Paul S. Appelbaum, M.D.

Presidential Address: Re-Envisioning a Mental Health System for the United States

Paul S. Appelbaum, M.D.

Members of the American Psychiatric Association, it has been an honor to serve you this year as President. This has been a year of many accomplishments for APA:

We campaigned for parity in health insurance coverage for mental disorders. We fought to block destructive cuts in state and federal budgets for mental health treatment. And we reiterated our commitment to protecting the public from the absurd notion that psychologists who have not graduated from medical school can safely prescribe medications for the treatment of psychiatric disorders. So far this year, I am pleased to report, we have defeated psychologists' efforts to practice medicine by legislative fiat in five states—and we will not desist until this threat to public health is put to rest once and for all.

We created an array of new services for our members, including *FOCUS: The Journal of Lifelong Learning in Psychiatry,* free online continuing medical education, and guidance on dealing with the new Health Insurance Portability and Accountability Act (HIPAA) medical privacy regulations—including extensive information available to members on the APA web site and an online bulletin board where HIPAA-related questions are answered by an APA attorney. And there will be more to come. No member will ever again need to wonder what benefits they receive from belonging to APA.

We made significant progress in placing APA back on firm financial footing. By generating a substantial surplus in revenues—while controlling expenditures—we were able to begin the crucial task of replenishing APA's reserves.

We hired a new Medical Director, Jay Scully, M.D., whose energy and enthusiasm have already brought renewed vitality to our operations.

And in the interest of increasing efficiency and reducing costs, we moved our offices to beautiful new quarters across the Potomac River in Arlington, Va.

These and all of APA's other achievements were made possible by the hard work of my colleagues on the APA Board of Trustees, of our members who serve in the Assembly and on our components, and of the wonderful people on the APA staff. My thanks to all of them, and as well to my family, especially my wife, Dede, whose support has been so important to me this year.

Mental Health Services in Crisis: The Defunding of a System

Last year in Philadelphia, I stood before you to describe the crisis in our mental health system (1). The genesis of that crisis lies in the uniformly inadequate resources allocated for the delivery of psychiatric care in America today. So poorly are psychiatrists, clinics, and hospitals compensated for the treatment they render that relying on insurance payments for patients' care is often literally a losing proposition. As a result, hospitals are closing psychiatric inpatient units, clinics are cutting back on services, and psychiatrists and other mental health professionals are finding that insurance reimbursements can no longer sustain their practices. The situation is compounded by the extraordinary additional costs imposed by the managed care industry, whose utilization review and other procedures often seemed designed primarily to discourage patients from pursuing treatment and psychiatrists from providing it.

The inevitable result of this situation, as I demonstrated for you starkly 1 year ago, is a critical inability of patients to access needed psychiatric care. Hospital beds are routinely unavailable in many parts of the country, forcing severely ill patients to wait for days in emergency rooms or to travel hours from their homes to find a hospital that can accept them. When outpatient care is required, patients who must rely on insurance coverage for their treatment face waiting lists of weeks to months in many hospital or community clinics, and they often find that those private practitioners who are listed on their managed care companies' panels are unable to accept any new patients at managed care rates. Simultaneously, they discover that what was once the safety net of the public mental health system, having been steadily drained of resources for decades, can no longer offer them even minimal treatment.

In the year since we spoke of these developments, which I characterized as the consequences of the "systematic defunding" of the American mental health system, things have become even worse. There has been no meaningful improvement in reimbursement for psychiatric treatment by the for-profit managed care companies that dominate the field. Indeed, the largest of these companies, Magellan, which covers in excess of 60 million Americans, has itself gone into bankruptcy (2). As most specialties saw their Medicare payments increase, psychiatry's actually decreased, based on a badly flawed formula that continues to favor procedure-oriented specialties (3).

