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MENTAL HEALTH PARITY: A DECADE AFTER THE MENTAL HEALTH PARITY ACT OF 1996

Sy Atezaz Saeed, M.D.

The essential purpose of health insurance is to protect individuals against financial loss when they need treatment. Disparities in insurance coverage between mental illness and other medical illnesses have been in place since contemporary health insurance first developed in this country. Several factors have contributed to the evolution of an insurance system with marked differences in coverage between mental and other medical illnesses. These factors have included poor public understanding of mental illness, persistent social stigma, public-private split in coverage, and ineffective advocacy. While parity addresses several of the areas that led to the disparity in the first place, the most important goal of parity has been to ensure that the protection against financial loss, when they need treatment, is extended to individuals with mental illness the same way it is available to people with other medical conditions. During the past decade we have seen a search for parity on both the state and federal levels. As the Mental Health Parity Act of 1996 turns a decade old, this is an opportune time for us to review the current status of mental health parity.

The Mental Health Parity Act of 1996 (MHPA):

The Mental Health Parity Act of 1996 (MHPA) is a federal law that prevents group health plans from placing annual or lifetime dollar limits on mental health benefits that are lower, less favorable, than annual or lifetime dollar limits for medical and surgical benefits offered under the same plan. For example, if a health plan has a $1 million lifetime limit on medical and surgical benefits, it cannot put a $100,000 lifetime limit on mental health benefits. The term "mental health benefits" means benefits for mental health services defined by the health plan for coverage. It is important to note that although the law requires "parity," or equivalence, with regard to dollar limits, MHPA does not require group health plans and their health insurance issuers to include mental health coverage in their benefits package. The law's requirements apply only to group health plans and their health insurance issuers that include mental health benefits in their benefits packages. If the group health plan has separate dollar limits for mental health benefits, the dollar amounts that the plan has for treatment of substance abuse or chemical dependency are not counted when adding up the limits for mental health benefits and medical and surgical benefits to determine if there is parity.

MHPA applies to most group health plans with more than 50 workers. It applies to group health plans for plan years beginning on or after January 1, 1998. The original sunset provision (providing that the parity requirements would not apply to benefits for services furnished on or after September 30, 2001) has been extended five times. The current extension runs through December 31, 2006. MHPA does not apply to benefits for substance abuse or chemical dependency. The law does not apply to group health plans sponsored by employers with fewer than 51 workers.

MHPA also does not apply to health insurance coverage in the individual market. However, the state law may require mental health parity in other cases.
Group health plans may impose some restrictions on mental health benefits and still comply with the law. For example, MHPA does NOT prohibit group health plans from:

- Increasing co-payments or limiting the number of visits for mental health benefits;
- Imposing limits on the number of covered visits, even if the plan does not impose similar visit limits for medical and surgical benefits; and
- Having a different cost-sharing arrangement, such as higher coinsurance payments, for mental health benefits as compared to medical and surgical benefits.

Cost of Mental Illness and Disparity

Today, millions of Americans with mental disorders remain without equal access to health insurance. Many health plans continue to discriminate against these people by limiting mental health and substance abuse healthcare services through imposing lower day and visit limits, higher co-payments and deductibles and lower annual and lifetime spending caps.

The combined indirect and related costs of mental illness, including costs of lost productivity, lost earnings due to illness, and social costs are estimated to total at least $113 billion annually[1]. It is estimated that depression alone costs the U.S. $43.7 billion annually, including

workplace costs for absenteeism and lost productivity ($23.8 billion), direct costs for treatment and rehabilitation ($12.4 billion), and lost earning due to depression-induced suicides ($7.5 billion)[2]. Health plans with the highest financial barriers to mental health services have higher rates of psychiatric Long Term Disability (LTD) claims, and companies with easier access to mental health services see a reduced incidence of LTD claims[3]. It has also been demonstrated that cutting dollars for mental health care can increase overall medical costs. For example, a 30 percent cost reduction in mental health services at a large Connecticut corporation triggered a 37 percent increase in medical care use and sick leave by employees using mental health services, thus costing the corporation more money rather than less[4].

Cost of Mental Health Parity:

A recent study of implementation of parity in the federal employees health benefits program (FEHBP), which covers 8.5 million federal employees, retirees and dependents, found that the added use and costs of mental health services were minimal, when compared with the experience of plans with less generous benefits[5]. This study confirmed that eliminating arbitrary and inflexible limits on coverage for treatment of mental illness is affordable for health plans and employers. The study examined what happened when the FEHBP program eliminated inequitable limits such as caps on inpatient days, outpatient visits, higher cost sharing and deductibles, etc. applied on coverage for mental illness and substance abuse. The Clinton Administration imposed this parity requirement by Executive Order in 1999. Over the two years examined, the study found that the proportion of people using mental health services rose by 1.35% to 2.75%, compared with the two years before the change. However, both spending and use of mental health services did not increase more than a set of similar large employer plans that kept limits on mental health services in place. Researchers found that any increase in costs was mainly due to inflation and an expected rise in the use of mental health services and medications. However, what did change with plans in the FEHBP program was a significant drop in out-of-pocket costs for those who used mental health services. In all but one of the plans, enrollees saw individual savings ranging from $8.78 to $87.06 as the cost of picking up those amounts were spread across the entire plan. This study demonstrated that implementing parity, and eliminating discriminatory limits on coverage, is affordable.

In another recent study Harris and colleagues examined the impact of state parity laws on access to services using the National Surveys on Drug Use and Health[6]. The study found a modest increase in use of mental health services in states enacting parity legislation, with effects concentrated in persons with low-to-moderate levels of distress. Regardless of parity status, rates of mental health treatment were dismally low, with only about one quarter of individuals in the high-distress group obtaining any mental health services. These studies[5-6] are consistent with previous studies of state parity laws, which have found relatively little impact of these regulations on utilization of mental health services[7-10].

SAMHSA estimates that severe mental illnesses account for 90 percent of any cost increases from parity. They further estimate that adding children to federal legislation would result in a cost increase of approximately 0.8 percent in managed care settings[11]. While the estimated annual cost to the nation of providing mental health coverage equal to physical health coverage for all children and adults is $6.5 billion, it is also estimated that this mental health coverage would result in savings for general medical services and indirect costs in the amount of $8.7 billion - a net annual savings of $2.2 billion[12]. Studies have found that overall medical care costs decrease for those using behavioral healthcare services, when such costs were generally increasing[13].

Federal Parity

Since the passage of the Mental Health Parity Act (P.L. 104-204) in 1996, many employers and insurers have violated the spirit of that law, by placing other restrictions on mental health benefits, such as limits on the number of covered outpatient office visits and number of days for inpatient care. Repeated legislative efforts in Congress to close these loopholes have won broad bipartisan support. President Bush at one time expressed support for, and pledged to push for enactment, of parity legislation, but has not renewed that call. Congressional leaders have blocked efforts to bring an expanded parity bill to an up-or-down vote, however, and Congress has instead simply kept the 1996 law in force, through a series of one-year extensions.

