National Alliance of Professional Psychology Providers

Failure

To

Serve

A White Paper on The Use of Medications As A First line Treatment

And Misuse In Behavioral Interventions

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A Statement Of Concern From: The National Alliance of Professional Psychology Providers

There is a crisis in our nation's behavioral health care system. Many factors contribute to this crisis, including financial, regulatory, and cultural issues. One of the most glaring problems in this crisis is the corporate healthcare industry's practice of placing earnings and exorbitant profits above the public interest at the expense of quality services to those in need. There is another significant factor contributing to the poor quality of services provided to patients suffering from behavioral disorders: a significant shift of behavioral healthcare from specialists, such as psychologists and psychiatrists, to primary care physicians. While well-meaning, the majority of primary care physicians is not trained or experienced enough to provide behavioral health treatment and diagnosis. These physicians have become naive distributors for drug manufacturers and collude with insurers in the face of solid research that shows that psychotropic medications are not effective or beneficial for an ever-growing number of patients. NAPPP accepts that not every primary care physician is a puppet of drug companies or the insurance industry. Most are caring and hardworking professionals. However, as a profession, primary care physicians know, or should know, that psychotropic medications are mostly ineffective and potentially dangerous to patients. As such, most physicians who prescribe psychotropic medication do so to the detriment of their patients.

The enclosed report, "A Failure to Serve," addresses this crisis by providing a perspective of the problems encountered by patients who need behavioral healthcare but are not receiving it. The authors provide solid solutions based on sound, up-to-date research to support our assertions and conclusions about this crisis in behavioral healthcare. The problems of the present system, in which behavioral health is provided in primary care settings, will become even more pronounced as the new healthcare mandates take effect. NAPPP is concerned that healthcare reform will continue and even exacerbate the violation of patient care that is ubiquitous and characteristic of the present system.

We believe that the concerns and problems addressed in this report need to be taken seriously as a public policy issue and that this issue should be a matter of public interest. Consumers of behavioral healthcare must be protected and provided with positive and cost-effective treatments. Should the current practices of behavioral health treatment be continued by primary care physicians, NAPPP strongly believes that patients in desperate need of these services will suffer as drug companies, healthcare insurers, and physicians all gain at patients' and the public's expense.

Among the problems thoroughly documented and detailed in the report are:

- 1. Medication as a first line treatment for behavioral conditions is unsupported by the most recent outcome research.
- 2. Providing behavioral healthcare in a primary care setting without an appropriate evaluation by a doctoral level psychologist is ineffective, non-beneficial, costly, and denies patients the standard of care required to treat behavioral disorders.
- 3. The growing incidence of adverse drug events can be directly tied to the lack of skills and training provided to physicians in medical school and practice. On-the-job training to prescribe medications must be preceded by solid educational preparation. Even the best medical schools provide only 90 hours of pharmacological education over a four-year medical school curriculum. The vast majority of medical schools provide far less training.
- 4. There is a long-term shortage of psychiatrists that will not be resolved. Because of this shortage, primary care physicians have become the dominant prescribers of psychotropic medications. Drug companies, seizing on physicians' lack of training, have deceived them and the public about the safety, effectiveness, and benefit of psychotropic medications. Consequently, patients have been put at risk and become literal guinea pigs for questionable medications such as antidepressants, antipsychotics, and other drugs marketed to treat behavioral disorders.
 - 5. Children and the aged populations are at the most risk as they are receiving treatment from the least prepared physicians, and are the targets of drug companies, which see children and the aged as "profit centers" in the ever-increasing quest for market share. Off-label use of medications among these populations are promoted by drug companies simply to expand the profitability of their existing products.
- 6. Taxpayers are also victims of the healthcare industry. Healthcare reform will now require an additional 30+ million people to obtain healthcare insurance. For those unable to afford insurance, their costs will be subsidized. NAPPP supports healthcare reform and universal coverage. We advocate and agree to extending care to everyone who needs it. What we are most concerned about, however, is having

taxpayers subsidize drug companies, insurers and providers whose products and services are not proven

to work as advertised. Costs for medications will continue to increase to a projected \$400 billion

by the time the new reform takes effect. We have a right and responsibility to require physicians to

work in the public interest -- and not as mere distributors for drug companies and in collusion with

insurers who gladly reimburse for ineffective medications because they are cheaper than providing

effective care.

7. Unlimited licensure of physicians contributes to a system in which patients are not being appropriately

served and subjected to undue harm. Limited licensure can improve competence and treatment outcomes.

It can greatly decrease the cost of healthcare while raising the standard of care provided to patients.

Patients suffering from behavioral disorders are among our most vulnerable citizens. We should not allow any

profession or entity to hide behind selective science and the professional domination of healthcare to subject

patients and the public to patently ineffective and non-beneficial treatments. We do not argue that the healthcare

industry and providers should be denied making a profit. Profit, however, must be balanced with the public

good and must honestly and ethically be earned, be based on real need, and be based on sound theories and

outcome research. Failure to hold physicians, providers, drug manufacturers and insurers to these minimal

standards will produce an even greater crisis in healthcare aside from the misery afflicted on a trusting

population at the mercy of a system concerned more with profit than results.

NAPPP believes that we can all do better, and we should strive to so.

For the purpose of this document, behavioral disorders are defined as any mental, emotional, or behavior

disorder included in the International Classification of Diseases-9th Revision Clinical Modification (ICD-9-

CM) or the Diagnostic and Statistical Manual (DSM IV) diagnostic manuals.

Signed:

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Executive Summary

Behavioral healthcare in America has largely been reassigned to primary care physicians as a result of the overall penetration in healthcare of for-profit managed care companies and insurers; the long-term campaign by drug manufacturers to replace effective behavioral interventions with medications; and a two-decades long shortage of psychiatrists. All of these factors have contributed to patients being denied effective treatments as the profits of these companies continue to increase. The healthcare reform bill recently signed by President Obama is unlikely to resolve any of the issues discussed in this report. In fact, the more likely outcome is that patients seeking and needing effective behavioral healthcare will not get it because the new healthcare bill further concentrates treatment and health decisions in primary care settings under the influence of insurance corporations and other third-party payers. As gatekeepers for physical ailments, primary care physicians perform admirably under difficult circumstances. However, patients needing behavioral healthcare are not receiving and cannot receive effective treatment from primary care physicians who generally are unskilled and lack training evaluating, diagnosing and treating behavioral disorders. This report discusses the problems and solutions associated with medications when used as a first-line treatment for behavioral disorders.

I. The Evidence Against Primary Care Physicians Providing Behavioral Healthcare

- The healthcare industry composed of physician groups, insurers, large contract providers, medical device companies, and the pharmaceutical industry has achieved total control of the healthcare system that routinely misleads and colludes with government regulators.
- The healthcare industry has embraced the myth that a behavioral disorder is a medical problem and implies that it is either genetically or neurohormonally caused, typically lifelong in duration and requiring treatment with medications.
- Primary care physicians providing behavioral healthcare overwhelmingly favor medications as first-line treatments for behavioral disorders despite the evidence that many of these drugs do not perform better than placebos.

- Renowned researchers have been writing voluminously for the need to require protocols, which include psychosocial and behavioral treatments with medications and, in some cases, in place of medications.
- Primary care physicians routinely provide drugs without obtaining an evaluation or appropriate diagnosis from a doctoral level psychologist or psychiatrist.
- Patients treated in primary care settings for behavioral disorders receive less than 50% of the standard of care that is required by medical guidelines.
- Behavioral healthcare patients are exposed to undue risk and harm as primary care physicians account for
 more than 80% of the prescriptions written for psychotropic medications. In effect, physicians have become
 virtual distributors for drug companies despite the mounting evidence that many of these drugs are
 unwarranted and risky to patients.
- Visits to emergency rooms for the abuse of pain medications and sedatives are now equal to or exceed visits
 for heroin and other illegal drugs. This is a direct result of physicians writing too many prescriptions for
 these drugs.

II. Reducing Adverse Drug Events From Physician Error

- Physician errors attributed to prescribing medications account for many deaths and harm to patients. The Institute of Medicine continues to report the risk to patients due to physician errors. While estimate may vary, the IOM believes that 100,000 deaths per year are caused by physician error. The IOM only counts deaths that occur in hospitals. There is no comparable data for harm occurring in outpatient settings because there is no formal reporting mechanism.
- Estimates of the annual cost due to increased harm from medication-related injuries ranges from a low of \$72 billion to a high of \$172 billion.
- Physician errors increase hospital costs on the average of \$6,000 per patient.

- Annual non-fatal injuries from Adverse Drug Events (ADEs) are estimated to be about 650,000.
- Many of the errors attributed to medications can be reduced or eliminated by better education and training.
 However, few medical schools have developed a curriculum to confront this problem. Physicians, at the best medical schools, receive only 90 hours of training in pharmacology. Most provide far less. Even fewer provide training to reduce adverse drug events.
- Medical psychologists are in the unique position of being a positive factor in reducing ADEs and they can
 provide behavioral health services effectively and efficiently. Primary care physicians and other nonpsychiatric physicians are not behavioral health specialists or psychopharmacologists.

III. Psychiatry In Crisis: Impacts on Primary Care, Patient Safety and Public Healthcare Policy

- The number of medical students choosing psychiatry as a specialty has continued to decline over the past
 two decades. The shortage of psychiatrists has been so steep and there are no credible solutions that will
 impact the decline.
- As a result of this shortage, about 70% of primary care physicians have reported difficulty in obtaining high-quality outpatient behavioral health services.
- Psychiatrists, as a whole, have abandoned providing behavioral healthcare treatments outside of medications.
 Few have sought or receive behavioral training. As a result, psychiatry no longer is a stakeholder in advancing effective patient care. Their economic survival is tied to drug companies, making their allegiance to patients highly questionable.
- Public safety has been compromised as psychiatry refuses to consider and implement alternative strategies to
 deal with their shortage. Public policy and public safety have been held hostage to economic factors as
 psychiatry continues to reject collaborative practice with psychologists.
- Despite the overwhelming evidence showing that some of the most successful outcomes in behavioral health treatment are a result of medications when appropriately diagnosed and used concurrently with behavioral therapy or psychotherapy alone, psychiatrists continue to subscribe to medication-only strategies.

IV. Antidepressant Medications Are Ineffective And Claims Are Misleading

- Biologically based imbalance theories have long been posited as a basis for antidepressant medications.
 These theories, although largely unfounded, untested and unproven, provide the foundation for medications sold by the millions of doses.
- There is no scientific substantiation or agreement that depression is caused by biological, chemical imbalances, defective genes, or that it is remedied in any significant way by available medications.
- Antidepressant medications actually build negatively impacts that ability to function without the drug and, over time, the condition becomes chronic. The data show that the longer one stays on this type of drug, the higher the likelihood of relapse of depression.
- The side effects of these drugs include cardiac complications, withdrawal, akathesia and motor abnormalities, sexual side effects, drug-induced violence, neuropsychiatric effects including insomnia, apathy, and mania. Physicians have responded to these side effects by prescribing additional medications, most of which are "off-label" and not authorized by the FDA.
- Behavioral approaches for depression are now well-established as effective first line treatments for depression. They are just as effective and, in many cases, more effective than antidepressants, and have no risk of side effects.
- The results of many clinical trials, meta-analyses and reviews point to one inescapable conclusion: Behavioral therapy works for the treatment of depression, and the benefits are substantial.
- Antidepressants only dampen or partially control some symptoms of the disorder and in a minority of patients, and therefore do not qualify as a "stand alone" or a "first line treatment."
- The evidence is clear that antidepressant medications work no better than placebos in nearly all patients with depression. The use of these chemicals on 32 million people, when they simply do not work, presents a moral dilemma and should be a major public policy concern.

- Research shows that most people will respond positively to behavioral intervention. Typically, 13 sessions
 of cognitive-behavioral intervention relieves symptoms and allows patients to resume work, family
 responsibilities and function well.
- Only a smaller number of patients, a minority of about 12-15%, respond solely to medications.

V. Physicians Often Do Not Provide Patients With Important Information When Prescribing Medications

- Most physicians routinely do not provide important information to their patients when they prescribe a medication. Research shows that only 62% of the necessary information about a medication is communicated, to patients. Only 35% of physicians advised patients of the adverse effects associated with a medication. In attempts to address this problem, it has become public policy to require dispensing pharmacists to provide the missing information that the physician is either too under-informed or too rushed to provide.
- Among the most profitable and growing segment of pharmaceuticals are psychotropic medications and their
 use by physicians for conditions for which they were not developed or FDA-approved. Physicians continue to
 prescribe these medications with no research or data that can provide any clues of the side effects when
 prescribed for a condition that has not been studied.
- The Nonpartisan Center for Public Integrity reports that pharmaceutical companies spent more than \$855 million for marketing, which is more than any other industry, between 1998 and 2006. Marketing comprises a significant portion of the cost of medications. These are at the low end of the estimates for drug company advertising. Advertising is unnecessary and many times violates FDA rules for marketing a drug.
- Even higher cost estimates for advertising by the Kaiser Foundation show manufacturer spending on advertising was almost twice as much in 2008 (\$11.3 billion) as in 1998 (\$5.9 billion). After increasing every year since 1996, the total amount manufacturers spent on advertising declined from 2004 to 2005 (from \$12.1 billion to \$11.7 billion), then rose to \$12.0 billion in 2006, falling to \$11.8 billion in 2007 and \$11.3 billion in 2008. The share directed toward consumers in 2008, through advertising on television,

radio, magazines, newspapers, and outdoor advertising, was more than 3 times that spent in 1998, \$4.4 billion compared to \$1.3 billion, though spending decreased 10% from 2007 (\$4.9) to 2008 (\$4.4 billion).

- The marketing strategy used by drug companies is similar to that employed by cereal makers, who line supermarket shelves with tens of boxes of the same sugar-laden cereals. Patients are being prescribed unnecessary medications and are not provided with important information and are not receiving the appropriate treatment because psychologists are being kept out of the treatment mix and because drugs, in the short term, are cheaper than more appropriate and proven care.
- The use of medical psychologists, those trained in applying behavioral interventions to medical problems
 and clinical psychopharmacology, are an effective solution to control the unnecessary rise and subsequent
 costs for psychotropic medications while providing patients with the necessary information to make
 decisions.

VI. Reducing Harm and Healthcare Costs: A Review Of A Physician's Unlimited License To Practice

- Generally, physicians are licensed under what is termed an "unlimited" license. Underlying the intent of unlimited licensure is the expectation and requirement that physicians only provide those services for which they have received specific training and education. Unfortunately, there is no entity that can police or oversee that physicians adhere to the intent underlying the justification for unlimited licensure. As a result, unlimited licensure contributes to undue harm to patients and is a public policy issue that needs to be addressed and modified.
- Psychologists, nurses, nurse practitioners and other healthcare professionals practice under what is termed a
 "limited" license. This means that these professionals can only practice what is stated in their scope of
 practice law. They can legally provide only those services for which they have specific training, education,
 and experience.
- State licensure boards establish procedures for granting initial licensure. However, in virtually all states, it is possible for a physician to practice medicine for a lifetime without having to demonstrate to the state medical board that he or she has maintained an acceptable level of continuing qualifications or competence.

- The Federation of State Medical Boards, raising the concern about on-going physician competency and the consequences that lack of training and competence can have on patient care and outcomes, believes that leniency extended to physicians is no longer acceptable.
- The ongoing advances in science and technology and the knowledge that is required to digest and make use of this knowledge by physicians is at the core of why unlimited licensure is bad for patients and is a direct cause of excessive healthcare costs.
- The FSMB issues a report that raises concerns about the generally poor quality of medical school applicants; the small amount of time that physicians have to devote to patients; and the shortage of American-trained physicians and the increased reliance on foreign-trained physicians with limited language skills.
- There needs to be a balance between professional autonomy and patient care. Unlimited licensure subverts treatment and ethical considerations because of economic issues, or the interests of corporations such as drug manufacturers and insurers. It does not promote a balance. It sabotages professional ethics and the foundation for an effective and efficient healthcare system.

VII. Medicating America's Children

- Prescriptions for antipsychotic medications to children aged 2 to 5 years doubled between the years 1999-2001 and 2007. The top-selling medicines in 2008 were anti-psychotics for schizophrenia and bipolar disorder, with \$14.6 billion in sales.
- The age of children being medicated with psychotropic drugs is getting younger, and the number of children
 given prescriptions is increasing every year. Yet, there is compelling research demonstrating the
 effectiveness of behavioral treatment to rapidly stabilize ADD and ADHD symptoms and without
 medication.
- There appears to be little evidence, if any, that these drugs are efficacious with this population of patients, yet physicians continue to prescribe drugs to children "off label" and at doses developed for adults.

- Drug manufacturers have been charged with hiding, obscuring and falsifying the results of clinical trials. The efficacy of Prozac, for example, could not be distinguished from placebo in 6 out of 10 clinical trials. The FDA, nevertheless, allowed Prozac to be prescribed to millions of patients including children.
- It is clear that bipolar disorder is being over-diagnosed in children and adolescents. Many of these patients are being treated in primary care settings. This is wrong, ill advised, and potentially dangerous to the patient. Patients diagnosed with bipolar disorder need to be evaluated and diagnosed by a doctoral psychologist or psychiatrist and regularly followed by both during the course of treatment.
- Many children are prescribed psychostimulants for attention-deficit problems. To date, not a solitary cause
 has yet been identified for ADHD. The National Institutes of Health Consensus Development Conference
 and the American Academy of Pediatrics agree that there is no known biological basis for ADHD. These
 drugs are top sellers for manufacturers.
- Large-scale research shows that children who are prescribed psychostimulants and are provided behavioral intervention have less need for these medications and experience rapid stabilization of their symptoms.
- Children are at great risk when taking psychostimulant drugs. In 2007, the FDA issued an administrative
 order that require that all makers of ADHD medications to develop and provide patients with Medication
 Guides. The FDA took this action because of complaints and the increasing data that concluded ADHD
 patients with heart conditions had a higher risk of strokes, heart attacks, and sudden death when using
 these medications.
- The psychological symptoms associated with these drugs include: hearing voices, experiencing hallucinations, becoming suspicious for no reason, or becoming manic.
- Strattera, a psychostimulant prescribed to children and teenagers, is more likely to produce suicidal thoughts
 in children and teenagers than in those who do not use this medication. Children who use Strattera must be
 supervised and their behavior carefully monitored because they may develop symptoms suddenly, and they
 are a serious threat to the child.

- ADD/ADHD are not the only conditions for which children are being prescribed potentially dangerous
 medications. Increasingly, children as young as five years old are being diagnosed with bipolar disorder by
 physicians, without even an evaluation by a psychologist.
- The use of antidepressant medications is commonly prescribed for pregnant women. The use of these drugs during pregnancy is based upon the false assumption that they are safe to the fetus and the mother. They are not and they can cause serious medical impairments for newborns.