Medicaid, which pays for more than 20% of all psychiatric care in this country (4), has been hit particularly hard. Faced by unprecedented budget deficits, states are simply slashing what they will pay for psychiatric treatment across the board, imposing counterproductive restrictions on access to psychiatric medications and, in the worst cases, dropping tens or hundreds of thousands of indigent people from the Medicaid rolls (5). Oregon is this year's poster child for discriminatory treatment of Medicaid enrollees with mental illness, depriving 100,000 persons of coverage for psychiatric treatment, while retaining coverage of every other kind of medical care (6). At the same time, funding is being reduced for state departments of mental health, with yet more state hospitals closing (7) and still more patients discharged to community services that are inadequately funded even to care for their current caseloads.

By now, you know what comes next. With the costs of providing care continuing to rise—take spiraling malpractice insurance rates as just one example—the availability of psychiatric services is steadily declining. Hospital inpatient units continue to close. Not long ago I received an anguished call from a psychiatrist in the Northeast whose hospital CEO had just told him that the excellent 20-bed psychiatric unit that he oversaw would be replaced by medical/surgical beds. The reason? The hospital needed the extra income that medical/surgical beds would provide. So long as psychiatry remains the poor sister of medicine, such stories will continue to proliferate (8). And an identical process is going on in community and hospital-based outpatient clinics (9). In a country in which only 20% of persons with a mental disorder receive any treatment in a given year, even more people are having trouble accessing care than was the case a year ago.

Re-Envisioning the Mental Health System

As important as it is to call attention to the crisis in access to and reimbursement for psychiatric care, merely sounding the alarm—as I urged you to join me in doing last year—is not enough. Psychiatrists work every day to overcome the obstacles placed before us and our patients by the current nonsystem of care. Hence, we are in the best position not merely to critique the ongoing muddle, but—even more important—to set out a vision for a genuine system of care. Toward this end, I appointed a special APA task force, chaired by our Vice-President Steve Sharfstein, M.D., to develop a vision statement for the mental health care system. The task force worked through the winter, producing an excellent document titled "A Vision for the Mental Health System" (10), which was endorsed by APA's Board of Trustees at its March 2003 meeting. Members of the media and government decision makers have already told me how useful they have found this document, which creates a set of benchmarks against which progress toward meaningful mental health system reform can be measured. I encourage you to access and read this report on APA's web site (10).

Today, I want to share parts of the "Vision" report with you, using it as a starting point to suggest some key directions in which we must begin to move, if we are to create a genuine system of mental health care.

I begin with what I consider to be the cornerstone of the task force's vision:

> Every American with significant psychiatric symptoms should have access to an expert evaluation leading to *accurate and comprehensive diagnosis* which results in an *individualized treatment plan that is delivered at the right time and place, in the right amount, and with appropriate supports such as adequate housing, rehabilitation, and case management when needed. Care should be based on continuous healing relationships and engagement with the whole person rather than a narrow, symptom-focused perspective. Timely access to care and continuity of care* remain today cornerstones for quality, even as a *continuum of services* is built that encourages maximum independence and quality of life for psychiatric patients. (10, pp. 1–2, italics in the original)

What would a system that could achieve these goals look like? Here I use the "Vision" report as a starting point but move beyond its specific recommendations.

For most people with mental disorders, I submit to you, care is best delivered in the context of the general health system. As many patients already receive treatment for mental disorders from their internists and family practitioners as they do from psychiatrists (11, 12). Primary care specialists write the majority of prescriptions for psychotropic medications (13). Rather than seeing this as a less-than-optimal situation, we ought to consider the involvement of primary care physicians in the treatment of mental disorders as a potential strength of a future, integrated system of care. Not only are patients likelier to have ready access to primary care physicians, but there are simply not enough psychiatrists to treat every person with a mental disorder. I remind you again of the National Comorbidity Study finding that 80% of persons with mental disorders receive no care in a given year, including more than 50% of persons with such major psychiatric disorders as schizophrenia and bipolar disorder (14). Meeting this demand requires more access to medical expertise than psychiatrists themselves can provide.

But this is not a task that all primary care physicians can fulfill right now. Many of them need additional training in the recognition and treatment of mental disorders as an important component of primary care. Nor can they do this on their own. Psychiatrists should be available to every primary care setting for consultation—preferably on-site—and treatment of the more challenging cases, of which there will be no shortage. Collaborative management of psychiatric disorders is the essential component

of an effective primary-care-based system. Far from excluding psychiatrists from the treatment of most patients, it will tap their knowledge and skills to a much greater extent than is possible today. And no discipline without medical training can possibly substitute for the needed medical expertise.