Mental Health Parity Timeline [Table Source National Mental Health Association[14]. Reprinted with permission]	
1993	Congress begins debate on mental health parity.
1996	Congress passes the Mental Health Parity Act of 1996 requiring that annual and lifetime dollar limits on mental health care not be stricter than for other medical care.
May 2000	The General Accounting Office (GAO) reports that while most employers complied with the 1996 Act, 87 percent of those plans restricted their mental health coverage in other ways, substituting new barriers for those ruled out under the law.
January 1, 2001	The federal government institutes mental health and substance abuse parity under the Federal Employee Health Benefits (FEHB) Program (the health plan covering federal employees including members of Congress, their dependents and staff).
March 15, 2001	The Mental Health Equitable Treatment Act (S. 543) – mirroring the mental health parity provisions adopted under FEHB – is introduced by Senators Domenici and Wellstone. (Rep. Roukema introduced broader parity bill in January 2001, H.R. 162; in March 2002, Roukema introduces H.R. 4066, a companion to S. 543.).
August 1, 2001	Senate Committee on Health, Education, Labor, and Pensions (HELP) unanimously adopts a compromise version of S. 543.
October 30, 2001	Senate by voice vote adopts parity provisions of S. 543 as an amendment to a Labor-Health and Human Services-Education appropriations bill.
December 18, 2001	Conferees on the Labor-HHS appropriations bill drop the parity amendment after House conferees reject it on party-line vote, citing objections of committees of jurisdiction. The conference explanatory statement says, "the conferees strongly urge the committees of jurisdiction…to convene early hearings and undertake swift consideration of legislation to extend and improve the mental health parity protections."
April 29, 2002	President Bush endorses parity, pledges to work with congressional leaders to win passage and announces establishment of a mental health commission.
March 13 and July 23, 2002	House Committees on Education and Workforce and Energy and Commerce, respectively, hold hearings on mental health parity, but take no further action thereafter on the legislation.
February 27, 2003	The Senator Paul Wellstone Mental Health Equitable Treatment Act (reflects compromises adopted in 2001), S. 486, is introduced by Senators Domenici and Kennedy; a companion, H.R. 953 is introduced by Reps. Kennedy and Ramstad on March 24th.
July 23, 2003	President's New Freedom Commission on Mental Health endorses parity.
October-November 2003	Senate debate surrounding the one-year anniversary of the death of Sen. Paul Wellstone leads to a Nov. 6th floor colloquy reporting that Sen. Judd Gregg, HELP Committee chair, indicated he would give high priority to mental health parity legislation early in 2004.
April 26, 2004	National survey conducted by Public Opinion Strategies for the Coalition for Fairness in Mental Illness Coverage shows that 78 percent of Americans believe it is unfair for health insurance policies to routinely limit mental health benefits and require people to pay more out-of-pocket for mental health care than for any other medical care.
April 26, 2004	The Senator Paul Wellstone Mental Health Equitable Treatment Act (S. 486/H.R. 953) has 69 co-sponsors in the Senate and 245 in the House of Representatives. Despite the two-year anniversary of the President's call for passage of parity legislation, no action has been taken or is scheduled on these bills in any of the committees of jurisdiction. More than 365 diverse organizations – including groups representing the faith community, families, veterans, educators, physicians, county government, corrections, and children – support this legislation.

This year, Reps. Jim Ramstad, R-Minn, and Patrick Kennedy, D-R.I., have introduced the Senator Paul Wellstone Mental Health Equitable Treatment Act, H.R. 1402, a measure that would require employers with more than 50 employees to provide comprehensive mental health and substance-use parity. While a parity bill has not been introduced this year in the Senate, Sens. Pete Domenici, R-N.M., and Edward Kennedy, D-Mass., who sponsored parity legislation in the last Congress, continue to work on this issue behind the scenes with an eye to passing a bill this year.

State Actions

To date, 36 states have made into law some form of mental health parity. Five state laws (CT, MD, MN, OR, VT) apply to all mental health and substance abuse disorders under private insurance plans. Six other states (IN, KY, ME, NM, RI, WA) have slightly less comprehensive laws that contain specific exemptions or limitations. Twenty-five states (AZ, AR, CA, CO, DE, HI, IA, IL, LA, MA, MO, MT, NE, NH, NV, NJ, NC, OK, SC, SD, TX, TN, UT, VA, WV) have laws that apply only to select groups, such as those with severe mental illnesses or government employees, or only prohibit certain forms of discrimination. A chart summarizing state mental illness parity laws is available at the website of the National Alliance for the Mentally Ill[15].

Several states have enacted laws that require insurance parity only for a small set of specified diagnoses or serious mental illnesses, however. These laws discriminate against children and adult whose illnesses can be as disabling as those specified in the laws, but do not fit neatly within the statutes' criteria. Adults excluded from protection under these laws include those who have post-traumatic stress syndrome, anorexia nervosa and bulimia, multiple personality disorders, and substance abuse disorders. Children with serious emotional disturbances and substance abuse disorders are also excluded.

Conclusions

While the costs to business and society of poor mental health care are significant, the price tag on mental health parity legislation is relatively small. The experience of states that have implemented parity legislation confirms that indeed mental health parity is affordable. While the Mental Health Parity Act of 1996 was an important step toward addressing disparity, it did not achieve parity in coverage for medical and mental health benefits. Its failure to achieve this goal can be attributed to three significant flaws[16]: 1) illness classification remains an issue and thus individuals still face the challenges of litigation; 2) MHPA includes significant exemptions; and 3) substantial loopholes in legislation allow insurers to avoid true parity.

There continue to be lingering question in regards to who should bear the cost of treating severe mental illnesses: the ill person and his or her family; the employer and fellow workers through their insurance plan; private social agencies; or some level of government? Some also ask whether the burden of severe chronic mental illness be viewed differently than similar chronic physical illnesses. Question has also been raised whether the efforts should focus on getting parity for all mental illnesses or only the illnesses currently understood to be "biologically based" and should parity laws include substance abuse treatment?

From a practical standpoint, there are also several relevant questions:

- What criteria should be used to determine whether treatment of mental illness is medically necessary?
- What should be the specified outcome of mental health treatment?
- How should we measure whether treatment has been successful?

Despite all these questions, today we have ample data to support the assertion that improving access to health insurance for the mentally ill is not only socially beneficial, but it is also economically sound. The cost of instituting mental health parity is far outweighed by the costs that employers bear because of the reduced productivity of untreated mental illness sufferers. Unfortunately, it is also clear that MHPA cannot address the current problems associated with disparities. To address these disparities there must be additional mental health policy legislation.

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CALL FOR PAPERS

The ***Psychiatrist Administrator*** invites articles on all areas of psychiatric administration and management with a focus on the roles and perspectives of psychiatrists in leadership and management roles. Please make submissions and inquires to:

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PRESIDENT'S COLUMN - FALL 2006

SHIV HATTI, M.D., MBA

Hello Friends,

Since my last communication with you many good things have happened in our organization. At the Annual APA Meeting, we offered two full days of courses on Administrative Psychiatry, this after a three-year hiatus. The courses were well attended and we received many very positive comments. We have been invited back by APA's scientific committee to resubmit one of the courses as-is, and also the other with some modifications. This is a testament to the outstanding job given by our faculty. We will be submitting material for both courses. In addition, our members presented four workshops: "Health Services Research" by Dr. Buwalda, "So you Want To Be Clinical Investigator" by Dr. Lazarus, "Doing More with Less: Challenges and Rewards of becoming a Psychiatrist Executive" by Dr. Saeed, and "Career Advancement in Academic Psychiatry for Early Career Psychiatrist" by Dr. Vergare.

