Texas Psychiatrist

# Seeking Equal Benefits for Psychiatric Illnesses

"Parity" has been a rallying cry for psychiatrists, advocates and family members who have been attempting to pass legislation that will require insurance companies to provide benefits for psychiatric illnesses that are the same as provided for "physical" illnesses. These attempts have been successful to a limited degree in Texas with passage of parity legislation in 1991 and 1997. However, the legislation passed in Texas still has limitations on benefits and illnesses covered.

Efforts will be made in the current legislation session to expand insurance benefits to cover all psychiatric disorders at the same levels other medical illnesses are covered. Two bills have been filed to date that will require health plans to provide coverage for the diagnosis and treatment of mental disorders under the same terms and conditions as coverage provided for the diagnosis and treatment of physical illnesses; HB 656 by Rep. Garnet Coleman (Houston) and SB 568 by Senator Rodney Ellis (Houston). Other "partial parity" bills filed so far include: HB 510 by Rep. Farabee (children); HB 659 and HB 1128 by Rep. Coleman (anorexia and bulimia nervosa); HB 919 by Rep. Eissler (children); and SB 92 by Senator Van de Putte (anorexia and bulimia nervosa).

In the 2007 Texas legislative session, it is expected that the business community will join psychiatrists, advocates and families in efforts to pass legislation calling for equal benefits for mental illnesses. As a result, the word "parity" will be de-emphasized because of negative connotations to the business community and instead, there will be a call for "equal benefits." This subtle change in terminology is intended to be more acceptable to the business community, which is the major purchaser of health insurance and can be a strong ally on this issue.

One tool that will be used in making the case for "equal benefits" is a recently published *"Employer's Guide to Behavioral Health Services."*

The *Guide* was published by the National Business Group on Health following a study performed by the National Committee on Employer-Sponsored Behavioral Health Services. The Committee consisted of 25 benefits and healthcare experts including academic researchers, disability management professionals, Employee Assistance Program (EAP) professionals, healthcare benefits specialists, representatives from managed care and managed behavioral health organizations, pharmacology experts and medical directors and benefits managers from Business Group member companies.

The following is a summary of key findings and recommendations of the Committee as documented in the *Guide*:

## Key Findings

1. **Mental illness and substance abuse disorders are serious, common, and expensive health problems.** In 2001 mental health and substance abuse treatment costs totaled $104 billion and represented 7.6% of total healthcare spending in the United States ($1.4 trillion). Unlike other medical conditions such as heart disease or diabetes, the indirect costs associated with mental illness and substance abuse disorders commonly meet or exceed the direct treatment costs.
2. **Research has conclusively shown that depression and other mental illness and substance abuse disorders are a major cause of lost productivity and absenteeism.** Mental illness causes more days of work loss and work impairment than many other chronic conditions such as diabetes, asthma, and arthritis. Approximately 217 million days of work are lost annually due to productivity decline related to mental illness and substance abuse disorders, costing United States employers $17 billion each year. In total, estimates of the indirect costs associated with mental illness and substance abuse disorders range from a low of $79 billion per year to a high of $105 billion per year (both figures based on 1990 dollars).
3. **Disability costs related to psychiatric disorders are high and continue to rise.** Mental illness and substance abuse disorders represent the top 5 causes of disability among people age 15-44 in the United States and Canada (not including disability caused by communicable diseases) [Note: includes employed and unemployed populations]. Further, mental illness and substance abuse disorders, combined as a group, are the fifth leading cause of short-term disability and the third leading cause of long-term disability for employers in the United States.
4. **The efficacy of treatment for mental illness and substance abuse disorders is well documented and has improved dramatically over the past 50 years.** For most mental illnesses there is a range of well-tolerated and effective treatments. Current research suggests that the most effective method of treatment is multimodal and combines pharmacological management with psychosocial interventions such as psychotherapy.
5. **A significant proportion of individuals with behavioral health problems are treated exclusively in the general medical setting, which has become the "defacto mental healthcare system."** Among patients diagnosed with a mental illness, 42% of those with clinical depression and 47% of those with generalized anxiety disorder (GAD) were first diagnosed by a primary care physician. Approximately 22.8% of individuals treated for a mental illness or substance abuse disorder, and half (51.6%) of patients treated for depression, are treated by a general medical provider such as a primary care physician. Further, it is estimated that 11%-36% of patients presenting at primary care have a mental illness. Numerous studies over the past two decades have found that the adequacy and quality of mental healthcare delivered in the general medical setting is suboptimal. In fact, the *National Co-morbidity Survey Replication* (NCS-R) found that only 12.7% of individuals treated in the general medical sector received minimally adequate care compared to 43.87% of patients treated in the specialty mental health sector.
6. **Primary care physicians (PCPs) and other general medical providers are — and will continue to be — an integral part of behavioral healthcare in the United States.** However, significant quality problems have been found with general medical providers screening, treatment, and monitoring practices. Many of the recommendations presented in the Guide suggest programs, benefits, and practices that will support general medical providers in the provision of high-quality behavioral healthcare services.
7. **Psychotropic drugs have become the major treatment modality in behavioral healthcare whether prescribed by general medical physicians (e.g., primary care physicians) or by behavioral health specialists (i.e. psychiatrists).** The availability of prescription medications as a method of treatment has improved the lives of many individuals with mental illness and substance abuse disorders. However, a number of quality problems have been identified with current psychotropic medication prescribing practices (e.g., pharmacological management is frequently the sole treatment modality). Further, the escalating cost of psychotropic drugs is of concern to employers. In 1987, psychotropic medications were responsible for 7.7% of all mental healthcare spending in the United States (including expenditures from private insurance, Medicare, Medicaid, etc); by 2001, psychotropic drug spending was responsible for 21.0% of total mental health spending. In 2001, private employers spent approximately 17% of their total behavioral health expenditures on prescription medications.
8. **While employers have focused their attention on the management of high cost chronic medical conditions (e.g., heart disease and type 2 diabetes), such management efforts have not fully addressed the significant additional burden of co-morbid mental illness. Access to specialty behavioral healthcare services is critical to delivering effective disease management services for chronic medical problems. Therefore, limitations on behavioral healthcare benefits may limit the efficacy of disease management programs for individuals with co-morbid medical and behavioral health conditions. Disease management programs will not realize their full potential without fostering better coordination between the general medical healthcare system and the specialty behavioral healthcare system.** Research has shown that individuals with chronic medical conditions and untreated co-morbid mental illness or substance abuse disorders are the most complicated amid costly cases. For example:
   - Healthcare use and healthcare costs are up to twice as high among diabetes and heart disease patients with co-morbid depression, compared to those without depression, even when accounting for other factors such as age, gender, and other illnesses.
   - Patients with mental illness and substance abuse disorders are often less responsive to treatment. For example, depressed patients are three times as likely as non-depressed patients to be non-compliant with their medical treatment regimen.
   - The presence of type 2 diabetes nearly doubles an individual's risk of depression and an estimated 28.5% of diabetic patients in the United States meet criteria for clinical depression.
   - Approximately one in six patients treated for a heart attack experiences major depression soon after their heart attack and at least one in three patients have significant symptoms of depression.
9. **Access to specialty mental healthcare services is constrained due to benefit design with higher co-pays, visit limits,**

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## INSIDE

# Volunteers Make the World Go Around

Leslie H. Secrest, MD, President, Texas Society of Psychiatric Physicians

Leslie H. Secrest, MD

As your President, I have been impressed by the contributions made by TSPP members and the members of our Chapters. Members not only provide the financial support for our infrastructure but also become the energy and muscle that moves our organizations forward. Meeting together as Psychiatrists we talk about and find ways to assist our communities, our patients, and our profession through volunteer activities. The vitality of Organized Psychiatry and Organized Medicine relies on our volunteer activities. Quite often volunteers and their contributions each day are over looked unless those activities happen to solicit our collective attention.
Unfortunately, some of the most important contributions go unnoticed because they become part of the structure and expectation of the organization.

The committee work in TSPP and the Chapters can be over looked because it is part of our expectation. If the list of committees is scanned, the contribution made by any one member will not be readily apparent. The discussions that transpired may be known only by those in attendance. Occasionally there will be an action item which will spring forth to move to another committee and ultimately an action or position will be taken. Throughout this process each contribution is extremely valuable as the dialogue brings clarity and consideration. Often the individuals who contributed their expertise, experience and point of view can never be fully and formally acknowledged. Scanning the committee list again with the question what has this committee done lately, an answer quickly emerges. The work of committee members have provided the structure and the process that creates what we are. Members are the fabric and without them and their contributions we would not be strong, effective, and efficient. In fact without even one of them, we would see a blemish in the fabric until a new member arrives and contributes to the dialogue. Being a part of the fabric year after year can be tiring and at times disheartening as the energy and contributions may seem to be unappreciated or unacknowledged.