VIII. Patients Deserve To Be Evaluated And Treated By Real Doctors

- Since the penetration of managed care as the gatekeepers to healthcare, behavioral health services have been the most negatively impacted.
- As managed care became the gatekeeper for behavioral health services, costs dropped 40% as a result of delaying services, denying claims, arduous utilization review procedures, phantom panels, and the use of non-doctoral level providers.
- The U.S. Surgeon General, in a report on mental health, admitted that private health insurance is generally more restrictive in coverage of mental illness than in coverage for somatic illness.
- Mental health parity legislation has not remedied the disparity in treatment for behavioral health patients.
 Insurers and managed care companies employ sophisticated utilization review procedures to delay and deny treatment.
- Insurers state that they need these procedures to contain costs. Studies by health economists have concluded that unlimited mental health benefits under managed care cost virtually the same as capped benefits: The average increase was about \$1 per employee compared with costs under a \$25,000 cap, which is a typical limit under cost-containment plans.

IX. The Treatment Of The Aged In Long Term Care

- The services psychologists provide patients in long-term care results in benefits to patients and the healthcare system. However, the underutilization of psychologists in these facilities remains a significant problem.
- The shift from a custodial care model to a functional capacity model that utilizes psychologists and other healthcare providers has increased the quality of care provided to nursing home patients.
- According to the American Geriatric Society, there are 1.5 million older adults in nursing homes. Anywhere
 from 65% to 91% have symptoms of a psychiatric disorder. Beyond these primary psychiatric diagnoses,
 many of the medical conditions presented on admission have underlying psychological factors that
 contribute to or exacerbate the conditions.
- Many research studies have repeatedly shown that higher costs and reduced quality of life for medically ill
 individuals are associated with depression, stress, and negative future outlook.
- The Institute of Medicine in a recent report projects significant shortages of all health professionals with specialized training in geriatrics and aging.
- Despite this prevalence of psychological disorders in nursing homes, psychological services, as elsewhere, have been negatively impacted by the medicalization of behavioral health. Elderly patients in nursing homes continue to be over-medicated and not provided the level of behavioral interventions that are needed.
- The Department of Health and Human Services published a report saying that 7 out of the 10 leading health and illness indicators are psychological, such as inactivity, obesity, smoking, substance abuse, behavioral illness, irresponsible sexual behavior, and violence. Many elderly patients never receive the appropriate treatment for these symptoms and are instead treated with ineffective drugs.

- Numerous studies looking at the effect of psychological interventions on medical utilization found that 90% of the studies showed reduced medical utilization following some psychological intervention and a corresponding reduction in cost.
- Studies show that there is an over-reliance of drugs in nursing home settings. These studies show that it is not uncommon for patients in nursing homes to be prescribed between 5 and 13 medications. The adverse drug events from this practice causes deaths and other harms to elderly patients.
- The increasing costs for medications clearly can be reduced if physicians, more often than not, would include behavioral interventions into the treatment plan.

Policy Statement

The National Alliance of Professional Psychology Providers (NAPPP) is a voluntary association of licensed doctoral-level psychologists. As an organization, we are not against the use of medications in the treatment of behavioral disorders. In fact, a large portion of our membership hold postdoctoral graduate degrees in clinical psychopharmacology and are board-certified medical psychologists. NAPPP has authored and introduced three legislative bills that would have authorized specially trained psychologists to prescribe medications. NAPPP has supported similar bills and statutes that have been introduced in many states. Because of our expertise in this matter, NAPPP believes that we have a responsibility to address the problems associated with using medications as a first-line treatment for behavioral disorders.

The positions we take on this matter are firmly rooted and based in scientific research as well as doctoral-level practice. The contributors to this report all are very experienced psychologists who are board-certified medical psychologists and highly trained in psychopharmacology. We do have a bias, however, and that bias is a desire to ensure that the public and our patients receive the safest, best and most efficacious treatment for their behavioral conditions. As providers in a vast and expensive healthcare system, we also are concerned that tens of billions of dollars are being spent on medication treatments that are not effective or safe for our patients.

We are concerned that billions more have been transferred to primary care providers who have little, if any, training in evaluating, diagnosing and providing the necessary treatment to patients experiencing behavioral difficulties. In a healthcare system that requires provable outcomes as well as cost effectiveness, NAPPP believes that we must act quickly and responsibly to alert the public, policymakers and physicians that the science and experience simply do not support this continued mismanagement of patients and the resources of our healthcare system. The positions and recommendations that are offered in this paper conform to best practices and the standards of care required to treat behavioral disorders. They are supported by the most recent and rational research findings. If adopted by physicians and policymakers, these recommendations will result in:

- 1. Significant increases in positive outcomes for patients.
- 2. A decrease in overall treatment costs for both physical illness and behavioral disorders.
- 3. A concomitant increase in patient safety.

Achieving these goals is not difficult or complex. It will, however, require organized medicine and insurers to put patients ahead of turf issues and their alliances with the pharmaceutical industry. Drug manufacturers have long asserted to the public experiencing behavioral health problems that the medical treatments they receive from drugs are a result of a long and rigorous process that demonstrate these medications are safe and effective. However, this assertion is far from what is scientifically proven or, in fact, a reality. Safety and effectiveness have proven to be little more than marketing slogans used by these companies to lure naive patients into a false sense of security. Moreover, many physicians, lacking the experience, knowledge and time to research the claims made about these drugs, also have naively accepted these generally false claims and have become the distributors for a host of drugs that simply do not work as advertised.

In fact, a number of legal actions for fraud, both criminal and civil, have been filed in the United States against psychiatrists, pharmaceutical companies and others for selling, distributing and prescribing psychotropic drugs that have no valid medical purpose. Unfortunately, organized medicine has a long history of not dealing with and covering up the reality that many of the treatments physicians provide to patients are not beneficial, are ineffective and, many times, even harmful.

In 2007, a report¹ published by the Congressional Budget Office outlining scientific evidence relied upon by the public and physicians with respect to medical treatments used and prescribed by physicians, authors found no hard evidence that demonstrates which treatments work best for which patients and, moreover, whether the added benefits of more-effective but more expensive services even warrant their use. Nevertheless, physicians tend to use more expensive treatments even in the absence of data on whether they work or are cost-effective. This study is not unique. In 1978, in a first for this type of study, the US Office of Technology Assessment reported that only 10% to 20% of medical treatment showed any evidence of their effectiveness.² With respect to treatment with psychotropic medications, both the biological theory that they are based upon and their efficacy is highly questionable given the poor scientific evidence relied upon by patients prescribed these drugs and practitioners prescribing them.

More recently, an important article published in the New England Journal of Medicine (NEJM) reported that, as a whole, patients experiencing a wide range of conditions are not receiving the standard of care by their physicians required for the conditions for which they are being treated. The authors report that patients being treated for depression, for example, only receive 57% of the standard of care required for that diagnosis.³ By any definition, a patient who only receives half of the standard of care required to treat a condition is being

shortchanged and put at risk. Moreover, the healthcare system, as a whole, is literally being defrauded of resources that could be better saved or used elsewhere. It is not unreasonable, therefore, to require physicians to obtain an evaluation and appropriate diagnosis from a doctoral-level psychologist or psychiatrist who is uniquely trained and qualified to provide these services, before writing a prescription for a medication that is not indicated or useful to the patient. This is a sound and rational procedure that is easily implemented and cost-effective.

To this end, the NAPPP advocates and calls for the American Medical Association and all other medical specialty groups, such as the American Academy of Family Physicians, to adopt guidelines and policies to require physicians to seek and obtain an evaluation and diagnosis from a doctoral-level psychologist before considering medication as a first-line treatment for behavioral disorders. NAPPP also advocates and calls upon these medical associations to require their physician members to adhere to and provide 100% of the standard of care for patients requiring behavioral treatments.

I. The Evidence Against Primary Care Physicians Providing Behavioral Healthcare

Absent from the discussion about patient care is the relationship of science, population demographics and epidemiology to the healthcare system. Field-tested providers have been locked out of any substantive opportunities to express their views about coverage, effective best practices and cost controls. Going forward, NAPPP will advance some very bold and, for some, controversial statements. Given the crisis that confronts the healthcare system, timidity is not an option.

NAPPP believes that the public needs to hear from very experienced healthcare providers who have made the long journey through a broken and co-opted healthcare system that is being driven further into the hands of the Primary Care Medicine and the marketing system that uses physicians, primary care and specialists as vehicles for unproven and costly treatment regimens. The result has been a system that largely is unresponsive to reform and a healthcare system that, in fact, promotes illness, habituation to analgesics and addiction to other drugs, large expenditures for ineffective care and a drain on the economies of local, state and federal governments. Businesses, both large and small, are diverting funds into healthcare expenditures that could very well provide greater benefits if directed to the appropriate providers and if physicians were required to adhere to the standards of care for behavioral conditions. As a result of this medical mismanagement, healthcare reform has little to do with health but more to do with:

- 1. Organized medicine's unwillingness to admit its shortcomings and desire to maintain physicians as the "masters" of all healthcare.
- 2. Political contributions to politicians who, naively or otherwise, fail to pass legislation that provides any real regulatory oversight over healthcare stakeholders.
- 3. The misplaced trust in the stated mission of the overall healthcare system.
- 4. Continued corporate control of health care.

Many studies have chronicled reports from consumer groups, government reports, and research that indicates the American healthcare system is substandard, ineffective and inefficient when it comes to the evaluation and treatment of individuals with substance abuse and mental health problems.⁴⁻⁶ These problems emanate from

an outdated health care belief that "primary care physicians can lead and manage the healthcare system". This belief holds that because the primary care physician is available and accessible in most communities, they will "screen" and "link" patients to the appropriate specialists for needed care. The system has several flaws and simply does not work this way for the following reasons.

First- Financial incentives are powerful primary reinforcers that have been scientifically proven to rapidly shape and maintain new behaviors. Unfortunately for patients and the public, these reinforcers have become perverse economic incentives. Physicians, however, have been financially rewarded for keeping mentally ill and chemically dependent patients in treatment and under their care rather than seeking an appropriate specialist assessment, much less transferring them to specialist treatment.

The primary care industry developed partial, inadequate, and even unproven treatments with no real rational, scientific, or amplitude of effect on mental illness and substance abuse. 47,8 Physicians devised short and marginally valid "screening instruments" that have a huge misidentification ratio and developed assessment protocols that are used in the absence of a well-done psychosocial history, mental status examination, collateral family interviews and family assessment, and psychological testing when indicated. These unproven and unreliable procedures miss most behavioral illness and chemical dependency identification in primary care centers and hospitals. They are so bioreductionistic that they focus only on the sequalae physical problems or diagnose "feelings and behaviors" such as "anxiety, depression, anger or marital problem, sleep disturbance, etc." rather than an appropriate diagnosis. Patients are then prescribed antidepressants or benzodiazapines with no rational to support these treatments. These treatments have been proven incomplete, inadequate, and ineffective. 9-11.

Despite this, primary care physicians and the primary care industry continue these inadequate treatments despite the evidence about their inadequacy, widespread articles exposing the problems with the approach and long-term costs and waste of human potential associated with it.¹² Patients and the public have every reason to suspect that a major cause of escalating healthcare costs is economically motivated.

Second- The healthcare industry composed of physician groups, insurers, large contract providers, medical device companies, and the pharmaceutical industry has achieved total control of the healthcare system that routinely misleads and colludes with government regulators. Regulators frequently put primary care physicians in control of nearly all of the system (community hospitals, state and federal clinics, primary care clinics, third

party payer systems, and healthcare law and standards development). Yet, there are no psychologists or psychiatrists staffing requirements before primary care centers can qualify to be certified for reimbursement from Medicare and Medicaid. Similarly, there are no such requirements enforced by hospital, nursing facility, or residential care facilities. Primary care physicians are simply "trusted" and "given the option" concerning when to staff these centers with such specialists, when to call them in on cases, and whether or not realistic treatment protocols beyond a tranquilizer, antidepressant or antipsychotic is used.

When we look at the effect and outcome of this approach, we find it has been an abysmal failure with catastrophic results. Patients are partially treated with weak or ineffective medications, their mental illness or substance *abuse* is rarely identified or it is ignored. Worse yet, they are given naive medical practitioner advice or "talks" masquerading as a much more complex process, referred to as "counseling". Many patients have been seriously harmed, injured or killed by these approaches. Others have had years of their lives wasted or damaged. People have lost marriages, children, jobs, productivity and income, and have lived in ongoing and unnecessary stress that has undermined their physical health and longevity. Even when these things become widely described in the literature, the control of the primary care industry is maintained as "necessary" and as "the best way".

Third- The healthcare industry has embraced the myth that a behavioral disorder is a medical problem and implies that it is either genetically caused or neurohormonally caused and, typically, lifelong. This myth maintains the medicine's control of revenue streams and patients as chattel within the healthcare system. Even though the scientific literature shows that there are no genetically determined mental disorders, and that even the most genetically loaded mental disorders (a minority of mental disorders) have a small percent that can be ascribed to or explained by a genetic component, the medical establishment perpetuates the insinuation that the mentally ill are suffering from "defective protoplasm" or genetic disorders.

Every parent raising young children knows there is a complex interplay between genetics, neurohormones and the environment and very slow autoplasticity of the central nervous system. They understand that hundreds of focused and intense hours are needed to grow the neural connectors and autoreceptor breaks to gain the coordinated and appropriate self regulation necessary to create complex awareness and behavior such as potty training, bedtime skills, table manners, impulse control and judgment processes such as learning not to dash into the street.

Relying on the unproven genetic based theory, each generation of patients is repeatedly, cyclically, and incessantly provided with ineffective and costly treatments based on "new" neurohormonal hypotheses for their behavioral conditions, even though top scientists have long since concluded these are "only theoretical" as one hypothesis after another is proven false. Even with the growing scientific evidence about the brain-changing effects of the environment and experience, and the autoplacity of the central nervous system, the primary care system perpetuates its myth. 13-15

Highly trained psychologists, psychiatrists and brain research scientists with many years of experience with mental illness have been raising the alarm about biologically based theories of behavioral disorders for decades. The public also has been warned by other experts in mental illness and by research authors in the legal arena that medicines as the only and first-line treatment in a treatment plan is a dangerous and ill thought-out approach to treatment, with significant, highly probable and predictable costs. Consequently, patients and the public have been left at the mercy of the primary care industry for their explanations of available science and health education. 22, 23

Renowned researchers have been writing voluminously for the need to require protocols that include psychosocial and behavioral treatments with medications ^{24, 25} and in some cases in place of medications ⁶. With such data, one would think that the government and certification and quality assurance organizations would require that primary care centers, hospitals, nursing homes, and residential care centers have staff psychologists or psychiatrists available. Although such a practice would be in the interest of the patient and would make good economic sense in the long run, one rarely sees psychologists routinely staffed and used in these situations. In fact, when such specialists attempt to get staff privileges and rules in place that allow them to be easily accessed by patients without going through the primary physician, they must go through the executive committee of the medical staff (primary care physicians). The committee rarely approves such access in spite of many statutes that requires it to place psychologists on medical staffs.

Thus, in primary care and health facilities in America, the primary care physician acts as a "gatekeeper." But, more often than not, they screen out the possibility that a patient will get effective care or receive the standard of care mandated by guidelines rather than provide symptom screening and automatic referral and linkage with such specialists when behavioral health symptoms are encountered. Whatever the rationale and whatever the intent, it is wrong and patients and the public are paying a high price for this negligence.

Fourth- Another myth that permeates the primary care system is how identifying a feeling or surface symptom, such as sleep problems or aggression, can determine a diagnosis and thus trigger the appropriate protocol to treat the patient. Anxiety manifests itself, for instance, in many behavioral disorders and is simply misdiagnosed by physicians as hypomania or a stress response. Other emotions, such as feeling "down" or "blue," anger, or fear are similarly not definitive of which mental disorder may be present. Yet, primary care physicians in clinics, nursing homes, and hospitals frequently treat these feelings and behavior disruptions as if they are a "diagnosis" and subsequently prescribe the wrong medications and unrealistic behavioral regimens that often make the condition worse. Presently, the over-prescription of pain medications and sedatives has resulted in visits to emergency rooms for abuse related to these drugs being equal or exceed visits for illegal drugs. ^{25a}

This often is seen when physicians prescribe to drug-addicted individuals, whose lives are splintering and creating great concern and anxiety, benzodiazapine medications. These medications increase depression and sleep problems, increase already noteworthy memory problems, and exacerbate the aging process already driven by the addiction and related nutrition deficits, lifestyle effects, and vitamin depletion. Moreover, one of the critical issue with practicing in nursing homes is the disturbing policy of patients being chemically restrained and addicted.²⁶⁻²⁹

Insurers and managed care companies reimburse for this approach since they understand that a patient does not need to be provided treatment that might cost more in the short run when they can be prescribed a few antidepressants or tranquilizers, which are very inexpensive. In such cases, which are all too common, the primary care physician and the managed care company are providing ineffective and dangerous treatment by using medications instead of using an integrated approach that is both beneficial and cost-effective.

Organized medicine has contributed to a virtual "War on Behavioral Treatment" with the overmedicalization of behavioral illness and by not using psychologists in all health facilities.³⁰ Hospital administrators, legislators and government officials, and even state and government employed psychologists, have gone along with this out of fear of retaliation of the health care industry and primary care physicians. This is understandable, since primary care physicians and insurers have effectively captured the American healthcare system, including facilities and third party reimbursers, who are in a position to withhold medical treatments, revenue, and cooperation and collaboration if challenged or exposed.

Often patients do not come to a healthcare provider for change or long-term health interests. Many patients simply want comfort and symptom control. The primary care system has built its industry on this awareness and has used the "right of the consumer" to remain silent and capitalize on a broken system for which they are rewarded. This mercantile vision and awareness is an economic and not a healthcare leadership role. It recognizes that many patients want short-term, passive, and palliative care and may be uneducated, uninvested, or simply don't believe in the possibility of change without a drug. Such patients want a very specific product-comfort/ Medications that offer minor or major tranquilization (increased tranquility), a little more pep, or interfere with normal membrane or cell functioning to inhibit impulsiveness or mood volatility are all they focus on. However, do physicians have a responsibility to act in the patient's interest or assent to a patient's request knowing that it is wrong? We think they do. No psychologist would treat a patient for depression knowing or suspecting that they might have a brain tumor that is responsible for the symptoms, no matter how much the patient is in denial or wants to avoid a consult with a specialist. Should physicians not be held to the same standard?

Summary

Moving more services and responsibility into primary care centers and breaking down the silos in the health and mental health systems is a long-held goal. It requires not just a change in where services are geographically located, but change from the bioreductionistic philosophy and hierarchy of decision making that is deeply embedded in the culture and traditions of the primary care and medical services industry. We will not achieve improvements in the quality and costs of care if we do not improve the leadership, traditions, and the broad application of science in these systems. Physicians and nurses are not trained or philosophically equipped to do this alone. There will have to be strong and enforced systemic and accreditation and reimbursement systems that require a broader staffing and presence of psychologists and other healthcare providers at all levels of the primary care and hospital system. The limits of medical care in decision-making, designing care plans, creating opportunities to deliver long-term care rather than palliative interventions, and with regard to limiting costly and debilitating side effects of care has been well established. The system has simply not been redesigned to accommodate this knowledge and science.