We had a very productive Annual Membership and Executive Committee Meeting in Toronto. Andrew Kolodney, M.D., made an excellent educational presentation entitled, "The Challenges and Rewards of Psychiatric Administration – Perspective of an Early Career Psychiatrist". Additionally, Kimberly Bogan, M.D., our new BMS Fellow, joined the Executive Committee meeting, and offered several initiatives which we hope will help to increase membership and participation rates of residents and early-career psychiatrists.

We received a grant of $10,000 from Astra-Zeneca. We thank Dr. Brandt, Dr. Lazarus, and Frances for their work in obtaining funding for our activities.

I am blessed with a great team at AAPA. Dr. Lazarus, our President-Elect, is always, available to help. Dr. Brandt, our Treasurer, keeps close watch on our financial health. Dr. Saeed, our Editor, continues to produce a good quality product in *Psychiatrist Administrator*. Dr. Herman, our AAOL representative, remains very active in the APA Assembly, and has recently been appointed to the Audit Committee of APA in addition to the Managed Care Committee.

Our goal at AAPA is to promote and educate medical leadership in behavioral healthcare. Please contact me if you have any suggestions or comments about our activities in education, financial needs, and membership growth.

The AAPA on line . . .

Visit our new website: **www.psychiatricadministrators.org**
and let us know what you think.
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IMPLICATIONS OF THE NEW MEDICARE DRUG BENEFIT FOR MENTAL HEALTH TREATMENT

Julie M. Donohue, Ph.D.

Introduction

The Medicare Improvement and Modernization Act (MMA) of 2003 authorized a new Medicare drug benefit (Part D) that offers a new source of drug coverage to the roughly one-fifth of beneficiaries who lack coverage (Kaiser Family Foundation 2005). The MMA also changes the source of coverage for approximately 7 million Medicare beneficiaries who are dually eligible for and had their prescription drugs paid for by Medicaid prior to 2006. The new Medicare drug benefit has important implications for mental health treatment. Medicare will become a major source of financing for psychotropic medications for individuals over the age of 65 and the 52% of Medicare's disabled population with a mental disorder (Donohue 2006).

Medicare Part D will likely expand coverage and access among beneficiaries with mental disorders. However, concerns remain that drug plans have financial incentives to impose restrictions on access to drugs, such as psychotropic medications, used by individuals with high expected drug costs. The Centers for Medicare and Medicaid Services (CMS) has dealt with these issues by enacting a number of special provisions for plan coverage and management of psychotropic medications. In this paper, I discuss the implications of Medicare Part D for mental health treatment among Medicare beneficiaries.

The paper is organized as follows. First, I discuss the importance of psychotropic drugs to contemporary mental health treatment and describe how psychotropic drugs are currently financed, in general, and for Medicare beneficiaries, in particular. I then briefly describe the Medicare Part D delivery system, and the financial incentives faced by drug plans administering the benefit. I go on to describe the statutory and regulatory rules put into place to guide drug plan formulary coverage of psychotropic drugs and provide some data on plans' formularies and use of management tools for psychotropic medications. Finally, I discuss the implications of Medicare Part D for access to psychotropic drug treatment among Medicare beneficiaries and Medicaid purchasing of psychotropic medications.

Psychotropic drug treatment: trends and financing

Psychotropic drugs are playing an increasingly central role in the treatment of mental disorders (Frank, Conti, Goldman 2005). The overwhelming majority of individuals who are treated for mental health or substance abuse disorders receive pharmacotherapy either alone (34 percent of those treated) or in combination with other outpatient treatment (e.g. psychotherapy) (41 percent) according to analyses of the Medical Expenditure Panel Survey (Zuvekas 2005). The introduction of new medications to treat mood disorders, attention deficit hyperactivity disorders, psychotic disorders, and other psychiatric conditions, led to an increase in the number of people receiving psychotropic drug treatment as well as the substitution of newer, more expensive agents for older drugs in the 1990s. Most of the psychotropic medications introduced in the last 20 years are similar to older agents in terms of efficacy but are easier to diffuse to patient populations due to more favorable side effect profiles and/or dosage forms (Frank and Glied, 2006). Expenditures on psychotropic drugs grew from $2.7 billion to $17.8 billion between 1987 and 2001 (Frank, Conti, Goldman 2005). Since 1997, the growth in spending on psychotropic medications has outpaced that for health care and prescription drugs overall (Frank, Conti, Goldman 2005).

Private health insurance covers 47% of expenditures on prescription drugs overall yet only 36% of psychotropic drug expenditures (Table 1). Consumer out-of-pocket spending and public insurance programs, particularly Medicaid, play a greater role in financing psychotropic medications than financing prescription

Acknowledgements: Dr. Donohue wishes to acknowledge support from the NIH Roadmap Multidisciplinary Clinical Research Career Development Award Grant (K12 RR023267) from the National Institutes of Health.

Table 1: Distribution of sources of payment for prescription drugs, and psychotrotropic drugs, by population (U.S. population and Medicare) in 2001

	All prescription drugs	Psychotropic Drugs		
Source of Payment	U.S. Population	U.S. Population	Medicare, age 65+	Medicare, under age 65
Out-of-pocket	31%	36%	59%	37%
Private Health Insurance	47%	36%	23%	13%
Public	22%	28%	18%	50%

Sources: Zuvekas (2005) analsis of data from Medical Expenditure Panel Survey 2001; Levit et al (2003) analysis of data from Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group

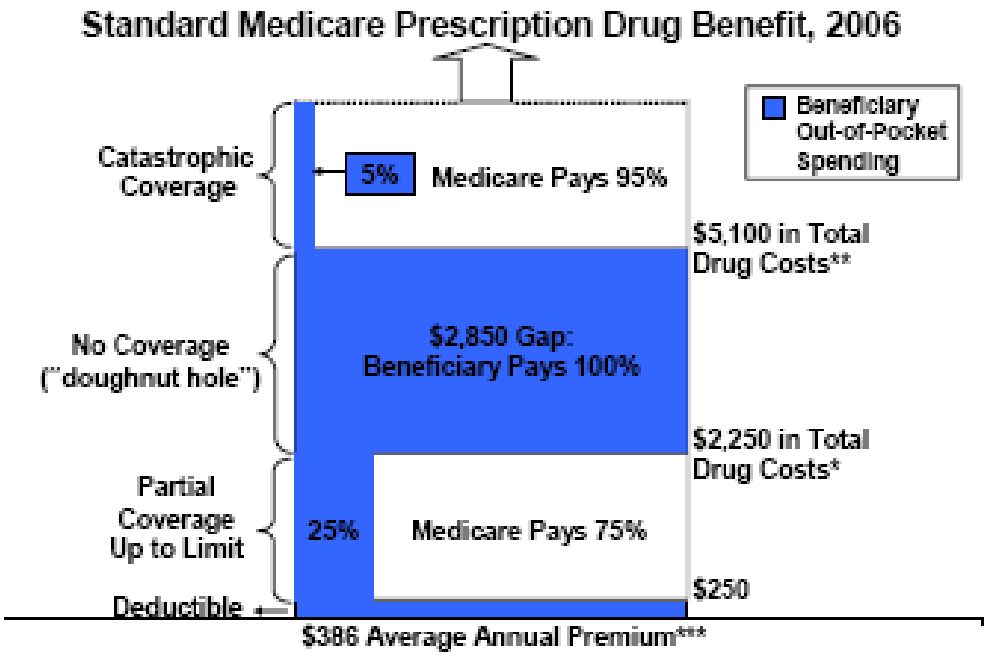
drugs overall. Thus, public policy regarding benefit design and delivery system of public insurance systems can have important effects on access to psychotropic medications. The importance of Medicaid as a financing mechanism varies depending on the class. In 2001, the Medicaid program paid for 75% of antipsychotic prescriptions compared to 18% of prescriptions overall (Duggan 2005).