Today, of course, there are multiple systemic obstacles in the way of widespread implementation of such an approach, although model programs organized along these lines have long existed (15, 16). When insurance coverage for psychiatric treatment is carved out from general health care—as is typical today—primary care physicians often cannot get reimbursed for dealing with psychiatric problems. Moreover, almost no insurer compensates psychiatrists (or other physicians) for consultation on patients whom they do not examine directly. This undercuts the most efficient model of psychiatric consultation in primary care and other general medical settings. Often described somewhat pejoratively as "curbside consults," these brief contacts can be all that is needed to assist nonpsychiatric physicians in managing cases or appropriately referring patients for psychiatric evaluation. In addition, when nonpsychiatric physicians are precluded from making direct referrals to psychiatrists—as they frequently are today—the relationships on which a consultative model depends can never develop. All of these self-defeating aspects of the current system need to be changed, a process that will be facilitated immensely by "carving" mental health coverage back into general health insurance plans.

It goes without saying that no primary-care-based system can succeed without every person having health insurance coverage. APA has long supported universal health insurance, a reform that is more crucial today than ever. Whatever universal insurance plan is adopted should cover treatment of psychiatric disorders on a nondiscriminatory basis compared with other forms of medical care. Nondiscrimination must go beyond benefits on paper to encompass the mechanisms of review for authorizing care. And, of course, the rates paid for treatment of psychiatric disorders must take into account the real costs of delivering such care. That is not the case today but is essential for both primary care and psychiatric physicians to be able to deliver effective treatment in this model.

As the task force recognized, for people with severe and persistent mental illness, special considerations come into play. Many of these patients can best be treated in the specialty psychiatric sector, where additional expertise and adjunctive services are available. They may require case management, social reintegration, employment training, assistance with housing, and other services that cannot be supplied in the primary care setting. For this extremely vulnerable group of patients, the most logical locus of care is a revitalized community mental health center (CMHC) network.

The Community Mental Health Centers Act of 1963 was the closest this country has ever come to acknowledging its responsibility to provide quality care for all persons with mental disorders (17). We can all point to problems in the implementation of the CMHC act. But its conceptual foundation was rock-solid: proactive efforts to provide mental health care are facilitated by assigning responsibility for a defined population in a circumscribed catchment area. No part of the country should be without such a facility. Refocused on the severely and persistently ill population, supported by ongoing allocations of state and federal funding (especially important for services that are not easily funded on a fee-for-service basis—e.g., case finding), given the flexibility to manage funding streams across the usual human services boundaries, emphasizing continuity of care, and evaluated by measurable outcome criteria, CMHCs would become the linchpin for serving people with long-term and severe psychiatric disorders. As a complement to this outpatient-oriented system, adequate numbers of beds should be available for acute and longer-term hospitalization when needed.

Funding a New System of Care

It is one thing, of course, to sketch the outline of a genuine system of psychiatric care—and it is only the barest outline that I have been able to present here today—and quite another to persuade the public and our political leaders to provide the necessary funding to make this vision a reality. Here, once more, the report of the "Vision" task force points the way. As the task force suggests, a methodology now exists for quantifying the impact of mental illness in our society, relying on the concept of the "burden of disease." A common metric—disability-adjusted life years—allows comparisons to be made across all medical disorders, in terms of both years of life lost and years lived with disabilities. When mental illness is looked at in this way, it becomes clear that psychiatric care is grossly underfunded. Mental disorders account for 20% of the total burden of disease in the United States, while only 5.7% of all health expenditures go to their treatment (18). Enlightened self-interest alone would suggest that this country should be investing a much greater proportion of its health care dollars in psychiatric care.

