



PSYCHIATRIST ADMINISTRATOR

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| | |
|---|----|
| AAPA Past Presidents..... | 58 |
| From the Editor | 59 |
| Presidents' Column | 60 |
| <i>It's Different Now</i> by Chris E. Stout, Psy.D., MBA | 62 |
| <i>Psychiatry After Managed Care</i> Steven S. Sharfstein, M.D. | 64 |
| Commentary on Dr. Steven S. Sharfstein's Paper "Psychiatry After Managed Care" Boris M. Astrachan, M.D..... | 68 |
| Perspective on Parity: Part II Steven Kouris, DO, MS, MPH | 70 |
| Ethics Column Steve Moffic, M.D. | 75 |
| <i>Instructions for Authors</i> | 81 |
| AAPA Council Members | 82 |
| Application for Membership | 83 |

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Coping with A National Tragedy

Having just returned from the APA Fall Component meetings in Washington DC, I had almost finalized our next issue and was planning on getting all the materials out to our Managing Editor on September 14. On the morning of September 11, I was in my car between two of my work locations when I heard on NPR what had just happened in New York and Washington DC. The horrific events of September 11, 2001 will forever have an impact on us. The huge loss of life is touching virtually everyone. Many of us are going through some of the same feelings - disbelief, fear, grief, loss, and anger.

Many think that the psychological effects of the terrorist attacks on the World Trade Center and the Pentagon are just beginning to be felt, and will grow in the coming weeks to months. As a clinical, administrative, and academic psychiatrist, I struggle with this tragedy on several levels: my own reaction to the tragedy, how it has impacted people I work with, how it is likely to affect the systems I work with, and how will, and can, we react to the challenges? Some have speculated that it is likely that the prevalence of mental illness among children and adults throughout the nation will rise in the wake of the attack. Some fear that the United States does not have the mental health infrastructure in place to cope with this increase.

Grief and loss are normal and universal human reactions, and each of us will cope with the loss in our own way and in our own time. While acknowledging that psychiatry as a medical specialty has no unique knowledge of how a country can recover from such trauma, in a statement from the American Psychiatric Association President Richard K. Harding, M.D. offered these suggestions for individuals and communities:

- Acknowledge your feelings of fear, anger and grief; talk with others about the tragedy and your feelings.
- Talk with your children or other children about the disaster and assure them that they are safe and protected in a strong nation. Limit television watching; don't allow children to view

the repetitive scenes of destruction over which they have no control. Instead, help children gain mastery over situations they can control such as homework or sports. Talk with children about hate and prejudice.

- Participate in community ceremonies that will be held across the country to remember and honor the dead and wounded, and rededicate yourself to the principles in which our nation stands.

- Contribute in some way to the rescue work and rebuilding effort through donations of time, money or other assistance to victims and their families. Write sympathy and support notes to affected individuals and groups. Give blood now and at regular intervals.

- Draw strength from your spiritual or religious beliefs and traditions.

- Resume your normal routine as quickly as possible. Be informed of unfolding events, but avoid wallowing in the gruesome detail.

- Understand that the strong feelings of grief can resurface sporadically even months after the events, and that such feelings are normal. Consult a medical or mental health professional if feelings of grief and loss or fears stemming from the event become chronic and impair your daily activities and relationships.

- Know that the tragedy will pass, buildings will be repaired and rebuilt, life will go on, and our nation will remain strong, but, as with a death in the family, life will never be quite the same.

In this issue we invited Chris E. Stout, Psy.D., MBA to offer his thoughts in a guest editorial that he has titled *It's Different Now*. Dr. Stout is noted for his work on terrorism, war, trauma, and civilian casualties. He served for a year as a consulting Special Representative to the United Nations for the American Psychological Association. He has worked around the world. His works have been translated into 5 languages. He is currently working on a book titled *The Psychology of Terrorism* (Praeger, 2002).

Sy Atezaz Saeed, M.D.
Editor

PRESIDENT'S COLUMN - FALL, 2001

Christopher G. Fichtner, M.D.



The tragic events of September 11 have changed the context of working, reflecting and living for all of us. Some issues seem larger, others smaller, and still others barely register in our consciousness against

the numbing reality of this new era. Members of the American Association of Psychiatric Administrators (AAPA) are experiencing the impact of this reality in both their clinical and administrative work.

Mental health professionals have commented on the likelihood that mental health needs will become greater in the setting of this unfortunate new reality. The mental health needs of those more directly affected by the events have been recognized, mobilizing professionals to help address the associated psychological trauma. And even at a distance, practitioners are now seeing the impact of these events reflected clinically in the presentations of their patients.

While for some this may engender expectations of a new era of funding for mental health programs, a more wary view would be that the impact of recent events on psychiatric administrators will likely be to challenge yet again the manager's capacity to do more with less. It seems at least intuitively clear, reinforced for me by recent budget discussions in an executive retreat setting, that re-prioritizations of resource allocation in the aftermath of 9/11 will push mental health further to the back burners than before. If so, the tasks of the psychiatric administrator will have the discouraging feature of presenting in the face of constricting resources, and leadership in the mental health systems of this era will not be for the faint of heart. Yet, for those inclined to take up such challenges—as many of our AAPA members are—

there will be opportunity to have a reasoned impact on these systems.

Our mission in the AAPA continues to be to promote medical leadership in behavioral healthcare systems, and to do so primarily by providing a forum within which psychiatrist administrators can engage in collegial dialogue within and across public and private settings, and learn from one another about how to provide the best possible services for our patients. Of the numerous seeds that have been so industriously planted in AAPA soil under the leadership of Past President Gordon Clark, M.D., we continue to emphasize those that have the greatest potential to further our mission. This *NewsJournal*, *Psychiatrist Administrator*, is an excellent example. Editor Sy Saeed, M.D. continues his work of compiling excellent contributions from psychiatrists working to solve administrative problems and achieve systems and service delivery improvements. In this issue, he has included an article by Chris E. Stout, Psy.D., M.B.A., reflecting on the impact of the recent disasters from the perspective of a mental health administrator and author on the subject of terrorism. Dr. Stout is Chief Psychologist for the Illinois Department of Human Services, Office of Mental Health.

We continue to develop the AAPA website under the direction of Webmaster Thomas Simpatico, M.D. The site now includes many more links to websites concerned with mental health and medical administration issues. Dr. Simpatico continues actively to seek input from any AAPA members who would like to be involved in website development, especially as content experts. In the area of education, traditionally a priority for AAPA, we have undertaken the development of a new program. At the request of the American Psychiatric Association's Committee on Psychiatric Administration and

Management, we have submitted a proposal to offer two full-day CME courses which, as a package, provide an overview of the basic concepts in administrative psychiatry addressed through the APA certification process. Collectively, the two courses draw upon contributions from eleven faculty members, and will address the areas of administrative theory, human resources, fiscal management, psychiatric care management, law and ethics. They will also address the areas of career development for administrative psychiatrists and the future of administrative psychiatry. We expect to offer these courses at the APA Annual Meeting next May, and hope that they will be helpful for psychiatrists developing administrative aspects of their careers and contemplating certification.

