the patient’s role in recovery. The role of the patient is not confined to just adhering to medications, but to taking steps to take charge of their medical care, social, and work spheres. Personal responsibility should not be underestimated. It instills a hope, as you are bringing back the control into the patient’s hands making them the most important agent of change.

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<tr>
<th>STEPS FOR PATIENT-PHYSICIAN COLLABORATION</th>
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<tr>
<td>1. Empathize with the illness / suffering and resulting need for medication.</td>
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<td>2. Identify the patient’s goals and align treatment goals with those of the patient.</td>
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<td>3. Empathize with the wish to not need medication or avoid dependency.</td>
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<td>4. Set up an open dialogue. Genuinely help the patient be involved in decision making.</td>
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<td>5. Discuss how medications / treatment will assist in achieving the goals of the patient.</td>
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<td>6. Discuss how your goals as a psychiatrist are not medication adherence, but in fact, improved patient functioning.</td>
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<td>7. Constantly engage patients in providing feedback and accept negative feedback about medication / treatment so it can be fine-tuned in each individual case.</td>
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Continued on Page 8
Innovations:
Metrocare Services’ ACER Launches Mental Health Services at Paul Quinn College

There’s a new benefit for students at the oldest historically black college west of the Mississippi, courtesy of Metrocare’s Altshuler Center for Education & Research (ACER) and UT Southwestern. In January 2015, Metrocare began providing a systematic mental health screening program and a student mental health clinic at Paul Quinn College in southeast Dallas. Paul Quinn’s President, Dr. Michael Sorrell, initiated discussions with Metrocare, and our ACER leadership recognized an opportunity to help people in need and to gain additional experience for our trainees.

Trainees providing services include a first-year psychiatry resident, a Licensed Professional Intern (LPC-I), a psychology PhD candidate and Dr. Jessica Moore, a third-year psychiatry resident. "Mental health is something we don’t talk about in the African American community," Dr. Moore notes. “There’s a lot of stigma associated with it. I think that it is so important to start a conversation about mental health on this campus to make people feel more comfortable so they can succeed in their academics and in their social life.”

Students are seen through scheduled appointments and on a walk-in basis. Systematic mental health assessment of students began in the spring of 2015, led by UT Southwestern Medical Center faculty, including ACER’s Medical Director Dr. Carol North, a member of the American Association of Community Psychiatrists.

The Paul Quinn initiative is one of many opportunities for trainees at ACER. The Center has partnerships with 25 local educational institutions for education and research. In 2015, 222 psychiatry residents, medical students, and other health care professionals received clinical and research training through ACER. The trainees who come through ACER receive valuable experience working in a community mental health setting, and many of them continue to work at Metrocare or in public health care. Seventy-six percent of psychiatry residents choose to return for more training at Metrocare, and, since 2010, 45 percent of residents and five percent of fellows have taken public sector jobs after completing their training.

Dr. Michael J. Sorrell, President of Paul Quinn College stated, “When we look back on signature moments in the creation of the New Urban College Model there will be little doubt that an enormous part of our success would have been our ability to address the emotional health needs of our students. You cannot write that chapter of this book without acknowledging the significance of the role Metrocare and UT Southwestern played. Their vision, compassion, and generosity is truly the stuff of legends, and for that we say thank you, thank you, thank you…We are working together to provide these students the best resources available.”

Submitted by:
Carol S. North, M.D., M.P.E.
Medical Director, The Altshuler Center for Education & Research, Metrocare Services
The Nancy and Ray L. Hunt Chair in Crisis Psychiatry and Professor of Psychiatry, The University of Texas Southwestern Medical Center
carol.north@utsouthwestern.edu

References:

Gaurav Mishra, M.D.
Child & Adolescent Psychiatrist at Imperial County, CA
Community Psychiatry Fellow at UC San Diego, CA
Voices of Hope for Mental Illness: Not Against, With by Jackie Goldstein, Ph.D.
CreateSpace Independent Publishing Platform, 2015

After over 40 years working in community psychiatry in various locations, as well as being involved in national and international organizations, I thought I knew most of what was relevant to our field. When I read the draft of Voices of Hope for Mental Illness: Not Against, With by Jackie Goldstein, I knew that my assumption was wrong. I knew of Geel, Belgian and knew that welcoming patients with severe mental illness into communities was essential to their recovery, but I didn't know there were so many other models out there that Dr. Goldstein found and visited. Why is that so important? We need oh-so-many more and can learn from these that exist how to establish them. When Dr. Goldstein asked me to do a back cover blurb, even though I usually turn these down, I jumped at the opportunity. Here it is:

"Perhaps you've heard of Anthony Bourdain. He is the world-renowned chef who hosts the television show 'Parts Unknown,' reflecting his travels around the world to 'eat and drink with people without fear and prejudice.' Perhaps, though, you have not yet heard of Jackie Goldstein. If not, now is the time. Dr. Goldstein is the academic psychologist who, without fear and prejudice, has traveled to parts unknown where she has eaten, drank, studied, and worked with people who have so-called severe mental illness. In this book, you will visit the places and meet many of the people that Jackie found and which provided realistic hope and models for better recovery. Although I have worked in community mental health for over 40 years, many of these were unknown to me. Among the success stories and systems, your heart may go out to the voices of Howie the Harp, Archie's Place, Brother Gould, and the young psychiatrist John Dorsey, among many others - all reminiscent of the legacy of the young Irish Princess, Dymphna. These people are members of communities in the United States that model principles established centuries ago in Geel, Belgium, adapting those principles to local settings. Indeed, Dr. Goldstein has found veins of gold and given them to us as presents to mine for the greater good of all our communities. Until they make a television series about these journeys, let us be inspired by the golden words of discovery you will find in these pages."

So, if you need any inspiration about what humanity at its best can do for those stigmatized and in need, you'll love this book. We should be grateful that Dr. Goldstein is involved in our community of community psychiatrists.

H. Steven Moffic, M.D., deemed a "Hero of Public Psychiatry" by the American Psychiatric Association

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Passing the Torch

It's been my honor and pleasure to serve as your Newsletter Editor for the past three years. As I leave this role, I am excited to continue working with this great organization as the new Associate Editor of the Community Mental Health Journal. Both of these publications are what they are because of our membership. The content you have contributed to this newsletter reflects an experienced, thoughtful, innovative, and passionate group of community psychiatrists. I have no doubt that our new Editor, Liz Frye will do an outstanding job!

Margie Balfour
2016 DUES STATEMENT
AMERICAN ASSOCIATION OF COMMUNITY PSYCHIATRISTS

Please Note: The information requested on this sheet will be used to provide information for the Membership Directory. Please take a moment to fill in the form as you would like your listing to appear. Then return the form with your check to the address below. Dues include on line subscription to the Community Mental Health Journal and AACP’s newsletter Community Psychiatrist. For a fee of $40 you can receive a hard copy of the journal.

We now offer joint memberships with the American Association of Orthopsychiatry, American Association of Psychiatric Administrators, and American Association for Emergency Psychiatry. Take advantage of the many resources of these organizations along with those of the AACP for a reduced joint membership fee!

General Member ................................................................. $150
Liaison Member (non-psychiatrist) .................................................. $100
International Member
   LI ..................................................................................... $35
   LMI .................................................................................. $50
   UMI .................................................................................. $75
   HI .................................................................................... $100
Member-in-Training ................................................................. No dues
Medical Student Membership ...................................................... No dues
Group membership (5 or more) ..................................................... $75

Joint Memberships
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