Private health insurance plays an even smaller role in financing psychotropic medication expenditures among Medicare beneficiaries. Beneficiaries age 65 and older pay for most (59%) psychotropic drug costs out-of-pocket while public sources (Medicaid) finance 50% of psychotropic drug costs for Medicare beneficiaries under the age of 65 who are eligible for Medicare as a result of a long-term disability (Table 1). Whereas, prior to 2006, Medicaid was the major public source of financing for psychotropics for Medicare beneficiaries, Medicare drug plans will now assume this role.

Medicare Drug Benefit Delivery System

The new Medicare drug plan market was designed to maximize beneficiary choice and promote competition among plans on quality and price. Beneficiaries may either stay in the fee-for-service (FFS) Medicare program and obtain prescription drug coverage by enrolling in a private prescription drug plan (PDP) or enroll in a Medicare Advantage-Prescription Drug (MA-PD) plan for all Medicare covered benefits inclusive of prescription drugs. In 2006, nearly 80 organizations offered 1,429 stand-alone PDPs. The number of plans and confusion among Medicare beneficiaries choosing plans has received a great deal of attention in the press (Pear 2006a, 2006b). Yet, nearly 90% of the PDPs were offered by 16 organizations which tended to use the same benefit structure, cost-sharing, and formulary among their different plans in each of 34 regions (MEDPAC 2006). The MMA establishes a standard benefit design that provides both up-front coverage and protection against high drug costs with a coverage gap, the infamous "donut hole." The standard benefit design calls for a $250 deductible, 25% cost-sharing until total drug expenditures reach $2,250, no coverage for total expenditures between $2,250 and $5,100, and 5% beneficiary cost-sharing above $5,100 (or *out-of-pocket* spending of $3,600) (See Figure 1). Individuals dually eligible for Medicaid and low-income beneficiaries will receive substantial subsidies to cover out-of-pocket costs. Dually eligible individuals and beneficiaries with incomes <135% of poverty pay no monthly premium, no deductible and low copays ($1-$5 depending on income-level and whether the drug is brand or generic). Individuals with incomes 135%-150% of poverty pay sliding scale premiums, an annual deductible of $50 and 15% cost-sharing. In addition, low-income individuals do not lose coverage in the donut hole. Approximately 7.3 million full benefit dual eligibles and Supplemental Security Income (SSI) recipients automatically received the low income subsidies in 2006. Unfortunately, only 1.7 million

Figure 1



Source: Kaiser Family Foundation Illustration of standard Medicare drug benefit, as described in the MMA of 2003. *Equivalent to $750 in out-of-pocket spending. ** Equivalent to $3,600 in out-of-pocket spending. *** Annual amount based on $33.20 national monthly beneficiary premium (CMS, August 2006).

of the 4.9 million non-dually eligible low-income beneficiaries who are eligible for the low-income subsidy applied for and received the benefit as of May 2006 (Kaiser Family Foundation 2006a).

Plans were permitted to offer either the standard benefit design or an actuarially equivalent or enhanced alternative. In practice, most (91%) plans have altered some feature of the standard benefit design. The feature of the benefit design most likely to be altered by plans is the cost-sharing. Instead of the fixed 25% coinsurance rate on prescription drug expenses up to the $2250 limit, most plans have adopted either a two-tiered copayment system (different copays for brand name and generic drugs), or a three-tiered system. Among those plans offering an actuarially equivalent three-tiered copayment system, average copays were $7 for generics, $22 for preferred brand name drugs, and $55 for non-preferred brands (MEDPAC 2006).

Economic incentives for Medicare Drug Plans

Requiring multiple plans to compete for enrollees rather than for a contract to serve a particular area creates the risk of adverse selection and incentives for plans to attract healthy enrollees (Huskamp, et al 2000). Unlike Pharmacy Benefit Managers (PBMs) which are not typically at financial risk for managing drug costs, PDPs will face some risk. Monthly payments will be risk adjusted to account for differences in enrollee drug spending. However, the current risk adjustment model is not likely to fully attenuate the risk of adverse selection in this context (Donohue 2006). Prescription drug spending is more persistent and therefore more predictable to consumers than other health spending. Pauly and Zeng (2004) found that 60% of individuals in the highest quintile of drug spending in 1994 remained in that quintile in 1998 while only 40% of individuals with the highest inpatient and outpatient spending were in the highest tier. Therefore, beneficiaries are likely to select plans on the basis of their drug spending (Ellis 1985). Medicare drug plans will have an incentive to impose limits on drugs frequently used by beneficiaries with high expected drug costs. Incentives to under-provide psychiatric medications in the context of the Medicare drug benefit may be particularly strong for several

reasons. First, psychiatric medications are among the most expensive classes of drugs. Antidepressants and antipsychotics ranked third and fourth in total dollar sales in 2003 (IMS Health). Antidepressant sales are high due to the sheer volume of their use while antipsychotic sales rank highly because of their high prices. Second, serious mental illnesses are chronic and persistent and individuals are likely to take medications for a period of years. Thus, spending on psychiatric drugs is highly persistent and predictable to consumers. In the Missouri Medicaid program, among individuals dually eligible for Medicare and Medicaid who used psychiatric drugs, 82% of those in the top quartile of drug spending in 2003 were also in the top quartile in 2004 (personal correspondence, Comprehensive NeuroScience, Inc. 2005).

Formularies and utilization management tools

PDP plans are permitted to use formularies or preferred drug lists to contain costs and negotiate lower prices with pharmaceutical manufacturers. Formularies, cost-sharing and other pharmacy management tools will be important mechanisms plans use to manage cost and quality. And yet, these tools may also be used by plans to discourage enrollment of beneficiaries with high expected drug costs. In order to manage costs, plans may either exclude costly drugs from their formularies or impose a high co-payment or coinsurance on certain drugs. Importantly, beneficiaries will face the full out-of-pocket cost for off-formulary drugs and these costs will not count toward an enrollee's out-of-pocket maximum spending limit. The MMA contains two important provisions related to use of pharmacy management tools including but not limited to formularies: (1) plans are required to offer a minimum of 2 drugs from each therapeutic category or class, and (2) plans shall not be permitted to use pharmacy management tools in such a way as to discourage enrollment of certain groups of beneficiaries (the so-called non-discrimination provision).

The MMA and formulary guidelines developed by the Centers for Medicare and Medicaid Services (CMS) imposed additional requirements for plans' coverage of some psychotropic medications while excluding other psychotropic drug classes from coverage. On the one hand, plans are required to list "all or substantially all" antidepressants, antipsychotics, anticonvulsants, anticancer drugs, immunosuppressant drugs, and HIV/AIDS drugs. CMS imposed this requirement due to concerns that plans would discriminate against patients taking these medications and because such a rule was consistent with the use of a broad and complex range of drugs for these diseases in actual practice (CMS 2005). However, CMS did not require plans to cover multi-source brands of the identical molecular structure, extended release products or all dosage forms. An analysis of plan formularies found that plans cover on average 92% of antidepressants in 2006 (Hoadley et al 2006). On the other hand, benzodiazepines, which are used by nearly 10% of Medicare beneficiaries, were explicitly excluded from coverage under the Medicare drug benefit (Donohue 2006; Bambauer, Sabin, and Soumerai 2005). To fill in the gaps, many state Medicaid programs have provided coverage of benzodiazepines for beneficiaries dually eligible for Medicare and Medicaid.