Although the AAPA Council did not meet formally at this year's Institute for Psychiatric Services, we are actively working on our priority agenda items including especially those initiatives discussed above. We have consolidated some committees to facilitate working relationships in overlapping areas, and we are involving our finance

committee in multiple areas to explore funding options as we further develop and expand our current projects. Suggestions from AAPA members as to how we can better serve your needs are of course always welcome. One innovative forum that has been well received is the *Psychiatrist Administrator* Ethics Column edited by Dr. Steve Moffic, which in case-presentation format provides an opportunity for discussion and consultation on complex issues involving ethical dimensions of psychiatric administration and management. I know that the Editor will welcome your suggestions for how the *Psychiatrist Administrator* can continue to develop as a useful and informative publication.

I look forward to working with you, the AAPA membership, to carry out our current initiatives, to create new learning opportunities in psychiatric administration and management, and to make this organization work better for you and ultimately in the service of our patients.

IT'S DIFFERENT NOW

Chris E. Stout, Psy.D., MBA

It's hard to know how to start a piece like this. I have presented and written on terrorism, and war, and trauma, and civilian casualties, a fair amount. I've worked with tortured children, talked with traumatized refugees, broken bread with former political prisoners. I've seen the aftermath of atrocities - exhumed corpses, mass graves, and murdered infants. I have gone on medical missions to far off places around the world. I have slides and statistics, bar graphs and citations, I can quote numerous facts and figures. But prior to 11 September 2001, all of that was done with a certain degree of clinical detachment. I would go somewhere else, and then come home. I have not ever been in an active war zone, nor a victim of a terrorist attack. After 11 September, I feel a bit different. I suspect you may, too. I suspect our colleagues, our patients, our friends, our families, and our staffs may as well.

We may rightly, or wrongly, presume these attacks will have a vast psychiatric impact. With perhaps greater certainty I believe there is a psychic impact that well extends beyond US borders. The rub is that many may confuse the two. I have seen much discussion on many List Servs as to dealing with PTSD after this, and while at first blush this seems quite reasonable, my only point is that grief, sadness, and fear, under these circumstances are indeed quite normal and to be expected. We need to thus not over-react in therapeutic zealotry and start to pathologize the grieving process.

I have also been amazed at the diversity, if not downright division, of some of the opinions and resultant debates posted as well - if one were to generalize from a sampling of the clinical practice List Servs I have frequented. There are debates as to violent and aggressive responses versus forgiveness and passivism, evil versus goodness, behavioral reinforcement versus social psychology theories, isolationism versus globalism, "we are victims" versus "we brought

this on ourselves," and my favorite dichotomy - "this is a start of the end" versus "this is the start of a new beginning." It seems the name of religion is used to support all opinions (it comes in handy that way in such debates I have found).

Locally, it has again become in vogue to call local state psychiatric hospitals or courthouses with a fictitious, but nevertheless disruptive and freshly upsetting bomb threats. Some years ago, I was involved with the emergency evacuation of an entire psychiatric hospital due to a flood. It was variably impactful on patients, their families, and the staff (Stout and Knight, 1986). But generalizability from that time and event transfers poorly to today.

Many non-colleague friends have asked "Do these recent acts of terrorism effect your patients?" There is no need to differentiate such a question along the lines of patient age or treatment venue (in- or outpatient, public or private). And with the exception of those patients unaware of the external environment, I simply say, "Yes, of course - everything that goes on effects everything that goes on." A quick survey of the complexity sciences literature bears this out, but we may not typically think of such as we may have become so insular to our specific work. Maybe not for everyone, I pray, but it sure happened to me. With all my travels, missions, advocacy, and research, I still was insulated from perceived evils as such didn't really effect me, my family, or my children. I became a bit calloused; perhaps jaded.

A friend and colleague, Jordan S. Kassalow, OD, MPH, from the Council on Foreign Relations in New York wrote a wonderful white paper on "Why Health Is Important to U.S. Foreign Policy." It offers excellent examples of the often unseen relationships between health and political stability or war. For example, he notes, "Research shows that low or declining average health status correlates over time with a decline in state

capacity, leading to instability and unrest (Price-Smith 1999). According to Andrew Price-Smith's research, high prevalence of disease in a state undercuts national prosperity, generates inter-elite conflict, exacerbates societal income inequality, and significantly depletes human capital" (Kassalow, 2001).

As for war, it is not difficult to understand the relationship between war and health status - "wars kill and injure soldiers and civilians, but they also destroy infrastructure and social structures, in both cases with adverse effects on the population's general health. Medical facilities are often singled out for attack in 'new wars' because they provide valuable loot, easy victims, and a way to demoralize civilian populations. War also causes exceptional mobility, and armies, peacekeepers, and refugees act as vectors for the transmission of disease" (Kassalow, 2001).

"There is also evidence of the reverse effect, that of health on war. Combatants in new wars are often the socially excluded, even if they only act as proxies for more socially advantaged groups. Poor health shortens people's time horizons, making them more likely to engage in risky behavior; conversely, strong democracies with broad support from healthy populations are less likely to engage in conflict, at least with each other (Doyle 1983)" (Kassalow, 2001).

My point? I would like you to keep in mind that through the work you do, the impact you have effects not only the individuals you work with directly today, but also their families, and potentially thereafter for generations. I have file boxes filled to the brim with the medical cost offset literature supporting such, but somehow the numbers seem a little less relevant today and their lives more so.

Dr. Stout is the Chief Psychologist with the Office of Mental Health in the Department of Human Services, State of Illinois.

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PSYCHIATRY AFTER MANAGED CARE

Steven S. Sharfstein, M.D.

In the decade of the 1990s, the United States embarked on an unprecedented social experiment to re-balance costs, quality, and access of health care through a rationing process called “managed care.” Payers, employers, government, the insurance industry, and some hospitals utilized managed care to decide who gets what from the health care system. This experiment is an economic success but has become a political failure (1). The essential strategy of managed care has been characterized as “giving with one hand while taking away with the other,” that is, offering comprehensive benefits with low cost sharing but restricting access through utilization management, gatekeeping, networks, and other rationing techniques. This strategy has provoked outrage from patients, physicians, and virtually everyone involved in the health care system. The reaction against restrictive physician panels, gatekeeping, utilization, and capitation has led to a full retreat by managed care so that choice of patients is now broadened, utilization review relaxed, and fee-for-service payment (albeit discounted) is back in vogue.

For psychiatry, the 1990s was characterized by phenomenal growth of behavioral carve-out companies, which specialized in restricting access and containing costs for psychiatric hospitalization and access to psychiatrists, as well as other mental health professionals. A great majority of Americans enrolled in health insurance plans have their psychiatric benefits managed by one of three for-profit, behavioral carve-out companies (Magellan, Value Options, and United Behavioral Health), creating a special backlash from patients, families, and the mental health professions (2).