Real healthcare requires real change rather than minor changes in failing philosophies and systems. The public and patients are right to demand that the government demonstrate the will and intelligence and power to check the considerable influence of the medical, pharmaceutical, and hospital corporation establishment and truly redesign and maintain a vastly different system. The anxiety and fear of these powerful dominating forces in

the current failed healthcare system is realistic. However, the needed changes to this system may not be expensive and ineffective as the industry will have us believe. What is required is a change in attitude and philosophy that physicians do not and should not be expected to know everything about illness. They alone have the power to significantly change the healthcare outcomes for patients. They alone can be instrumental in changing a system that makes a profit on non-beneficial and ineffective treatment. They alone are in a position to make healthcare cost effective. It will mean, however, that they must first acknowledge that a license to practice medicine should not be construed as a license to collude with insurance companies, pharmaceutical companies, and medical device companies to exercise undue influence and power over healthcare.

II. Reducing Adverse Drug Events From Physician Error

During the calendar year ending 2001, more than 3 billion prescriptions for medications were written in the United States at a cost of more than \$132 billion dollars.³²⁻³⁴ Estimates project this cost to rise to more than \$400 billion by the year 2014. The passage of the prescription benefit bill during the Bush II administration greatly increased these costs. The growing use and reliance on prescription medications presents American society with major health, public safety, and public policy dilemmas. The helpfulness and efficacy of many prescribed medications is unarguable. When used appropriately for the conditions indicated, pharmaceuticals can contribute to the quality of life. On the other hand, medications are not without risk.

Estimates of the annual cost due to increased harm from medication related injuries ranges from a low of \$72 billion to a high of \$172 billion.³² The fact that the increased harm and costs from medications may actually exceed the total annual cost of medications themselves begs for further study. Fatalities from adverse drug events in the United States are estimated to exceed 100,000 people on a yearly basis.³⁵ Annual non-fatal injuries from Adverse Drug Events (ADEs) are estimated to be about 650,000.^{35,36} These statistics are alarming, but they only represent fatalities and harm to those patients in hospital settings. Data for ambulatory patients is sorely lacking due to an absence of an enforceable policy for systematically reporting ambulatory ADEs.

It is important for all healthcare providers to be knowledgeable regarding adverse drug events associated with prescription medications. Psychology, as a health care profession, is no exception. Knowledge of ADEs is particularly important for those psychologists seeking prescriptive authority. Knowledge on the types and incidence rates of ADEs also can shed light on whether medical school training is a necessary prerequisite to safely prescribe medications as argued by opponents of non-physician prescribers. Medical studies have long been concerned with patient safety related to the use of medications.^{37, 38} The Harvard School of Public Health conducted one of the first studies to look at ADEs associated with prescription medications.³⁹ This Harvard benchmark study was a first attempt at trying to quantify the types and incident rates of medication errors in a large population of hospitalized patients. In a sample of more than 30,000 hospitalized patients, they concluded that medication errors were associated with serious outcomes that negatively affected patient safety. Overall, they found that adverse events from medications comprised about 20% of total errors.

All prescription medications approved by the US Food and Drug Administration (FDA) are for specific purposes. Most medications are of little use outside their stated purpose, although many medications are used

"off label" with little or no data to support their use. 40 Cardiovascular, gastrointestinal, endocrinological, antibacterial and hematological drugs are examples of medications that have little or no use for conditions other than purposes for which they are approved. These classes of medications comprise the greater share of fatalities and serious ADEs. 41-43

The FDA delineates two types of drug related adverse events. Type A ADEs are harms resulting from prescription medication errors and other avoidable errors. Harms can range from a simple and minor rash to death. Type B ADEs are harms not related to errors but to the unique response of the patient to the drug, e.g., anaphylactic shock. "Undetected hypersensitivity or unknown inherited response to a medication" comprise this category of ADEs. The types of errors described in studies reporting on ADEs seem to change very little from year to year. ^{44, 45}

Prescribing of the wrong dose or the wrong medication, even when known allergies to a medication exist, is a major problem. Overdosing is another serious problem. When errors such as these occur time and again, chance occurrence is not a viable explanation.⁴⁶ In response to the escalating ADE problem, many hospitals have implemented ADE reduction programs such as using pharmacists to review physician medication orders.

A review of physician orders by pharmacists in order to provide medication counseling on all new prescriptions is now required by Medicare. This federal requirement has resulted in pharmacists being granted limited prescriptive authority in more than 40 states. Many of these prescription review programs have reduced ADEs associated with the types of errors presented in the cited studies. There are many variables that can explain ADEs, e.g., physician distraction, workload, unfamiliarity with a specific medication. Specific training on ADE pitfalls in all pharmacological training is recommended for safe prescribing.

The Institute of Medicine (IOM) of the National Academies of Sciences performed a comprehensive investigation of medical errors and published this landmark study as To Err Is Human (2000).³⁴ One of the major findings of that study was that annual fatalities from medication errors surpassed deaths from motor vehicle accidents (43,458), breast cancer (42,297), and AIDS (16,516). Many of the findings and conclusions of this study, however, have been challenged.^{49,50} Generally, these studies dispute both the incident rate and seriousness of ADEs cited in the IOM study. Acknowledging that some of the findings on ADEs may be overstated, the IOM study sheds much light on the risks associated with current prescribing practices.

Classes Of Medicines Most Related To Injury And Harm To Patients

Opiate and cardiac medications contribute the greater share of all ADEs and fatalities.^{51,52} Available data suggests that the risks of ADEs associated with psychotropic medications may be far less than those of drugs used for other disorders but nonetheless potentially dangereous.^{53,54} Although the data cited in many studies is more than 10 years old, the more recent studies generally are consistent with the earlier studies.

In the year ending 2000, more than 16,000 deaths from gastrointestinal complications were attributed to non-steroidal anti-inflammatory drugs. ⁴³ In addition, several thousand more deaths involving cardiovascular complications also were attributed to this same class of medication, which is used to treat common inflammation. ⁴⁸ Increasingly, we see psychotropics being used for conditions for which they are not approved and with populations never intended. Psychotropic drugs are often used by managed care organizations as a less costly substitute for psychotherapy. Weight loss, dermatological problems, student behavioral control, autism, inappropriate behavioral restraint, podiatry, pain management, and in dentistry, are examples of applications not indicated by research or, in many cases, by logic. Antidepressant medications are being prescribed for an ever-expanding catalog of newly created problems. ^{55,56} Uses of these medications, like many medications, go beyond those initially indicated and their use becomes more questionable.

Newer atypical antipsychotic medications, for example, are finding even greater use for non-psychotic conditions such as insomnia, and with children⁵⁷, who are populations generally excluded from drug trials. The incidence rates of injury and hepatotoxicity from psychotropic drugs are an area that physicians need to be concerned and remain alert about when prescribing these drugs. The standard of care requires baseline blood tests, which should be repeated to insure against liver and kidney damage. However, few primary care physicians follow these requirements. Greater risk to patients from psychotropic medications occurs when these types of medications are prescribed by medical professionals who are not specifically trained in clinical psychopharmacology, and in the diagnosis and treatment of behavioral disorders.

An analysis of ADE studies, including fatalities, associated with psychotropic medications shows that psychotropic medications need strict monitoring when prescribed alongside other drugs. These studies show that opiates, cardiovascular and non-steroidal anti-inflammatory drugs (NSAID) medications comprise the greatest share of serious ADEs. Clozaril, a drug used to treat schizophrenia in a population of treatment resistant patients, registers about 10-15 fatalities for every 10,000 patient years. This is why behavioral

healthcare requires that patients be seen for follow-up care while on psychotropic medications. Primary care physicians do not have the time or inclination to provide this care.

The intention here is not to scare, but to warn of the potential harms that can result from the inappropriate use of psychotropic medications. When ADEs do arise from the use of psychotropics, they can be attributed to prescribing the drug for the wrong populations, errors in the prescriptions³¹ and to the inherent uniqueness in response of the patients receiving them. A few studies have provided some insight into the classes of drugs most associated with ADEs in hospitalized and outpatient settings.

Medical School Is Not The Most Effective Way To Reduce Prescribing Errors

Steel ⁶¹ argues that many ADEs are related to limited medical training in pharmacology and calls for physicians to be licensed to prescribe medications only in their specialty. Wiggins & Cummings⁶² reported 1 million episodes of mental health care where psychologists with documented training in psychopharmacology managed both the combined use of psychotherapy and psychotropic medications without patients' complaints of how psychologists dealt with their medications. Several studies of the effectiveness of prescribing psychologists in the military show that they perform safely and with high standards. ⁶³ These data suggest that the greatest danger to patients may not be a function of who prescribes but the content and quality of training one gets to learn how to prescribe. ^{64,48,39} Thus, the available data does not support the broad assertion that medical school education can fully prepare physicians to prescribe safely.

Physicians need to go beyond medical schools' more limited training experiences in pharmacology by focusing greater attention on preventable ADEs. Given what we know about many of the causes of ADEs, specific training recommendations can easily be implemented to significantly reduce Type A ADEs. One positive recommendation would be to provide training in drug-drug interactions between drug classes. With more than 8,'000 medications now in general use, it is almost impossible to recall specific drug-drug interactions between single medications. Since most medications in a class behave similarly, this could reduce ADEs. For example, generally, non-steroidal medications (NSAIDS) can have serious drug-drug interactions with anti-hypertensives. Knowing this can alert physicians to this interaction and would require a more detailed look into specific drugs that are being considered in these classes. Conversely, a more thorough understanding of the patient would reduce errors resulting from polymorphisms and other significant pharmacodynamics.

We now have available very detailed, but easy to use, computerized pharmacology. These programs are easy to update and take very little time to master. In cases in which multiple medications are being used, performing a simultaneous drug-drug interaction search can take seconds. Pharmacology programs should train in their use and require students to acquire and use this technology. Yet, many physicians resist newer technology and still use written prescriptions which are difficult to read and cause many errors.

Many ADEs occur due to prescribers writing an incorrect dose of a medication. For example, medications, such as Levoxyl, a thyroid hormone substitute, must be prescribed in microgram doses. This drug is responsible for a significant number of ADEs with serious consequences simply because the prescriber writes the dose as milligrams. Reducing this type of ADE can be accomplished simply by providing training in dosing arithmetic similar to that required of nurses and physician assistants. Along this line, ADEs related to writing errors, which bad handwriting is the cause, can be significantly reduced by eliminating hand written prescriptions. Students who are trained from the beginning to order prescriptions in type will tend to use this method when they gain authority to prescribe.

Clearly, prescribing medications requires skills that must start with early training. As in many professions, there are those who may lack the skills needed to correctly and competently perform tasks.⁶⁵ Training that addresses ADEs is not prominent and included in the core subject matter of the majority of medical schools.⁶⁶ While this type of training may not guarantee the competence of any one prescriber, without specific training in ADEs, we may invite only more ADEs and their consequences.

Medical psychologists are in the unique position of being a positive factor in reducing ADEs while at the same time providing behavioral health services effectively and efficiently. General practitioners and other non-psychiatric physicians are neither mental health specialists nor psychopharmacologists. Commenting on a recent study on ADEs, Steel,⁶¹ in his article, advocates that non-physicians and sophisticated computer systems need to be part of the prescribing process if ADEs are to effectively be controlled.

Concluding Statements

Collaboration between psychologists and physicians can result in more effective and safer treatment for behavioral health patients by reducing ADEs. Their knowledge of ADEs, pharmacological training, and the practice by psychologists to spend as much time with patients to develop working differential diagnoses, allow them to promote higher-quality behavioral healthcare, while being a conduit to physicians about their patients

condition. With better treatment comes efficiency and a significant reduction in overall health care costs.⁷²⁻⁷⁴ The Therapy in America Survey ⁷¹ reports that an estimated 59 million people received some form of mental health treatment in the two years reported on in the study. However, an estimated 24 million people received no treatment, even though they reported having symptoms severe enough to warrant a diagnosis and treatment.

Patients experiencing depression and seeing a general practitioner are often undiagnosed or misdiagnosed. McGynn³ reports that only 53% of patients with depression receive an adequate standard of care; their symptoms go untreated or they are given medications for something they may not even need. Misdiagnosis, inappropriate medications, insufficient training in mental disorders, and poor pharmacology skills can all increase the likelihood of ADEs. Suicide rates among people who are not being seen by a mental health professional are several times greater than those patients receiving treatment.^{75,76} Psychologists can fill a significant gap in behavioral healthcare by prescribing psychotropic medications, when appropriately indicated, and providing related psychological services.

III. Psychiatry In Crisis: Impacts on Primary Care, Patient Safety and Public Healthcare Policy

There is a general shortage of healthcare providers, ranging from physicians to physical therapists. These shortages will reach crisis levels when more than 30 million people are mandated in 2103 to acquire healthcare insurance and are added to pool of prospective patients. Even now, absent those more than 30 million, it is difficult to schedule an appointment with a primary care provider. Thus, healthcare reform will not and cannot guarantee access to care or to timely medical care. This holds true particularly in locations where physicians are in short supply, are not accepting new patients, or where physicians reject certain types of medical insurance, such as Medicare and Medicaid.

We can see the results of shortages by looking at what has happened in one medical specialty. There is a growing shortage of psychiatrists in the USA. This shortage has fueled a mental health crisis by severely limiting access to psychiatric care for those in need of mental health services. As a result, it is estimated that 70 percent of primary care physicians nationwide reported difficulty in obtaining high-quality outpatient mental health services. Shortages in psychiatry is a not a new phenomenon. The AMA reports that the supply of U.S. psychiatrists shrank 27 percent between 1990 and 2002. Meanwhile, physician staffing industry data indicate that demand for psychiatrists increased by 16 percent over that same time period (www.LocumTenens.com 2005 Compensation and Employment Survey-Psychiatry). The factors driving this crisis are, indeed, complex. For example, medical students are increasingly less attracted to mental health rotations. The number of American medical school graduates choosing psychiatric residencies is also dwindling, further adding to the shortage and the problem of access to psychiatric services.

At the same time, the aging of the psychiatrist population is decreasing access. Almost half (46%) of the more than 20,000 U.S. psychiatrists are 55 years or older, compared to approximately 35% of all U.S. physicians, according to the AMA.⁸⁴ Adding further to the problem of psychiatric access is the fact the pool of available physicians across all categories also is shrinking. The government estimates that it would take an additional 16,000 physicians to serve the needs of the 35 million Americans who live in underserved areas.⁸⁵ This gap is expected to widen to 24,000 physicians by 2020. Psychiatry is well aware of this access problem. Data presented at the American Psychiatric Association Annual Meeting concluded that these trends in the psychiatric workforce are leading to access problems (APA's Office of Research and the American Psychiatric Institute for Research and Education (*APRIE*)).

The access issue in California, for example, is quite severe. With about 36 million people, there are about 5 available psychiatrists for every 100,000 Californians. The shortage of psychiatrists in California has been a continuing problem for the past two decades. Other states also have reported shortages of psychiatrists. With one out of five American's experiencing a diagnosable mental health condition, a Harris Interactive Survey conducted in 2004 conducted on behalf of *Psychology Today* and Pacific Behavioral Health showed that only one-third receive the treatment they need. The reality is that currently there are not enough psychiatrists, nor in the future will there be enough psychiatrists to fill the exploding needs of those seeking psychiatric care in California or elsewhere. The shortage of psychiatrists has profoundly affected the penal systems, state hospitals, and county mental health facilities that provide services to millions of patients, nationwide. For fiscal year ending 2004, the state of California reported that it was unable to fill 191 vacancies for psychiatrists to serve in positions in county-operated mental health programs and state hospitals.

States are experiencing vacancies for psychiatrists across every program category, especially in programs servicing children, adolescents and the elderly. Experience in California demonstrates what others states have long faced. There are only 209 psychiatrists listed in the California Children Services Provider Panel that serves children through the state MediCal Program (Medicaid) or through other state funded programs. Although the panel serves children, not all of the psychiatrists on this panel are board-certified as child and adolescent psychiatrists. Only 44% of California psychiatrists listing a specialization in child and adolescent psychiatry are board-certified, compared to 63% who are board-certified in general psychiatry. Board certification in family practice and internal medicine is more than 75%. The shortage of child and adolescent psychiatrists has reached a crisis level and the American Academy of Child and Adolescent Psychiatrists (AACAP) describes it as "staggering." But, urban areas and large states such as California are not the only ones affected by psychiatric shortage. As a general statement, access to healthcare in rural areas of America is severely limited, access to behavioral healthcare even more so. 138

No one disputes the need or the extent of the shortage in psychiatry. As is true with the shortage in general psychiatry, the shortage in child psychiatry is not likely to be reversed. Geriatric populations are even in more desperate need of psychiatric care, especially when one considers that only 40% of the geriatric psychiatry residency slots are filled each year. "There are not enough trainees in the pipeline, so we won't even be able to keep up with those who are retiring," Dr. Kenneth Sakauye, chair of APA's Council on Aging told "Psychiatric News." What is important about the shortage in psychiatry is the impact that it has on behavioral healthcare, primary care, and overall healthcare policy. As the shortage of psychiatrists has increased dramatically over the

past two decades, primary care physicians have had to take up the slack for their colleagues. Behavioral healthcare has been shifted to primary care physicians even though they lack the training, skills, and time to treat these disorders. Consequently, about 83% of the prescriptions for psychotropic drugs are issued in primary care settings. The effect on patients has been disastrous as behavioral health treatment simply cannot be effectively or efficiently provided in a primary care venue. The following discussion addresses some key issues regarding the problem of psychiatric access resulting from psychiatric shortages.

Primary Care and the Treatment of Behavioral Health Disorders

Psychotropic medications have become the first line treatment for most mental health conditions. Shortages of psychiatrists have forced primary care physicians to shoulder the burden of providing first line medication treatment. The use of antidepressant medications has become so ubiquitous that more than 70% of all antidepressants are prescribed by primary care physicians. 92-97 Another factor explaining this trend is that physicians and patients have been lulled into believing that these medications are safe and without serious side effects. Now, with many more years of data, many studies are showing that antidepressant medications are not as safe as previously thought, especially without careful and knowledgeable monitoring. This places many primary care physicians in a very difficult and potentially high-risk situation. Due to lack of psychiatric access, they are *de facto* prescribing the psychotropic medications that patients *may* need and hoping that no adverse drug events occur. Unlike behavioral health practitioners, primary care physicians cannot provide the important follow-up care and concurrent psychotherapy that the majority of these patients require.

Primary care is not the best venue for the evaluation, diagnosis, and treatment of mental disorders. Studies repeatedly demonstrate that many primary care physicians do not provide mental health patients the requisite minimal standard of care. 99-101 In fact, one of the largest studies looking at the standard of care provided in primary care settings shows that patients who are depressed or experiencing problems from substance abuse receive care significantly below the minimal standard of care with only 53% of the standard designated for depression and 10% of the standard for substance abuse issues being met. These failures can be ascribed to the challenges inherent in evaluating mental disorders and finding an appropriate medication regimen, if even necessary, that will help these patients. Recognition of major depressive disorder in primary care remains a challenge 102 and one study showed that primary care physicians missed the diagnosis of major depression in 66% of patients with the illness. 103 Adding to the problem, psychiatric clerkships are not popular choices in medical school, further adding to the primary care physician's inability to correctly diagnose and treat the broad range of mental health concerns that present in their offices. 104,105

The inherent problems of providing mental health care in primary care settings directly impacts access to care. If the care received is not adequate to the needs of the patient and the standard of care to treat behavioral disorders is not met, then those patients do not have access to appropriate care. Ability to get an appointment in a reasonable time period and at a reasonable price will be of little value if a patient cannot receive care appropriate to his condition and need.