The amazing part of all this is that members return year after year and can spend a life time being the fabric with very little acknowledgement and yet quickly spring forward when there is a new need that requires the expenditure of more volunteer resources. A legislative year is often a time when there is a sudden need for the recruitment and expenditure of volunteer resources. Not to say that the off year doesn't often demand a quick mobilization of resources. Our individual resources are the most precious ones we have, our time, our intellect, our creativity, our emotions and our energy. The return on our expenditure is the satisfaction that by combining our unique individual contributions, public policy is affected, patient care and access is advanced, patient safety is improved, and our profession is invigorated.

Often the enrichment, the enjoyment, the humor, the affection, the good times and the growth as individual members working together is placed in the background and is over looked by the urgency of situations or the boredom of the routine. Experiencing our membership and our volunteerism as enjoyable brings a certain serenity that invigorates, that energizes, that excites, and that returns us again. Focusing on and fostering satisfaction is some of our challenge. The satisfaction and serenity that members experience in their daily volunteering nurtures the strength in our organizations.

TSPP and the Chapters are leaders locally, leaders in the state and leaders nationally. At times we fail to give our selves credit for what we achieve. As an organization we are a valued resource, providing leadership and thoughtful vision. Now that we are in the midst of the legislative session, please plan to attend our Capitol Day, February 28th. This allows our legislators to know that we are a special resource and readily available.

Lastly, thanks to each of you the unsung heroes and heroines who give of yourselves and quietly make TSPP and the Chapters a leader and a resource to our nation, to our state and to our communities. You do make the world go around. ■

Hurricane Recovery Program

## Access to Care

The *Access to Care* program is a mental health and substance abuse program for people who were impacted by Hurricanes Katrina, Rita and Wilma, and their family members. Survivors are able to receive financial assistance for mental health counseling, medication and substance abuse treatment during their recovery. The program can be used to pay for services with licensed providers and clinics anywhere in the country and is retroactive to August 30, 2005. Anyone who resided in a FEMA designated pre-disaster hurricane zip code prior to landfall and suffered significant impact is eligible. Anyone who lost a close family member as a result of the hurricanes, regardless of their place of residence at the time of the hurricanes, is also eligible for assistance. Mental health professionals, case managers and interested clients can get more information about eligibility, covered services and how to enroll, by visiting the program's website: www.a2care.org or by calling: 1-866-794-HOPE, a 24/7 toll-free, multilingual line staffed with trained mental health professionals.

This program is an initiative of The American Red Cross Hurricane Recovery Program and is administered by Link2Health Solutions, a private non-profit subsidiary of The Mental Health Association of NYC.

To discuss outreach opportunities or request materials or more detailed program information, contact Jennifer Cronin, jcronin@mhaofnyc.org or 212-614-6328.

## APA Fellowship

If you have been a General Member for at least five consecutive years, the APA invites you to apply for Fellow status. In addition to the membership requirement mentioned, the following eligibility criteria must be met:

- Certification by the American Board of Psychiatry and Neurology, the Royal College of Physicians and Surgeons of Canada, or the American Osteopathic Association.
- Three letters of recommendation from current Fellows, Distinguished Fellows, Life Fellows or Distinguished Life Fellows.
- 30-day review period for TSPP to offer comments about the Fellowship candidate.
- Approval by the APA Membership Committee.
- Approval by the APA Board of Trustees.

To apply, you must submit an Fellowship Application form and the three letters of recommendation to the APA by September 1, 2007. Members who apply and are approved for the category of Fellow this year will officially become Fellows on January 1, 2008 and will be invited to participate in the Convocation of Distinguished Fellows during the 2008 APA Annual Meeting in Washington DC.

To obtain a Fellow Application form, please contact the APA Membership Department, 1000 Wilson Blvd., Suite 1825, Arlington, VA 22209 or call 1-888-35-PSYCH.

### In Memoriam...

**Bruce H. Beard**, MD, Dallas
**George A. Constant**, MD, Victoria

## MEMBERSHIP CHANGES

### TEXAS SOCIETY OF PSYCHIATRIC PHYSICIANS

*The following membership applications have been approved by the TSPP Executive Committee and have been transmitted to the APA.*

**Member in Training**
Afzal, Khalid, MD, El Paso
Garza, Magdalene, MD, San Antonio
Gonzalez, Sylvia, MD, Spring
Lara, Christell, MD, Galveston
McAdams, Carrie, MD, Plano
Moore, Audrey, MD, Houston
Neal, Cheryl, MD, Houston
Opalacu, Thaddeus, DO, Mansfield
Park, Eun, MD, San Antonio
Patel, Nishant, MD, Houston
Regwan, Heather, MD, Helotes
Salib, Micael, MD, El Paso
Shakil, Rubina, MD, Austin
Sullivan, Joachim, MD, Temple
Vaughan, Lucretia, MD, Missouri City
Vitali, Ariel, MD, Lubbock

**General Member**
Bushong, Criag, MD, (Reinstatement) Houston
Loya, Altaf, MD, Houston

### TEXAS ACADEMY OF PSYCHIATRY

*The following membership applications have been approved by the Texas Academy of Psychiatry.*

**General Member**
Dobyns, Robert, MD, Austin
Fagala, Gwen, MD, Amarillo

**Member in Training**
Garcia-Pittman, Erica, MD, Dallas
Opalach, Thaddeus, DO, Mansfield


Texas Society of Psychiatric Physicians

# Committee Meetings/CME Dinner Program/Executive Council Meeting

## April 28-29, 2007 • Adolphus Hotel • Dallas

Make plans to join your friends and colleagues for TSPP's Committee Meetings, complimentary luncheon (underwritten by Acadia Healthcare) and 2-hour CME accredited dinner program on Saturday, April 28 at the award-winning Adolphus Hotel, 1321 Commerce Street, Dallas, TX. The TSPP Executive Council will meet on Sunday, April 29.

TSPP's committee meetings have been scheduled in conjunction with the TexMed Annual Convention in Dallas and members are also encouraged to attend TMA's Section on Psychiatry Program Friday, April 27, 9:00am-5:00pm, at the Hyatt Regency Hotel.

Following the conclusion of committee meetings on Saturday, the TSPP CME Committee has arranged a 2 hour Category 1 CME Dinner Program "Practical Clinical Applications of the CATIE (Clinical Antipsychotic Trials of Intervention Effectiveness) Studies" by noted speaker, Michael Schwartz, MD.

To confirm your meeting attendance and/or register for the CME Dinner Program, please complete the enclosed RSVP & Registration Form and return to the Texas Society of Psychiatric Physicians' Office, 401 West 15th Street, Suite 675, Austin, TX 78701 (fax 512/478-5223) by March 28. For additional information, visit our website www.txpsych.org or contact our office at 512/478-0605; e-mail tsppofc@aol.com. We look forward to seeing you at the TSPP meetings in April.

**TSPP has arranged a limited, special DISCOUNTED room rate of $139.00 single or $149.00 double occupancy for TSPP meeting attendees at The Adolphus Hotel. FOR ROOM RESERVATIONS: 1/800/221-9083 BEFORE MARCH 28 OR UPON SELL-OUT, WHICHEVER OCCURS FIRST.**

TEXAS SOCIETY OF PSYCHIATRIC PHYSICIANS

**Committee & Executive Council Meetings &**
**CME Dinner Meeting "Practical Clinical Applications of the CATIE Studies"**

April 28-29, 2007 • Adolphus Hotel

**R E G I S T R A T I O N**

NAME: _____

ADDRESS / CITY / STATE / ZIP: _____

E-MAIL ADDRESS FOR MEETING CONFIRMATION: _____

| YES, I will attend | NO, I will not attend | COMMITTEE/EXECUTIVE COUNCIL |
|---|---|---|
| _____# Attending | | **Luncheon - NO CHARGE - if pre-registered before meeting - Underwritten by Acadia Healthcare** |
| ☐ | ☐ | Academic Psychiatry |
| ☐ | ☐ | Children and Adolescents |
| | | Constitution and Bylaws **(NOT MEETING)** |
| ☐ | ☐ | Continuing Medical Education |
| ☐ | ☐ | Ethics |
| ☐ | ☐ | Fellowship |
| ☐ | ☐ | Finance |
| ☐ | ☐ | Forensic Psychiatry |
| ☐ | ☐ | Foundation Board of Directors |
| ☐ | ☐ | Government Affairs |
| ☐ | ☐ | Members-in-Training Section |
| | | Nominating **(NOT MEETING)** |
| ☐ | ☐ | Physician Advocacy |
| ☐ | ☐ | Professional Practices |
| ☐ | ☐ | Public Mental Health Services |
| ☐ | ☐ | Socioeconomics |
| ☐ | ☐ | Strategic Planning & Coordinating |
| ☐ | ☐ | Texas Academy of Psychiatry Membership |
| **$35.00 Per Person** ____ **# Attending** | | **CME Dinner Program: "Practical Clinical Applications of the CATIE Studies" - Michael Schwartz, MD $35.00 Per Person Prior to 3/28; $45.00 AFTER** |
| ☐ | ☐ | (Sunday) Executive Council Meeting |