Managed care for psychiatry was given a special boost during the 1980s by the expansion of for-profit, private psychiatric hospitals. The scandals involving one or more of these hospital chains, well-publicized fraud and abuse investigations, and large monetary penalties from

government led to the universal recognition by employers of the need to manage ever-growing psychiatric benefits. These problems of the 1980s centered around hospitalization of adolescents and substance abuse (28-day programs especially). The impact of managed care was much broader and more dramatic for psychiatry than the rest of medicine. In the decade of 1988 to 1998, one study demonstrated for private employers a 55 percent reduction for mental health benefits in contrast to a seven-percent reduction for general health care benefits (3). Access to psychiatric hospital care was greatly restricted; many patients had to shift to public programs such as Medicaid and Medicare to continue having any level of expensive psychiatric hospitalization. In addition, care was restricted to psychiatrists for medication management visits (often of brief duration) and psychotherapy limited to a handful of visits. Both inpatient and outpatient benefits for psychiatric care declined dramatically, and all of this occurred in the era of ever-expanding parity.

Parity for mental health services has been the rallying cry for patients and the professions for almost 20 years. In the past few years, parity legislation has passed in numerous states, and a national parity bill based on annual and lifetime benefits passed the United States Congress in 1996. Parity, however, underscores the political failure of managed care.

The strategy of providing comprehensive, non-discriminatory “parity” benefits on the one hand while insisting on strict managed care by the behavioral health care carve-out companies on the other has undermined the trust between patients, their clinicians, and the government. It has confused everybody on the workings of the system, and infuriated many. Now the rallying cry in state legislatures throughout the country is for “non-discriminatory utilization review,” and behavioral carve-out companies are now in retreat due to the outcry of patients, families, and media

exposés of the consequences of managed care denials. Panels of clinicians are being broadened even as more and more clinicians refuse to take managed care fees. “Phantom networks” are a common complaint of patients trying to find a clinician on one of these panels. What will be the role of psychiatrists in an emerging brave, new marketplace after managed care?

In order to predict and ascertain the role for clinician and administrative psychiatrists in this emerging era, it is useful to review various roles of the other power centers in the health care industry that impact on the financing of psychiatric care. These sectors include employers, insurers, government, and consumers.

The fact that in America employers retain a central role in the design and financing of medical care is an historical accident reinforced by extraordinary tax subsidies and a bygone era of lifetime employment. Who would design a universal health insurance system today that placed the CEOs of major corporations, entrepreneurial capitalists, and small business owners in charge of health benefits for the great majority of Americans? And yet, that is the role they continue to have. Let’s not forget that it was employers who sought to control the costs of health and mental health care by moving millions of employees into health maintenance organizations and hired the for-profit behavioral health care carve-out companies. Now faced with the threat of litigation and the backlash of very angry employees and their unions, employers are retreating from managed care and embracing an approach that provides information and incentives for employee choice combined with more cost sharing on their part as the primary method of employer health benefits policy.

Insurance and the insurance industry were invented to pool risks and spread them across a broad population, predict cost trends, and set premiums. They play a significant role in the design and pricing of various products that consumers are encouraged to buy. They played

a major role throughout the 1990s in creating managed care mechanisms for employers and government to control health care costs. They could not control the major epidemiological and cultural trends that created this strong consumer backlash, epitomized in popular media and now leading to a federal Patient’s Bill of Rights. Insurers no longer want to be the bad guys and are trying to identify their true customer (the individual consumer) and want to facilitate rather than frustrate consumer choice.

Government plays the role of the employer in providing health benefits for those who are not employed (the elderly, retirees, and the poor) and also serves as a major insurer through the Medicare and Medicaid programs. Government has an important role in ensuring the safety and effectiveness of medical treatments, underwriting research and training, limiting fraud and abuse, but because of the nature of democracy, they are not in a good position to dictate who gets what, from whom, and how much. Politicians have discovered that to be in favor of managed care is one way of losing elections. The backlash to the Clinton health proposal of the early 1990s showed the natural American reluctance to concentrate power and authority in Washington, DC, for the financing and delivery of health care.

And so we are left with consumers who want to direct their own health care, financially subsidized by employers and government. These consumers have been empowered by the new internet-based information revolution, direct consumer advertising by pharmaceutical companies and other health care providers, and have much greater access to the latest information on the science and art of medicine. They also want advice from their physicians, but more and more want to retain final authority over their medical decision making.

So then what is the role of physicians, in particular physician psychiatrists, in this new era?

The natural role of the physician is being an advocate for the doctor-patient relationship;

servicing as an agent of the patient; and offering information, advice, services, and support. Physicians naturally advocate for more resources to be devoted to health care, especially for their patients, and do not want to consider the patients who are not in their office as well as the balancing of patients' needs with other economic priorities such as education or national defense. Physician organizations that try to manage care have been conspicuous failures in the marketplace of managed care. What about the future of psychiatrists in the new post-managed care marketplace?

The Adaptation of Psychiatrists

Psychiatrists have been improving their position in the non-managed, private, out-of-pocket marketplace. Many Americans have discretionary income where they can afford to pay \$2,000-\$20,000 a year for outpatient mental health care. Psychiatrists with the competitive advantage of being able to provide both medication and psychotherapy in a variety of subspecialty arenas have thrived, especially in those areas of the country where there is a shortage and clear need. This has been especially true in the subspecialty of child and adolescent psychiatry.

Further, the robust epidemiology of mental illness simply cannot be "managed away." Even within the insured and managed care marketplace, there are many opportunities for psychiatrists to thrive and grow. The emerging trends in the health care marketplace to develop highly-subspecialized enterprises ("niche" services) led to the creation of diagnostic-specific treatment centers such as for anxiety affective or obsessive-compulsive disorders as well as specialized care for children, adolescent, and geriatric patients. Combining psychotherapy and psychopharmacology as part of a comprehensive treatment plan, working closely with primary care practitioners and other mental health professionals, demand for skilled psychiatric clinicians currently and for the foreseeable future exceeds the supply.

Psychiatrists are clinical innovators, working

with patients in the public sector, caring for special populations such as children under Medical Assistance or AIDS patients, developing special initiatives to reduce Workmen's Compensation payments and dealing with the tremendous costs to employers of worker disability, forensics such as child custody work and medical legal services, children with emotional and learning disorders at school at all ages, prevention programs such as smoking cessation, wellness programs, stress management. All are examples of recent innovations led by psychiatric clinician entrepreneurs.

Psychiatrists are also natural leaders of teams and systems of care. Again, with the robust epidemiology, there is the need for many different disciplines and subspecialties in trying to deal with the large number of Americans who can benefit from effective psychiatric intervention.

Psychiatrists perform leadership roles in a variety of managed and unmanaged settings, and will continue to do so.