Public Policy Questions That Psychiatry and Primary Care Must Answer

Psychiatry has failed to increase its numbers despite several proposals that have been advanced since at least 1980.⁷⁹ These include increasing the number of psychiatric nurse practitioners and physicians' assistants to be psychiatric "extenders"; the use of teleconferencing, and training primary care physicians to prescribe psychotropic medications.¹⁰⁶ The continued and growing shortage raises many serious longevity issues for psychiatry as a medical specialty and for organized medicine as a whole. To patients, however, this issue has much more importance. The long-term prospect for psychiatry to remain relevant to behavioral health practice and policy is poor and questionable. The challenge to organized medicine resulting from severe psychiatric shortage raises many questions. Can primary care physicians continue to provide adequate mental health services to their patients as the number of psychiatrists decline as the number of patients increases? Will patients continue to accept primary care physicians as their primary behavioral healthcare provider? As the number and complexity of psychotropic medications grows will primary care physicians continue to be willing to put their patients and themselves at risk by prescribing psychotropics? Given the shrinking supply of all categories of physicians, will there be enough primary care physicians to deliver behavioral health services? Lastly, is a primary care setting the best alternative to providing behavioral health treatment?

The answers to these questions and the policy decisions underlying them will determine whether or not psychiatry and organized medicine act in the best interests of patients or continue to sit back and watch the access crisis grow. Until now, both psychiatry and primary care physicians have not advanced a single workable solution to any of these questions. Moreover, both have fought and resisted any effort by psychologists, nurses, and other healthcare professions, who have advanced workable and safe solutions, to remedy this crisis. Organized medicine has used the same slogan, "concern for patient safety", that they used at the turn 20th century when they tried to restrain others from providing "hot baths" as a medical treatment. Medicine has a long history of using patient safety as a tool to protect, expand, and save its own practice. The control that medicine has over healthcare practice and policy is probably the single most important factor in explaining

rising healthcare costs while at the same time decreasing outcomes when compared to other developed healthcare systems.

Prescriptions For Medication Only Are Not The Answer

Prescriptions for many types of psychotropic medications are starting to decrease. Prescriptions for SSRI antidepressants have decreased about 20% from their 2003 levels.¹⁰⁷ This is mostly ascribed to the reports of increases in suicidal behaviors and the subsequent "black box" warnings ordered by the FDA for these types of medications.^{107a-111} Similarly, prescriptions for psychostimulants to treat ADD and ADHD have decreased due to reports of deaths associated with their use.¹¹²⁻¹¹⁴ Many studies show that atypical antipsychotics are not as safe as once thought and may not be as effective as many "old" line antipsychotics.¹¹⁵⁻¹²⁵ In fact, the overwhelming evidence shows that the most successful outcomes in mental health treatment are a result of medications used concurrently with psychotherapy¹²⁶⁻¹²⁸ or psychotherapy alone.^{129,130} In spite of the clear findings of the outcome research on this issue, the vast majority of physicians continue to write prescriptions they know to be ineffective and non-beneficial without first establishing a valid diagnosis from a psychologist or psychiatrist, when available. It is inconceivable that this situation will improve when so many more patients will be added to the treatment rolls.

The lessons from these studies together with the problems of treating behavioral health disorders in a primary care setting are clear: one model for providing this health care in the short--term is an integrated model in which both medications, when necessary, and psychotherapy are provided by a psychologist and a collaborating physician. In the long term, specially trained psychologists who can prescribe medications is the best model. The severe shortage of psychiatrists, coupled with their abandonment as a profession of providing psychotherapy, make it difficult for psychiatry to be part of the overall solution. In fact, psychiatry may be the obstacle. Primary care physicians are simply unable to provide effective integrated treatment due to lack of time and appropriate training. In those states where psychologists are authorized to prescribe, access to care, patient care safety have been increased without a single complaint or case of harm being reported. Nevertheless, both psychiatry and organized medicine have fought and resisted psychology prescribers for almost two decades.

Changes In Public Policy Are Needed

Assuming the obvious that psychiatry is unlikely to increase in sufficient numbers to make a difference and primary care settings are not the best venue for treating mental disorders, alternatives must be found. A proven

solution exists. Clinical psychologists with advanced post-doctoral training in psychopharmacology should be granted prescriptive authority and used to prescribe and monitor medications for patients suffering from behavioral disorders when indicated. These skilled healthcare professionals have and will continue to become partners with physicians, ensuring patients have access and receive a higher standard of care than is now available. Several states and the United States Armed Forces have already turned to psychologists to prescribe psychotropic medications. Putting aside "turf" issues, psychologists trained in clinical psychopharmacology and medical psychology afford the best chance for patients to receive competent treatment where access to psychiatrists is restricted or absent.

The arguments that psychiatry and medicine have raised against psychologists prescribing should no longer be looked at by the public or policymakers as valid. The argument that the only way psychologists can safely prescribe is through medical school training simply has no merit. Let's be clear on these issues: Harm to patients through errors in prescriptions are a result of those trained in medical school. Thus, simply having graduated from a medical school has not protected patients from harm. It is the type of education and training that is the salient issue. Appropriately trained psychologists have written hundreds of thousands of prescriptions to military personnel and their families without any incidents or reports of patient harm¹³³⁻¹³⁷.

Moreover, psychologists in New Mexico and Louisiana and those prescribing under military contract serving soldiers in Iraq and Afghanistan have demonstrated that they can prescribe safely and provide high quality service. These psychologists work side by side with primary care providers and psychiatrists as colleagues. Collaboration is inherent in all psychological practice and continues with those prescribing psychotropic medications. Surely, doctoral-level psychologists with many years of experience evaluating, diagnosing, and treating mental disorders, who have undergone post graduate training in clinical psychopharmacology, and have passed both a supervised internship in prescribing and national boards in psychopharmacology, can perform safely and effectively.

Many psychologists already are *de facto* prescribers. Routinely, psychologists recommend and advise physicians and other prescribers regarding the appropriate psychotropic medications to be prescribed for a patient's mental health condition. Prescriptions are filled and the psychologist monitors and manages the patient while on the medications. Physicians rely on psychologist's expertise in evaluating, diagnosing, and treating mental disorders. Now, with their extensive training in clinical psychopharmacology, physicians can also rely on psychologist's stellar safety record of prescribing psychotropic medications.

We can see an example of the impact that prescribing psychologists can have on access by revisiting the vacancy problem in California State mental hospitals and County mental health facilities discussed earlier. The statewide mental health system typically has several hundred vacancies for psychiatrists at any given time due to the shortage. Statewide, there are more than 600 psychologists presently employed in the mental health system, excluding contract providers. Many of these psychologists have completed training in psychopharmacology. If the state and county mental health system were able to use the full training and skills of these psychologists, there would be no shortage of personnel in a very short period of time. These psychologists can provide medication management services to patients without any increase in costs since they are already in the system.

With the exception of electroconvulsive shock, which many psychologists find objectionable and not an effective treatment, there are few services psychiatrists provide and that psychologists could not. In California, psychiatrists are prohibited by law from providing routine medical work-ups on incarcerated patients or patients in state hospitals. They must employ an internist or general practitioner for medical services. Private hospitals generally follow the same practice. Aside from prescribing medications, psychologists perform the same services as psychiatrists do, with the important addition that psychologists deliver psychotherapy and most psychiatrists do not. Both have hospital privileges and both are licensed as independent practitioners. So why does psychiatry and organized medicine fight and resist what would obviously be a sound solution to the present and growing crisis?

In California, as elsewhere, the answer is clearly economic. Based on the newly established salary of more than \$250,000 that a psychiatrist is paid, the State of California could save a minimum of \$50,000,000 if psychologists were used to the full extent of their training. This dollar savings does not include the costs of benefits. Moreover, with the numbers of psychologists already employed in these settings, there would be no future shortage. Other savings can be realized because psychologists pay for their own psychopharmacology training while psychiatric training is subsidized through Medicare and other government programs. However, the greater cost is to patients, who are unable to have adequate access to psychiatrists, who simply are not available.

Clearly, while psychiatry and some in organized medicine attack the scope of psychologist's training in psychopharmacology, the objective comparison of that training to other healthcare professionals who are allowed to prescribe medications shows that psychologists have greater training where it is needed and require greater testing as well as a formalized supervisory period. Yet, nowhere in the many proposals advanced by psychiatry to address and alleviate psychiatric shortage are psychologists given any consideration, despite clear and objective evidence that psychologists are a safe and cost-effective solution that can provide patients with quality care. This glaring omission can be ascribed to many factors, including well-intentioned concerns by some. However, as psychologists are economic competitors of psychiatrists, one must suspect that this is a major factor for resisting a proposal that is both workable and accepting to patients.

Opposition from psychiatry and organized medicine will continue to disenfranchise patients and hurt their credibility with legislators who must respond to the mental health crisis. As just a few more states pass prescriptive authority legislation, other states will quickly follow as the positive experiences from states allowing prescriptive authority are seen. All parties to an adversarial struggle may have a lot to lose with a continued turf battle but patients will be the real collateral casualties.

IV. Antidepressant Medications Are Ineffective And Claims Are Misleading

Practitioners in psychology are ethically bound to remain conversant with and informed about the scientific foundations for our interventions, and to adapt our techniques to those proven conceptualizations of disorder and appropriate interventions. Using scientific findings and practices, the psychologist must first assess patients in such a way so as to establish an accurate diagnostic picture, which are based on specific scientific findings and aid in the selection of the most appropriate treatment.

Psychologists have long been the leaders in the development of a broad range of diagnostic tools, understanding of brain physiology, psychopharmacological agents, learning, social, and behavioral skills based on scientific bodies of evidence and related theories and techniques. As the premier diagnosticians, providers of behavioral healthcare, and compilers of scientific evidence in the behavioral health fields, psychologists have a duty to speak out and make the public aware of effective treatments, choice of treatments, the limitations of certain treatments, and of the risk/benefit analysis of certain treatment choices.

Psychologists have a moral, ethical, scientific, public service, and legal (informed consent) interest in complying with these duties. Unfortunately, our colleagues in medicine, who also share these same ethical considerations, have allowed drug manufacturers to obscure and manipulate the science behind the use of psychotropic medications. Clearly, no physician explicitly prescribes medications they do not believe will help their patients. We make no such claim or imply that they do. Nevertheless, on a whole-scale and widespread basis, physicians routinely prescribe psychotropic medications despite the evidence that the underlying science is absent, contradictory and, in some cases, clearly manipulated by the drug companies.

Antidepressant Medications

We start our discussion with antidepressants because they are the most widely prescribed psychotropic medications; yet few studies have comprehensively analyzed the conditions for which these medications are prescribed. Depression is a disorder that affects millions of Americans and people around the world, robbing them of their productivity, creativity, ability to function effectively in their families; in some studies, one in five people, directly or indirectly, die due to depression. The disorder increases the likelihood of addiction, shortened life span, and of divorce and disability. Biologically based imbalance theories have long been posited as a basis for antidepressant medications. Followed and joined by genetic etiologies, these theories, although

largely unfounded, untested, and unproven, provide the foundation for medications sold by the millions of doses. The science is clear: There is no scientific substantiation that depression is caused by biological, chemical imbalances, defective genes, or that it is remedied in any significant way by available medications. Psychopharmacology interventions for depressive illness are not an effective stand-alone or first line treatment plan. On the other hand, there are effective behavioral interventions for the various types of depression.

With respect to antidepressants, the scientific evidence shows that this class of medication is not appreciably more helpful in treating depression than placebo^{8,9,12,139,142,146,151,157,158,159,162,168,169,170,171,174,177,178,183,179,181}.

The research on antidepressant medications shows they only work in a small minority of the most severely depressed patients, and then only on a minority of the depressive symptoms and syndromes. Research scientists and psychiatrists in Canada, Germany, Britain, the Netherlands, the U.S.A., as well as a host of other countries, have chronicled the limits of these medicines in the treatment, eradication, and prevention of future episodes of depression. the treatment, eradication, and prevention of future episodes of depression.

As early as 1990, NIMH joined researchers and psychiatrists in the world to finally conclude that patients treated with antidepressants relapse rapidly upon cessation of the drug, and that cognitive therapy-treated depressed patients fare better in the long term and have the highest "stay well rate." Antidepressants are therefore not curative of even the minority of symptoms they affect, with most relapsing within a short period of discontinuing the drug. Moreover, taking the medication actually builds up less and less ability to function without the drug, and the condition becomes chronic. ^{148,149,153} In other words, the longer one stays on this type of drug, the higher the likelihood of relapse. ¹⁸⁴

Leaders in the psychiatric field have noted that they, the government, and the industry are not really interested in the problems that these data point out, and is not likely to vigorously investigate them. ¹⁶⁰ The scientific data regarding the efficacy of antidepressants has been so poor that world leaders in psychiatry have publicly stated in major scientific journals and publications, calling the first-line use of these drugs everything from unscientific to magical thinking, myth, and wishful thinking. Others have looked at the data and concluded that the elevation of antidepressants to the level of the first-line treatment for depression is a hoax. ^{5,6,22}

Further, the side effects of these drugs include cardiac complications, metabolic complications due to significant changes in body weight, withdrawal, akathesia and motor abnormalities, sexual side effects, drug-induced violence, neuropsychiatric effects including insomnia, apathy, and mania. Serotonin Syndrome is a life-

threatening side effect that can be caused by drug interactions with other antidepressants. The long-term side effects of antidepressants include the induction of brain adaptations which may be depressogenic (cause depression) and pathogenic. Some animal studies tend to show that antidepressants modulate the expression of genes, Providing a basis for suspecting that permanent effects the long-term administration of antidepressant medications can have a negative effect on the glial cells of the brain or the brain in general. These drugs are therefore very much in the high-risk category of interventions.

Psychotherapy Is Effective And Without Side Effects

Psychotherapy approaches for depression are now well-established as effective first line treatments for depression and just as effective and, in many cases, more effective than antidepressants without the risk of side effects. In a review of the published research on psychotherapy and depression, the author concludes, "The results of these clinical trials, meta-analyses and reviews point to one inescapable conclusion: Psychotherapy works for the treatment of depression, and the benefits are substantial." In fact, when psychotherapy is compared to antidepressant interventions on the long-term, it outperforms antidepressants for both the severely and non-severely depressed patients 156.

Medications Can Control Only Some Symptoms Some Of The Time

Medication interventions as first-line treatments are potentially effective in controlling some symptoms in a minority of patients, but all have significant risk of dangerous side effects and drug interaction effects. Depressive spectrum disorders are disorders that have psychological, social, physiological, chemical, family and relational, occupational, self-regulation, and financial components. It is unrealistic and misleading to assume that an antidepressant can change and control all of these components and produce relief or a cure. When a person recovers from depression using skills learned in psychotherapy, neuroplasticity produces changes in the central nervous system from learning, and literally changes his brain structure and response pattern. Changes in self-esteem, self identity, and decision-making should not be attributed to an external element like a drug Again, there is no scientific basis to conclude otherwise.

According to Kirsch ^{159 p. 162}, "It is like learning to read, write, or ride a bicycle." He notes that patients have changed and have new skills that they can reuse as needed. Antidepressants only dampen or partially control some symptoms of the disorder and in a minority of patients, and therefore do not qualify as a "stand-alone" or a "first-line treatment." When such changes are attributed to a medication, they are misleading. Medications can only represent an adjunctive or second-line intervention, or a minor component of a realistic treatment plan.

Antidepressants research shows the medicine only works in a small minority of the most severely depressed patients, and then only on a minority of the depressive symptoms and syndromes.

There are No Laboratory Tests That Can Show A Chemical Imbalance

The basis for using medications to treat behavioral disorders rests upon a foundation that has yet to be scientifically established. When a medication is prescribed for depression, there is an implicit assumption that the brain is lacking a significantly less amount serotonin, for example. How does the physician know this? Does the physician have a test to substantiate this? Presently, there are no laboratory tests that can indicate any amount of neurotransmitters, which form the basis for prescribing antidepressant medications. In fact, there are no established parameters that indicate what is the "normal" amount of serotonin, or any other neurotransmitter that psychotropic medications are based upon. All of this is assumed and helps explain why different people react differently to these medications. It's a guessing game that is costly, ineffective, and sometimes harmful. Nevertheless, some advocates ask: Why do some patients respond to these medications? One factor that has been established is the placebo effect. Some people respond positively to anything even something that has absolutely no value, such as an inert starch.

Antidepressant medications represent the most frequent treatment for major depressive disorder. However, there is little scientific evidence, if any, that they have a specific pharmacological effect relative to pill placebo for patients with less severe depression. ¹⁵⁰ Leuchter ¹⁶³ and his researchers at UCLA examined the brain functioning of responders to selective serotonin reuptake inhibitors (SSRIs) compared to a placebo. After nine weeks of treatment for major depression using quantitative electroencephalography, they concluded that placebo responders showed a significant increase in prefrontal concordance (i.e., a measure of cerebral perfusion), whereas medication responders showed a decrease in this area. In an article published in Newsweek, the author concluded that the news about depression was "depressing" because the evidence is clear that they work no better than placebos and there was a "moral dilemma" in that how can 32 million people who suffer from depression be told that their medications simply didn't work? ¹⁴⁰

The question, of course, is do we continue to engage in and collude with drug companies and "morally conflicted" physicians simply to keep patients from learning their medications may be worthless? NAPPP thinks we should not. To do so is misplaced and harmful to patients, particularly when there are effective treatments available. The problem is that drug companies cannot make a profit on psychotherapy. Moreover,

insurers, who really do know that these medications are essentially ineffective, go along with the ruse and are part of the collusion because medications are cheaper than behavioral intervention.

With all the data pointing to the ineffectiveness of antidepressant medications, some might wonder: Why not simply give patients a placebo? Would it not be safer and less expensive to do so? If one is relying strictly on economic arguments, yes, placebos would be less expensive. However, depression is a serious disorder and can kill. Many people suicide because they are depressed. Placebos will not and cannot cure depression -- they just perform as well or better than medications.

To relieve or cure depression, the scientific data shows that:

- 1. Most people will respond positively to behavioral intervention. Typically, 13 sessions of cognitive-behavioral intervention will do it.
- 2. A smaller number will respond positively to medication along with behavioral intervention.
- 3. A smaller number of patients, a minority of about 12-15%, respond solely to medications.

The challenge is to discern who will respond best to which treatment. The most important factor is to obtain an appropriate evaluation and diagnosis. If a patient is going to be treated for depression, would it not be important to know that they actually are experiencing depression? Herein lies the real dilemma, both clinical and moral. The vast majority of patients are not evaluated or receive an appropriate diagnosis from a doctoral psychologist or psychiatrist before medications are prescribed. It is clear that those patients who do best with behavioral intervention do so relatively quickly. They do so because they have been correctly diagnosed and treated appropriately. Non-responders, who also have been appropriately evaluated and prescribed a medication and followed by a psychologist also do well for the same reasons, plus the addition of the placebo response. The minority of responders who do well on medications do so for many reasons. First, their response is simply a matter of luck -- a chance occurrence. Second, they may in fact be one of the group that do have a genetic variation. Last, this group may be the most responsive to the placebo effect. Nonetheless, the key issue for all

of these patients is to have an appropriate evaluation and diagnosis before any treatment plan is implemented. This ensures the best outcome and becomes the most cost effective in the long run.