**METHOD OF PAYMENT: ☐ Check ☐ VISA ☐ MasterCard ☐ American Express**

Credit Card #_____ Exp. Date_____

Name of Cardholder (as it appears on card) _____

Zip Code Where You Receive Credit Card Statement _____

**CANCELLATION POLICY: In the event of cancellation, a full refund will be made if written notice is received in the TSPP office by March 28, 2007, less a 25% handling charge. No refunds will be given after April 15, 2007**

MAIL / FAX FORM TO TSPP BY MARCH 28, 2007 to 401 West 15th St. # 675, Austin, TX 78701 / FAX 512/478-5223

**TEXAS SOCIETY OF PSYCHIATRIC PHYSICIANS**

## CME DINNER PROGRAM • APRIL 28, 2007

### Practical Clinical Applications of the "CATIE" (Clinical Antipsychotic Trials of Intervention Effectiveness) Studies

Michael Schwartz, MD

**REGISTRATION FEE:** $35.00 PRIOR TO MARCH 28 / $45.00 AFTER MARCH 28

Please complete the attached Registration Form and return with payment to Texas Society of Psychiatric Physicians, 401 West 15th Street, Suite #675, Austin, TX 78701 or if paying by credit card, fax to 512/478-5223.

**MEETING SITE:** The Adolphus Hotel, 1321 Commerce Street, Dallas, Texas. TSPP has arranged for a limited, discounted room rate of $139 single or $149 double occupancy at the Adolphus until March 28 or upon sell-out, whichever occurs first. For room reservations please contact the Adolphus Hotel at 1/800/221-9083.

**PARKING:** The Adolphus offers covered, valet parking for overnight guests at a rate of $20.00 per day and includes in/out privileges. A special day rate of $12.00 (no in/out privileges) is extended to attendees without room reservations.

**TARGET AUDIENCE:** This CME program is designed in a format consisting of a lecture and direct discussion and is designed to provide its' primary target audience of Psychiatrists, as well as other specialties of medicine, with clinically-relevant information regarding practical treatment recommendations and clinical applications of the CATIE Studies.

**OBJECTIVES:** At the conclusion of this presentation participants will be able to:

- Specify the evidence for differences in efficacy between first and second generation antipsychotics, and among the different second generation agents.
- Discuss the comparative side effect profiles for these classes of medications.
- Describe to patients the current rationale for use of antipsychotics in specific clinical situations

**ACCREDITATION STATEMENT:** The Texas Society of Psychiatric Physicians designates this educational activity for a maximum of two *AMA PRA Category 1 Credits*™. Physicians should only claim credit commensurate with the extent of their participation in the activity.

The Texas Society of Psychiatric Physicians is accredited by the Texas Medical Association to provide continuing medical education for physicians.

**FOR ADDITIONAL INFORMATION: CONTACT TSPP AT 512/478-0605 OR E-MAIL TSPPOFC@AOL.COM**

*This program is funded in part by an educational grant from Eli Lilly and Company and AstraZeneca, which had no control over its content.*

**S C H E D U L E**

**SATURDAY, April 28**

| | | |
|---|---|---|
| 7:30 AM - 8:00 PM | Registration / Information | Mezzanine Foyer |
| 7:30 AM - 8:55 AM | Foundation Board of Directors Breakfast Mtg | Directors |
| 8:00 AM - 5:00 PM | DBSA | Dan Moody |
| 8:30 AM - 4:00 PM | Committee Hospitality | Sam Houston AB |
| | ***Complimentary Refreshments & Light Hors D'oeuvres For Committee Members*** | |
| 9:00 AM - 10:30 AM | Socioeconomics | Pat Morris Neff |
| | Academic Psychiatry | W. Lee O'Daniel |
| | Finance | Executive |
| | Physician Advocacy | Sam Houston C |
| 10:30 AM - 12:00 PM | Professional Practices | Pat Morris Neff |
| | Fellowship | Executive |
| | Strategic Planning & Coordinating | Sam Houston C |
| | Texas Academy of Psychiatry Membership | W. Lee O'Daniel |
| 12:00 PM - 1:30 PM | Committee / Member Luncheon | John Neely Bryan |
| | **** No Charge if Pre-Registered Prior to Meeting ** Underwritten by Acadia Healthcare (See Registration Form to Register)** | |
| 1:30 PM - 3:00 PM | Public Mental Health Services | Pat Morris Neff |
| | Ethics | Executive |
| 3:00 PM - 4:30 PM | Continuing Medical Education | Sam Houston C |
| | Forensic Psychiatry | Pat Morris Neff |
| | Children and Adolescents | Executive |
| | Members in Training | W. Lee O'Daniel |
| 4:35 PM - 6:00 PM | Government Affairs | Pat Morris Neff |
| 6:30 PM - 8:30 PM | CME Dinner Program "Practical Clinical Applications of the CATIE Studies", Michael Schwartz, MD | Sam Rayburn AB |
| | **$35.00 Per Person Prior to 3/28/07; $45.00 After 3/28 and On-Site (See RSVP/Registration Form to Register)** | |

**SUNDAY, April 29**

| | | |
|---|---|---|
| 9:00 AM - 12:00 PM | Executive Council | Dan Moody |
| | **Complimentary Continental Breakfast for Council Members** | |

Part 4 Overview and Summary

# Prescribing Medications: the True Brass Tacks

R. Sanford Kiser, MD, President, Texas Academy of Psychiatry

Are you ready for the true brass tacks? The truth about prescribing medications?

The three previous articles of this series have been a warm up, and now we are ready to get down to a summary of the hard facts.

Why are hard facts so important? The answer is obvious. In this day and time medications can treat more illnesses than ever before, but medications cost more than ever before. Physicians, patients, and third-party pharmacy benefit managers need the best information possible to utilize medications that can deliver optimal results, both medically and financially.

Unfortunately, the decision making procedures for these determinations all too commonly have involved processes known as ignorance, foolishness, claptrap, poppycock, nonsense, baloney, drivel, hogwash, twaddle, garbage, bunkum, silliness, falsehood, balderdash, and deep-down dumbness.

The phrase "getting down to brass tacks" means to clear out these types of confusing obscurities and false generalities, in order to find out the real truth about something.

Let us summarize some of the "medication myths" that we have addressed in this series.

**Medication Myth #1:** *The "Gold Standard" for Drug Information is Found in the Physicians Desk Reference (PDR)*

**The True Brass Tacks:** The information in the PDR is limited to a summary of the information that the drug manufacturer submitted to the Food and Drug Administration (FDA) for approval of the drug to be labeled and marketed as safe and effective for a single condition. That information came from years of pharmaceutical research trials costing millions of dollars. In some cases, subsequent experience and research with an approved drug can yield information about other beneficial uses, called "off-label" uses.

Unless a financial incentive is present, a drug manufacturer is not likely to spend the years or dollars required for FDA approval and labeling for an additional indication, particularly if the newly discovered off-label use of the medication is already widespread.

Consequently, decision making processes which restrict the use of a medication only to the FDA labeling information in the PDR is a misuse of the FDA approval process, a process which is limited to evaluation of safety and efficacy of the drug for a single purpose.

The myth giving rise to this misuse of the FDA approval process has been as hard to dispel as the myths of Bigfoot, the Loch Ness Monster, and the Abominable Snowman. As far back as a quarter of a century ago, the FDA issued a bulletin attempting to clarify this misconception (FDA Medical Bulletin, Volume 12, Number 1, April 1982). This bulletin states:

*"The appropriateness or the legality of prescribing approved drugs for uses not included in their official labeling is sometimes a cause of concern and confusion among practitioners.*

*The Federal Food, Drug, and Cosmetic (FD&C) Act does not … limit the manner in which a physician may use an approved drug. Once a product has been approved for marketing, a physician may choose to prescribe it for uses or in treatment regimens or patient populations that are not included in approved labeling. Such … uses may be appropriate and rational in certain circumstances and may, in fact, reflect approaches to drug therapy that have been extensively reported in medical literature….*

*Valid new uses for drugs already on the market are often first discovered through serendipitous observations and therapeutic innovations….*

*With respect to its role in medical practice, the package insert is informational only. FDA tries to assure that prescription drug information in the package insert accurately and fully reflects the data on safety and effectiveness on which drug approval is based."*

The brass tacks nailing this medication myth to the wall of facts is clear in this FDA bulletin. To pretend that the initial drug data for FDA approval is the totality of information for the drug is to pretend that the first Caribbean island discovered by Columbus is the totality of the New World.