Psychiatrists have always worked in more than one setting and will continue to have a variety of opportunities to treat patients and deal with the public health needs of communities (4).

Final Comment

Recently, Robinson asserted that "the consumer era in health care is emerging due to the rejection of governmental, corporate, and professional dominance" (1:p 2628). We've seen recently the power of the consumer to shape the managed care marketplace in the strong push for a Patient's Bill of Rights in the Congress. Consumers definitely want quality care and value, that is, high quality tempered by cost considerations. Psychiatrists as physicians must be relentless advocates for quality. How that's defined in the marketplace and who defines it is a political issue that will pit psychiatrists against insurance and managed care interests and possibly the government in the next few years. Working closely with employers to understand their needs and their definition of quality as well as paying attention to patients as "customers" will help psychiatrists lead the march toward

developing quality standards and systems of care. The practice guidelines will then replace medical-necessity decisions by third- and fourth-party reviewers. The Hippocratic Oath compels physicians to put their patients' needs first and foremost. Leadership in the health care marketplace requires psychiatric leaders to assert themselves with renewed vigor beyond the immediate necessities of income and practice.

Dr. Sharfstein is Medical Director and CEO of the Sheppard and Enoch Pratt Health System, and Clinical Professor of Psychiatry at the University of Maryland Medical School, Baltimore, Maryland.

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Welcome! New Members

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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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Commentary on Dr. Steven S. Sharfstein's Paper, *"Psychiatry After Managed Care"*

Boris M. Astrachan, M.D.

Psychiatry is a unique medical discipline. More than any of our sister medical specialties, we in psychiatry extend our practice into areas of habilitation and rehabilitation, social control and individual development.¹ For many of our patients, effective care requires that we access and work with families, the schools and the workplace.

Psychiatrist administrators working in public sector settings always have been involved in managing care. Our work in attempting to organize a panoply of services to treat and rehabilitate our patients is constrained by relatively fixed budgets and fixed expenses (personnel costs, contracts for services, etc.). Within constraints we struggle to meet the needs of those we serve.

Increasingly the term "managed care" within psychiatry has come to represent the effort of corporations, largely in the for-profit sector, to constrain expenditures for psychiatric services, and through that process to generate profit. The major strategies utilized include discounted payments to providers, limiting use of services and provider substitution strategies. The development of information systems (IS) has provided an infrastructure for managed care. But efforts to use IS to support clinical psychiatric care remain limited.

Sharfstein in his informed and well-written article notes that an accident of history has given industry, abetted by government, the major role in providing for health care benefits through insurance programs. But while corporations may be "retreating from managed care and embracing an approach that provides information and incentives for employee choice combined with more cost sharing", they will surely seek new directions if these strategies fail to keep costs from rising once again.

Sharfstein identifies the growth of an

increasingly informed and assertive consumer movement, and sees promise in working together with employers, consumers and government to enhance quality, to develop practice guidelines.

He describes how we in psychiatry adapt to a changing environment, dealing with that population which can afford to pay for care, seeking niche opportunities and working to develop quality standards. He helps us understand where we are going in health care, and what are the opportunities.

Sharfstein identifies the reluctance of government to engage in meaningful discussion on the shape of health care and issues of access and cost. Such failure is a failure of government's obligation to address the needs of the uninsured and underinsured members of our population. Such a failure of obligation reflects the absence of our national will to provide at least minimal health care coverage for all.

And in the face of government's failure, what of our obligations? Psychiatrist administrators who serve public sector patients have the obligation to act prudently in the political world to attempt to support the needs of those who require our services; to seek alliances with other groups in this process, and to press for greater discourse about the needs and responsibilities of those we serve. We have professional obligations to question what we do. There is always more to learn, more to do and new ways to organize our services. Sharfstein addresses the what is, and only touches on our obligations. We are not without influence if we chose to speak for care. But our obligations to patients and profession would also insist that we need engage in a larger dialogue about managing care.

As psychiatrist administrators and practitioners, we too often act as if we do not know what services our patients require as well as what they want. And at times we seem to

forget the importance of understanding the ecological context in which care is delivered. Substance abusing patients generally require specialized services and coordinated care with other physicians. Depressed patients who do not rapidly respond may need medication and assessment for group treatment. Schizophrenic patients may be well served by working with family members and through referral to Assertive Community Treatment programs. Practitioners and psychiatric programs and facilities have obligations to engage with patients in managing care. Managing the use of these specialized services raise questions about privacy and confidentiality. How can we best respect legitimate individual rights and concerns while providing enhanced services? How do we use information systems to enhance quality? We need to think about and address such questions.

We have the obligation to develop enhanced information systems so that our programs may become more effective as well as more efficient. And a further obligation to identify how such systems may legitimately link to other data, so that children may be better served not only in our practice, but in the schools, etc. We have obligations to our employees, to keep them learning, to keep them focused on service to

others, and to see that they are adequately rewarded. And we have an obligation to ourselves, our profession and our patients to engage in dialogue about patient needs, treatment strategies, and how we may improve what we do.

And when we cannot deliver all of the services that we should (regardless of the reasons), we must seek such consolation as we can from the knowledge that we have sought to utilize our resources as best we can, to serve those who are our patients; that we have tried to serve our organizations, profession and employees well. These are, and have always been our obligations. As psychiatrist administrators, we need to be leaders in managing care.

Dr. Astrachan is Distinguished Professor Emeritus of Psychiatry at the University of Illinois College of Medicine, Chicago, Illinois.

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PERSPECTIVE ON PARITY: PART II*

Steven Kouris, DO, MS, MPH

During the past decade, the quest for mental health parity has intensified on both the state and federal levels. Part I of this review briefly chronicled the history behind efforts at the federal level, up to the passage of the Mental Health Parity Act of 1996. Part II begins with an overview of the Act, examines the state of parity since the bill's implementation, and takes a look at more recent initiatives.

THE MENTAL HEALTH PARITY ACT OF 1996

President Clinton signed the Mental Health Parity Act of 1996 into law on September 26, 1997, and with the leadership of Senators Pete Domenici (R-NM) and Paul Wellstone (D-Minn), this landmark law received unprecedented bipartisan support. The parity provisions did not completely eliminate discriminatory coverage, however, it nonetheless represented an historic first step toward equalizing health insurance plan coverage for treatment of mental illnesses and other medical conditions.