In conjunction with formularies or preferred drug lists, drug plans are permitted to use other pharmacy benefit management tools such as quantity limits, step therapy, prior authorization, generic substitution and therapeutic interchange. CMS considers use of these tools to be appropriate insofar as they "drive medically appropriate and cost-effective access to Part D covered drugs" (CMS, 2005). In 2006, most plans applied these utilization management tools to at least some drugs on their formularies but use of these tools is concentrated among relatively few classes. For example, while all PDPs use prior authorization for at least one drug the median plan applies prior authorization to only 9% of the drugs on its formulary (MEDPAC 2006). Plans typically apply these tools in therapeutic categories with high-cost drugs and/or drugs with elevated safety risks (MEDPAC 2006). Table 2 lists the drug classes that are targets for plan prior authorization requirements. Antidepressants and antipsychotics are among those classes most often targeted by plans due to the heterogeneity in drug prices within these classes. For example, antipsychotic prices can differ by a factor of 10 to 20 (Rosenheck et al 2001).

Table 2: Part D Plans' Use of Prior Authorization in Selected Categories

Therapeutic Category	Median % of listed drugs subject to prior authorization, among plans that use it	
	PDP	MA-PD
All drugs	9%	9%
Aytpical antipsychotics	33%	33%
Dylipidemics	13	17
Immune suppressants	83	71
Metabolic bone disease agents	17	17
Molecular target inhibitors	75	75
Opiod Analgesics	12	9
Oral hypoglycemics	17	11
Proton Pump Inhibitors	50	75
Renin-angiotensins	2	4
Reuptake Inhibors (Selected antidepressants)	5	5

Source: Medicare Payment Advisory Commission (MEDPAC) Report to the Congress 2006

Impact of Medicare Part D on Access to Psychotropic Medications

The impact of Medicare Part D on beneficiaries depends on their previous sources of drug coverage, level of drug spending, and the characteristics of the plan they choose (e.g. formulary, and cost-sharing). For Medicare beneficiaries previously without drug coverage, Part D is likely to improve access to medication therapy for mental disorders. Evidence suggests that cost-related underuse of prescription drugs is common and can lead to negative health outcomes (Maio et al 2005). Beneficiaries' out-of-pocket expenditures for prescription drugs are estimated to be 37% lower, on average, under Part D (Kaiser Family Foundation 2004). Beneficiaries who receive low-income subsidies who were not previously enrolled in Medicaid are estimated to achieve the highest level of savings, spending 83% less under Part D (Kaiser Family Foundation, 2004). Given that disabled and elderly Medicare beneficiaries pay for 37% to 59% of psychotropic drug costs out-of-pocket, respectively, (See Table 1) Medicare Part D could significantly reduce economic barriers to initiation of and adherence to medication therapy for mental disorders among this population.

The dual eligibles, whose drug costs were previously covered by Medicaid, are responsible for modest cost-sharing ($1-$5 depending on their income level and the drug they are taking). In order to maintain continuity in drug coverage, dual eligibles were auto-assigned to plans in their region in the fall of 2005. Beneficiaries who did not choose another plan were automatically enrolled in the plan by January 2006. The assignment algorithm used did not take current drug utilization into account (Morden and Garrison 2006). There is substantial variation with respect to how tightly Part D plans manage psychotropics in terms of formulary restrictions, prior authorization and step therapy. For example, one study found that the number of antidepressant drugs for which providers and patients need to seek prior authorization varies from 1 to 6 depending on the plan (Donohue, Epstein, and Frank 2006). The extent to which dually eligible beneficiaries with mental disorders experience treatment disruptions as a result of enrollment in Part D will depend on the characteristics of the plans to which they are assigned.

Impact on Medicaid programs

The transition of dually eligible beneficiaries to Part D will also have a significant impact on Medicaid drug spending. In January 2006, approximately half of state

Medicaid program's market share shifted to PDPs (Morden and Garrison 2006). The ability of states to negotiate rebates with manufacturers of psychotropics may be reduced due to this loss of market share. Moreover, some have estimated that prices paid by PDPs are 14% to 50% higher than what Medicaid would have paid, had the dually eligible continued receiving drug coverage through those programs (Schondelmeyer 2006). Moreover, states are not off the hook financially for dually eligible beneficiaries. To help offset the cost of the new drug benefit and recapture a portion of state Medicaid dollars previously spent on outpatient prescription drugs for this population, the federal government requires each state to make monthly payments to the Medicare program, known as "clawback" payments. Each state's clawback payment for 2006 is the product of 2003 per capita drug spending for full benefit dual eligibles; the estimated growth in per capita drug spending nationally between 2003 and 2006; the number of full benefit dual eligibles in the state; and a phase-down provision (Kaiser Family Foundation 2006). Some state officials have objected to the clawback formula because they estimate that costs for 2006 would have been significantly lower than they had been in 2003 due to aggressive cost containment policies implemented in some states in recent years.

Conclusions

The new Medicare drug benefit will provide an important source of financial protection for Medicare beneficiaries with mental disorders. For beneficiaries who did not previously have drug coverage, the new benefit could substantially improve access and adherence to psychoptropic drug treatment. However, PDPs are permitted flexibility in how they design their formularies and cost-sharing, and in the use utilization management tools. Therefore, the extent to which Medicare beneficiaries benefit from the new drug benefit will depend in large part on the details of the plan in which they enroll. CMS rules for PDP formulary coverage of antidepressants, antipsychotics and anticonvulsants go a long way to ensuring access to a range of appropriate medications to treatment mental disorders. Yet, some plans have imposed prior authorization requirements on commonly used drugs in these classes. Depending on how these policies are implemented in practice, they could lead to treatment disruptions among a highly vulnerable population (Soumerai 2003). CMS should examine the impact pharmacy management tools on treatment patterns and health outcomes among beneficiaries with mental disorders.

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CRUCIAL CONVERSATIONS: HAVE YOU HAD ONE LATELY?

Arthur Lazarus, M.D., M.B.A.

Joseph Grenny is co-author of the *New York Times* bestsellers *Crucial Conversations* and *Crucial Confrontations*. He has consulted with more than 300 of the *Fortune 500* companies on corporate change initiatives over the past 30 years, including healthcare organizations. Research conducted by Mr. Grenny and his colleagues suggests that physicians who provide the best care are the ones willing to engage non-physician executives in conversations related to practice administration. In doing so, physicians effect change by spending a significant amount of time on activities unrelated to direct patient care.