**Medication Myth #2:** *Evidence-based Prescribing is the Only Proper Way to Prescribe Medications*

**The True Brass Tacks:** In a perfect world we would have evidence-based, black-and-white answers to all medical decisions, including decisions about the proper choice of medications. Unfortunately we are not in that perfect world yet; in fact our world is so imperfect that different people can have different definitions of "evidence-based medicine."

The current state of imperfection in evidence-based approaches to prescribing decisions arises primarily from two factors:

(1) The information for evidence-based medication prescribing is derived from multiple types and levels of scientific data. The data sources include material from the FDA approval process, consensus of experts, anecdotal reports, open design studies, single blind studies, double-blind studies, multi-center double-blind studies, and meta-analyses of the medical literature. All this information can be consolidated into practice guidelines which typically set forth a general framework for guiding medication prescriptions for the average patient.

Nonetheless in the real world we treat individual patients, and not the abstract "average" patient. Therefore the evidence for the best medication choice for each individual patient is guided by an empirical clinical technique, which parallels the "N of 1" research design, in which a patient is used as his/her own control for drug effects.

(2) There are huge gaps in the scientific literature. Despite decades of modern medical research and the vast array of clinical publications, there are too many questions that have not been asked, too many hypotheses that have not been tested, and too many answers that are still unknown. We delude ourselves if we think we have enough information for clear-cut evidence-based prescription decisions.

Paradoxically, our deficiencies in this area are being highlighted by our successes in pharmacogenetics and pharmacogenomics research. The discoveries in those areas are revealing individual variations in the coding in the human genome for the multitude of factors involved in both pharmacodynamics and pharmacokinetics.

In spite of these limitations, continuing advances in computer and internet technology are accelerating the creation and communication of large databases facilitating evidence-based guidance in medication decisions. The National Guideline Clearinghouse, an agency of the U.S. Department of Health and Human Services, has a compendium of practice guidelines at their website, http://www.guideline.gov. The National Center for Biotechnology Information (NCBI) is a division of the National Library of Medicine at the National Institutes of Health. The NCBI website, http://www.ncbi.nlm.nih.gov, provides access to powerful online clinical and basic research literature databases, as well as other resources for evidence-based medication decisions.

The irony of modern medication decisions is that, in spite of all our wishes for evidence-based, easy answers, the true brass tacks securing safe and proper patient care still lies in the time-tested importance of the individual and unique doctor-patient relationship.

**Medication Myth #3:** *Polypharmacy is Always Bad*

**The True Brass Tacks:** The term "polypharmacy" can describe a number of clinical situations. Some, but not all, of those situations can potentially be harmful.

One example of potential harm is a patient going to multiple doctors, who prescribe multiple medications for the same condition, with none of the doctors being aware of the other doctors' prescriptions ("doctor shopping"). A second example is a patient surreptitiously going from doctor to doctor to support an addiction disorder. Even in straightforward cases, a complicated medication regimen can be difficult for a patient to follow, and differentiation between symptoms and additive side effects or drug-drug interactions can be difficult.

R. Sanford Kiser, MD

Nonetheless, modern research has increasingly revealed detailed information regarding drug action — all the way from absorption via different routes, through activities at various receptors, to excretion by different mechanisms. This information has led to an increasingly sophisticated body of knowledge that has led to the development of "rational polypharmacy" as a new standard of care in many clinical situations.

A panel of experts of the National Association of State Mental Health Program Directors has reviewed the evidence for rational polypharmacy in psychiatry. A summary of their findings can be found at their website, http://www.nasmhpd.org/general_files/publications/med_directors_pubs/polypharmacy.pdf. Their summary describes examples of rational polypharmacy practices in psychiatry supported by the medical literature, including (1) multi-class polypharmacy, i.e. use of drugs of different classes to treat one condition, (2) adjunctive polypharmacy, i.e. the use of a second medication for side effects of another medication, and (3) augmentation, i.e. use a low dose of a second medication to enhance the benefits of another medication.

The brass tacks bottom line for "polypharmacy" is that it is a word that can be used loosely and inappropriately to foster confusing generalities. Polypharmacy can come in multiple forms, some of which emerge from ignorance. However, the use of multiple medications, derived from a thoughtful, knowledgeable understanding of drug pharmacodynamics and pharmacokinetics, is not just polypharmacy. It is rational polypharmacy. ■

# TSCAP Summer Conference

Steven R. Pliszka, MD, President, Texas Society of Child and Adolescent Psychiatry

The Texas Society of Child and Adolescent Psychiatry will hold its annual meeting July 27-29, 2007 at the Moody Gardens in Galveston, Texas. The theme of the meeting will be, "New Directions in Child and Adolescent Psychiatric Treatment." We plan to delve into new advances in clinical neuroscience that will shape the practice of psychiatry in the next five years: pharmacogenetics, brain stimulation methods and the ethics of psychopharmacology in children and adolescents. Our keynote speaker will be James McCracken, MD, the Chief of the Child Psychiatry Division of the University of California at Los Angeles. Dr. McCracken and his faculty are some of the leading researchers in the world in the genetics of psychiatric disorder. In the future, pharmacogenetic assays will help predict response to treatment and identify patients vulnerable to side effects.

In the last few years, brain stimulation tasks such as magnetoencephalography (MEG), vagal nerve stimulation (VNS) and deep brain stimulation (DBS) have been developed for research into and treatment of psychiatric disorder. VNS is currently approved for treatment of adult depression and epilepsy. We will review the basic principals of these techniques and have a case presentation of a child with comorbid major depression and epilepsy whose depression responded when his epilepsy was treated with VNS.

Finally, we will have a presentation and panel discussion on psychiatric polypharmacy in children which will qualify as the ethics credit of your continuing medical education (CME) annual requirement. There is great public concern about the use of psychotropics in children; there are a growing number of complaints being file with the Texas Medical Board against psychiatrists on this issue. It is critical for all Texas psychiatrists to be aware of the current trends in this area.

Steven R. Pliszka, MD

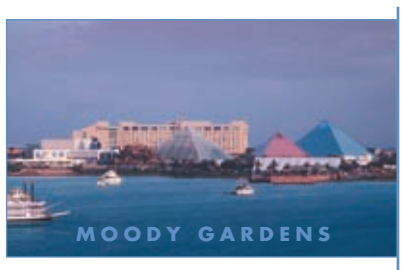
The Moody Gardens is a beautiful and relaxing setting and is ideal for bringing the family. The society warmly invites all the members of the Federation of Texas Psychiatry to attend. We hope to see you there. ■

# Texas Society of Child and Adolescent Psychiatry

# Summer Meeting and Scientific Program

## "New Directions in Child and Adolescent Psychiatric Treatment"

**July 27-29, 2007 • Moody Gardens Hotel • Galveston**




### General Information

#### *Location*

All events will take place at the Moody Gardens Hotel, Seven Hope Boulevard, Galveston, Texas, 1/800/582-4673.

Surrounded by 242 acres of breathtaking gardens and majestic pyramids, the Four Diamond Moody Gardens Hotel, Spa and Convention Center is Galveston Island's premier meeting destination. Moody Gardens features: the ten story Rain Forest Pyramid, the IMAX 3D Theater,the Discovery Museum,the IMAX Ridefilm Theaters, Palm Beach - Moody Gardens secluded fresh water, white sand beach featuring crashing waterfalls, crystal clear lagoons, Jacuzzi's, volleyball courts and paddleboats, the Colonel Paddlewheel Boat and the Aquarium.

Golf and tennis facilities are available to Moody Gardens guests at the Galveston Country Club. The hotel concierge will make arrangements for you.

#### *Hotel Reservations*

TSCAP has arranged a limited, special discounted room rate for conference attendees at the Moody Gardens Hotel of $175.00 single - quad occupancy until July 5, or upon sell-out of the discounted room block, whichever occurs first.

To place your reservation call (888) 388-8484 and identify yourself as an attendee of the Texas Society of Child and Adolescents Conference.

Check-In Time: 4:00 pm
Check-Out Time: 12

### Opening Welcome Reception with Exhibitors

A special Welcome Reception has been planned to open the event, Friday, July 27, beginning at 6:30 pm until 8:00 pm in Floral Hall A-1 at the Moody Gardens Hotel.