Key Provisions

The Mental Health Parity Act of 1996 amended the Employee Retirement Income Security Act (ERISA) and the Public Health Service Act. The law equalizes aggregate lifetime limits and annual limits for mental health benefits with those for medical and surgical benefits (Typical caps for mental illness coverage are \$50,000 for lifetime and \$5,000 for annual, as compared with \$1 million lifetime and no annual cap for other medical disorders). The law covers mental illnesses (i.e., "mental health services," as defined under the terms of individual plans); it does not cover treatment of substance abuse or chemical dependency. Existing state parity laws are not preempted by the federal law (i.e., a state law requiring more comprehensive coverage is not weakened by the federal law, nor does it

preclude a state from enacting stronger parity legislation). The law applies only to employers that offer mental health benefits; it does not mandate such coverage. The law allows for many cost-shifting mechanisms, such as adjusting limits on mental illness inpatient days, prescription drugs, outpatient visits, raising co-insurance and deductibles, and modifying the definition of medical necessity. (Therefore, lower limits for inpatient and outpatient mental illness treatments are expected to continue, and in some cases, actually expand to help keep costs down.) The law applies to both fully insured state-regulated health plans and self-insured plans that are exempt from state laws under ERISA. It has a small business exemption which excludes businesses with 50 employees or less. The law allows an increased cost exemption; employers that can demonstrate a one percent or more rise in costs due to parity implementation will be allowed to exempt themselves from the law. Also included is a directive to the NIMH Advisory Council to prepare yearly reports on the impact of parity. The law took effect on January 1, 1998, and expires on September 30, 2001.

What's not covered

The Mental Health Parity Act of 1996 does not provide a mandate for mental health benefits to be offered in health insurance plans; coverage for treatment of substance abuse or chemical dependency; rules for service charges, such as co-payments, deductibles, out-of-pocket payment limits, etc.; designations for the number of inpatient hospital days or outpatient visits that must be covered; coverage in connection with Medicare or Medicaid; restrictions on a health insurance plan's ability to manage care; or provisions for business with 50 or fewer employees.

**Part I of this article appeared in our previous issue (Psychiatrist Administrator, Vol. 1, Issue 2, pp. 38-42)*

POLICY PERFORMANCE

The primary purpose of parity legislation is to ensure the availability of services by removing the disincentive to seeking treatment that limited coverage produces. Moreover, the greater availability of comprehensive and flexible treatment options holds the promise of more cost-effective treatment. This in turn can be expected to reduce medical costs, disability costs and a variety of indirect costs to society. Additional important benefits sought from mental health parity include reduced discrimination and social stigma, reduced financial burden on consumers, and prevention of adverse selection for those health plans and public service organizations already providing care for the most severely affected populations.

Despite concerns by opponents that the costs associated with adopting parity are necessarily high, recent studies and early experiences with parity have proven this assertion incorrect. According to the 1999 study, *Effects of the Mental Health Parity Act of 1996*, the effects are positive, with employer sponsored health plans reporting minimal or nonexistent cost increases. As a result, the majority had not taken nor planned any compensatory actions to control costs. Improved substance abuse coverage was an unintended benefit reported by many plans responding to the survey.

A subsequent report by the U.S. General Accounting Office (GAO) last year indicated 86% of employers reported full compliance with the new law by the end of 1999. Employee access to mental health services was not reportedly altered. While compliance with dollar limits of coverage has continued to climb, some plans have countered with more restrictions on the number of covered hospital days and office visits, or other benefit design features. Only 3% of employers report that compliance with federal parity has increased their claims costs. None have dropped mental health benefits. Published estimates of costs associated with federal parity are typically less than 1%. In states with the most comprehensive parity laws,

estimated cost increases range from 2 to 4%.

Opinion on whether the Mental Health Parity Act of 1996 was truly successful varies in large part on the observer's perspective regarding the intent of the bill's passage. If the bill had been substantially stripped of its teeth by the political process, why was its passage still viewed as such an important step? Supporters, including many legislators motivated by family or personal struggles with mental illness, believed that to support parity was to begin to reverse a discriminatory and unjust situation. The National Alliance for the Mentally Ill (NAMI) and other mental health advocacy groups believe that the parity issue is less about health care than about civil rights. Viewed in that light, the passage of this bill had very important symbolic impact. It also was an acknowledgement of the incremental nature of policy change. Passage of the bill, it was hoped, could lead to a change in the national view of mental disorders and create a climate in which further changes are possible.

One measure of this effect is the subsequent passage of parity laws at the state level. In 1996, only 6 states had parity laws for mental health or substance abuse. Currently 32 states have parity laws and virtually all are expected to have some form of legislation soon. There is, however, considerable variation in how individual states define eligibility standards and set service limitations. Parity in Maryland, for example, includes all mental and substance abuse disorders, while New Hampshire's law specifies coverage only for severe biologically based mental disorders. Exemptions also vary from state to state. Maryland's parity law excludes companies that are self-insured or that have fewer than 50 employees.

The economic impact of implementing state parity laws is beginning to appear in the literature. Minimal increases in annual costs are reported in California, Colorado, Minnesota, and Pennsylvania, whereas decreases are seen in Maryland, North Carolina, and Texas. At the same time, service access and utilization are reported

to have been enhanced. Also worth noting is the granting of mental health parity to millions of federal employees by the Clinton administration. This affects health plans all over the country and is a critical and large pilot for mental health parity. Unfortunately, implementation problems under the Bush administration have thus far served only to frustrate providers.

The fear of high costs associated with the implementation of parity led to the watering down of the original federal parity bill and still hampers legislative efforts at state and federal levels. Early estimates of skyrocketing (over 10%) costs were based on what is now considered inappropriate economic and actuarial models. Recent empirical studies and economic simulations show that within a managed care environment any increased costs of parity are modest and access to care is increased. A 1998 NIMH-supported study by Harold Varmus reported that: (1) in systems previously using managed care, implementing parity results in less than 1% increase in costs; (2) in systems that introduced parity and managed care together, costs actually went down; (3) introducing parity in any system leads to increased managed care activity.

The Washington Business Group on Health has reported on the experiences of eight large employers, representing 2.4 million covered lives, who early on had made the decision to offer generous mental health benefits (consistent with the current definition of full parity) and continue this practice because they believe that it is actually helping their “bottom line” by decreasing absenteeism, disability payments, and lost productivity. Using an even broader perspective, Burnam and Escarce reported that despite the onset of parity during the late 90’s, the escalation of costs due to mental health coverage in a managed care environment slowed to such a degree that the actual percentage of an HMO’s costs devoted to mental health care was only 3-5% vs. 10% for the overall health care budget. Thus, mental health parity laws did not cause a massive increase in dollars spent. In fact, the

major effect of parity might only have been to increase the use of managed care cost-containment practices.

