Donna M. Norris, MD
APA President-Elect Candidate Statement for the American Association of Community Psychiatrists

QUESTION 1*: Some believe in healthcare as a "right". Do you ascribe to this notion and why/why not? If you do agree that there is a right to healthcare access, what is the nature of this right and how would it be implemented? In your practice, administrative, and advocacy experiences, what specific activities can you point to in order to support your position on this issue?

Donna Norris, MD: This question highlights one of the major challenges facing American psychiatry today. It encompasses the legal rights and values of our society, in which, we as physicians, have both an ethical and professional responsibility to provide care to those in need. I believe that it is a right to have access to health care. And, as members of this society, we have a moral obligation to assure that all citizens have access to basic medical care without having to go into bankruptcy or suffer needlessly from chronic illnesses that result from lack of early identification or availability of preventive care. This is true whether for the least or worst among us, and is especially important for persons with mental illness who suffer from high rates of co-morbidity and have life expectancies shorter by 20 years compared to those persons without mental illness.

Last year we saw mental health parity become the law. As we come closer to the implementation of this new law, we must remain proactive to assure that mental health services for illnesses and substance use disorders are accessible and comparable to care offered for other medical disorders. Psychiatry must remain in the forefront, working with legislative, medical, and advocacy groups to improve a healthcare system that is neither effective nor sustainable in its current structure. We must continue to build alliances with allied psychiatric organizations, other medical colleagues, and advocacy groups to end stigma and to focus on building positive futures for our patients and their recovery.

During my years of working as an advocate for patients and the profession, I have learned that achieving the goal of quality healthcare for all will take much work. Past advocacy activities in which I have been involved include working to: 1) create access to health care for the uninsured, 2) develop strategies to reduce cost and increase psychiatrist's abilities to manage patients on Clozapine, and 3) support parity for mental health services and eliminate discriminatory practices and policies. As President of the APA, I will work to assure that psychiatry continues to be involved in the ongoing health care reform discussion, promoting increased access for individuals in need of psychiatric services, especially the underserved and uninsured populations. I will remain vigilant and proactive, working with governmental relations and other advocacy groups to address issues of reimbursement in the public and private sectors. I will support efforts already underway to better coordinate our patients' care with our primary care colleagues. Finally, I will work to support additional resource development for state

associations and district branches to meet the challenge of shrinking state budgetary constraints which impact the delivery of mental health care and substance abuse services. I am strongly committed to working with AACP to achieve these goals.

QUESTION 2: Given the state of the APA budget and the restructuring of APA staff and components, how will the organization be effective in supporting the interest of underserved populations that receive care primarily in the public/community sector? What ideas do you have to integrate allied organizations and to mobilize local DBs in such an effort?

Donna Norris, MD: The APA budget and restructuring of APA staff and components are major changes for the association. It will be important that members not allow fiscal challenges to redirect APA from its mission and priorities to provide quality psychiatric care and advocacy for patients. My medical career is devoted to advocating for the mental health needs of our patients, including children, the elderly and returning veterans. I am committed to this continuing this work. The work of advocacy and lobbying for our patients and our profession is important work for the Assembly of district branches and state associations many of whom are members in AACP and provide significant leadership for this and other APA components. The Council on Advocacy and Government Relations chaired by Bob Cabai, MD with vice chair Carl Bell, MD and the Council on Healthcare Systems and Financing chaired by Anita Everett, MD are important APA components focused on public psychiatry. A new program, the Transformational Leadership in Public Psychiatry Academy, focuses on preparing early and mid-career psychiatrists to become not just leaders, but leaders to make those important changes in the public system which will improve its capacity to provide real services to patients. AACP leaders are involved in developing the curriculum for this program and serve as mentors to these young members. Fiscal challenges call for creative solutions. AACP and APA are planning a collaboration to seek support from SAMHSA on Recovery to Practice that will develop a curriculum for psychiatrists to adopt recovery-oriented practice that embraces hope, strength, goal achievement and choice for people with mental illness. Recovery is an important concept which should be incorporated in the work of all psychiatrists, especially those who work with people with severe and persistent mental illness.

QUESTION 3: DSMV's development process has been controversial. What is your view concerning the opinion that it is premature to be producing a new DSM given the relative lack of scientific advance concerning diagnostic categorization?

Donna Norris, MD: The DSM-V developmental process will be delayed with its publication now changed from May 2012 to May 2013. This additional time will permit time for a number of the criticisms which question the DSM-V's prematurity to be addressed. There have been calls for information about the process which will be more transparent with the publication of proposed criteria. Once the recommended changes are posted in January 2010, 35 field trials will be initiated to examine changes in

existing diagnostic criteria. This will allow opportunities for public comment and feedback over a two month period after which a new draft will be developed and prepared for Board of Trustees' review. It is anticipated that a vote by the Board of Trustees will occur in approximately March 2012. The Board has appointed a DSM-V oversight committee which will also review the process. As chairperson of the Ad Hoc Board Task Force that vetting the work group members, I know that the members engaged in this work are motivated to offer the best scientific product possible. There are few diagnoses in the DSM-V to which we can point to as represented by new scientific advances. Commentaries considering the implications of the DSM-V in forensic work are scheduled to be published in the next few months. Opening up the process by permitting member review of the work products and deliberations of the workgroups is an important step forward. I am supportive of the ongoing work in the profession which seeks to bring clarity to our understanding of our patients. The DSM-V must be usable and practical for use by community psychiatrists and primary care physicians.