Beyond this, we need to make it perfectly obvious to decision makers at the federal and state levels that mental illness ignored does not simply disappear. The costs of untreated mental illness are shifted elsewhere in our society: to the correctional system, which may now house and treat more people with mental illness than our public mental health facilities; to the health care system, which covers the costs of emergency, inpatient, and often outpatient care for those without insurance coverage; to our social welfare system, which provides welfare and disability payments to persons who, with adequate treatment, might be self-supporting; and to patients' families, who often substitute for an ineffective mental health system and bear the staggering costs. Were the financial resources now being con-

sumed to compensate for the deficiencies of the current mental health nonsystem utilized to provide quality psychiatric care, we could afford to implement the vision of a genuine system of care.

The value of a vision is that it creates a "big picture" into which each of our incremental efforts can fit. Once we know what we need to do, it remains to muster the courage to do it. When the task seems too difficult, the outcome uncertain, our efforts unappreciated or ignored, we can draw inspiration in this quest from our patients, who often struggle to overcome precisely these feelings as they make their way through life. So I leave you with the words of the early 19-century Chassidic master Rav Nachman of Bratzlav, who himself suffered from recurrent, intense depressive episodes. Rav Nachman would say to his followers, "*Kol ha'olom kulo, gesher tsar m'od*" ("The world in its entirety is a very narrow bridge"); "*v'haikar lo lefacheid klal*" ("and the most important thing is to have no fear").

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Response to the Presidential Address

Marcia Kraft Goin, M.D., Ph.D.

It is a great honor to stand here today assuming the responsibilities of your APA President. This past year our organization has had the great good fortune of having a strong, dedicated leader, Paul Appelbaum. Working closely with Paul has been a privilege, sharing with him the same vision for our profession and our organization.

I want also to acknowledge some of the many people who have helped and inspired me. Dr. Joe Yamamoto, psychiatrist, educator, and humanitarian, has been the most influential figure in my academic career. His encouragement and expectations in academia, research, and public psychiatry propelled me forward into unexpected and rewarding terrain. I am indebted to many good friends and advisors within APA: Carol Nadelson, Carolyn Robinowitz, Dan Borenstein, Herb Sacks, Martha Kirkpatrick, Drew Clemens, Herb Peyser, Sherwyn Woods, and Rod Burgoyne. My department chairperson, George Simpson, has provided thoughtful counsel and patiently suffered my many absences. John Goin, my late husband, a charismatic physician, believed I could do anything I put my mind to. Jessica and Suzanne, my creative daughters, offer me love and warmth, which makes all things possible.

A few weeks ago in meeting with a group of first-year medical students, I was asked why I had chosen to become a psychiatrist. I launched into a description of some of the remarkable discoveries of the last few decades: demonstration on fMRI of the neurocircuitry involving the anterofrontal cortex, the limbic system, and hippocampal activity; Kandel's extraordinary findings about neuroplasticity; the integration and interrelationship of neurogenomics; and the mapping of the brain that shows with increasing clarity the neurobiological effects of attachment, attunement, and psychopharmacology.

I was holding forth with passion when I realized that their eyes were beginning to glaze over and some were nodding off. They had lost their bearings in a territory that was familiar to me but that at this point in their education was only a complicated maze of names, connections, and neuroanatomy they were struggling to memorize.

Seeing their soporific reaction, I stopped and then backtracked in time to when I was a first-year Yale medical student, in order to recall what offered real meaning for me. Why had I chosen to become a psychiatrist?

Yale's Department of Psychiatry was the national leader in psychiatric research, teaching, and clinical investigation. The department was eclectic, not trapped in dogma. Remarkable mentors lectured to the medical students and convened small seminar groups. Most important, we met and talked with psychiatric patients. One of the first patients I got to know was Bill, a college student. He was in physical restraints when I saw him in the emergency room. He looked terrified, and his voice quavered when he spoke. Unseen voices were telling him he was evil and were threatening to rip out his heart if he didn't repent. Listening, I was struck by how frightening and terrifying psychiatric illness can be!

As I met more patients and listened to their stories, I realized that in certain respects these patients' symptoms were clearly less tolerable than physical pain and the suffering qualitatively different from and often worse than that of patients with physical pain. People with depression, struggling to shake off the inertia of their illness, try to work and take care of their families while weighed down by inexplicable heaviness and suicidal thoughts. The paranoid person, tormented day and night, is frightened by unseen and unexplained dangerous plots and by menacing voices that are unheard by others.