Other investigators have looked at the effects of parity on access to mental health care in a different manner. Rather than focusing on dollars spent on mental versus physical health care, they reported on changes in the types of services provided in the new parity plus managed care environment. Mechanic and McAlpine (1999) are perhaps the only investigators to address the issue of whether managed health care plus parity, has affected not only frequency of visits but also other aspects of care. These authors confirm that dollars spent on behavioral health care are decreasing as a percentage of employers’ health costs. They point out that it is hard to square this decrease in spending with the large body of data that show poor, inadequate treatment for most mental disorders in most systems. Nonetheless, they state that dollars spent is not a good proxy for quality. The authors do point out that the greatest overall reduction in inpatient days occurred in the area of mental health. This might arguably have been appropriate. However, these reductions in days do not seem to relate to severity of illness. One would also expect reductions in inpatient care to correlate with increases in alternative (i.e. outpatient, residential) means of care. In one case, a large employer using a behavioral health carve-out plan was shown to substantially increase outpatient payments and to modestly increase residential care payments during a period of declining inpatient use related to managed care. Studies of other managed care plans, however, showed significant decreases in overall utilization of mental health services, including number of outpatient visits, despite dramatic decreases in inpatient care. Moreover, decreases were also seen in outpatient visits for the most severely disordered. Thus, parity laws, by triggering increased managed care cost-containment activity, might have actually decreased the amount of care provided for mental disorders. Interestingly, there is no clear evidence of decreased usage leading

to poorer outcomes. The few data available only hint at this possibility. If one measures the impact of mental health parity law on increasing access to mental health care, one would have to conclude that the 1996 federal law has achieved no benefit.

Recent Federal Efforts

Senator Domenici and other staunch proponents of mental health parity did not simply accept the compromise legislation and forget about the parity issue. Efforts to amend the federal parity law have continued. In March, Senators Domenici and Wellstone introduced The Mental Health Equitable Treatment Act of 2001 (S. 543). This bill would require health plans that offer mental health coverage to provide full parity between mental health and other health services by prohibiting unequal treatment limits or financial requirements. Specifically, it prevents the use of more restrictive limits on hospital days or outpatient visits, and higher co-payments or deductibles or out-of-network charges. It also eliminates the exemption currently permitted for employers who show more than a one percent rise in premiums due to compliance with parity requirements, and it eliminates the sunset provision of the original 1996 Parity Act slated to occur September 30, 2001. The bill originally decreased the small business exemption to only companies with less than 25 employees, however, in committee, this was expanded to include companies with 50 workers or less in order to gain needed support. This bill was sent to the Senate Health, Education, and Pensions Committee in July and unanimously approved on August 1, 2001. Some committee members, however, predict a contentious debate when the bill comes to the floor of the Senate.

The Medicare Mental Health Modernization Act of 2001 was introduced April 4th into both the Senate (S. 690) and the House (H.R. 1522) by Senator Wellstone and Representative Stark respectively. These identical bills establish parity by amending title XVII (Medicare) of the Social Security Act to provide for elimination of the

current 190-day lifetime limit on inpatient psychiatric care and a reduction of the 50% co-payment (to 20%) for outpatient treatment. In an attempt to increase access to community mental health services it ensures coverage of intensive residential services under Medicare part A and intensive outpatient under part B. It also provides coverage of marriage and family therapist and mental health counselor services under Medicare and excludes clinical social worker services from coverage under the Medicare skilled nursing facility prospective payment system. Both bills are currently in committee.

Another related proposal was introduced into the House in January by Representative Roukema. The Mental Health and Substance Abuse Parity Amendments of 2001 (H.R. 162) amends the Public Health Service Act, Employee Retirement Income Security Act of 1974 (ERISA), and the Internal Revenue Code of 1986 to prohibit health plans from imposing unequal limits on coverage of not only mental health services but also substance abuse/chemical dependency services. This measure was referred to committee where no action has yet been taken.

Finally, mental health parity has become an integral part of a more sweeping effort at health care reform. In recognition that the United States has the most expensive, but not necessarily the most cost-effective, efficient, comprehensive, or equitable health care system in the world, there is a concurrent resolution before the House of Representatives (H. CON. RES. 99) introduced by Rep. Conyers and over two-dozen colleagues, directing Congress to enact legislation by October 2004 that provides access to comprehensive health care for all Americans. It states:

Resolved by the House of Representatives (the Senate concurring), that the Congress shall enact legislation by October 2004 to guarantee that every person in the United States, regardless of income, age, or employment or health status, has access to health care that—

- (1) is affordable to individuals and families, businesses and taxpayers and that removes financial barriers to needed care;
- (2) is as cost efficient as possible, spending the maximum amount of dollars on direct patient care;
- (3) provides comprehensive benefits, including benefits for mental health and long term care services;
- (4) promotes prevention and early intervention;
- (5) includes parity for mental health and other services;
- (6) eliminates disparities in access to quality health care;
- (7) addresses the needs of people with special health care needs and underserved populations in rural and urban areas;
- (8) promotes quality and better health outcomes;
- (9) addresses the need to have adequate numbers of qualified health care caregivers, practitioners, and providers to guarantee timely access to quality care;
- (10) provides adequate and timely payments in order to guarantee access to providers;
- (11) fosters a strong network of health care facilities, including safety net providers;
- (12) ensures continuity of coverage and continuity of care;
- (13) maximizes consumer choice of health care providers and practitioners; and
- (14) is easy for patients, providers and practitioners to use and reduces paperwork.

Conclusion

Potential benefits from adopting parity legislation appear to outweigh the economic risks inherent in expanded coverage. Successful experimentation among the States adds a degree of comfort for legislators who are skeptical of previous study results. Within the context of larger health care reforms, momentum is now growing rapidly in Congress for passage of more extensive federal measures during this session. As the streams of health policy formulation, agenda

setting and years of advocacy merge into a strong, unrelenting force, a window of opportunity for significant health policy change has developed. Another perfect storm may be upon us.

Dr. Kouris is with the Department of Psychiatry, University of Illinois College of Medicine at Rockford, Illinois.

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Is There An Ethical Way?

Column Editor: H. Steven Moffic, M.D., Chair, Ethics Committee

COLUMN INTRODUCTION:

At the end of our last column, we presented an ethical question posed by Lawrence Beasley, M.D. That question will be the one discussed in this issue's column, along with the comments and example which Dr. Beasley connected to the question.

ETHICAL QUESTION:

Dear Dr. Moffic:

As is usually the case for Ethics Committees, there are typically more questions than answers. Please add the following one to your list:

Shouldn't psychiatrists or psychiatric administrators (note which comes first in this title) not administrators or similar non-medical regulators make decisions on clinical care?

Much of what drives quality care in Psychiatry is the time we are able to devote to each patient. Administrators and fiscally driven systems will encourage (if not coerce or require) physicians to see as many patients in as short amount of time as they are willing to do. This decreases the quality of care and also removes the pressure on the system to change and improve. Psychiatrists must, therefore be the gatekeepers, or in essence dam-keepers against this flood of patients in order to preserve quality care. To succumb to these pressures and consequently condone this level of care is, it would appear – unethical.

Perhaps the Ethics Committee of the AAPA could put forth specific recommendations regarding reasonable time allotments.

For Example:

A new patient to require at least one (1) hour for evaluation (1½ preferably) and a typical follow-up to be at least thirty (30) minutes. A fifteen (15) minute medication check should be reserved for only the few most stable patients on maintenance therapy only.

Let's float this for comment.