Feelings Are Not A Diagnosis

Diagnosing feelings such as anxiety, depression, anger is not defining a psychiatric disorder or diagnosis, and often leads to inappropriate medication selection and application. To use the knowledge and findings of the available and updated science base, one must first start with accurate diagnoses. General medical personnel are ill-equipped and ineffective in accurately identifying, diagnosing, and effecting linkages with mental health services and specialists. And psychopharmacological intervention has ever demonstrated efficacy in changing personality or eradicating mental illness. The effectiveness of antidepressants diminish quickly, and the vast majority of patients treated with these drugs relapse soon after treatment. There is evidence that the longer the treatment with antidepressants alone, the more significant the relapses.

The brain has scientifically demonstrated autoplasticity and can change with training, experience, and specialized interventions, such as psychoeducation and behavioral intervention. Every patient and family suffering from serious mental illness deserves an accurate diagnosis from a doctoral-level psychologist and a comprehensive treatment plan to include behavioral intervention, family therapy and psychoeducation, behavioral case management, and appropriately selected and monitored palliative techniques such as medications (where indicated), crisis intervention, and psychiatric hospitalization (when indicated). Every hospital, primary care center, nursing home, and other healthcare facility should be required to staff doctors of psychology for the purpose of specialty diagnoses and treatment planning, and mental health service design and delivery.

V. Physicians Often Do Not Provide Patients With Important Information

When Prescribing Medications

Discussing and providing patients with the necessary information when prescribing medications should be a hallmark and ethical practice. However, many physicians routinely fail to provide important information to patients when they prescribe medications. By not providing adequate information, they hinder a patient's ability to adhere to the medication regimen and introducing more potential risk to the patient's health. The authors of the study graded physicians using a 5-point Medication Communication Index. The average mean score was 3.1 out of a possible 5, where 5 was the highest and best score. They found that only 62% of the necessary information about a medication was communicated, to patients. Only, 35% of physicians advised patients of the adverse effects associated with a medication. 185

The result of this failure to communicate places unneeded risk on the patient and contributes to the patient not improving. This leads to further prescribing of additional medications because the patient is not improving. This cycle of polypharmacy continues until something works, or the frustrated and ill patient seeks other help. A simple remedy that requires physicians to spend more time with patients winds up misusing resources and while subjecting patients to ineffective treatments. Patients who present with behavioral disorders typically have attention and focus problems, and are among the most victimized by this type of physician failure.

Off Label Prescribing And Drug Company Advertising

It is no secret that the pharmaceutical industry is garnering huge profits and is likely to make even more under what will pass as healthcare reform. Among the most profitable and growing segment of pharmaceuticals are psychotropic medications, and their use by physicians for conditions for which they were not developed or FDA-approved. For example, The Nonpartisan Center for Public Integrity reports that pharmaceutical companies spent more than \$855 million for marketing, which is more than any other industry, between the years of 1998 and 2006. True marketing expenditures, however, are hard to come by.

In 1996, the industry as a whole spent \$32 million on direct-to-consumer (DTC) antidepressant advertising. By 2005, that number grew to \$122 million. The figure for 2008 has not been reported, but it is clear that advertising does work. More than 164 million antidepressant prescriptions were written in 2008, totaling \$9.6 billion in U.S. sales. Today, whether in ubiquitous television commercials or magazine advertisements,

consumers are exhorted to tell their physicians the name and type of medication that they want. Physicians, for the most part, willingly respond. Yet, with respect to antidepressants, the latest science casts great doubt that there is any significant difference between any of the SSRI medications and, moreover, whether they really work as advertised. One obvious question is whether the ads are driving the incidence rate of depression, or is greater awareness of depression driving the increasing number or prescriptions? The answer to this question is important not only for its clinical significance, but also because it is important to the economics of healthcare reform.

Is Depression A Function Of Advertising Dollars Or Greater Awareness?

One could make the case that depression is being diagnosed more frequently today than a decade ago because of greater public awareness, and because primary care physicians have become the first-line providers of mental healthcare. However, study after study shows that primary care physicians, as a group, lack the expertise to diagnose depression as well as other mental disorders. Is9,190 In fact, patients who are clinically depressed receive less than 60% of the standard of care that organized medicine requires in their treatment guidelines. And, not just by mere coincidence, patients who are clinically depressed typically go for several years before getting the appropriate diagnosis and treatment from primary care physicians. This does not mean that primary care physicians are bad people or incompetent. Most are not. The problem is they just aren't skilled clinical psychologists and, problematically, the "training" they do get, typically comes in the form of a young, attractive drug sales representative.

On the other hand, why would an industry quadruple its advertising budget for a single class of drug if advertising was ineffective? These are not new facts but they are relevant. Psychotropic medications are proliferating. We call this the "Cerealization of Medications." The marketing strategy is no different than that employed by cereal manufacturers who line supermarket shelves with tens of boxes of the same sugar laden cereals. It's called getting and holding market share. Patients are being prescribed unnecessary medications and not getting the appropriate treatment because psychologists are being kept out of the treatment mix and because pills, in the short term, are cheaper than more appropriate and proven care.

Medical Psychologists Can Reduce Costs And Provide Needed Services

Very few primary care physicians use any established instruments to diagnose depression or to help them to manage this disorder. Many physicians have admitted that, if they do use some type of instrument, they do so primarily to enhance patients' acceptance of the diagnosis when they anticipated or encountered resistance to the diagnosis. The major reasons why physicians do not use any established diagnostic tools is primarily due to the competing demands for the physician's time, the unfamiliarity of the objective criteria of depression, and how the physician views the patient from subjective behaviors. Many physicians simply reinvent tests that have no application in the way physicians use them.

The use of medical psychologists, those trained in applying behavioral interventions to medical problems and clinical psychopharmacology, can be and are an effective solution to control the unnecessary rise and subsequent costs for psychotropic medications. It appears that psychologists are the only behavioral health profession speaking out against the proliferation and overuse of psychotropic medications. As trained professionals, we read the literature and understand its implications. We are specifically required as a condition of our license to know and understand diagnostic instruments. All doctoral-level psychologists are trained and have experience in psychological testing, their use, and interpretation. Where psychologists prescribe medications, we prescribe less. Our training as psychologists allows us to diagnose mental disorders quickly and accurately and we provide the most effective behavioral interventions when treating. Because medical psychologists rely less on medications than other practitioners, drug companies align themselves with psychiatry and other physicians against prescriptive authority for psychologists. The result is increased use and costs for medications and less effective treatment for patients.

So why do primary care physicians do it their way? Primarily, psychologists are not generally consulted because behavioral health has essentially been transferred to primary care. The bulk of healthcare dollars go to physicians. The behavioral health part of all healthcare expenditures is about 5%. Lastly, organized medicine wants to keep its turf intact. Anything that allows psychologists to practice to the full extent of our education, training, and skills is a threat to medicine. They are naïve in taking this approach because the role that a psychologist takes in the healthcare system with respect to medications is to modify downward or eliminate the number of medications a patient may take and we prescribe medications as a last resort. This is why drug companies support the move of behavioral health into primary care. They know that appropriate treatment will cost them money and profit. Patient care is only a consideration when it is profitable. Physicians are in the sole position of remedying the lack of care provided to patients.

VI. Reducing Harm and Healthcare Costs: A Review Of A Physician's

Unlimited License To Practice

Generally, physicians are licensed under what is termed an "unlimited" license. Underlying the intent of unlimited licensure is the expectation and requirement that physicians only provide those services for which they have received specific training and education. Unfortunately, there is no entity that can police or oversee that physicians adhere to the intent underlying the justification for unlimited licensure. As a result, unlimited licensure contributes to undue harm to patients, and is a public policy issue that needs to be addressed. There are few, if any, restrictions as to what they can practice under their scope of practice. With little risk of liability, physicians can incorporate into their practice whatever services that any other licensed healthcare professional provides. No other healthcare professional enjoys such protection in law. In fact, this concept was implemented at the turn of the last century, and is clearly out of date and out of touch with current knowledge. The justification for licensure of healthcare professionals is to protect the public. The justification by physicians for unlimited licensure was that rural America had so few physicians that they needed to provide a wide range of services, and limited licensure would result in patients being denied care. America no longer is an agrarian society, and unlimited licensure has not resulted in better patient care.

Psychologists, nurses, nurse practitioners and other healthcare professionals practice under what is termed a "limited" license. This means that these professionals can only practice what is stated in their scope of practice law. Typically, they can legally provide services that they have specific training, education and experience and that fall only into the categories of services that are specified in their practice law. The concept of limited licensing was designed to protect the public from practitioners who are not qualified to provide a specific service due to lack of training, education and experience. It is easy to see that limited licensing is a very good way to achieve this goal. The question is: Why are physicians granted this exception when it is clear that the lack of specific behavioral health training and education significantly contributes to ineffective treatment, runaway medical costs, and harm to patients?

The Federation of State Medical Boards

The Federation of State Medical Boards (FSMB) is a tax-exempt organization representing the 70 medical boards of the United States and its territories. The mission of the FSMB is "To continuously improve the quality, safety and integrity of health care through developing and promoting high standards for physician

licensure and practice." The FSMB produced a study specifically relating to the problems inherent to the unlimited licensing of physicians. In its report, the FSMB concluded:

"While state licensure boards may establish a rigorous procedure for granting initial licensure, in virtually all states, it is possible for a physician to practice medicine for a lifetime without having to demonstrate to the state medical board that he or she has maintained an acceptable level of continuing qualifications or competence." 193

Interestingly, in its response to the FSMB, the Association of American Physicians and Surgeons (AAPS) advocates that one way to improve the quality of care would be for physicians to employ evidence-based principles in diagnosing problems and prescribing remedies. ^{194,195} NAPPP agrees with the AAPS, and we would like to see this implemented particularly with respect to patients receiving treatment by primary care physicians for behavioral disorders.

The AAPS also addresses many of the concerns that NAPPP has with respect to the lack of behavioral health education and training with non-psychiatric physician care. They cite: 1) The general poor quality of medical school applicants; 2) The small amount of time that physicians have to devote to patients; 3) The shortage of American-trained physicians and the increased reliance on foreign-trained physicians with limited language skills. NAPPP agrees with all of these factors. In fact, these issues impact patients suffering from behavioral disorders more than any other malady. Behavioral disorders and their treatment require clear and specific training and intellect, clear communication, a clear knowledge of the patient's culture and a significant amount of time to be spent with the patient.

Moreover, for the past 15 years, psychiatry, as an example, has had to recruit foreign-born residents to fill their declining training slots. All of these issues are present in a primary care setting where only minutes can be provided to the patient by a physician with *little or no training in behavioral health*, who increasingly is foreign born and trained, who may possess limited language skills, and cultural understanding.

The Medical Home Model

The concept of the "medical home" model is one in which a primary care physician essentially is responsible for the overall health of a patient and arranges for the total needs of a patient to be met. This means getting the appropriate referrals to specialists and other healthcare professionals when necessary. Ideally, the model calls for many specialists and healthcare providers being housed under the same roof. The concept was initially formulated by the American Academy of Pediatrics (AAP) in 1967. In 2002, AAP issued a formal policy statement expanding the concept to include accessibility, continuity, and comprehensive, family-centered, coordinated, effective care. The American Academy of Family Physicians (AAFP) and the American College of Physicians (ACP) have issued statements, separate from the AAPS, on their own models for improving patient care. What is important about the medical home concept is that two of the guiding principles are based upon having physicians refer patients to an appropriate provider for treatment and employing evidence-based medicine to provide the best treatments available based on objective research. 195a

No one could argue or disagree that the "medical home" concept has the potential for improving patient care and outcomes. The problems, as has been pointed out throughout this document, is that physicians have accepted the medicalization of behavioral healthcare, prescribing medications for mental, emotional, and behavioral conditions when the best data shows medications are the least effective. Most primary care physicians prescribe medications without an appropriate evaluation and diagnosis by a psychologist or psychiatrist. They prescribe medications off-label for conditions for which there are proven behavioral treatments. One of the more egregious and dangerous practices is prescribing antipyschotic medications for patients presenting with relatively simple sleep problems.

Moreover, if physicians were committed to employing evidence-based medicine, few, if any, would be prescribing antidepressants and the host of psychotropic medications now prescribed. The objective clinical data on these medications, at least those that are published and have not been suppressed by drug manufacturers, show that, on the whole they are not effective. Then there is the issue of expecting a primary care physician to be a supervisor not only of the patient's care, but also of the independently licensed professionals who provide treatments to patients.

In order to be an effective supervisor, as opposed to an administrator, primary care physicians would have to have specific knowledge of the presenting problem, but also know which provider and which treatment would be the safest and most effective for the patient. In our opinion, this is asking too much of primary care physicians. They would need specific education and training on when and to whom they should be referring a patient. This type of training, while fundamental in the training of psychologists and other healthcare professionals, is relatively absent from medical training and practice. Yes, primary care physicians know when to refer to a medical specialist, but they lack the knowledge base when a referral is needed to a healthcare

provider outside of medicine. This is the rationale behind the medicalization of all health and health-related maladies. If there is a problem, the assumption is that it is a medical problem and there is a medical solution.

Physicians Are Not Trained To Review Drug Company Research

It has been widely reported that pharmaceutical companies many times will report only "positive" results of clinical trials concerning their products. They routinely will omit the non-findings or negative findings in which a new drug or procedure may have proved more harmful than helpful. The basic motivation for this practice clearly is the financial interests that pharmaceutical or medical device companies have when they are the source of a study's funding. For example, pharmaceutical maker GlaxoSmithKline suppressed and hid results from several clinical trials that not only failed to show treatment effectiveness for off-label use of its SSRI among children and teens, but also showed possible increased risk of suicidal tendencies in this age group.

Another example of how drug manufacturers fool physicians and the public can be seen with the drug Abilify. The antipsychotic drug Abilify is an FDA-approved medication for treating schizophrenia. The FDA later approved it to also treat mania and depression. Yet, the more important information about this drug is that there is no real scientific evidence that it contributes to any reduction in symptoms related to depression. Moreover, this is an antipsychotic medication that can cause death in the elderly who have dementia. It can also cause a significant and dangerous increase in blood sugar, resulting in both cardiovascular problems and diabetes.

Physicians rely upon these reports from drug companies to make important clinical decisions. The problem is that the average physician has little, if any, research experience or training in statistical methodology. As a result, physicians who lack this training accept bogus findings about the efficacy of these drugs and prescribe them to patients. With respect to behavioral disorders, cases in which drug manufacturers apparently find it easier to suppress and manipulate negative data, these patients are put at high risks when prescribed many of these medications. In comparison, psychologists are trained in all aspects of research and statistics starting in undergraduate school all the way through their doctoral training. Using statistics to hide, manipulate or simply lie is easily detected by psychologists.

The practice of modern medicine centers on drug therapy. How many patients visit a physician and come away without a prescription? Not many, if at all. Given this reality, does it make any sense for physicians to have an unlimited license to prescribe when they cannot even demonstrate a working knowledge in how to detect statistical manipulation of the studies that they rely upon to prescribe these medications? We think not. Limited

licensure can reduce many of the problems and risks due to faulty prescribing because physicians will have far less medications to learn about. Risks due to of-label prescribing will be reduced. Moreover, the expenditures for relatively worthless medications will decrease. Everyone is a winner with limited licensure: Physicians, the public, patients and taxpayers all gain.

The NAPPP Proposal

The remedy is simple: Medical licensure boards should subject physicians to the same limited licensing under which every other healthcare professional provides services. Physicians should only provide services when they can specifically demonstrate that they have had and passed the requisite education as determined by their respective medical and specialty boards. They should be limited to providing services only in their proven fields of specialization. This also means that physicians should be required to refer patients to qualified specialists both inside and outside of medicine. Limited licensing would require that physicians could not prescribe medications for conditions outside of their specialty. This would allow physicians to concentrate on the medications to treat conditions that they legally are able and licensed to treat.

Presently, any physician can prescribe any approved medication and can also prescribe medications for conditions for which the drugs are not FDA-approved. For example, we see many physicians prescribing harmful anti-psychotic medications such as Zyprexa and Seroquel to patients complaining of sleep interruption. These anti-psychotic medications have grave side-effects including significant weight gain, cardiovascular problems, diabetes and heavy sedation. When used to treat sleep disorders, which even the FDA states are best handled by behavioral intervention, non-psychiatric physicians are exposing their patients to harm that far exceeds the benefits of sedation.

Limited licensing is not an intrusion on professional autonomy. Psychologists have worked under these restrictions since our inception as licensed providers. In fact, psychologists are the only healthcare practitioners who must determine that a patient's condition is not one that is physical in origin and, if it is physical, must be referred to a physician for treatment. Only after ascertaining that the patient does, in fact, present with a behavioral disorder, can we proceed to treat. We do not see this as an intrusion to our professional autonomy.

We accept limited licensure as a safeguard for patients and because it is the rational and ethical thing to do. We accept scope of practice limitations and seek legislative changes only when we can make the case that we are able to provide a new service and are qualified to do so. Yet primary care physicians are put in the untenable

position where they must treat patients for behavioral disorders for which they have little or no training. This situation does not bode well for patient safety, and exposes primary care physicians to increased professional liability, a contributing factor to malpractice insurance and awards and increased healthcare costs.

One would think that primary care physicians would appreciate being relieved from the liability they are subjected to when treating patients with behavioral disorders. Yet organized medicine resists changes to scope of practice of other healthcare professionals under the guise of patient safety. This resistance is odd, because primary care physicians routinely prescribe medications for behavioral disorders without the necessary education and training for safe and successful outcomes. These patients are at risk, and pay a heavy price for the assertion that physicians have the ability to diagnose and treat any malady even though they do not have the expertise to do so. NAPPP believes that specially trained medical psychologists would provide this relief to physician colleagues by integrating behavioral health into primary care, resulting in physicians limiting their care to their specific expertise.

Professional Autonomy

Clearly, physicians go through a rigorous training process to obtain their initial medical degree. But so do other healthcare professionals. Professional autonomy is a concern for all of us. There must, however, be a balance between the patient's interest and professional autonomy. To subvert treatment and ethical considerations because of economic issues, or the interests of corporations such as drug manufacturers and insurers, is not a balance. It is sabotage and represents a wholesale disregard for the reasons one enters healthcare. As consumers and providers, we are stakeholders and our concerns also must be heard. America has become a culture that is reactive to events only after disaster strikes. NAPPP believes that the deaths of more than 100,000 patients a year from medication errors qualifies as a disaster. We believe that we must be proactive. Following the concerns presented in the FSMB report is one way to produce a balanced remedy. Limiting scope of practice to areas of expertise developed through education, training, and experience is another and, in our opinion, an additional option.