Listening to stories about real people, my medical students came alive. It was a new discovery for them to realize that these illnesses are diagnosable and treatable. They could hear the tragedy of the illnesses that if untreated spread from the patient to his or her family and friends. Many students began to realize the relevance and importance of our work and to explore the prospect of becoming psychiatrists.

This story is important, not just for medical students, but for society. We must attract the best and brightest to our specialty; our work and its potential must become known to others. The American Psychiatric Association must continue to expand its programs to increase public awareness, press for access to care, battle for destigmatization, and assure the recruitment and training of researchers and clinicians to improve patient care and safeguard the future of psychiatry.

Currently, we are in the best of times when we look at contemporary research. But, paradoxically, we are in the worst of times in not being able to deliver the benefits of new learning. Federal and state budget deficits are draining necessary resources from every aspect of society. Our patients are the most vulnerable because of the blindness of decision makers to the harsh consequences of mental illnesses.

Newspapers are rife with tragic stories resulting from funding cuts in essential services. On May 4, 2003, *The Oregonian* reported the following story about Farrah Russell (1):

> At age 22, she'd endured schizophrenia for more than three years and had considered taking her life

more than once.... But on this gray January day, she embraced the future.... And then came a tersely worded letter from the state. "This notice is about an important change," said the computer-generated form letter that arrived six days after Farrah moved out of her parents' home and into her own apartment. "The program which allows you to get a cash payment and medical care each month is ending.... The state no longer has the funding to provide this program. It will end on Jan. 31, 2003."

On Feb. 5, the manager of Farrah's apartment building gave her a 72-hour notice of eviction. Less than 24 hours later, Farrah swallowed a 30-day supply of her antipsychotic medications and died alone in her bedroom.

The closing of psychiatric hospitals, the subsequent crowding in psychiatric emergency rooms, and the elimination of community mental health resources speak to the abandonment of our nation's health and social responsibilities. We must vigorously address the root causes and the consequences of this political folly. Some consequences include homelessness, family disintegration, loss of work productivity, and a geometric increase in the mentally ill in jails and prisons. Our children, our future are at risk. There is a rising tide of abuse and neglect cases in the juvenile court system, a paucity of residential treatment centers for juveniles with demonstrable mental illness, and elimination of after-school programs, which serve the important function of providing a hot meal for poor children—the only one of their day.

There are other, more subtle, consequences of problems in the health care delivery system. The large amount of time required for administrative activities diminishes markedly time spent in patient care. This intolerable development spurred by the managed care industry and the depletion of government funding is ultimately wasteful and contrary to patients' needs, and it distorts the training model. There is a myth among decision makers that there is a pill, a cost-effective panacea, that will cure psychiatric illnesses, and this fantasy is contributing to the diminished role of the psychiatrist.

APA's outreach to business continues to inform decision makers in the corporate arena about the enormous costs, both human and financial, when psychiatric illness goes untreated or insufficiently treated. In February 2003, Mercer Human Resource Consulting and Marsh, Inc., an insurance broker, reported that 70% of 723 employers found that stress or depression had markedly increased as a disability condition. This figure is much higher than that of other health problems, including cancer, repetitive trauma, and cardiovascular illness.

In the United States, $24 billion a year is lost in disability, absenteeism, and decreased productivity. Employees represent 50% of the insured population in the private sector, and chief executive officers are alert to the fiscal consequences of failing to provide adequate mental health benefits.

The fight for parity must be fought on many different battlegrounds. Proposed legislation would apply only to employers who already offer mental health coverage, and then only to those with 50 or more employees. There is talk of restricting disorders, excluding, for example, posttraumatic stress disorder, anorexia nervosa, and autism. Under such fiscal constraint, employers may well drop their mental health coverage or circumvent the legislation by requiring higher copayments and deductibles.