RESPONSE 1:

Dear Steve:

Decisions about clinical care should be made by physicians, and in mental health settings preferably by psychiatrists, or by psychiatrists who are acting as Psychiatric Administrators. Time is an integral part of a psychiatrist's, or any other physician's, interaction with the patient. While it is true that fiscally-driven systems will encourage physicians to see as many patients as possible in a short time, it is the responsibility of the physician to make sure that adequate time is devoted to each patient so that an evaluation can be made, appropriate therapy can be delivered, questions can be answered, medications can be prescribed, possible side effects can be anticipated, the treatment plan can be updated, and future treatment can be planned. It is the responsibility of the physician (psychiatrist, or other clinician) to preserve the quality of care for the patient.

Physicians are sometimes pressured to perform tasks that are unethical. This would include such things as writing prescriptions for patients that they have not seen, seeing patients without having adequate time for careful assessment, signing off on the care of non-physician clinicians when they are not adequately supervising these clinicians, or acting as supervisors for other clinicians when they, in fact, are not doing so. This would only be a partial list.

It would seem to me quite difficult to evaluate a new patient in less than an hour. Not only is the initial session necessary for gathering information, and forming preliminary diagnoses, but also for setting up a beginning treatment plan, establishing a rapport with the patient, and giving hope for the future. Typical follow up visits should be for at least thirty minutes, if any psychotherapy whatsoever is to be rendered. Fifteen-minutes

medication checks should clearly be reserved for only the most stable patients who are on maintenance medication therapy only, and it is unlikely that much real therapy could be done in a session as short as fifteen minutes. In fact, a thirty-minute psychotherapy session would probably be mostly (only?) for supportive therapy, or would involve a patient who had previously been in therapy for quite a while with longer sessions, such as forty-five minute sessions, and was now reasonably stable.

Sincerely,

Dale M. Davis, M.D.

RESPONSE 2:

Dr. Moffic:

Now to Dr. Beasley's concerns, which are well taken. One to one and a half hours does indeed seem mandatory for a reasonable quality initial psychiatric evaluation which, I assume, also includes relevant general medical history and perhaps limited assessment. All subsequent follow-up visits MUST be at least 30 minutes; documentation has to be worked into this also. This timeframe should apply to all patients not in reasonable remission as determined by goals agreed upon at the time of the initial evaluation. In fact, the first several of these 30 minutes visits would probably involve further history clarification as well as issues related to treatment per se. I don't see how we can deliver the required empathic dynamic verbal interchange with patients more rapidly. To do so would force us to abdicate roles for which we have been trained, roles that set us apart from all other physicians and which our patients expect (whether they are consciously aware of it or not). Fifteen minute sessions would be only for patients clearly in remission, but who require long term follow-up and medication over time.

—Roy Varner, M.D., Professor, UT Medical School, Houston, Harris County Psychiatric Center

RESPONSE 3:

Dear Steve:

With regard to the question that Dr. Beasley raises in his letter, my main focus would be to make a clear distinction between clinical decision-making and administrative decision-making. There is no question that at times they come in conflict and because of this it is probably advisable not to make one person responsible for both. In one sense, this is the same conflict that comes up when a treating psychiatrist is asked to write an occupational evaluation.

On time issues, it is always most advisable to emphasize quality of care and not get caught up in bottom line issues other than to say someone else has to make those decisions.

I hope this will be of some help and the suggestion Dr. Beasley makes is too general since psychiatry is such a heterogeneous field. There are reasonable differences of opinion as well as institutional differences.

Very truly yours,

Gerald H Flamm, M.D.

RESPONSE 4:

Dear Steve,

RE: "Shouldn't psychiatrists or psychiatric administrators not administrators or similar non-medical regulators make decisions on clinical care?"

I think there is no question of general agreement on this point, whether from clinical or non-clinical staff members in a system; the difficulties seem to come in implementation rather than principle, particularly in the practical economics of time allotment per patient per clinician, on which the most stringent pressures generally fall on the psychiatrist; i.e., the person with the most knowledge and experience, the leader of the treatment team, and the person (usually and hopefully) with the prescription pad and the license to use it.

This leads to the even more important issue raised in Dr. Beasley's next paragraph and to his

suggestion for an ethical guideline to address the allotment of specific amounts of time for services:

“A new patient to require at least one (1) hour for evaluation (1 ½ preferably) and a typical follow-up to be at least thirty (30) minutes. A fifteen (15) minute medication check should be reserved for only the few most stable patients on maintenance therapy only.”

Having worked from time to time in community mental health clinics and been faced with what seemed a deluge of patients, all new to me and needing record review with confirmation of data, if not complete evaluations, I am in total sympathy with the above concerns: however, a number of variables exist which cannot be adequately addressed by the time issue. A few are listed below.

1. The time required for an evaluation varies with:
 - a. the experience and skills of the examiner
 - b. the setting; for example, a quiet room with adequate furnishings and ventilation with no interruption might shorten considerably the time required
 - c. preliminary work by other clinicians, its format, their expertise, reliability, and the legibility of their reports
 - d. patient factors such as coherence, intellect, cooperation
2. Time and economics fail to mesh when the notoriously poorly-reliable consumer of public services fails to show up.
3. Availability and accuracy of dictation systems.

Some balance should clearly be negotiated on an individual basis to allow adequate time for the psychiatrist to fully and ethically evaluate the patient, but I believe this is as a “free-standing” principle cannot be addressed as such.

We are left therefore with the content of the psychiatric evaluation as a measure of medical, psychiatric, and administrative ethics. This

important issue is included, if not specified, in a number of areas; first of all, in our allegiance to our patients addressed in **Section 1:** “*A physician shall be dedicated to providing competent medical service with compassion and respect for human dignity*” – we cannot provide care without adequate evaluation and information and there is no such thing as a “medication check” without those two essential elements; then by the **PRACTICE GUIDELINES FOR PSYCHIATRIC EVALUATION**, which defines (or suggests, if your prefer) the components of a psychiatric evaluation in a concise and easily measured format; thirdly, in the very core of personal and medical ethics stated in **Section 2:** “*A physician shall deal honestly with patients....*”

Yours, truly,

June A. Powell, M.D.

RESPONSE OF EDITOR:

Dr. Beasley’s query seems to bring up at least two important ethical questions, which seem related to one another. Let’s address them one by one.

- 1) Who should make the final decisions on clinical care, the clinical psychiatrist, a psychiatric administrator, or a non-medical administrator?