Yes, a license is an intellectual property right and should be protected. Nevertheless, a license is a state-authorized privilege that can be changed. This privilege can be properly taken or modified, as long as there is a process safeguarded in law. It is unacceptable for physicians to resist and fight against a limited license while at the same time advocating for malpractice reform that limits their liability for negligence. This is a prime example of wanting to have one's cake and it eat it, too. Quality and safety are improved by stated limitations.

Competition also can improve quality and decrease overall healthcare costs. Organized medicine needs to become part of the solution and not remain a major part of the problems plaguing healthcare.

Concluding Statement

There is evidence that physicians practicing outside their education and training contributes to a system in which patients are not being appropriately served and are being subjected to undue harm. Limited licensure of all healthcare providers to practice within the scope of their education and training can improve competence, treatment outcomes, and greatly decrease the cost of healthcare while raising the standard of care provided to patients.

VII. Medicating America's Children

NAPPP is concerned about the increased prescribing of psychotropic medication in the child and adolescent population. A very recent study new study from Rutgers University and Columbia University shows that prescriptions for antipsychotic medications to children aged 2 to 5 years doubled between the years 1999-2001 and 2007. The top-selling medicines in 2008 were anti-psychotics for schizophrenia and bipolar disorder with \$14.6 billion in sales. The studied group was a population of privately insured children. Moreover, the age of children being medicated with psychotropic drugs is getting younger and the number of children being medicated increasing every year. These same researchers produced a previous study in a population of children enrolled in a government Medicaid program. They concluded that children seen by physicians insured under Medicaid are about four times as likely to be prescribed an anti-psychotic medication.

What is more problematic about this growing practice is there appears to be little evidence, if any, that these drugs are effective in this population of patients. Physicians, on the other hand, seem unconcerned about the lack of evidence or effectiveness of these drugs. They are aware, however, that children are not part of the population included in clinical trials, so why the rush to prescribe wholesale these potentially dangerous medications to such a vulnerable population? This is an important question. What we do know is that these drugs are dangerous in adult and aged populations. Given the lack of data, can we rationally infer there is a great likelihood that danger extends to children? We believe we can.

The Role Of The Federal Drug Administration (FDA)

The manifest role of the FDA is to approve the use of medications, medical devices and other drugs for their use in medical treatment. It is supposed to be both a licensing agency and a watchdog to protect the public from dangerous drugs and devices. Few would argue that the FDA has accomplished or achieved its stated mission. The FDA is essentially controlled by the drug industry. Its overview of medications and the research supporting manufacturer's claims to market these drugs simply are appalling. Drug manufacturers have been charged with hiding, obscuring and falsifying the results of clinical trials. The efficacy of Prozac could not be distinguished from placebo in 6 out of 10 clinical trials. The FDA, however, was quick to authorize its use. When introduced, Prozac was almost immediately prescribed to children. Even though many researchers pointed out to the FDA that many antidepressant trials have serious methodological weaknesses, the FDA still approves these drugs. Moreover, the FDA was well aware there is an industry practice in which negative results are less likely to be published than those with positive results.²⁰¹

This practice makes it difficult to ascertain the effectiveness or meaningfulness of studies actually showing differences or improvements to existing drugs. It is because of these issues that NAPPP questions the specific efficacy of antidepressants relative to pill placebo, particularly when these drugs are prescribed to a vulnerable population of children. The FDA needs to perform its job more effectively. Physicians, on the other hand, need to be less "pad happy" when prescribing these drugs. Patients will be better served by a physician who looks at the underlying research before using his patients as guinea pigs for the drug companies. Better yet, refer these patients to a psychologist, who is more qualified to make an appropriate diagnosis and who will recommend a treatment plan based on the latest outcome research.

Does ADD/ADHD Qualify As A Real Diagnosis?

Before even considering ADD/ADHD as a medical problem, it seems to us that the current use of psychostimulants also should be scrutinized as a treatment option. Many of the patients are treated after being referred for ADD/ADHD had long-standing but undiscovered sleep disorders. Not surprisingly, psychostimulants do produce gains in performance with these patients. One would expect these results if a sleep disorder is present. For too long, many have accepted that ADD/ADHD are established conditions that need medical as opposed to behavioral treatment.

To date, not a solitary cause has yet been identified for ADHD. ADHD will likely prove to be an umbrella term for a number of behavioral and/or neurologically based disorders. Furthermore, there hasn't been any identified cause specific to ADD, leaving open the likelihood that ADD may be a catch-all condition. The National Institutes of Health Consensus Development Conference and the American Academy of Pediatrics²⁰⁴ agree that there is no known biological basis for ADHD. The more one reviews the literature on hyperactivity or ADD, the less certain we are about what it is, or whether it really exists as a stand-alone disorder. So, at issue is not only the question of drugs for the treatment for attention-deficit problems, but also the question of why physicians prescribe these medications for children when other factors may be the cause of the problems. In May 2010, The American Medical Association issued a news release on this specific issue, detailing the numerous comorbidity conditions found along side ADD/ADHD. In that release, several researchers made the following statement: "Among children and adolescents with attention-deficit/ hyperactivity disorder, more than 80

percent had a diagnosis of at least one other psychiatric disorder, most commonly oppositional defiant disorder and conduct disorder, according to new research presented at the American Psychiatric Association's Annual Meeting. (AMA News lease, May 26, 2010)"

It is important to note that the conditions specified in the news release are behavioral disorders. Moreover, the issue is whether the condition labeled ADD/ADHD is a primary diagnosis or a symptom related to other, established behavioral disorders. It appears that the latter is the case, and raises to the question of why these children are being treated with drugs when they more than likely are experiencing a behavioral disorder amenable to non-drug treatment.

Children Diagnosed With Attention Deficit Problems

In 2007, the FDA issued an administrative order that requires that all makers of ADHD medications to develop and provide patients with Medication Guides. The guides must contain and warn patients, in clearly readable language, to possible heart and psychiatric problems related to ADHD medicine. The FDA took this action because of complaints and the increasing data that concluded ADHD patients with heart conditions had a higher risk of strokes, heart attacks, and sudden death when using these medications. The psychological symptoms associated with these drugs include hearing voices, having hallucinations, becoming suspicious for no reason, or becoming manic. The FDA found that these symptoms occurred in patients who had no history of behavioral disorders. Ritalin is a psychostimulant medication prescribed primarily to children.

In addition to Ritalin, the non-amphetamine based medication prescribed to children with ADHD is Strattera. The FDA warns that children and teenagers who use Strattera are more likely to have suicidal thoughts than children and teenagers with ADHD who do not use this medication. Child who use Strattera must be supervised and their behavior carefully monitored. Symptoms may develop symptoms suddenly, and they are a serious threat to the child.

These medications have become ubiquitous in schoolyards across America. In 2001, the average total annual expected cost per patient was \$1,631 for Concerta, and \$2,080 for Ritalin. Adderall, another widely used psychostimulant cost \$2,232 per patient. ²⁰⁵ In 2003, psychostimulants had sales of \$2.4 billion. By 2008, sales of Adderall reached \$1.1 billion while sales of Starttera were \$479 million. ²⁰⁶ Clearly, these medications are big profit-producers for the drug companies, but are dangerous when prescribed to children. The FDA has been derelict in its duties and too industry-friendly. The FDA appears unwilling to challenge the drug companies, no matter how demonstrable the research on the dangers and ineffectiveness of these medications.

The FDA, as well as every pediatric physician group, are aware of the effectiveness of non-drug treatment for attention-deficit problems. ²⁰⁷⁻²⁰⁹ They also are aware of the problems with the long term use of

psychostimulants.^{210,211} These medications can change brain structure and inhibit growth in children. Moreover, these drugs are sold on school grounds as a "drug of choice" because they are so easy to get.^{212,214} It seems that these drugs are viewed by so many professionals as potentially dangerous to children that some in the psychiatric community prefer that marijuana be prescribed instead of psychostimulants.

An important study by Cummings and Wiggins published in 2001,^{214a} looking at children and adolescents diagnosed with ADD/ADHD and prescribed psychotropic medications when entering treatment, showed a dramatic reduction in the use and amount of medications at the conclusion of treatment when these patients were provided with behavioral interventions. Cummings and Wiggins advocated for a collaborative model between primary care physicians and psychologists to bring about a rapid stabilization of the patient's condition while at the same time reducing or eliminating medications. This was not a small study. The records of 168,113 episodes of children and adolescents over a four-year period, who received behavioral intervention while on medication, was reviewed for the study. At the conclusion of treatment, only 13% of the children remained on medications contrasted with about 67% of children and adolescents who were on medication when they first entered behavioral treatment. More importantly, 95% of the 5 to 6 year olds and 92% of the 1 to 17 year olds did not need any medication at the end of treatment. This success was achieved with an average of only six sessions of behavioral intervention. The implications for cost control are obvious. However, the rapid stabilization of symptoms without medication and over such a short time is impressive and important.

Contrast these results with the meager clinical trials reported by the drug manufacturers of psychostimulants. Although this data comprises a large number of data points, both the number of prescriptions for psychostimulants continues to increase along with the costs for these medications. In the same time period, behavioral intervention has significantly been diminished. But even as the use of psychostimulants is questionable, some psychiatrists have called for adding marijuana to be used in treating attention deficit symptoms.

Recently, an article appeared in the New York Times ²¹⁵ reporting on the use of marijuana for treating children with ADD/ADHD. The Times article is just one of several that have been popping up since medical marijuana initiatives have been passed a handful of states. Initially, the use of marijuana to treat pain and suffering related to the side effects of chemotherapy and to increase appetite in HIV patients were used as the rationale for the medical marijuana initiatives. Right now, however, a patient can get a prescription for almost any type of complaint. Anxiety, depression and other behavioral disorders are now at the top of the complaint list. Thus, it

is not surprising that more disorders are being added to the list.²¹⁶ How safe can a drug be when psychiatrists are advocating that these patients would be better off with marijuana?²¹⁷

Childhood Bipolar Disorder

Psychostimulants are not the only drugs to which children and adolescents have been subjected. Increasingly, children as young as 5 years old are being diagnosed with bipolar disorder by physicians without even a thorough evaluation by a psychologist. Every psychologist has had a patient who was diagnosed by a psychiatrist or physician as having "Bipolar Disorder." In the case of children, adolescents and young adults, this label appears more frequently than any objective analysis shows it should. A 2005 study by Jennifer Harris, a clinical instructor at Harvard Medical School, published an article in the Journal of the American Psychiatric Assn. that clearly shows that much of the evidence that juvenile bipolar disorder is as widespread as currently diagnosed is highly suspect. A major finding of this research is: "Diagnoses for children are generally far less precise and meaningful than they are for adults. These uncertainties should be discussed with patients and their families, particularly when bipolar disorder is being considered as a "diagnosis." Dr. Harris' alarm is not a singular call that questions the overdiagnosing of bipolar disorder. 218,219,220.

Frequently parents have no place to turn to get appropriate information when their child's behavior appears different. Many articles on bipolar disorder available on the Internet imply that a simple pill prescribed by a psychiatrist will make everything better. What these articles do not tell parents, or anyone else for that matter, is that the physician most likely has received many "incentives" for prescribing medications as opposed to ordering an evaluation to find out if the child really does have bipolar disorder. Thus, getting labeled with a bipolar disorder diagnosis has increasingly been part and parcel of medical practice.

Typically, by the time psychologists are recommended, patients are resistant to make appointments because, as the truism goes, "psychologists do not prescribe medications." In those infrequent cases in which a psychologist is consulted, we become the referral source for psychiatrists and we lose the patient. I am not suggesting we lose the patient because psychologists cannot prescribe medications. We lose the patient because psychologists typically are not part of the treatment process. The ability to prescribe not only gives one control over the treatment process but also the ability NOT to prescribe. Many physicians and parents simply do not understand this, as they want relief for their children and are not provided with the information that physicians often withhold. As a consequence, patients are reluctant to listen about alternative diagnoses or alternatives to medications. Physicians gain, patients lose. It is not uncommon for patients and parents to hear that, "You must

take this pill for the rest of your life. Bipolar is a lifetime diagnosis." Imagine, some people take solace in finally getting a diagnosis before realizing how desperate they were that getting a lifetime diagnosis of mental illness made them happy.

Then reality sets in. Most psychiatrists these days prescribe Abilify for bipolar disorder. Yet, Abilify, as is true of most or all psychotropic medications, has not been tested in children or teenagers. These are serious drugs, and a 15-minute session or shorter that leads to a lifetime prescription is patently absurd and unwarranted. Psychologists can provide a proper and appropriate diagnosis that can spare parents and their children a lifetime of misery. We are specialists at looking at differential diagnoses. We can do better because we are not standing in line at the drug company counter waiting for a handout. As to cost-effectiveness, having an appropriate diagnosis is key to controlling healthcare costs. Bipolar disorder is now replacing the pediatric diagnosis du jour of Attention Deficit Hyperactivity Disorder. NAPPP does not think that there is any absence of a connection between the increase in these diagnoses and the push by drug companies in the psychiatric and medical communities.

NAPPP believes that ceding ground to physicians at the expense of our patients is unacceptable. Psychologist specialists need to be part of the treatment process. To get this, we need to have the ability to question medications as being the first and only consideration in a treatment plan. There are just too many psychotropic medications being prescribed for our children and for the wrong reasons. Medicine will never admit to this, because it is part of a drug distribution system that maintains its status and provides physicians with too many perks and incentives to prescribe medications. We need to change this process. Medicating without thorough, professional diagnosis and research into alternative treatments is not only wrong, but abusive to the patient. Medications may be necessary for some patients, but their irresponsible overuse is a serious problem.

Some solutions, which NAPPP endorses, is to regulate when and how some of these medications are used. We advocate eliminating ads for prescription drugs from television and magazines. We did this for alcohol because, as a society, we recognize that advertising is directly related to substance abuse. Also, physicians should be empowered and mandated to better inform parents of the possible harms many drugs can cause their children, and that no medications will be prescribed unless there is a thorough evaluation by a qualified, doctoral-level psychologist. Physicians need to be trained and directed to shift more of their concentration on the underlying causes of behavioral disorders in children. Today's society can be very difficult for many people. Stress can produce many symptoms that can lead to many problems. Learning to manage stress is a long-term solution.

Medications are short-term, at best. Medicating a child without a substantial evaluation should never be equated with good medical treatment, counseling and professional guidance.

Even Fetuses Are Not Safe From The Misuse of Antidepressants

The use of antidepressant medication is commonly prescribed for pregnant women. The use of these drugs during pregnancy is based upon the false assumption that they are safe to the fetus and the mother. A recent study, however, challenges this assumption.²²¹ Women who are pregnant and who are prescribed Selective Serotonin Reuptake Inhibitors (SSRIs) may increase their risk of having a miscarriage by 68 percent. Clearly, physicians strive to relieve a patient's symptoms. They typically justify the use of antidepressants in pregnancy invoking the idea that, while taking antidepressants during pregnancy may pose health risks for the fetus, stopping may pose risks for the mother.²²² Overall, drug manufacturers' studies conclude that the risk of birth defects and other problems for the fetus is low, but these studies may be suspect because manufacturers are notorious for downplaying and even hiding studies that show harm. Few medications have been proved safe without question during pregnancy, and some types of antidepressants have been associated with health problems in newborns.

Although SSRIs comprise similar compounds and act similarly, they seem to produce a different set of problems to newborns. Lung problems, septal heart defects; brain and skull abnormalities, and abnormalities of the abdominal organs have been reported with SSRIs.²²³⁻²²⁵ Tricyclic antidepressants and Monoamine Oxidase Inhibitors, two other classes of drugs used to treat depression, also present significant risks to newborns.²²⁶ If medications were the only alternative to treat women who are pregnant and severely depressed to the point where they were a danger to themselves or their fetus, then perhaps some of these risks would be acceptable. However, there are available behavioral treatments that work well and pose no risks to mothers, the fetus, or the newborn. Moreover, since primary care physicians have such a dismal record diagnosing depression, there is no reason to believe that OBGYNs are any better at evaluating and diagnosing behavioral disorders.

What appears to be the case is that physicians, with some exceptions, no matter their motivation to relieve symptoms, simply are not up to the task, and are putting their patients and newborns at risk when they prescribe antidepressant medications in and out of pregnancy. Consequently, every population is at risk when behavioral healthcare is seen as a "medical" disorder and treated by physicians who are not trained in behavioral health or are not inclined to refer to a psychologist, who are trained to evaluate, diagnose and provide treatment to these vulnerable populations.

VIII. Patients Deserve To Be Evaluated And Treated By Real Doctors

It is reasonable for patients to be confused when trying to decipher the many types of professionals who provide behavioral health services. One thing is clear, however: There are distinct differences between how these professionals are trained and the services they are legally allowed to provide. Notably, the most confusion is between a psychologist and a psychiatrist. A psychologist is a doctor-level behavioral healthcare provider who received his doctoral degree from a university or professional school of psychology. Psychologists are not medical doctors. Psychiatrists attend medical schools and, upon graduation, typically complete a residency in psychiatry. However, a physician may practice as a psychiatrist without any additional training beyond medical school. Both professionals have doctor's degrees.

Psychologists typically hold undergraduate and postgraduate degrees in psychology, in addition to their doctoral degree. Psychologists complete residencies in behavioral health. Psychiatrists typically complete residencies in treating behavioral disorders with medicines only. It is uncontested, however, that psychology doctors have the most extensive training and experience in treating, assessing, researching and objective diagnosing of behavioral disorders. Doing a Google search on each profession's contribution to knowledge of the human brain yields the following results: There are 4,850,000 citations for psychology and 1,620,000 for psychiatry. This does not mean that psychiatrists are less capable than psychologists. This simply suggests that psychiatry has generally morphed into a limited practice of prescribing medications. Most psychiatrists do not provide therapeutic services beyond medications. ^{227,228} Depending upon the state where both are licensed, psychologists and psychiatrists provide services both in inpatient and outpatient venues. The behavioral health services include treatment, evaluations, and prescribing of medications.

Both psychologists and psychiatrists can obtain specialty certifications, and most do. Psychologists also specialize and receive certifications and additional education and training in a wide array of specialties, including clinical psychology, neuropsychology, child psychology, medical psychology, family psychology, forensic psychology, gerontology, psychopharmacology and many others. Psychiatry also has these specialized areas of training. To obtain these specialties, both professionals must have additional education, training, supervision and testing. Psychologists and psychiatrists can receive board certification for their additional training. Non-doctoral level personnel cannot be board certified in any specialty area of practice. These

personnel "specialize" by virtue of on-the-job training. There is no testing or other objective means to assess their claims of specialized training.

The following is a comparison of the training and services provided by different practitioners who provide behavioral services.

Licensed Clinical Social Workers (LCSW)

A Licensed Clinical Social Worker generally possesses a master's degree in social work. LCSWs have experience in social and human services; clinical social work includes providing services in the fields of medical and public health, families and children or substance abuse and mental health. The National Association for Social Workers, www.socialworkers.org, reports that most states require a master's degree in social work as a prerequisite for licensure. In addition to a master's degree, obtaining a license for social work typically requires two years of intern experience and a licensing exam. Some states provide a different type of license for those social workers with undergraduate-level degrees. LCSWs provide many important services to rural America and to underserved populations in urban areas. They are highly skilled clinicians and may very well be the foundation for the mental health system due their large numbers and the areas they serve. While LCSWs do provide many important services, they are much more limited in their scope of practice compared to psychologists and psychiatrists.