### Continuing Medical Education

#### *Accreditation*

This activity has been planned and implemented in accordance with the Essential Areas and Policies of the Texas Medical Association (TMA) through the Joint Sponsorship of the Texas Society of Psychiatric Physicians and the Texas Society of Child and Adolescent Psychiatry. The Texas Society of Psychiatric Physicians is accredited by the Texas Medical Association to provide continuing medical education for physicians.

The Texas Society of Psychiatric Physicians designates this educational activity for a maximum of eight (8) *AMA PRA Category 1 Credits™* .

Participants should only claim credit commensurate with the extent of their participation in the activity.

The presentations "The Ethics of the Use of Multiple Psychopharmacologic Agents in the Treatment of Children and Adolescents and Panel Discussion: Medical-Legal Issues Surrounding the Use of Multiple Psychopharmacological Agents in Children and Adolescents" has been designated by the Texas Society of Psychiatric Physicians for two (2) hours of education in medical ethics and/or professional responsibility.

### Scientific Program Target Audience / Program Goals and Objectives

The primary target audience of the program consists of Child and Adolescent Psychiatrists, Psychiatrists and other specialties of medicine. This continuing medical education activity will be presented in a classroom style format, with didactic lectures supplemented with audiovisual presentations, case presentations and question and answer discussions.

At the conclusion of this program, attendees will be able to:

#### Pharmacogenetics in Child and Adolescent Psychiatry

- Understand the basic principles of pharmacogenetics.
- Discuss how pharmacogenetics affects the tolerability of psychotropic medications.
- Discuss research to predict treatment response in child and adolescent psychiatry using pharmacogenetics.

#### Brain Stimulation Technologies in Psychiatry

- Understand the basic principles of vagus nerve stimulation (VNS) and transmagnetic Stimulation.
- Know the indications for VNS.
- Discuss current research in new brain stimulation techniques.

#### Case Presentation of VNS

- Discuss how VNS is used to treat epilepsy in children.
- Discuss possible psychological effects of VNS in epileptic children.
- Discuss the interaction of VNS with a child's psychopharmacological treatment.

#### Use of Multiple Psychopharmacological Agents in the Child with Severe Aggression and/or Mood Lability

- Review the current literature on the use of multiple agents in severe psychiatric disorders.
- Discuss barriers to the research on the effectiveness of two or more medications in psychiatric disorder.
- Discuss recent guidelines issues by the Texas State Department of Health Services for the use of multiple psychotropic agents for foster children.

#### The Ethics of the Use of Multiple Psychopharmacologic Agents in the Treatment of Children and Adolescents

- Discuss the standards for off label use of psychotropic medication in children and adolescents.
- Distinguish research from pharmaceutical company marketing in dosing and selection of agent.
- Discuss informed consent issues related to long term side effects with poly-Psychopharmacology.

#### Panel Discussion: Medical-Legal Issues Surrounding the Use of Multiple Psychopharmacological Agents in Children and Adolescents

- Discuss how standard of care is arrived at and how peer review determines if care is substandard.
- Discuss current development in the political process regarding regulation of Psychiatric treatment.
- Provide input to colleagues on current practices in the psychopharmacology of Children and adolescents.

### Featured Speakers / Discussants

**James Boger, MD –** Resident Instructor, PGY 3, Department of Neuropsychiatry - Lubbock, TTUHSC, School of Medicine

**James McCracken, MD –** Director, Department of Child and Adolescent Psychiatry, UCLA, Los Angeles, California

**Steven Pliszka, MD –** Professor and Deputy Chair, Department of Psychiatry, UTHSCSA, San Antonio

**Valerie Robinson, MD –** Assistant Professor, Department of Neuropsychiatry - Lubbock, TTUHSC, School of Medicine

**Sarah Sacha, DO –** Assistant Professor, Department of Psychiatry, UTHSCSA, San Antonio

**Sarghi Sharma, MD**
Assistant Professor, Department of Psychiatry/Behavioral Sciences, UTMB, Galveston

## PROGRAM AT A GLANCE

**Friday, July 27, 2007**

| | | |
|---|---|---|
| 1:00 pm - 5:30 pm | Exhibits Set-Up | Floral Hall A-1 |
| 4:00 pm - 5:30 pm | Executive Cmte Business Mtg | Iris |
| 6:30 pm - 8:00 pm | Opening Welcome Reception with Exhibitors | Floral Hall A-1 |

**Saturday, July 28, 2007**

| | | |
|---|---|---|
| 7:00 am - 3:30 pm | Exhibits | Floral Hall A-1 |
| 7:30 am - 8:30 am | Complimentary Continental Breakfast with Exhibitors | Floral Hall A-2 |
| | **Scientific Program: NEW DIRECTIONS IN CHILD AND ADOLESCENT PSYCHIATRIC TREATMENT** | |
| 8:15 am - 8:30 am | Welcome and Announcements | Floral Hall A-2 |
| 8:30 am - 10:30 am | Pharmacogenetics in Child and Adolescent Psychiatry *Jim McCracken, MD* | Floral Hall A-2 |
| 10:30 am - 10:50 am | Refreshment Break w/Exhibitors | Floral Hall A-1 |
| 10:50 am - 11:50 am | Brain Stimulation Technologies in Psychiatry *Sarah Sacha, DO* | Floral Hall A-2 |
| 11:50 am - 12:00 pm | Break / Lunch Set-Up | |
| 12:00 pm - 2:15 pm | Luncheon Program: Case Presentation of VNS *Resident Case Presentation - Presenter: James Boger, MD / Discussants: Valerie Robinson, MD and Sarah Sacha, DO* | Floral Hall A-2 |
| 2:15 pm - 2:30 pm | Break | |
| 2:30 pm - 3:30 pm | Use of Multiple Psychopharmacological Agents in the Child with Severe Aggression and/or Mood Lability *Steven Pliszka, MD* | Floral Hall A-2 |
| 3:30 pm - 4:30 pm | Exhibitors Depart | Floral Hall A-1 |

**Sunday - July 29, 2007**

| | | |
|---|---|---|
| 8:00 am - 9:00 am | Membership Business Meeting Breakfast | Floral Hall A-1 |
| | **Scientific Program** | |
| 9:15 am - 10:15 am | The Ethics of the Use of Multiple Psychopharmacologic Agents in the Treatment of Children and Adolescents *Sarghi Sharma, MD* | Floral Hall A-2 |
| 10:15 am - 10:30 am | Refreshment Break | |
| 10:30 am - 11:30 am | Panel Discussion: Medical-Legal Issues Surrounding the Use of Multiple Psychopharmacological Agents in Children and Adolescents *Steven Pliszka, MD and Randall Sellers, MD* | Floral Hall A-2 |
| 11:30 am - 11:35 am | Closing Remarks / Adjourn | |

## CME / SCIENTIFIC PROGRAM / LUNCHEON

Fax Back (512) 478-5223 or Mail: 401 West 15th Street, Suite #675, Austin, TX 78701; Questions or Special Assistance: Call Debbie Sundberg (512) 478-0605 or E-Mail: *tscapofc@aol.com*

NAME _____ DEGREE _____

MAILING ADDRESS _____ CITY _____ STATE _____ ZIP _____

TELEPHONE NUMBER _____ FAX NUMBER _____

E-MAIL _____

NAME OF SPOUSE/GUEST(S) ATTENDING WELCOME RECEPTION _____

*Conference fee includes the Saturday and Sunday Scientific Program; the Friday evening welcome reception; the Saturday and Sunday continental breakfasts and Saturday luncheon.*

### REGISTRATION

| | *Before July 14* | *After July 14* | |
|---|---|---|---|
| TSCAP Member Physician | $195 | $215 | _____ |
| Non-Member Physician | $250 | $270 | _____ |
| Allied Health Professional | $180 | $200 | _____ |
| Trainee - Member/Non-Member | No Fee | $30 | _____ |

### SOCIAL EVENTS

Friday Welcome Reception

☐ Friday Welcome Reception – *indicate if attending and if bringing any Guests, if so, their Name(s):* _____ _____

☐ Saturday Scientific Program Luncheon, indicate if attending

☐ Sunday Membership Breakfast, indicate if attending

**TOTAL REGISTRATION** _____

### PAYMENT INFORMATION

Method of Payment - Make checks payable to "TSCAP"

☐ Check ☐ VISA ☐ MasterCard Credit Card

#_____ Exp. Date _____

Name of Cardholder (as it appears on card) _____

Signature _____

Credit Card Billing Address _____
ADDRESS CITY STATE ZIP

**CANCELLATIONS** – Deadline for cancellation is July 14, 2007. In the event of cancellation, a full refund will be made if written notice is received in the TSCAP office by July 14, 2007, less a 25% handling charge. NO REFUNDS WILL BE GIVEN AFTER JULY 14, 2007.