While our Ethical Principles for Psychiatric Administrators only address the role of the psychiatric administrator, it does imply what the answer should be. The Preamble and its connected Annotation put the needs of the patient as the first priority. Therefore, who is in the best position to address these needs? While it may seem self-evident that the person to do so would be the clinical psychiatrist, since the psychiatrist would either have seen the patient and/or supervised another non-medical clinician, such a response does not address the issue of accountability and outcomes. Given figures that 30% or so of health and mental health treatment has been unnecessary or inappropriate (Moffic,

1997), how can “competent medical service” (Section I) be assured? Here it seems that some system of objective monitoring must be in place, whether that is in the office of a solo private practitioner or a mental health system. The monitoring can be done in several ways: patient satisfaction surveys, the use of published clinical guidelines and/or medical algorithms, supervision, chart reviews, and outcome studies. Usually, a psychiatrist who is also an administrator, would be most likely to be able to set up a relevant, objective monitoring program. In a mental healthcare system, Section 5 and Annotation 4 would seem especially 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 (4). Given both the unique as well as occasional overlap of skills and training of the different mental health disciplines, the psychiatric administrator should strive to make the most cost-effective use of the apparent strengths of each mental health discipline.

2) Is the amount of time spent with a patient connected to quality care, and if so, should there be specific “reasonable” time allotments for different clinical visits?

While it may seem self-evident that allowing “reasonable” and enough time is the ethical way for quality of care, there may be more here than it seem at first glance. Perhaps because it seems self-evident, to the best of my knowledge (and a literature search), there are no published studies comparing different time frames for evaluation or medication checks (or psychotherapy, for that matter). The lack of such comparison is one reason that managed care was able to challenge our historical time allotments and essentially reduce a med check under those systems to 15 minutes (with some flexibility at times for time, though not payment, given no-shows). Given this

lack of research, the onus is then on psychiatric administrators to use whatever information is currently available to set up the time allotments in their systems. Some of our “Ethical Principles” seem relevant to keep in mind when considering this challenge.

SECTION 1

“A physician shall be dedicated to providing competent medical service with compassion and respect for human dignity.”

Annotation (1) for Psychiatric Administrators. Knowing that the quality of medical services can be affected by a wide variety of variables, including the skills of clinicians, the organization of the delivery system, and the adequacy of funding, the psychiatric administrator will strive, though may not always succeed to do what is possible to have competent mental health services in the organization. “Competent” does not mean ideal services, but rather refers to the average expectable outcomes given the current state of psychiatric knowledge and available delivery systems.

Annotation (4). To substantiate that competent psychiatric services are being provided, the psychiatric administrator should support and/or foster the development of relevant outcome studies and strive for continuous quality improvement.

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 (2). The psychiatric administrator should stay abreast not only of general psychiatric advances in knowledge, but also relevant administrative, political, and business knowledge that may influence the functioning of healthcare systems. Information relevant to others in the organization and to the public should be shared with them.

RESPONSE 5:

Here we come full circle, both back to Dr. Beasley and also to the last issue of *Psychiatrist Administrator*. About two months after his original ethics question, we received this letter from Dr. Beasley.

Dear Dr. Moffic:

After writing to you on May 11, 2001 (copy enclosed) responding to your requests for Ethics Questions, I read the April 2001 issue of "*Psychiatrist Administrator*". Coincidentally, one of the articles was very relevant to some of my same concerns (a copy is enclosed for your convenience). I would borrow this to submit as a somewhat more elaborate, nonetheless pertinent answer to my own question.

Why not formally adopt the recommendations listed in the article or at least consider the possibility.

Sincerely,

Lawrence B. Beasley, M.D.

To encourage readers to re-read Dr. Mini's, et al article, we won't quote any details, except to say that the recommendation (among many others in the article) for visit times in the article is not at all far from Dr. Beasley's recommendations. This unexpected "coincidence" may suggest we are considering a major ethical issue for psychiatrist administrators.

INVITATION FOR FOLLOW-UP COMMENTARY:

But what does our readership think about this ethical question and the recommendations. Should our organization take some public stand on these matters? We welcome your comments, or other ethical questions, which can be published

in an upcoming issue of the *Psychiatrist Administrator*.

INVITATION FOR OTHER QUESTIONS:

Given the current ethical challenges that face psychiatrist administrators, we're quite sure there are many more questions to deliberate. Please send them to us for consideration in future columns.

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Thanks for your interest and participation.

Reference:

Moffic, H.S.: *The Ethical Way: Challenges and Solutions for Managed Behavioral Healthcare*, San Francisco, Jossey-Bass, 1997.

Mini, L.J.; Hantoot, M.; Patel, M.; Reed, D.; Weinstein, S.: The role of psychiatrist in the community mental health center: What should they do? How many do you need?. *Psychiatrist Administrator* 2001, 1:19-25.

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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.

The choice of "Psychiatrist Administrator" is intended to distinguish the NewsJournal from other publications in mental and behavioral health administration in terms of its focus on the roles and perspectives of psychiatrists in leadership and management within evolving systems of care.

The purpose of the NewsJournal is to provide up-to-date, accurate, and easily understandable information to our readership and to contribute to the body of scholarly work in the area of psychiatric administration and management. Your article should be written in a clear, straightforward style that is pleasant to read.

PREPARATION OF MANUSCRIPT

Manuscripts should be typewritten on standard (8 1/2" x 11") white paper with 1" margins on all sides. The entire manuscript, including references and figure legends, should be double-spaced. Each element of the manuscript should begin on a new page: title page, abstract, text, references, tables (typed 1 per page), figure legends. Number pages consecutively through the manuscript. Manuscripts should be no more than 3000 words of text (not including references or tables).

A separate page should be included giving the title of the paper, the names, titles, and affiliations of each author, and the mailing address, email address, and phone and fax numbers of the corresponding author. Any grant support requiring acknowledgment should be mentioned on this page. Acknowledgments other than those of grant support should be put at the end of the text.

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Figures should be numbered consecutively as they appear in the text. Illustrations - line drawings, graphs, or charts - should be of camera-ready quality.

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Manuscripts are reviewed by the editor, editorial board members, or other reviewers. Manuscripts may be edited for clarity, style, conciseness, and format. The edited manuscript will be sent to the corresponding author for approval. Authors may be asked to respond to editorial queries or make revisions.

Authors will receive page proofs before publication. The author should return corrected proofs to Frances Roton, Executive Director AAPA, within three days of receipt; delays in returning proofs may result in postponement of publication.

MANUSCRIPT SUBMISSION

Manuscript submission is a representation that the manuscript has not been published previously and is not currently under consideration for publication elsewhere.

Three copies of the manuscript should be sent to Sy Saeed, M.D., Editor, Psychiatrist Administrator, Department of Psychiatry & Behavioral Medicine, University of Illinois College of Medicine @ Peoria, 5407 North University Street, Suite "C", Peoria, Illinois 61614-4785. The manuscript should be accompanied by a transmittal letter giving the name, address, email address, and phone numbers of the corresponding author. The letter should indicate that all authors have seen and approved the manuscript and that the manuscript has not been published or is not under consideration for publication elsewhere. A disk copy of the complete manuscript, including tables and references, should also be submitted. Please label the disk with the name of the first author and title of the article and indicate what hardware and software were used. **You can also submit the manuscript electronically by sending it as an e-mail attachment to the editor at SAaeed@UIC.Edu.**

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