There Are Many Types Of Counselors

Counselors are non-doctoral level providers. They work in a wide variety of community venues. Their duties vary greatly depending on their scope of practice law. Typically, counselors will have completed a one-year post-baccalaureate degree. They cannot provide services to Medicare or Medicaid patients. They do not have hospital privileges or are allowed to provide services beyond counseling. Many are allowed to use the title "psychotherapist," but their scope of practice law generally does not allow for psychological testing, evaluations or treating all but the least serious problems. Counselors, as the name implies, are not behavioral healthcare providers or specialists.

Counselors employed in educational, vocational, and school settings provide individuals and groups with career, personal, social and educational counseling. School counselors work with students, other individuals and organizations to promote the academic, career, personal, and social development of children and youth. School

counselors help students to select academic and career goals. Counselors also advise students. Some counselors specialize with students who have academic and social development problems or other special needs.

Marriage And Family Therapists

Marriage and family therapists (MFTs) are non-doctoral level providers. MFTs, as their title implies, provide services to individuals who are having difficulties in their relationships. MFTs enhance communication and understanding for families and deal with family and individual crises. They provide their services to individuals, families, couples, and groups. Marriage and family therapy differs from traditional therapy. Much less emphasis is placed on an identified psychological conflict. MFTs focus on looking and understanding their clients' interactions within their existing family or the relationship's environment. Marriage and family therapists also may make appropriate referrals to psychologists and other doctoral-level professionals.

Substance Abuse Counselors

Substance abuse counselors generally have limited, specific training and are considered paraprofessionals. These counselors work with people who have problems with alcohol, drugs, and other addiction problems. They seek to help people to identify behaviors and problems related to their particular addiction. Counseling can be done on an individual or a group setting. They are trained to assist in developing personalized recovery programs that help to establish more positive behaviors and coping strategies. Often, these counselors are former patients who were addicted to alcohol and drugs. Many counselors are part of a team of community outreach professionals aimed at preventing addiction and educating the public.

Less Training And Experience Means More Profit For Insurers

Insurers Prefer Less Expensive Providers

Since the penetration of managed care as the gatekeepers to healthcare, behavioral health services have been the most negatively impacted. One of the earliest studies on the impact of managed care on mental health services found that immediately after managed care became the gatekeeper for behavioral health services, costs dropped 40%. The decreased cost was not due to greater efficiencies. Although some proportion is attributed to both delays and denials of services, the single contribution to the decrease in costs is due to insurers using counselors and other non-doctoral level personnel in place of psychologists and psychiatrists. Typically, non-doctoral level counselors cost about 40% less than psychologists or psychiatrists. What is important about this development is not that counselors work for less and are cheaper. The fact that they do clearly has an economic impact for the

profit status of the insurers. The real impact, however, is on quality patient care. Counselors have significantly less education, less training, and less experience. They are not legally able to provide a wide range of behavioral health services and, yes, they do cost less. It is not an unreasonable conclusion to state that much of insurer's profits are made from behaviorally ill patients as they employ cheaper labor for services.

As early as 1992, managed care companies and insurers began reducing behavioral health services using the concept of "utilization review". The concept is simple. Hire a team of people who have never seen the patient and give them the authority to "review" and approve requests for services. Much of the time, the reviewers are not professionals in the area of expertise as the requestor of the services. Utilization reviewers have comprised counselors, clerical workers, nurses and primary care physicians. All of these groups have the authority to both challenge and approve behavioral health services requested by a psychologist or psychiatrist. From the very beginning, managed care and insurers have developed so many practices to reduce, deny, and delay behavioral health services, all at the expense of patients and for increased profit. ²³¹

These healthcare mega-companies continue to use these practices, citing the need to control costs. A U.S. Surgeon General report on mental health²³² states:

"Private health insurance is generally more restrictive in coverage of mental illness than in coverage for somatic illness." (Chapter 6)

The question is why? The cost of healthcare for non-behavioral health services comprises 95% to 96% of total healthcare expenditures. In 1999, when managed care essentially completed its penetration into healthcare, that number was around 10%. It defies logic and mathematics to conclude that services that comprise 10% of expenditures require practices to reduce costs, while the remaining 90% is not subjected to the same level of cost-cutting. It is this type of behavior that has been the impetus for mental health parity legislation. A Rand Corporation study commissioned in 1998 to evaluate the real costs of mental health services to aid Congress in analyzing data for parity legislation concluded:

"The assumptions used during the parity-legislation debate had substantially overstated the actual cost of mental health services under managed care.

Unlimited mental health benefits under managed care cost virtually the same as capped benefits: The average increase was about \$1 per employee compared

with costs under a \$25,000 cap, which was a typical limit in other existing plans." ²³³

Thus, employing less thoroughly trained counselors, utilization review teams, delays and denials of services are all unnecessary and have no relationship to cost containment. What these tactics do show, however, is that insurers and managed care companies engage in very complicated, albeit useless tactics that deny behavioral healthcare services to those in need for reasons unrelated to care, simply to increase their bottom line. They employ less-trained providers as part of their strategy to increase profit.

Delaying Services Through Phantom Panels

One of the tactics managed care companies and insurers use to delay and deny services is the use of phantom panels of providers. These companies simply list names of providers who either have resigned from the panel or have never even requested to be on the list of providers.²³⁵ Patients are given these lists when they request services. The problem is that phantom providers do not provide services because they are not available.

Patients are then forced to wait long times to be seen by the few real providers or abandon seeking treatment. When they persist, patients are forced to accept treatment by a non-doctoral level provider, which, of course is what the company really wants. These patients receive no real initial assessment because counselors are not able to provide these services. Social workers can do an adequate evaluation, but these companies typically do not authorize or reimburse for evaluations of behavioral health patients. As a result, patients are provided substandard care and these companies add to their bottom line through phantom panels. Many state agencies have looked into this practice and have warned these companies against their use. However, every company still uses phantom panels. Cummings, et al, produced an excellent analysis of the economics and history of behavioral healthcare and managed care.²³⁶

Doctoral-Level Providers Are More Qualified And Deliver Higher-Quality Services

Managed care companies, in response to criticism of their use of non-doctoral level providers, routinely point out that there are no studies that show doctoral training leads to better treatment outcomes or higher quality care. The problem, of course, with this type of notion and conclusion is that extensive, specialized training and education in any field is questionable. The entire education system is based on the assumption that the more years devoted to study, training, and experience, the better prepared an individual is to provide a higher level of service. The entire basis of medical specialty, for example, is based on extended periods of residency above the initial degree. Although every medical license issued by every state in the United States allows physicians to

perform surgery, would anyone seriously argue that, as a whole, physicians who devote 3-5 additional years learning surgery does not lead to better outcomes and higher-quality services? The same can be said of any other profession that requires additional training beyond a doctoral degree. We have found no studies that even address this issue outside of behavioral health. So, saying that doctoral level psychologists, who average five years post baccalaureate education with more than 4,000 hours of internships, additional years in post-doctoral fellowships obtaining specialty training, and experience both in inpatient and outpatient venues, can demonstrate no greater outcome in treatment than non-doctoral providers is both ludicrous and a deception. This deception is used simply to ration care and to increase profit.

Non-doctoral level providers do have a place in behavioral healthcare. They can provide many services that do not reach the level of seriousness requiring a psychologist or psychiatrist. As for cost-saving, many of the services that non-doctoral level practitioners provide are elective services and should really not be covered by insurance. Marriage and relationship issues, for example, should be an elective service. Typical adolescent rebellious behavior and academic issues should be viewed as elective services. Anxiety disorders, depression, behavioral issues related to a medical disorder, psychosis, acute and chronic mood disorders, and other serious behavioral conditions require doctoral level intervention. Using less-trained providers simply denies the seriousness of the patient's condition so that a company's profit can be maximized at the patient's expense. More highly trained professionals provide a more detailed and multifaceted assessment of a patient's condition. Doctoral-level psychologists have significant training in doing and understanding the important research related to understanding and treating behavioral conditions. This training benefits patients and this is the issue concerning healthcare.

IX. The Treatment of The Elderly In Long Term Care

The services psychologists can provide patients in long-term care results in benefits to patients and the healthcare system. Prior to the Nursing Home Reform Act of 1987, the traditional model of care in nursing homes was referred to as the *custodial* model. When looking at the negative stereotype of the nursing home, the *custodial* model represents much of what was undesirable about these settings, and is much less common today than even a decade ago. The *custodial* care model provided for the basic needs of patients, their food, cleanliness, medication and whatever medical care was necessary. But, there were no expectations for keeping the patient at his or her highest level of functioning, or for individualizing the psychosocial care. Fortunately, with nursing home reform 1987, and the accompanying emphasis on patients' psychosocial needs and restraint reduction, that traditional *custodial* model has evolved into what is now called a *functional capacities* model. Here, in addition to the usual focus on patients' medical condition and requisite nursing care, we are also interested in looking at different areas of functioning of the residents and developing individually tailored, multi-disciplinary care plans that take into account patients' level of cognitive, psychological, and behavioral functioning.

This shift from *custodial* care to a model that emphasizes *functional capacities* has had a profound effect on the professional role of psychologists in these settings, and underscores the position that comprehensive care for older adults in nursing homes goes beyond medical and pharmacological approaches. Rather, it should include psychological assessment and treatment while also incorporating professional consultation, staff training and education, and care planning. In fact, NAPPP believes that treating patients only in the medical context constitutes under-treatment when the care team is not looking at patients' co-morbid psychological issues, or the patients' ability to recover from or better manage their medical conditions, or offering new ways to cope with an irreversible illness or disability. NAPPP advocates for the multi-dimensional role of psychologists in nursing homes, and how this role favorably impacts patients' well being as well as the cost of long term care.

Nursing Home Demographics and the Need for Psychological Treatment

Data from the National Nursing Home Survey (2004) revealed that mental disorders were the second leading primary diagnoses among residents at time of admission (16.4%), second only to diseases of the circulatory system (23.7%). According to the American Geriatric Society ²³⁷, there are 1.5 million older adults in nursing homes, and anywhere from 65% to 91% have symptoms of a psychiatric disorder. An alternate look at the incidence of psychiatric illness in older adults reveals that 89% of this age group who have a diagnosed mental

illness resides in nursing homes, while only 11% are in psychiatric hospitals. This is attributed to the sharply reduced number of long-term psychiatric hospitals in the U.S., and the fact that nursing homes are now the setting of choice for the population with chronic psychiatric illness when they cannot be managed in community-based residences. In nursing homes, depression, behavioral symptoms, and dementia are the most common psychiatric problems.²³⁸ Behavioral symptoms include verbal and physical aggression toward staff, other residents and visitors, non-compliance with nursing care, disruptive outbursts, inappropriate sexual behaviors, and agitation and wandering. Further, when psychiatric problems are present, these problems are associated with worse health outcomes, higher rates of hospitalization, higher emergency room use, and higher staff turnover.

In addition to the presence of depression, behavior disturbances and dementia noted in the AGS data, there are many other disorders that are psychological in nature, including adjustment disorders, grief and bereavement conditions, anxiety and other mood disorders, sleep and eating disturbances, chronic psychiatric conditions (e.g., schizophrenia and other psychotic disorders), and personality disturbances (e.g., paranoid, antisocial, borderline and obsessive-compulsive personality disorders). There are also many types of cognitive dysfunction caused by dementia (e.g., Alzheimer's, Parkinson's disease) and by delirium.

Beyond these primary psychiatric diagnoses, many of the medical conditions presented on admission have underlying psychological factors that contribute to or exacerbate the conditions. Examples include hypertension and high blood pressure, respiratory disease (e.g., chronic obstructive pulmonary disorder, emphysema), obesity, congestive heart failure, non-malignant pain, diabetes, and kidney failure. Management of each of these medical conditions, whether presenting in acute or long term care, can benefit from the contributions of a psychologist, particularly if the psychologist has a background in behavioral medicine or health psychology. We now know that approximately 133 million people have chronic conditions in the United States, according to the Disease Management Association of America (DMAA).²⁴³ This is projected to increase to 157 million by the year 2020.

The DMAA proposes that the principle of disease management includes a system of coordinated healthcare interventions and communications for populations with conditions in which self-care efforts are significant. To the extent that this population with chronic diseases gets older and is placed in nursing homes, the need for the behavioral health psychology specialist will only increase. Compounding the incidence of chronic disease,

many research studies have repeatedly shown that higher costs and reduced quality of life for medically ill individuals are associated with depression, stress, and negative future outlook. 244,246,254

One additional – and major – factor to consider in addressing the need for psychological services is the shift in the nursing home admission pattern and the change in population. A study published by the National Hospital Discharge Survey²⁴⁰ gives a contemporary picture of nursing home admissions, divided into the "short stayers" and the "long stayers." Short stay is defined as up to eight weeks; "long stayers" are generally over eight weeks, and on average, up to two years. "Short stayers" are considered sub-acute, with a variety of issues, usually very short-term rehab issues, but also some terminally ill conditions. These short-term admissions will receive intensive treatments and return to the community whenever possible. The "long stayers" are those who don't succeed in their rehab (if that was the plan), or they are known at the outset that long term placement will be necessary. Often, there may be other more serious conditions with the long-term, chronic care population, such as cognitive impairment or a combination of cognitive and physical impairment.

Many skilled nursing facilities are converting long-term care beds to these short-term, Medicare Part A beds. Medicare will pay for the rehabilitation portion of the nursing home stay, as long as the patient remains eligible to receive these benefits. Once the patient gets off Part A, no longer qualifies for Part A, or loses Part A eligibility, the patient either returns home or is transferred to a long-term care unit in the facility. The "short stayers", then, by definition, are in the Part A portion of their stay, and Medicare reimburses the facility for these Part A days.

The National Hospital Discharge Survey also reflected a trend that the admissions from hospitals are "quicker and sicker." The length of stay is shorter in the acute care hospitals. There are more transfers from the acute to the sub-acute, and there is a higher volume of patients passing through the system. And, of course, there is a higher medical acuity, but these patients end up in nursing homes, nonetheless. This means that we are seeing more admissions, and more discharge activity. Even the term "nursing home" is less in favor, and is being replaced by "rehabilitation center," and names with similar connotation.

The recommendations from the NHDS report strongly advocate greater interdisciplinary collaboration, including all different types of staff expertise and staff input. Again, the behavioral health professional is central to this collaboration, with an emphasis on interdisciplinary involvement, discussion, and participation in treatment planning with other team members.

Shortage of Trained Professionals

The Institute of Medicine (IOM) recently reported on the future health care workforce for older Americans in a publication, *Retooling for an Aging America: Building the HealthCare Workforce*.²⁴⁸ The publication projects significant shortages of all health professionals with specialized training in geriatrics and aging. This shortage is attributed to a number of factors, including relatively fewer faculty and training institutions with expertise in aging (in contrast with other health care fields), aging of the workforce itself, and reduced financial incentives to provide professional services to older patients. In a landmark study, Jeste et al.²⁴⁹ reported that the demand for trained mental health professionals far exceeded the supply, and that at the time of that publication, the number of psychologists to work with the elderly was only 10% of the total number needed, and that percentage would drop to 5% by 2030. (Psychiatrists were at 55% of the current demand, and licensed clinical social workers were at 18%.)

Clinical Role of Psychologists in Nursing Homes

Many of the traditional professional services provided by psychologists in nursing homes address residents' adjustment disorders. These conditions are often precipitated by sudden placement in the facility, following an acute medical event, such as a stroke or fracture from a fall. Chronic medical conditions can also trigger a need for long-term placement, in which the patient now requires 24-hour nursing care, for diagnoses such as heart disease, severe respiratory disease, or progressive dementias such as Alzheimer's or Parkinson's disease. Other placements may be less sudden, but the adjustment difficulties are still exacerbated by a loss of independent functioning, separation from one's home and family, and becoming dependent on caregivers. Depression and generalized anxiety symptoms are frequently in the clinical picture, and manifested typically by withdrawal and isolation, eating and sleeping problems, non-compliance with treatment plans, and disruptive behaviors. Also, behavior problems often accompany the mental decline seen that accompanies dementia.

As stated earlier, many nursing home admissions may be medically triggered, but the patients can have coexisting psychiatric disorders that complicate the stay and require the interventions of a mental health specialist. Of course, the theme of death and dying must be included in the purview of the consulting nursing home psychologist, as well as counseling and support for the patient's family, and psychoeducation on a variety of clinical issues. Cognitive and psychological assessment is also essential with this older adult population. Brief measures of cognitive functioning, the presence and severity of psychological disturbances, decision-making capacity, and attitudes toward recovery, among many other factors that can be looked at, play an important role in treatment planning.

Limitations of the Biomedical Model

Despite the prevalence of psychological disorders in nursing homes, psychological services have been impacted by the medicalization of behavioral health. Essentially, this biomedical model looks at disease in isolation from the patient. The disease is on the center stage. It is independent from the person suffering from it. Each disease has a specific cause and the cause can be correctly determined through enough diagnosis. Essentially, this biomedical model says the patient is a passive recipient in the process.²⁵⁰

Unfortunately, there are many, unfavorable consequences of this limited viewpoint. First, this does not allow us to address the psychological risk factors for morbidity, or the pathways that lead to over-utilization of medical services. We are just looking at the disease; we are not looking at the precipitating, or predisposing psychological risk factors. Secondly, the biomedical model does not allow us to look at the actual psychological impact of having a medical illness. A third consequence of this view is that typically a primary care physician is treating these psychological conditions because he is the one consulted by the patients, and behavioral health professionals are not consulted.

NAPPP subscribes to an alternate model, the biopsychosocial model:

The body does not function in a vacuum. The mind and body are closely related, such that an imbalance in one leads to symptoms or disease in the other. One interpretation of this model speculates that treating patients only in the biomedical context could constitute under or mal-treatment, if the psychological conditions are not being considered, including patient's attitudes about recovery, or their motivations that impact the onset or management of the medical condition. Without the behavioral health perspective, the patient is often being treated without taking into account the whole clinical picture. This contributes to uneven recovery, potential harm and increased healthcare costs.

Costs Associated With The Biomedical Model

We know there are significant financial health care costs that are unnecessary effects of medicalization because we are not addressing significant psychological factors influencing management of or recovery from medical conditions. The Department of Health and Human Services published a report ²⁴² saying that seven out of the ten leading health and illness indicators are psychological, such as inactivity, obesity, smoking, substance abuse, behavioral illness, irresponsible sexual behavior, and violence. Further, early research on causes of death in the United States indicated that seven of the nine leading causes of death are psychological in nature.²⁵¹ This

is not new information, but it is related to the need to address the underlying psychological issues in the short-term stay nursing home patient.