# Seeking Equal Benefits for Psychiatric Illnesses

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**and management of utilization. These additional financial limitations are not applied to psychotropic drug benefits or to many behavioral health interventions delivered in the general healthcare setting.** This has created a perverse incentive for patients to a.) access mental healthcare from general healthcare providers (where there are no visit limitations and co-pays are significantly lower) and to b.) rely on psychotropic medication as an exclusive method of treatment.

10. **Limiting behavioral healthcare services can increase employers' non-behavioral direct and indirect healthcare costs.** One study found that limiting employer-sponsored specialty behavioral health services increased the direct medical costs of beneficiaries who used behavioral healthcare services by as much as 37%. Further, the specialty behavioral health service limitation substantially increased the number of sick days taken by employees with behavioral health problems. The study concluded that savings attributed to limiting behavioral health benefits were fully offset by increased use of other medical services and lost workdays.
11. **Employers have tightly managed behavioral health benefits delivered by the specialty mental healthcare system, but have not as yet implemented comprehensive and integrated management programs to address quality and costs for psychotropic drugs and behavioral health services delivered by general medical providers.** Specialty mental health services have been managed tightly by managed care systems over the past two decades. Utilization review techniques and other methods have reduced the percent of total healthcare dollars employers spend on mental healthcare benefits. In fact, private employers experienced a 50% decline in their mental healthcare premiums (not including the cost of psychotropic drugs) during the l990s: the average cost of private employers' behavioral healthcare premiums dropped from 6.1% of total claims costs in 1988 to 3.2% in 1998. Yet, employers have not adequately managed the cost or quality of behavioral healthcare services delivered in the general medical setting despite the high proportion of patients treated for behavioral disorders in the general medical setting. Further, employers are not receiving good value for their investment in psychotropic drugs.
12. **The lack of coordination and integration among managed care vendors of employers (MCOs, MHBOs, EMs, PBMs, and others) has created significant quality and accountability problems.** Employers can address these problems by improving the design of their health insurance benefit structures, and by requiring their behavioral health vendors and managers to coordinate with one another.

## Recommendations

**I. Recommendations Directed at Health Plan Benefits and Services**

The key findings described above guided the development of the Committee's recommendations for the delivery of standardized and integrated behavioral health services.

The recommendations featured in the *Guide* are meant to guide employers as they develop their medical and behavioral health benefit plans. Employers are encouraged to add these recommendations to contract language with Managed Care Organizations (MCOs), Managed Behavioral Health Organizations (MBHOs), Pharmacy Benefit Managers (PBMs) and/or Disability carriers as appropriate. Adoption of the recommendations will require employers to change their vendor contract language and to make changes to their benefit structures. Adoption of recommendations regarding best-practice implementation and quality improvement measures will necessitate that employers instruct their MCOs, MBHOs, PBMs to track patient and provider data. Wherever possible, the management vendors should incorporate the recommended standards as a part of their normal provider performance review. Employers should require these vendors to present their findings of these reviews annually.

1. **Recommendations to Improve the Delivery of Covered Behavioral Healthcare Services in the General Medical Setting**
   a. **Documentation and Monitoring** - Document diagnosis upon initiation of treatment.
   b. **Addressing the High-Risk of Co-Morbidity** - Screen for depression and other common behavioral health conditions among individuals with chronic medical illnesses.
   c. **The Importance of Tracking Patient Progress** - Monitor patient progress with standardized evidence-based instruments. Reimburse patient monitoring as a lab test.
   d. **Collaborative Care** - Use the collaborative care model to address the needs of patients with mental illness and/or substance abuse disorders who are receiving treatment in primary care.
2. **Recommendations to Improve Collaboration Between Providers in the General Healthcare System and the Specialty Behavioral Healthcare System**
   a. **Referrals to the Specialty Behavioral Healthcare System** - Coordination of care upon referral from primary care to specialty behavioral healthcare.
   b. **Improving the Collaboration Between Disease Management Programs, General Medical Care, and Specialty Behavioral Healthcare** - Employers should require their disease management vendors, as part of their regular practice, to periodically screen all patients enrolled in their respective programs for common behavioral health conditions, and coordinate care with other providers as indicated.
3. **Recommendations to Improve Benefit Design for Behavioral Health Screening and Treatment Services**
   a. **Equalizing Benefits Structures** - Equalize medical and behavioral health benefit structures
   b. **Reimbursement for Non-Psychiatrist Physicians** - Reimburse primary care and other non-psychiatrist physicians for screening, assessing, and diagnosing mental illness and substance abuse disorders, [Rules and policies regarding the payment of non-psychiatrist physicians (e.g., primary care physicians) for the treatment of mental illness and substance abuse disorders should be well publicized to primary care physicians, other non-mental health providers, and their clinical/business administrators.]
4. **Recommendations to Improve the Accuracy and Quality of Prescribing Psychotropic Medications in the General Medical and Specialty Behavioral Healthcare System**
   a. **Adoption of a national best-practice guideline for the prescribing and monitoring of psychiatric drug interventions** - Require MCOs, MBHOs, and PBMs to adopt a national best-practice guideline for the prescribing and monitoring of psychiatric drug interventions.
   b. **Annual assessment of provider performance in relation to the nationally accepted standard best-practice guideline chosen** - Require MCOs, MBHOs, and PBMs to annually assess their provider's performance in relation to the nationally accepted standard best-practice guideline they have chosen (4a) [Employers should also require that their healthcare managers (i.e. MCOs, MBHOs, and PBMs) to provide them with a summary of the data collected, problems that were identified, and the performance plan improvement to address these problems, annually.]
   c. **Periodic Review of Formulary** - Periodically review the formulary and make adjustments as necessary based on information garnered from the assessment suggested in 4b.
5. **Recommendations to Improve Behavioral Healthcare Services for Individuals with Serious Mental Illness**
   a. **Evidence-Based Treatment Modalities for the Seriously Mentally Ill (SMI)** - Provide coverage for evidence-based treatment modalities for seriously mentally ill children and adults. Such evidence-based modalities include:
      - Targeted clinical case management services;
      - Assertive community treatment (ACT) programs;
      - Therapeutic nursery services; and
      - Therapeutic group home services.
   b. **Providers of Evidence-Based Treatment Modalities for the Seriously Mentally Ill (SMI)** - Direct MCOs and MBHOs to add providers that can deliver the evidence-based treatment modalities described in 5a to their networks.
   c. **Annual Review of Behavioral Health Treatment Modalities** - Direct MCOs and/or MBHOs to annually review behavioral health treatment modalities and make recommendations about whether new treatment modalities should be added to employers' benefit structures.

**II. Recommendations Directed at Disability Management Vendors and Services**

6. **Recommendations to Improve Employer Management of Behavioral Health Disorders that Qualify for Short- and/or Long-Term Disability Benefits**
   a. **Review short-term and long-term disability management programs and instruct vendors to actively manage all behavioral health disability claims.**
      - Involve a behavioral health specialist in certification of psychiatric disability and treatment planning.
      - Involve a behavioral health specialist in the review of the treatment plan.
      - Refer employees on disability for a psychiatric condition to EAP for return-to-work assistance.

**III. Recommendations to Improve Employee Assistance Program Services**

7. **Recommendations to Improve the Structure of Employee Assistance Programs (EAPs)**
   a. **Reduce redundancies between EAPs and health plans by restructuring EAPs. EAPs should not duplicate services offered through the health plan (MCOs and MBHOs), but should be restructured, if necessary, to provide the following functions:**
      - Support management in addressing issues of productivity and absenteeism that may be caused by psychosocial problems.
      - Assist in the design and development of a structured program to deliver health promotion and healthcare education tools that significantly affect employee and beneficiary health and productivity and lead the effort to deliver behavioral healthcare education programs.
      - Functionally coordinate with other health services including health plan, disability management, and health promotion.
   b. **Based on all analysis of current EAP services, the NCESBHS found that an important function that EAPs provide is assessment and short-term counseling for individuals at risk of mental illness and substance abuse disorders and those with problems of daily living (e.g., divorce counseling, grief processes). In the restructuring of EAP, as recommended in 7a, it is essential that these services be retained and provided by an EAP or other entity.**
   c. **Conduct periodic organizational assessments to evaluate the effects of work organization on employee health status, productivity, and job satisfaction.**

For a copy of *"An Employer's Guide to Behavioral Health Services"*, visit the Federation's website at www.txpsych.org. ■

BILL SUMMARIES

# 2007 Texas Legislature

The following is a sampling of some of the bills that have been filed to date by members of the Texas Legislature and that are being tracked by the Federation. A more complete listing of bills is available on the Federation's website (www.txpsych.org) under Public Policy.