If you do not have the time to read Mr. Grenny's books, at least read his recent article in *Physician Executive* (volume 32, issue 4, pages 12-15), "Knowing No Boundaries: Five Crucial Conversations for Influencing Administration." There are various types of conversations that physicians may initiate that could result in better relationships with hospital staff, improved quality of care, and greater productivity. These conversations fall into one of five general categories:

1. Concerns with competence. Physicians fail to deal with colleagues who are perceived to be incompetent. Instead, they try to work around the problem physician (or nurse), ultimately resulting in patient harm and poor quality of care.
2. Administrative decisions. Physicians rarely try to overturn administrative decisions that adversely affect their practice. They do not take the time to speak to the right people in the right way to try to exert influence over these decisions.
3. Mistrust of administration. Friction between administrators and physicians appears to be as bad right now as it has ever been. And yet most physicians have only expressed these concerns to their colleagues or others who have little influence to make things better.
4. Staffing problems. Nursing shortages and cost and reimbursement pressures may prevent physicians from delivering high-quality care, yet very few physicians have productively and effectively influenced these issues. Worse yet, physicians have tended to act in anger, alienating themselves from administrators who have developed a bias for excluding physicians in future decisions.
5. Protocol and process problems. Over two-thirds of physicians feel left out of clinical decisions that directly affect them. At the same time, the vast majority of administrators complain that physicians are resistant, apathetic, or obstinate to attempts to involve them in the decision-making process. Both sides probably have valid reasons to feel the way they do. The important message is that physicians who speak up and express dissatisfaction with administrative policies stand the best chance of changing those policies.

Consider the following example described by Mr. Grenny in his article in *Physician Executive*. A patient's incision was beginning to dehisce after he had surgery to resect his colon. The surgeon on call became irritated when alerted by the nurse (the physician had long-standing concerns about the nurse's competence). The surgeon concluded that the situation was manageable and ordered the nurse to redress the incision. The nurse put up a feeble protest and then followed the surgeon's order. Soon after, the patient vomited and burst his stitches, spilling his organs onto the bed. He died shortly thereafter. Perhaps the outcome could have been avoided if the surgeon had had a crucial conversation with the nurse (or the nurse's manager) when the surgeon first developed an impression that the nurse was incompetent.

I had a similar experience in my residency when I was on call. The outcome was tragic but not deadly. A medical resident in the emergency room awakened me at midnight. She informed me that a patient with a history of schizophrenia was experiencing an exacerbation of auditory hallucinations. "Would it be okay to increase his dosage of haloperidol and send him back to the boarding home," the resident asked me? She added, "I don't think you need to see him." I was more than happy to stay in bed and be spared a face-to-face consultation, so I approved the treatment plan. Two hours later (now

2 a.m.) the resident paged me again. She exclaimed, "Dr. Lazarus, remember the patient I told you about with schizophrenia, well the paramedics just brought him back. He jumped off the roof of his boarding home and it looks like he broke both his legs."

I was devastated. By the time morning rolled around, rumor had spread that I "blew it." I discussed the case with my supervisor. He noted that, although I did nothing wrong, I probably should not have relied on the assessment of a lesser-trained individual (the ER resident) and I should not have endorsed her treatment plan. It proved to be a valuable lesson early in my career. From that time on, I always made a point to evaluate patients myself, even if not requested to do so, or even if other medical personnel had undertaken an assessment. Rather than track down the ER resident and review the situation with her in detail, I lived in shame for some time after the incident.

Fortunately, I have managed to have a few crucial conversations following my residency. An important conversation occurred in 2005, when my company, AstraZeneca Pharmaceuticals, asked me to provide testimony to the Pennsylvania Medicaid Pharmacy and Therapeutics Committee. The fate of atypical antipsychotics on the state formulary, including my company's product, was at stake. I provided compelling evidence for the efficacy and safety of my company's product, and, at the same time, I advocated for "open access" for all atypicals. A decision was made to include several of the atypical drugs on formulary including the one my company manufactured. More importantly, I was able to positively influence able-bodied administrators, pharmacists, and physicians, and obtain an outcome that would benefit severely and persistently mentally ill patients and their families.

However, not all of my ventures have been as successful as the experience in Pennsylvania. I vividly recall a time between 2000-2001 when the Kentucky-based managed care organization I worked for was undergoing changes at the highest levels of senior management. My position was vice president of behavioral health. My new boss, a pathologist, asked me to produce a five-year strategic plan for the company. In essence, my strategy called for a "carve-in," a recommendation that all contracts with managed behavioral healthcare organizations be allowed to sunset so that mental health operations could be gradually folded into the company. Whereas this strategy has become popular and successful in many HMOs, my boss did not endorse it, and I was eventually terminated from the company.

So, while Mr. Grenny makes the point that physicians must willingly spend some portion of their time holding conversations that are crucial to continuous improvement in the systems that enable high-quality care, there is no guarantee that such conversations will be heeded or that change will occur. In addition, outspoken physicians risk being labeled as troublemakers, becoming alienated from management and targeted for the chopping block. In this regard, physicians should bear in mind the inspirational words of Michigan's poet laureate Edgar A. Guest:

'Tis better to have tried in vain,
Sincerely striving for a goal,
Than to have lived upon the plain
An idle and a timid soul.

'Tis better to have fought and spent
Your courage missing all applause,
Than to have lived in smug content
And never ventured for a cause.

For he who tries and fails may be
The founder of a better day;
Though never his the victory,
From him shall others learn the way.

Arthur Lazarus, MD, MBA, is senior director of clinical research for AstraZeneca Pharmaceuticals in Wilmington, Delaware. He is associate editor of Psychiatrist Administrator and President-Elect of AAPA.

WELCOME NEW MEMBER!

August 2006
Gerald Cohen, M.D., New York, NY

COLUMN EDITOR: H. Steven Moffic, M.D.

ETHICS COLUMN

Should a Psychiatrist Administrator Support a Pharmaceutical-Sponsored Free Lunch?

This particular column will be the first in a projected series called "A Day in the Ethical Life of a Psychiatrist Administrator". It is an attempt to isolate and discuss some of the typical real-life, day-to-day ethical challenges a typical psychiatrist may encounter. For me, the genesis of these forthcoming columns came shortly after the new millennium began, when I was asked to write about "A Day in the Life of an Academic Psychiatrist: Hippocrates Is Watching" (Academic Psychiatry 27:199-201, 2003) and a companion piece "A Day in the Life of an Academic MBHO Medical Director" (Wisconsin Psychiatrist, Winter: 24-25, 2002). I would appreciate any response or discussion on the topics, and will consider printing selected ones in the next issues. H. Steven Moffic, M.D.

Back at the start of the new millennium, Monday lunch used to be the favorite part of my workday. A pharmaceutical company-sponsored lunch in particular was anticipated, which we scheduled once a week as part of a staff meeting. There is usually great food for the whole multidisciplinary staff, though the brief presentation is for the psychiatrists, seemingly to convince us that one of the new antidepressants is better than the others. On this particular day, this recommendation comes in the form of a tablet that dissolves quickly on the tongue. More convenient, it would seem, but is it really better? Or more cost-effective? As Medical Director, I have allowed and supported such lunches for several reasons: it helps the morale of the non-M.D. staff; the accompanying free samples help financially in our public sector clinic; and sometimes, the information provided us is even useful, such as learning some "tricks of the trade" as taking Zoloft with yogurt or Lunesta with apple juice. On the way out, I grab a bit of the leftover food to take home for my wife to enjoy.

As I leave, I start to feel a little guilt. Is it appropriate to take some of the leftovers? Worse yet, can I and the other psychiatrists keep our objectivity on medication choice, when prior research studies show that pharmaceutical company "gifts" do indeed influence prescribing patterns, no matter that most of us individually think that it does not? Actually, we seem to think that it influences our colleagues, but not ourselves. Common sense also would tell us there is a significant influence. Otherwise, why would the pharmaceutical companies spend so much time and money on such activities? And, as psychiatrists, it would seem that we should be especially attuned to the subtle influence of the social relationship that the well-groomed and super-friendly representatives try to establish with us. It's harder to ignore a product of someone you like.