What about our patients who are in the jails and prisons? A few years ago I was at a meeting held at the Los Angeles County Jail with representatives from the National Alliance for the Mentally Ill, the mental health staff, and the court system. A mental health worker described the dilemma posed by successfully treating an inmate with psychiatric illness but then having the results disappear after discharge with the absence of continuing treatment. He asked the judge, "Isn't there some way to have the prisoners stay longer?" What does this say about our society when the jail system is seen as the principal treating system! The Los Angeles County Jail, as mandated by the courts, has a 50-bed, well-staffed psychiatric hospital and 2,300 other inmates in a special section where they receive psychiatric medications and ongoing evaluations.

I am working closely with the APA Corresponding Committee on Jails and Prisons and the excellent staff in the APA Office of Healthcare Systems and Financing to analyze data from ongoing studies across the country. These data identify the rising costs of the criminal justice system, to both the states and the federal government, because of the massive influx of untreated psychiatric patients in jails and prisons. Untreated psychiatric patients don't disappear. They sit in overburdened emergency rooms, often live on the streets, and ultimately may wind up in jail. Long-range planning imperatives must meet the needs of the psychiatric patient community in these hard economic times.

The health care delivery system's serious problems have been daunting to economists for the past two decades. With urgency, APA must assemble a group of scholarly advisors to explore the impact of current policies on psychiatric care and to construct politically viable recommendations to improve health outcomes for the mentally ill, the disadvantaged, and children and their families.

I have pointed to the external challenges, but what about our internal ones? I think, for example, about the divide that has occurred in our field since the 1960s between the biological psychiatrists and the psychologically committed psychiatrists. In the 21st century, this polarization is contrary to the best interests of patient care and is not supported by modern neurobiological research. We have gone far beyond the search for the single gene or neurotransmitter to explain psychiatric illness, to an understanding that the biological processes are far more complex and involve both facilitating and protective elements, which in turn are highly influenced by environmental and developmental

factors. It is folly to separate nature from nurture and see them as independent of one another. In both research and clinical practice we must strive for an integration of these complex factors that will lead to greater depth in understanding our patients and, therefore, to better treatment. The journey from Kandel's studies of learning in the simple *Aplysia* to an increasingly complex understanding of how neurobiology is shaped by external influences should become a paradigm for our goals in clinical practice and research. APA must continue a strong advocacy role in encouraging and facilitating an integration of the biological and psychological in education and research as well as in clinical practice.

APA will continue to influence the clinical practice of psychiatry through the medium of the practice guidelines and continuing medical education. In many ways the practice guidelines serve as an ideal model for education as long as they are not used as a cookbook.

We are fortunate that in this time of national and state fiscal vulnerability we have a strong organization with many members who are devoted to fighting the good fight. This past year in my visits to the Bronx, Alabama, Texas, Hawaii, Illinois, New Jersey, Washington state, and, most recently, Minnesota I have met many of our talented colleagues and have been impressed with their dedication and their work.

We must remain firmly committed to the best in psychiatric education and research. If we don't advocate for our patients, there will be neither time nor money to use that education to provide quality care. It is moving to see the rapidly increasing awareness of our young psychiatrists. They know that we must be front and center in the battle for our patients and our profession or our patients' needs will go unheeded and our profession diminished.

Our capacity to do better has never been greater. This nation has always been a work in progress, and it will always be. This national view is mirrored in the values of our APA. We have it in our power to take our organization to new heights of accomplishment. That is our challenge. Your APA is there to meet that challenge, and I am proud to be a part of it. We need your help and involvement in the years ahead, and from the look of the crowds gathered here in San Francisco I see that we can count on it.

Thank you.

Presented at the 156th annual meeting of the American Psychiatric Association, San Francisco, May 17–22, 2003. Dr. Goin, 130th President of the American Psychiatric Association, is Professor of Clinical Psychiatry and Director of Residency Training, Adult Psychiatric Outpatient Department, Keck School of Medicine, University of Southern California. Address reprint requests to Dr. Goin, Suite 1115, 1127 Wilshire Blvd., Los Angeles, CA 90017-4002; mgoin@usc.edu (e-mail).