## ALLIED HEALTH

**HB 1096, Rob Orr — ADVANCED NURSE PRACTITIONERS AND PHYSICIAN ASSISTANTS:** Increases from 3 to 6 the number of advance nurse practitioners and physician assistants that may be supervised by a physician for prescribing privileges and removes the requirement that the supervising physician be on site.

**HB 1546, Jodie Laubenberg — PSYCHOLOGY:** A psychologist may delegate to a qualified and properly trained person acting under the psychologist's supervision any psychological test or service that a reasonable and prudent psychologist could delegate within the scope of sound psychological judgement if the psychologist determines that: the test or service can be properly and safely performed by the person; the person does not represent to the public that the person is authorized to practice psychology; and the test or service will be performed in the customary manner and in compliance with any other law. The delegating psychologist remains responsible for the psychological test or service performed by the person to whom the test or service is delegated. The psychology licensing board may not adopt a rule that operates as an absolute prohibition or restriction on the delegation of psychological acts.

## MENTAL HEALTH

**HB 40, John Davis — EMERGENCY DETENTION:** A physician may order the transportation of a person to an inpatient mental health facility if the physician examined the person within 24 hours and the physician concludes from the examination that the person is mentally ill and there is a substantial risk of serious harm to the person or others unless the person is immediately restrained. The physician shall immediately file an application for detention within the facility after the person is transported.

**HB 452, Paul Moreno — LOCAL MENTAL HEALTH AUTHORITIES:** Allows a local mental health authority to contract for services from: 1) a subsidiary of the local mental health authority; 2) an entity formerly a subsidiary of the local mental health authority; 3) an entity affiliated with a subsidiary of the mental health authority; 4) an entity to which a treatment facility of the local mental health authority or its subsidiary has been sold or transferred; or 5) an entity that has on its governing board a member of a governing board of the local mental health authority or its subsidiary.

**HB 518, Elliott Naishtat — EMERGENCY DETENTION/PRELIMINARY EXAMINATION:** Extends the time period allowed for detaining a person for a preliminary examination from 24 hours to 48 hours. SB 261 Judith Zaffirini EMERGENCY DETENTION: Specifies that jails or nonmedical facilities used to detain persons charged with or convicted of a crime are not a suitable facility for detention of persons taken into custody under mental health detention.

## ECONOMIC

**HB 510, David Farabee — MH INSURANCE:** Requires health benefit plans to provide coverage for an enrolleee who is a child for the diagnosis and treatment of a mental disorder under the same terms and conditions as coverage provided for physical illnesses.

**HB 656, HB 659, Garnet Coleman — MH INSURANCE:** Requires health benefit plans to provide coverage for the diagnosis and treatment of mental disorders under the same terms and conditions as coverage provided for the diagnosis and treatment of physical illnesses.

**HB 1128, Garnet Coleman — MH INSURANCE:** Adds anorexia nervosa and bulimia nervosa to the list of "serious mental illness" mandated for coverage under health benefit plans.

**HB 664, Dawnna Dukes — HMO's:** All covered services offered by an HMO must be sufficient in number and location to be readily available and accessible within the service area to all enrollees. An HMO shall make general, special and psychiatric hospital care available and accessible 24 hours a day, seven days a week, within the HMO service area. An HMO shall arrange for covered health care services, including referrals to specialists, to be accessible to enrollees on a timely basis. A physician or provider who submits a claim to and accepts payment from an HMO may not bill the enrollee for the services for which the claim was made.

**HB 839, Craig Eiland — REGULATION OF SECONDARY MARKET FOR PHYSICIAN DISCOUNTS:** Each contracting agent (a covered entity engaged, for monetary or other consideration, in leasing, selling, transferring, aggregating, assigning, or otherwise conveying a physician or physician panel to provide health care services to beneficiaries) must register with the Dept. of Insurance. To be eligible to claim a discounted rate after execution of a contract, a payer must be added to the contract through separate amendment that is signed by the affected physician. The contract amendment must be presented to the physician for the physician's signature not later than the 90th day before the date of any anticipated disclosure, sale, transfer, aggregation, assignment, or conveyance to the payer of the physician's discounted rate. A payer may not claim or otherwise offer a physician's specific contracted rate for services except to the extent that the rate is based on the contract that directly controls payment for services provided to the patient and is stated on the explanation of benefits or remittance advice and on any patient identification card issued to the patient.

**HB 919, Rob Eissler — MH INSURANCE:** Requires health benefit plans established by the Teacher Retirement System to provide coverage for an enrollee who is a child for the diagnosis and treatment of anorexia nervosa and bulimia nervosa. Such coverage must be the same as coverage for physical illnesses.

**HB 1003, Helen Giddings — WORKERS COMP:** Utilization review agents performing reviews of health care services under Worker's Compensation must be doctors licensed to practice in Texas.

**HB 1051, Elliott Naishtat — MEDICAID AND CHIP:** For Medicaid and child health plan programs, HHSC shall establish provider payment rates that are at or above the level established during the state fiscal biennium beginning September 1, 2002, apply annual inflation increases to provider payment rates and enact a plan to bring provider payment rates to Medicare levels. HHSC is to implement a community outreach and education campaign to provide information relating to the availability of health benefits to children under the child health plan and Medicaid programs. The eligibility period for a child under the child health plan shall be the earlier of 12 months or until the child is 19 years of age.

**HB 1069, Bill Zedler — BALANCED BILLING:** Each benefit plan that provides health care through a provider network shall provide notice to its enrollees that a facility-based physician or other health care practitioner may not be included in the health plan's provider network such facility-based providers may balance bill the enrollee for amounts not paid by the health benefit plan. Balance billing means the practice of charging an enrollee in a health benefit plan that uses a provider network to recover from the enrollee the balance of a non-network health care provider's fee for service received by the enrollee from the health care provider that is not fully reimbursed by the enrollee's health benefit plan.

**HB 1169, Garnet Coleman; SB 481, Leticia Van de Putte INSURANCE:** Regardless of whether a health benefit plan provides mental health coverage, a health benefit plan must provide coverage for an enrollee, from birth through the date the enrollee is 18 years of age, for a physical injury to the enrollee that is self-inflicted in an attempt to commit suicide or by an enrollee with a serious mental illness.

**HB 1224, John Davis; SB 419, Eddie Lucio, Jr. — MH INSURANCE:** Requires a health benefit plan to provide coverage for autism spectrum disorder. Autsim spectrum disorder means a neurobiological disorder that includes autism, Asperger syndrome or Pervasive Developmental Disorder.

**HB 1436, Patrick Rose — MH INSURANCE:** Requires health benefit plans to provide coverage for eating disorders

**SB 92, Leticia Van de Putte — MH INSURANCE:** Adds anorexia nervosa and bulimia nervosa to the list of "serious mental illness" mandated for coverage under health benefit plans.

**SB 380, Leticia Van de Putte — BALANCED BILLING:** Each benefit plan that provides health care through a provider network shall provide notice to its enrollees that a facility-based physician or other health care practitioner may not be included in the health plan's provider network such facility-based providers may balance bill the enrollee for amounts not paid by the health benefit plan. Balance billing means the practice of charging an enrollee in a health benefit plan that uses a provider network to recover from the enrollee the balance of a non-network health care provider's fee for service received by the enrollee from the health care provider that is not fully reimbursed by the enrollee's health benefit plan.

**SB 568, Rodney Ellis — MH INSURANCE:** Requires health benefit plans to provide coverage for the diagnosis and treatment of mental disorders under the same terms and conditions as coverage provided for the diagnosis and treatment of physical illnesses.

## CHILDREN

**HB 1111, Sylvester Turner — TEXAS YOUTH COMMISSION:** The TYC may not allow a child committed to it to participate in a medical, psychiatric or other type of research programs.

**HB 1113, Sylvester Turner — JUVENILE PROBATION SYSTEM:** The juvenile probation system may not allow a child within its system to participate in a medical, psychiatric or other type of research programs.

## SUBSTANCE ABUSE

**HB 437, Ruth Jones McClendon — PRACTICE GUIDELINES:** The Texas Medical Board is to establish guidelines for the treatment of severe acute or chronic pain by a physician. The guidelines shall apply without regard to a patient's prior or current chemical dependency or addiction, but may include standards and procedures applicable to patients with prior or current chemical dependency or addiction.