Then I think that maybe we should have had some discussion about the rep's presentation and how to choose an antidepressant after the rep left. That kind of discussion should be especially valuable to our students present. On occasion, we've done that in the past when the presentations have seemed to be outrageously biased.

We continue on with such lunches until I step down as Medical Director about 3 years ago. Gradually, our whole organization decides to decrease pharmaceutical company presence, whether that be lunches, pens, or post-its. By now, there are no more free staff lunches, but also even less discussion about medication choices and expert guidelines. We do still sign for free samples, which are less than before, and at that time, the reps can leave a little treat. As I write this, I'm munching on a muffin left by one company rep.

I think back to that dissolvable Remeron that was a focus of the long-ago lunch. A generic Remeron became available since, Remeron reps disappeared, and it seems that we are using much less of it (including the generic mirtazepine).

Now I have a longer time perspective and a different authority perspective. We now also have our *Ethical Principles for Psychiatric Administrators* where the following Section and Annotation seems particularly relevant:

Section 5

"A physician shall continue to study, apply, and

advance scientific knowledge, make relevant information available to patients, colleagues, and the public, obtain consultation, and use the talents of other health professionals when indicated."

Annotation (3)
In order to avoid conflict of interest, which may compromise patient care, the psychiatric administrator should make available consultants, clinicians, or reviewers outside of the system to provide objective opinions, care, appeal, or review.

Pharmaceutical-sponsored lunches are still quite common in medicine generally and nationally, but more controversial. On 7/28/06, the New York Times had a story on "Drug Makers Pay for Lunch as They Pitch". At one Pulmonary Clinic, lunches were apparently provided on a daily basis by different companies. The estimate is that millions of dollars are spent a year nationally on such lunches. These lunches escalated since 2002 when more lucrative gifts were generally curtailed.

Taking all of this together, I now think that pharmaceutical company lunches, if modest, can be ethically appropriate and useful if:

1. All companies are given equal opportunity .
2. Such free lunches should not be more often than once a week and be part of another relevant activity.
3. After all presentations, there is a discussion of the brief presentation after the representative leaves.
4. Objective literature and experts on the medications are available and discussed on a regular basis among the prescribers. For instance, much discussion is needed on the CATIE studies that compare the much cheaper generic antipsychotic perphenazine with the new atypicals. Ironically, free samples can actually make the atypicals cheaper in a given clinic.
5. Compensatory time is spent discussing supplemental or alternative treatments, such the psychotherapies and self-help strategies.

But what do you think or do? How does your organization interact with pharmaceutical company representatives? Please let me know. I will keep completely confidential whatever you would like.

Dr. Moffic is a professor in the Department of Psychiatry & Behavioral Medicine at the Medical College of Wisconsin as well as in the Department of Family and Community Medicine.

"Meet the Experts" Luncheon
for Residents, Fellows and Medical Students during
APA's 2006 Institute on Psychiatric Services in New York, NY
Friday, October 6, from 12 noon to 1:30 p.m.
Art Lazarus, M.D. will be representing the AAPA

COLUMN EDITOR: Kathy Cable, MLS

LITERATURE SCAN

We welcome Kathy Cable as the new Column Editor for ***Literature Scan.*** Our thanks to Jo Dorsch who served the journal in the role of *Column Editor* for last three years.

The *Literature Scan* is our regular column that reviews recent literature of interest to administrators in behavioral health care systems. The column covers a period of approximately 6 months. Papers are selected on such topics as administration, consumer satisfaction, delivery of health care, education, efficacy, ethics, evidence-based practice, leadership, and management. The daily demands of administration and practice often leave little time for browsing journals. It's our hope that this column may fill the gap.

Downs M, Small N, Froggatt K. Explanatory Models of Dementia: Links to End-of-Life Care. *International Journal of Palliative Nursing.* 2006 May; 12(5): 209-13. (Review). The authors of this article describe four models used to understand dementia. Developing evidence is given about how approaches to end-of-life care for people with dementia can move beyond traditional therapeutic pessimism towards optimizing the capacities of those with dementia and mobilizing imaginative care practice.

Dunn LB, Palmer BW, Keehan M, Jeste DV, Appelbaum PS. Assessment of Therapeutic Misconception in Older Schizophrenia Patients with a Brief Instrument. *American Journal of Psychiatry.* 2006 Mar; 163(3): 500-6. In this study, focus is placed on how "therapeutic misconception" is an important topic in research ethics because it may impede informed consent. With a hypothetical, double-blind, placebo-controlled trial as a stimulus, the authors examined the frequency of a key aspect of therapeutic misconception with a true/false scale in 87 middle-age and older patients with schizophrenia or schizoaffective disorder. Results showed that the subjects demonstrated variable performance on the therapeutic misconception measure. The authors agreed that patients with schizophrenia show a substantial incidence of beliefs associated with therapeutic misconception. In addition, the authors believe that further work should focus on refining measures of therapeutic misconception, identifying participants or protocols in which it may warrant greater concern, and developing educational interventions to mitigate it.

Flannelly KJ, Koenig HG, Ellison CG, Galek K, Krause N. Belief in Life-after-Death and Mental Health: Findings from a National Survey. *Journal of Nervous and Mental Disease*. 2006 Jul; 194(7): 524-9. The objective of this study was to examine the association between belief in life-after- death and six psychiatric symptomology measures. In a national sample of 1403 American adults, it was found that there was a statistically significant inverse relationship between belief in life-after-death and symptom severity on all six symptom clusters known to influence mental health. The analysis indicated that no significant association was found between the frequency of attending religious services and any of the mental health measures. Findings suggest that it may be more valuable to focus on religious beliefs than on religious practices and behaviors in research on religion and mental health.

Keith S. Advances in Psychotropic Formulations. *Progress in Neuro-Psychopharmacology & Biological Psychiatry*. 2006 Aug 30; 30(6): 996-1008. The author's objective is to discuss advances in formulations for various psychotropic agents that have been developed for treatment of psychiatric illnesses. To find information, a search of data published between 2002 and 2005 in Medline and EMBASE was conducted. The results found that new formulations of psychotropics can offer advantages over older formulations in terms of convenience, side-effects, efficacy, and onset of action. Additionally, results generally confirmed the author's expectations that treatment-related factors can help to enhance patient's satisfaction with treatment and compliance, thereby improving patient prognosis and outcomes in both acute and outpatient management.

Kishi Y, Kathol RG, McAlpine DD, Meller WH, Richards SW. What Should Non-US Behavioral Health Systems Learn from the USA?: US Behavior Health Services Trends in the 1980s and 1990s. *Psychiatry Clinical Neuroscience.* 2006 Jun; 60(3): 261-70.
In this article, the authors examine and assess behavioral health service trends in the United States during the last two decades. They address the issue of how independently managed behavioral health care has dominated administrative practices. The authors agree that targeting behavioral health for reduction in health-care spending through independent management, starting with diagnostic procedure code or diagnostic-related group exemption, may not be the wisest approach in addressing the increasing fiscal burden that medical care is placing on the national economy.