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Paul S. Appelbaum, M.D., 129th President, 2002–2003

Loren H. Roth, M.D.

Last winter when Paul Appelbaum, the 129th President of APA, asked me to introduce him today, I was proud and delighted. But I was dismayed when the organizers of this opening session informed me that I have only 5 minutes to do so. I will conform to that official request.

I first met Paul in 1980. He was fresh from his psychiatric residency at the Massachusetts Mental Health Center and already making important empirical and analytic observations on patient competency and the right to refuse treatment. Paul joined our Law and Psychiatry Program at the University of Pittsburgh. It was soon apparent to all in the program that he was something very special, gifted, a keen observer, an excellent writer and speaker, direct and honest, professional, and dedicated to psychiatry and its patients in all ways. He had a twinkle in his eye. And he was efficient. As the months went by I rapidly realized that in recruiting Paul we had struck gold. He was Mozart, we were Salieri. We would do best to further his genius so that all might advance.

Now it is 23 years later, and I am pleased to introduce him today to be recognized and listened to by all of American psychiatry, including forensic psychiatry. We have profited considerably from Paul's highly original intellectual contributions to law and psychiatry, his organizational leadership in the most important professional forums, including APA, and his advocacy for patients and our profession in these challenging times in the halls of Congress and extensively within other fields of medicine, including his efforts regarding how best to conduct scientific research with human subjects.

As a graduate of Columbia College and Harvard Medical School and as the A.F. Zeleznik Professor of Psychiatry, Director of the Law and Psychiatry Program, and chairperson of the Department of Psychiatry at the University of Massachusetts Medical School, Paul is known to us all—not only as our feisty and highly competent President of APA, but also through his two decades of informative writing in *The American Journal of Psychiatry* and *Psychiatric Services*. He has been the author or coauthor of 13 books—four of which were distinguished by APA as the year's outstanding book in law and psychiatry (1–4)—and hundreds of papers and chapters, the leader of influential commissions, and the recipient of prestigious awards; there is no area of general psychiatry and forensic psychiatry where Paul's voice has been silent. As pertains to the logic and practice of informed consent (5), psychiatric ethics, especially in forensic psychiatry (6), the understanding of the influence of law on psychiatry (7), and the prediction of dangerousness (4) so as to better guide psychiatric practice, our President is simply "the best." His textbook with Tom Gutheil set the standard in the field for the practicing clinician (7). His original work with Tom Grisso in the assessment of patient competency has had and will have broad influence in our field for decades to come, for research and better treatment of both civil and criminal patients (3).

Predictably, Paul has had a great Presidential year. As is only fair, and required in business circles, Paul's recent APA achievements can and should be judged by the objectives he delineated to us in the pre-election debates. For example, did Paul advocate this year in powerful ways to increase access to psychiatric care for patients, despite the negativity of local and national funding policies? Yes, as exemplified by his work with the President's Commission on Mental Health.

Did Paul's Presidency affect the APA organization in helpful ways? Yes, through his knowledge and contributions to the budgetary process, through his assistance in reorganization of the Central Office, through his present projects in revising and updating the APA ethics guidelines, and through his organizational mandate to psychiatry and APA to delineate now the essential characteristics of a caring and effective mental health system—to name only a few.

When Paul promises, he delivers. We are a better APA because of Paul's tenure as President. And Paul has consistently delivered emotionally and otherwise for his accomplished and very close family. Paul and Dede, his wife of 29 years, herself an accomplished author on social and environmental history, are the parents of Binyamin, a reporter; Yoni, who this week graduates from Columbia University, and Avigail, in her second year at Barnard.

For those of you who do not know Paul, I recommend that you read him carefully, apply what he teaches, and more important, consider the character and integrity of the man behind the words. Leaders lead by having vision, by informing and motivating others to do what they do best, and by raising our spirits through their own hard work and excellence of product. Paul, the scholar and thinker, is such a leader.

Let us listen then to this everywhere-acknowledged major figure in American psychiatry, to his insights and recommendations for psychiatry, patient care, and the formulation of public policy. And let us all subsequently act to help him to achieve this challenging vision for the good of our craft and our patients.

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