**HB 574, Ruth Jones McClendon — PATIENT'S BILL OF RIGHTS IN PAIN TREATMENT:** A patient who suffers from severe chronic or acute pain may request or reject the use of any or all modalities to relieve the pain; choose from the appropriate pharmacologic treatment options to relieve the pain, including opiate medications, without first having to submit to surgery or a medical procedure that results in the destruction of a nerve or other body tissue or the implantation of a drug delivery system or device; and ask the patient's physician to provide an identifying notice of a prescription to treat the pain for the purposes of emergency treatment of law enforcement identification. A physician may refuse to prescribe opiate medication for a patient who requests that treatment for severe chronic or acute pain only if the physician provides the patient with the name of another physician who is qualified to treat the pain employing methods that include the use of opiates.

## LEGAL

**HB 1534, Elliott Naishtat — MEDICAL USE OF MARIHUANA:** It is not an affirmative defense to prosecution for the possession of marihuana that the person possessed the marihuana as a patient of a physician licensed to practice medicine in this state pursuant to the recommendation of that physician for the amelioration of the symptoms or effects of a bona fide medical condition. A physician may not be denied any right or privilege or be subject to any disciplinary action solely for making a written or oral statement that, in the physician's professional opinion, the potential benefits of marihuana would likely outweigh the health risks for a particular patient.

**SB 249, Rodney Ellis — DEATH PENALTY:** Prohibits a death sentence of a defendant, who at the time of the commission of the capital offense, was a person with mental retardation. A pre-trial hearing must find that the defendant was a person with mental retardation at the time the capital offense was committed.

**SB 440, Bob Deuell — MAXIMUM PERIOD OF COMMITMENT DETERMINED BY MAXIMUM TERM FOR OFFENSE:** A defendant may not be committed to a mental hospital or other inpatient or residential facility for a cumulative period that exceeds the maximum term provided by law for the offense for which the defendant was to be tried. On expiration of the maximum term, the defendant may be confined for an additional period in a mental hospital or other inpatient or residential facility only pursuant to civil commitment procedures.

## OTHER

**HB 414, Rob Eissler — PHYSICIAN'S PROFILE:** The Texas Medical Board is to remove any record of a disciplinary action for an administrative violation if the violation occurred more than five years from the annual review of a physician's profile.

**SB 30, Jane Nelson — TEXAS MEDICAL BOARD:** A license applicant who is not a

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# From the Federation...

J. Clay Sawyer, MD, Chairman, Federation of Texas Psychiatry

J. Clay Sawyer, MD

Past columns have dealt extensively with the fact that, as physicians in general and as psychiatrists in particular, we all have a duty and a responsibility to take steps necessary to ensure that we offer both the best quality of care to our patients and reasonable access to that care. Maintaining our high educational standards, and continually updating our own theoretical and practical knowledge, meets part of that standard; TSPP's annual scientific program is a primary means of achieving that goal. But further steps are necessary: an active role in advocating for our profession and for our patients is an effort we should all undertake, an effort at which we have been, and can continue to be, successful.

Past experience reveals proof of that success. If not for the efforts of TSPP members in the past on individual and collective bases, non-physicians would even now be performing psychiatric admissions and prescribing psychotropic medications. For the good of our present and future patients, we cannot allow that to happen. We must also carry the message of the House of Medicine regarding other efforts by non-physicians to assume physician roles without the benefit of proper and complete medical training. All of these messages are interrelated and centered on quality patient care. Performing this mission is one reason why the Federation of Texas Psychiatry exists.

In an effort to begin the process of accomplishing these many and worthy goals during the current Texas legislative session, the Federation is sponsoring our latest Capitol Day later this month on Wednesday, February 28, 2007. The program will begin at 10 am in the Thompson Auditorium of the Texas Medical Association Building in Austin at 401 West 15th Street. We will hear legislative updates from Federation and TMA lobbyists as well as news from other mental health advocacy organization partners. We will then visit with various legislators and reconvene in the afternoon for debriefing.

Complete registration information and legislative contact information will have been mailed to TSPP members, to Academy members, to TSCAP members, and to other psychiatrists by the time this column appears in the Texas Psychiatrist, the Federation newsletter. For now, though, all participants should contact their state representatives and state senators as soon as possible for appointments between 11 am and 4 pm on the 28th.

A small fee will be charged for physicians to participate, but residents can attend for free and are heartily encouraged to do so. White coats are recommended for all physician attendees to maximize impact. Wear them if you have them!

This work is not particularly hard, but it is necessary. Legislators want to see their constituents, and they have great respect for busy physicians who take the time and make the effort to go to Austin to see them. Let's not disappoint them!

The Federation speaks with the power of the voices of the nearly 46,000 physicians who belong to its member organizations. Let's not let this clout go to waste!

See you in Austin on the 28th. ■

# 2007 Texas Legislature

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United States citizen or an alien lawfully admitted for permanent residence in the United States must present proof satisfactory to the Texas Medical Board that the applicant has practiced medicine or has signed an agreement to practice medicine as a condition of the license for at least three years in an area in this state that is designated as a health professional shortage area or a medically underserved area.

**SB 36, Jane Nelson — TEXAS MEDICAL BOARD:** An applicant who, on September 1, 2005, held a physician-in-training permit or had an application for the permit pending before the Texas Medical Board must pass each part of the examination within three attempts, except that, if the applicant has passed all but one part of the examination within three attempts, the applicant may take the remaining part of the examination one additional time. However, an applicant is considered to have satisfied the requirements if the applicant: passed all but one part of the examination within three attempts and passed the remaining part of the examination within six attempts; is specialty board certified; and has completed in this state an additional two years of postgraduate medical training approved by the board.

**SB 414, Eddie Lucio Jr. — PHARMACEUTICAL REPORTING:** Each year, a manufacturer or repackager that sells or repackages prescription drugs in this state shall submit a report to DSHS that discloses any gift, fee, payment subsidy, or other economic benefit received by a physician, physician's office, hospital, nursing home, pharmacist, health benefit plan administrator or other person authorized by law to dispense or prescribe drugs in this state in connection with detailing, promotional or marketing activities of the manufacturer or repackager, directly or through its pharmaceutical marketers. ■

## CALENDAR OF MEETINGS

### FEBRUARY

**28** **CAPITOL DAY**
Texas Medical Association Building
401 West 15th Street
Austin, Texas 78701
Contact: Debbie Sundberg, 512/478-0605

### APRIL

**26-28** **TMA TexMed 2007**
Hyatt Regency Hotel, Dallas, Texas

**27** **TMA SECTION ON PSYCHIATRY PROGRAM**
9am-5pm
Contact: TMA, 512/370-1300 or www.texmed.org

**28-29** **TSPP COMMITTEE AND EXECUTIVE COUNCIL MEETINGS AND CME PROGRAM, "Practical Clinical Applications of the CATIE Studies," presented by Michael Schwartz, MD**
Adolphus Hotel
Dallas, Texas
Contact: Debbie Sundberg, 512/478-0605

### JULY

**27-29** **TSCAP SUMMER CONFERENCE**
"New Directions in Child and Adolescent Psychiatric Treatment"
Moody Gardens Hotel
Galveston, Texas
Contact: Debbie Sundberg, 512/478-0605

### NOVEMBER

**2-4** **TSPP ANNUAL CONVENTION & SCIENTIFIC PROGRAM**
Westin Galleria Hotel
Houston, Texas
Contact: Debbie Sundberg, 512/478-0605

### FEDERATION OF TEXAS PSYCHIATRY

The Federation was established on July 1, 2004 with the following purposes:

A. to promote the common professional interests of psychiatrists;

B. to facilitate the coordination of and work in concert with state professional psychiatric associations and state professional subspecialty psychiatric associations, to unify programs that advance public and professional education and advocacy for psychiatry and persons with psychiatric illnesses;

C. to provide centralized services to state professional psychiatric associations and state professional subspecialty psychiatric associations;

D. to make psychiatric knowledge available to other practitioners of medicine, to scientists, and to the public; and,

E. to promote the best interests of patients and those actually or potentially making use of mental health services.

The TEXAS PSYCHIATRIST is published 5 times a year in February, April, June, August, and October. Members of Federation member organizations are encouraged to submit articles for possible publication. Deadline for submitting copy to the Federation Executive Office is the first day of the publication month. Copy must be edited, acceptable for publication.

Display advertising is available and publication is determined on a case by case basis by the Editorial Board. The Editorial Board reserves the sole right to accept or reject any submitted advertising copy.



Federation of Texas Psychiatry
401 West 15th Street, Suite 675
Austin, Texas 78701
(512) 478-0605
(512) 478-5223 (FAX)
TxPsychiatry@aol.com (E-mail)
http://www.txpsych.org (Website)

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