Lee S, Knight D. District Nurses' Involvement in Mental Health: An Exploratory Survey. *British Journal of Community Nursing.* 2006 Apr; 11(4): 138-42.
This article reports on a survey of district nurses' involvement in mental health interventions in one county. Results from the survey showed that a large proportion of the county reported no involvement in mental health interventions. In addition, results showed that among psychiatric professionals, district nurses tended to have the most frequent contact with social workers. GPs were the most likely person to whom DNs made referrals, followed by community psychiatric nurses. The authors recommend that there is a need for DNs and their primary care teams to foster a closer working relationship with mental health specialist services.

Levine R, Fink M. The Case Against Evidence-Based Principles in Psychiatry. *Medical Hypotheses*. 2006; 67(2): 401-10. Levine and Fink point out that there is an organized movement by governmental, academic and commercial interests to make evidence-based practice the standard of care in the United States. They indicate there is little proof that this model can be adapted to psychiatry. They specify number of misinterpretations in gathering data such as the diagnostic system, the validity of the data from clinical trials and how these are applied to clinical practice. Levine and Fink stress that the discipline of psychiatry relies on imprecise and unstable diagnostic criteria. In addition, there is substantial evidence to indicate that both investigators and patients can distinguish between active treatment and placebo in double-blind studies and more importantly negative outcomes are frequently not reported. The authors stress that when the conclusions derived from evidence-based psychiatry are applied to clinical practice they have little to offer and often produce poor treatment outcomes. Finally, the system itself is considered an untested hypothesis and the application of evidence-based practice to psychiatry is potentially dangerous.

Munk-Olsen T, Laursen TM, Videbech P, Rosenberg R, Mortensen PB. Electroconvulsive therapy: predictors and trends in utilization from 1976 to 2000. *J ECT.* 2006 Jun;22(2):127-32. With the question whether the use of electroconvulsive therapy (ECT) have changed during the last decades due to advances in psychopharmacology and organizational changes of psychiatric care, the objective of this study was to identify predictors for receiving ECT for the first time and to describe temporal trends in ECT utilization. A register-based case-control study, the sample included 2010 cases treated with ECT between 1976 and 2000 and 148,284 controls. Unipolar affective disorders, long duration of admissions, and no history of previous admissions were strong predictors of receiving first ECT. Despite a decrease in available inpatient beds, the treatment is used in 5.5% of admissions, and during the last 15 years of the study period, ECT utilization has been remarkably stable.

Page MJ. Methods of Observation in Mental Health Inpatient Units. *Nursing Times.* 2006 May30-June 5; 102(22): 34-5. (Review) This article discusses the nature of observation in mental health inpatient units. It concludes that the practice is likely to continue as it provides a written record of what has occurred; even so, the author stresses that the quality of nursing intervention is more likely to have a significant impact on patients than observation.

Pollio DE, North CS, Eyrich KM, Foster DA, Spitznagel EL. A Comparison of Agency-Based and Self-Report Methods of Measuring Services Across an

Urban Environment by a Drug-Abusing Homeless Population. *International Journal of Methods in Psychiatric Research*. 2006 Mar; 15(1): 46-56. The purpose of this paper is to advance the methodology for studying service assessment by comparing self-report and agency-generated methods. The study compared 30-day self-reported service use for homeless individuals, randomly recruited from a single urban environment. Comparisons were made between self-report and agency-based data on shelter use, outpatient mental health service use, outpatient substance abuse service use, and drop-in/day treatment use. Findings demonstrated that the two methods of collecting service data are generally not in accordance with the individual level. Demographic characteristics and diagnoses were associated with decreased reliability between the two methods of data collection. Both methods of assessment appeared to capture overlapping but not identical information. Ultimately each method of assessment has different utility to researchers and providers wishing to assess service use.

Preskorn SH. Pharmacogenomics, informatics, and individual drug therapy in psychiatry: past, present and future. *J Psychopharmacol.* 2006 Jul;20(4 Suppl):85-94. With the advent of more medications, the frequency and extent of polypharmacy has exploded. In addition to simply having more drugs from which to select with different pharmacological profiles, many newer medications are also more selective in their pharmacological actions and thus are often better tolerated and safer when used in combination. In addition, there is the concern that the trade-off for more selective pharmacology may have been better tolerability at the expense of reduced efficacy, which clinicians then compensate for by using more medications in combination. The author argues that polypsychopharmacology has been present from the beginning of the modern era of psychopharmacotherapy and continues to be the rule rather than the exception. Science has primarily informed the clinician about safety concerns rather than efficacy concerns when using such combinations. The author concludes that will change in the future with a better understanding of the pathophysiology of psychiatric illnesses which in turn will lead to improved therapies and the potential for more rationally derived combination treatments.

Tschirch P, Walker G, Calvacca LT. Nursing in telemental health. *J Psychosoc Nurs Ment Health Serv.* 2006 May;44(5):20-7. The article discusses a cooperative project involving an academic health sciences center, a state university, a women's shelter, and a community mental health center in East Texas, a medically underserved, rural region of Texas. The U.S. Department of Commerce provided grant funding to develop a telehealth network to provide an evaluation, referral, and treatment program for victims of domestic violence. Nurses were involved in all phases of the project, from initial conception through development, implementation, and evaluation. The authors concluded that all of the women involved in the study had significant mental health issues and other health concerns that were not being addressed by the existing health care delivery system. Without the use of telehealth, these women would have had limited access to primary health care and virtually no access to mental health services.

Ray SL. Whistleblowing and organizational ethics. *Nurs Ethics*. 2006 Jul;13(4):438-45. The article discusses an external whistle blowing event that occurred after all internal whistle blowing through the hierarchy of the organization had failed. The autor argues that an organization that does not support those that whistle blow because of violation of professional standards is indicative of a failure of organizational ethics and discusses several ways to build an ethics infrastructure that could reduce the need to resort to external whistle blowing.

Kathy Cable, MLS is the Health Sciences Reference Librarian at the Laupus Health Sciences Library at East Carolina University – and liaison librarian to the Brody School of Medicine.

The *Psychiatrist Administrator* is the official publication of the American Association of Psychiatric Administrators (AAPA). Established in 1961, AAPA is the premiere educational, networking, and support resource for psychiatrists interested in administration and management. The AAPA promotes medical leadership and medical excellence in behavioral healthcare systems, including services for mental illness, substance use disorders, and developmental disabilities.

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Component Workshop at the 58th APA Institute on Psychiatric Services, New York, NY

Doing More with Less:
Challenges and Rewards of Becoming a Psychiatrist Executive

Chair **Sy Atezaz Saeed, MD, L. Mark Russakoff, M.D.**
Participants **Brian M. Hepburn, MD, Nalini V. Juthani, MD,**
Arthur L. Lazarus, MD, Lydia Weisser. DO

Increasingly, psychiatrists are assuming executive roles as health systems consolidate operations and the complexity of care delivery increases. The psychiatrist executive's position may be viewed as the hub around which the many spokes of the wheel of the mental health system turn. The psychiatrist executive is responsible for integrating the needs of the patients and the physicians in the community into the vision, mission and goals of the health system. Psychiatrist executives face a variety of challenges. The critical skills of a successful psychiatrist executive include strong leadership, technical expertise, and management know-how. Managing change has become one of the most critical competencies of psychiatrist executives. Asking to do more with less is a common problem that psychiatrist executives face today. With this predicament come a set of challenges and rewards.

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