Moreover, there are numerous studies reporting the medical cost offset of behavioral health services with medical patients. Chiles, Lambert and Hatch conducted a meta-analysis of 91 studies, looking at the effect of psychological interventions on medical utilization, and found that of these 91 studies, 90% showed reduced medical utilization following some psychological intervention and a corresponding reduction in cost. This is further evidence that behavioral health approaches can reduce unnecessary utilization of health care services, and can improve the overall care of the individual. ²⁴¹

Psychologists working with these patients can accomplish several objectives: Providing necessary psychoeducational information about the medical condition, its etiology and contributing factors, and steps toward self-management. Psychologists are also able to reduce the high levels of psychological stress, and change unhealthy behaviors, or so-called health risk behaviors. Psychologists can provide social support and help to identify or mobilize new sources of social support. We can detect and treat under-diagnosed behavioral illness and we can also address the somatization issues where patients keep presenting with multiple, and often vague medical complaints, request frequent doctor visits and trips to the emergency room, and overall seek more attention from their medical providers.

What does the psychologist do with these primary medical conditions? With both the short- and the long-term nursing home admissions, the psychologist first helps the patient understand the emotional impact of the condition that led to his or her admission. The patient may have had a fall, but what are the accompanying emotional considerations that this person needs help with? Secondly, we assess the values and perceptions of the patient regarding his future. What is this person's outlook like?

Third, we identify what kinds of barriers there are in participating and benefiting from rehabilitation and help to overcome these barriers, collaborating closely with the rehabilitation team. Fourth, we offer therapeutic interventions that facilitate the safe and effective progress of rehabilitation, effectively, helping the patient to stay engaged once he does become involved in his physical therapy. And, fifth, psychologists trained in medical psychology, including psychopharmacology, can significantly reduce polypharmacy, adverse drug events and the significant costs associated with additional hospitalization as a result of inappropriate

prescribing. This means continually integrating the different approaches among the healthcare providers, to ensure these patients are involved in and maximize their benefit from their treatment.

The psychological approaches employed with the long-term, or chronic care patient, are different. With these cases, it is necessary to monitor depression and withdrawal, assist with adjusting to and accepting irreversible physical illness and debility, and identify positive sources of reward, support, and social involvement. This often takes place in the process of understanding an individual's resistance to treatment, and supporting his or her decision-making process, while informing the patient of other possible courses of action. Finally, it is necessary to address the person's thoughts and fears about death, whether imminent or not.

This brings the focus back to interdisciplinary collaboration, reiterating the major premise that the mind cannot be separated from the body. The more we can advocate this interdisciplinary collaboration, the better patients will be served and costs contained. This is done by being allowed to provide the services we are fully trained and experienced to do, while supporting and facilitating a culture of integrated care. It is necessary to keep reiterating the premise that patients are not isolated from their disease, while emphasizing the importance of the behavior health approaches in understanding, assessing and treating the patient, especially where the coping resources are limited or taxed. The treatment provided by psychologists in nursing home settings is characterized by brief, problem-focused interventions in which the emphasis is on shared understanding of treatment goals and barriers. Moreover, psychologists are trained to provide concise information and to provide the needed updates on a patient's condition. As part of an interdisciplinary team, this communication with medical professionals is mandatory and necessary. ²⁴⁷

Barriers to Effective Care

There are several barriers to more effective care in nursing homes from the perspective of a practicing geropsychologist. Some have been alluded to already, namely, the tendency to separate the medical condition from the psychological condition, rendering attempts to treat the patient's physical problems, in the absence of understanding the emotional and attitudinal problems, frequently unsuccessful. This treatment pattern also leads to another complication, the tendency to over-rely on psychoactive medications to address psychological and behavioral problems before non-medication approaches are used. Psychotropic medications are drugs that affect an individual's mental processes and behavior, and are considered legally inappropriate if they are not used to ensure the physical safety of patients or of others. Federal law stipulates that each resident's drug regimen must be free from unnecessary drugs, defined as any drug used in excessive dose, for excessive duration, without adequate monitoring, without adequate indication for its use, or in the presence of adverse

consequences, which indicate the dosage should be reduced, or discontinued. This rule was implemented to reduce and eliminate drugs to chemically restrain patients.

There are generally four categories of psychotropic medications: anti-psychotic, antidepressant, anti-anxiety, and hypnotic sedatives. These medications are frequently prescribed to nursing home patients. Psychotropic medications have their place in nursing homes, and can be an effective adjunct in the overall treatment plan for many patients. However, psychologists should always be part of the intervention strategy with any patients on these medications, for two reasons.

First, the medications do not help the patient learn new ways to manage or cope with a stressor, but rather only serve to reduce the symptoms of the condition, such as tearfulness, agitation, or disordered thought processes. Psychological services include helping with the development of more effective coping skills, problem-solving, and affective expression. The second reason for including psychologists as a complement to the use of medications is to help with the patient engaging in non-purposeful, non-intentional but difficult, obstreperous behaviors. These patients are too confused to participate in or benefit from counseling and psychotherapy, or any one-on-one direction, but yet display problem behaviors. In these cases, the requisite approaches include milieu or environmental strategies to modify the problem behaviors. This is accomplished by developing behavior management programs and consulting with staff on optimum caregiving approaches for these residents. These behavior management strategies can shape or modify behavior by changing the environment that the patient is responding to, instead of resorting to higher or excessive dosages of the psycho-active medications.

The challenge with working with patients who are too cognitively impaired to benefit from psychological services is the lack of reimbursement. Most insurance plans, including Medicare, cover counseling and psychotherapy, and assessment, but these plans do not cover staff consultation, case conferences, supervision of behavioral interventions, or staff training. Consequently, these services are provided on a *pro bono* basis, and are not made available to the majority of dementia cases that would benefit from these psychological consultations. By not reimbursing for these services, Medicare and other insurers save money on one end but wind up paying much more on the other end. Patients, however, pay the highest price.

Another barrier that has been observed with this population is ageism, or stereotyped views of the older adult based on the person's age, and not on his or her functional abilities. These views are held by health care

professionals, insurers, family members, and even by elderly individuals themselves. The belief, for example, that depression or dementia is inevitable in advanced age is an ageist viewpoint, and creates additional barriers to contributions that psychologists can make. Depression in advanced age may be common, but it is never normal. To the extent that psychologists can promote a greater understanding of the role that behavioral health assessment and treatment approaches play in nursing homes, and can integrate these approaches with the rest of the health care team, true comprehensive care can take place.

The Inappropriate Use Of Medications In The Elderly

Inappropriate medications, in and of themselves, may not be the major cause of adverse drug reactions in the elderly. It is the inappropriate use of drugs that is the major problem when treating the elderly. Adverse drug events with this population can be prevented by reducing the number of drugs prescribed to this population.²⁵⁶ It is not uncommon for patients in nursing homes being prescribed between 5 and 13 medications,²⁵⁷ according to a recent study of the elderly in nursing home. The researchers reported that the median number of prescribed medications was 5 and ranged up to 13 medications. Thirty-two percent of the patients studied received inappropriate medications. Patients prescribed more than 5 medications were 3.3 times more likely to receive an inappropriate medication than those taking 5 or less medications. Half of the patients studied with inappropriate prescriptions experienced significant adverse effects of the inappropriate medications. Sixteen per cent of all admissions to hospitals were associated with such adverse effects. The researchers defined an inappropriate medication based on the Beers list²⁵⁸, a list of medications agreed on by the majority of researchers.

Polypharmacy among the elderly is a serious problem, many times resulting in death and is a major factor in increased healthcare costs.²⁵⁹ More than 770,000 people are harmed or die each year in hospitals from adverse drug events associated with polypharmacy.²⁶⁰⁻²⁶² The costs for these preventable hospitalizations adds up to \$5.6 million each year per hospital. These projective costs do not include the ancillary costs associated with malpractice and litigation costs, or the actual costs of the harm to patients. Total U.S. hospital expenses to treat patients who suffer adverse events associated with inappropriate prescribing and polypharmacy during hospitalization are estimated at between \$1.56 and \$5.6 billion annually.²⁶³⁻²⁶⁶ These costs and the harm to patients can be significantly reduced when these patients are being followed and treated by a psychologist. The majority of these medications are prescribed by physicians who rarely see the patient and generally are prescribed at the request of a staff member of the nursing facility.

Concluding Statements

The care of the elderly in nursing facilities is a major concern and public interest issue. The costs for providing care to this population will only increase as the population ages. Medicare costs, a major concern for both legislators and policymakers, needs to be looked at from the perspective of "best service delivery" as opposed to the cost-cutting strategy that most advocate. It is clear from our analysis that better services can be provided as costs are decreased if medical care and decisions also include psychologists, nurses and other healthcare professionals.

The increasing costs for medications that clearly can be reduced if physicians, more often than not, would include behavioral interventions into the treatment plan. Policymakers, as they frequently tend to do, need to look at the whole picture instead of looking at the many, small details of eldercare. The message is clear, however, leaving physicians in charge of care can and will only lead to increasing costs for care and increased harm to patients. The best available data supports this conclusion.

X. Recommendations

The recommendations that NAPPP is proposing are provided according to the issues discussed in each section of this report. Recommendations are presented by section topic.

I. The Evidence Against Primary Care Physicians Providing Behavioral Healthcare

- #1. Except in emergency situations, NAPPP recommends that primary care physicians seek and obtain an evaluation and appropriate diagnosis from a doctoral-level psychologists before prescribing a psychotropic medication for patients whose condition is primarily behavioral in presentation. This includes, but is not limited to, patients whose main complaints are depression, anxiety, attention deficit symptoms, sleep disorders, stress, and substance abuse.
- #2. When it has been determined that psychotropic medications are an appropriate part of a treatment plan for patients with behavioral disorders, primary care physicians must ensure that these patients are followed by a doctoral-level psychologist. This will ensure patient adherence to the medication regimen and provide the primary care physician with timely and important information on potential side effects if experienced by the patient.
- #3. NAPPP recommends that primary care physicians engage doctoral-level psychologists in a collaborative relationship so that patients can be seen promptly and better served when they present with behavioral disorders.
- #4. NAPPP recommends that primary care physicians provide all patients with 100% of the standard of care required for their specific, diagnosed condition. Anything less is inconsistent with providing the highest-quality of care and denies patients their right to healthcare. The standards of care for specific conditions are the "floor" for treatment and not the "ceiling".
- #5. As the visits to emergency rooms related to the abuse of pain medications and sedatives now outpace visits due to illegal drugs, NAPPP recommends that patients receiving these medications be evaluated and followed

by a doctoral-level psychologist both before a prescription is written and before prescriptions for these drugs are refilled. This will save untold dollars that are now being spent on emergency room visits and will significantly decrease addiction from these drugs and the related costs of treating substance abuse.

II. Reducing Adverse Drug Events From Physician Error

- #1. NAPPP recommends that all prescribing health care providers use the many computer programs now available to record and transmit prescriptions. Research and experience demonstrates that many errors are a result of poorly written and misunderstood handwritten prescriptions.
- #2. NAPPP recommends that primary care physicians keep current on the latest research with respect to all medications, but specifically with the research on psychotropic medications.
- #3. NAPPP recommends that primary care physicians do not prescribe psychotropic medications new to the market. Waiting for a least one year before prescribing newly approved medications by the FDA will enable physicians to obtain a clearer understanding about how a new medication works in comparison to older, better-understood medications. Patients should not be guinea pigs for drug manufacturers, which consistently bring to market "new" drugs based on fast, but typically small samples of unrepresentative patient populations and may perform no better than an existing medication.
- #4. The manner in which clinical trials are conducted must be reformed. NAPPP recommends that medications under study be compared to the existing "gold standard" in the medication class and to a placebo. This procedure will allow for meaningful comparisons and will eliminate drugs that offer little, if any, benefit over existing drugs. This procedure also will reduce the cost of drugs by eliminating non-beneficial drugs being brought to market.

III. Psychiatry In Crisis: Impacts on Primary Care, Patient Safety and Public Healthcare Policy

#1. NAPPP recommend that primary care physicians seek and establish a collaborative relationship with psychologists trained and specializing in health and medical psychology. These specially trained psychologists can provide physicians with many services to patients whose conditions have a behavioral relationship. Medical and health psychologists specifically treat patients with medical conditions related to coronary problems, stress,

life and health impacting issues such as obesity, substance abuse, chronic pain syndrome, eating disorders, smoking, adherence to treatment and medication regimens, and life-changing strategies.

- #2. NAPPP recommends that primary care physicians use the services of a medical psychologist trained in clinical psychopharmacology when considering a new psychotropic medication for their patients. Medical psychologists do not have any financial relationships with drug companies and can provide physicians with an objective evaluation of these medications.
- #3. NAPPP recommends that The American Board of Medical Specialties, organized medicine's agency that regulates specialty certification, adopt rules that require psychiatrists to complete training in behavioral interventions. Psychiatrists whose sole practice is providing medications is not in the patient's interest, not in the public interest, and has established an unethical tie between psychiatry and drug manufactures. There already exists doctors of pharmacy whose specialty is providing recommendation on psychotropic medications. Psychiatrists whose sole practice is providing medication consultations duplicates this service and contributes to the shortage of psychiatrists.
- #4. NAPPP recommends that states no longer allow medical doctors to practice as psychiatrists without specialty training in the diagnosis and treatment of behavioral disorders. Patients deserve to be treated by qualified practitioners.
- #5. NAPPP recommends that all healthcare providers be required to demonstrate the ability to communicate clearly and effectively with patients. Effective communication reduces errors and increase patient care and outcome. It is particularly important that physicians and all healthcare providers demonstrate the ability to communicate with patients in the language that the patient speaks and understands.
- #6. NAPPP recommends that psychiatrists who provide patients with psychotropic medications be required to provide behavioral treatment as long as the patient is on medication. Psychiatrists who are not trained to provide behavioral interventions should be required to refer the patient to a licensed, doctoral-level psychologist who can provide the needed treatment and management. Outcome research clearly shows that patients on psychotropic medications do best when they concurrently receive behavioral interventions.

#7. NAPPP recommends that the American Psychiatric Association formulate and adopt rules for their members prohibiting gifts from the pharmaceutical industry, receipt of medical samples, attendance at industry-sponsored events, consulting for industry, contact with pharmaceutical representatives, and disclosure of relationships with pharmaceutical companies. Every other major medical association, except psychiatry, has adopted similar rules. Patients require their providers to be objective and to work in their best interests and not as extenders for drug manufacturers who provide perks to prescribe their brand of medications.

IV. Antidepressant Medications Are Ineffective And Claims Are Misleading

- #1. NAPPP recommends that physicians re-evaluate the general notion that behavioral disorders are a result of genetic, hormonal, or chemical imbalances that are lifelong and need to be treated solely with medications. The most current research does not support any cause-effect relationship between these factors and behavioral disorders. This will allow physicians to better assess the needs of their patients and to arrive at better treatment outcomes. This will also reduce healthcare costs resulting from irrelevant treatment and unneeded medication costs.
- #2. NAPPP recommends that primary care physicians adopt a medication policy for antidepressant medications that recognizes antidepressant medications are less likely to perform as the length of time patients take these drugs increases. Patients on long-term antidepressants require routine monitoring and re-evaluation before prescriptions are renewed. This can best be accomplished when the patient is being managed and concurrently seen by a licensed, doctoral-level psychologist. If the patient's behavioral condition is accompanied by a serious medical condition, a consultation with a medical psychologist trained in clinical psychopharmacology would benefit the patient and provide the physician with the information to help in making further decisions on continuing the medication, if indicated.
- #3. NAPPP recommends that physicians adopt a medication policy for antidepressant medications based on unbiased research demonstrating efficacy for the specific patient demographic being treated, and for the specific dosages and length of time of treatment.

- #4. NAPPP recommends that primary care physicians minimize the off-label use of psychotropic medications. Off-label use of this class of medications is potentially dangerous to the patient and increases the potential risk due to drug-drug interactions.
- #5. NAPPP recommends that all prescribing health care providers reduce and/or eliminate polypharmacy as much as possible. It is important that prescribing providers understand the dangers of polypharmacy as it relates to psychotropic medications.

V. Physicians Often Do Not Provide Patients With Important Information When Prescribing Medications

- #1. Direct communication to patients about their medications is an important part of increasing patient adherence of their medication regimens. NAPPP recommends that primary care physicians and other prescribing providers either devote a reasonable amount of time to accomplish this important function, or provide patients with a consultation with a healthcare professional who can provide this information.
- #2. There are many computer-based and online services available to prescribing health care providers that provide objective data about medications. NAPPP recommends that physicians utilize these services to obtain information on medications that is more objective than that received from drug company representatives.
- #3. NAPPP recommends that all prescribing health care providers refrain from accepting gifts or any other perks from drug company manufacturers.

VI. Reducing Harm and Healthcare Costs: A Review Of A Physician's Unlimited License To Practice

#1. NAPPP recommends that state licensure for all health care providers be based on a limited license and that unlimited licensure be eliminated. Limited licensure mandates that healthcare professionals should only provide services within their specific area of education, training, and experience. It is clear that specialty training and certification does not protect patients from health care professionals who provide services in areas where they do not have training or sufficient experience.

- #2. NAPPP recommends that all prescribing health care providers should be restrained from prescribing psychotropic medications without formal education and training in the diagnosis and treatment of behavioral disorders. This class of medications carries risk to patients even under the best of circumstances, but that risk is increased when the medications are prescribed by a physician who has no or little training in the pharmacology and recommended uses of these drugs. In the absence of obtaining a consultation from a psychiatrist due to the ongoing shortage of psychiatrists, NAPPP recommends that primary care physicians obtain the services of a medical psychologist who is specifically trained in clinical psychopharmacology.
- #3. Since prescribing medicines has become a ubiquitous part of medical practice, NAPPP recommends that medical schools establish a reasonable number of hours for training physicians in pharmacology and including psychopharmacology. Training in pharmacology in most medical schools rarely exceeds 40 hours over a four-year curriculum. This level of training is insufficient and places patients at risk. NAPPP suggests no fewer than 120 hours of pharmacology be provided to physicians in their training programs.
- #4. The Medical Home Model is a flawed model for delivering quality and effective healthcare, because this model presupposes primary care physicians are qualified and trained to be supervisors of other specialists and healthcare professionals. The data suggests that this simply is not the case. NAPPP recommends that the limited licensure of physicians precede the medical home model. Until this is achieved, any implementation of the medical home model most likely will fail and provide patients with substandard healthcare.

VII. Medicating America's Children

- #1. NAPPP recommends that primary care physicians do not prescribe psychostimulant medications for children and adolescents who present with attention-deficit symptoms without first referring the patient for an appropriate evaluation by a doctoral-level psychologist, and not before the patient has completed a behavioral intervention program.
- #2. Too many young children and adolescents are being prescribed a wide array of psychotropic medications with little justification or evidence of their efficacy in this population of patients. NAPPP recommends that primary care physicians halt the over-prescribing that clearly is a result of drug company marketing. Physicians need to self-regulate their prescribing practices. Should self-regulation fail, states should consider legislating prescribing standards as they apply to children and adolescents.

#3. Since children are not part of clinical trials, physicians need to limit off-label prescribing to this population. Off-label prescribing of drugs is a product of drug company marketing that typically skirts the edge of the law against such marketing. Only physicians are in a position to protect these patients from the potential harm from off-label prescribing.

#4. Given the potential danger to children and adolescents prescribed psychostimulant medications, NAPPP recommends that any child or adolescent prescribed these drugs also be under the care of a doctoral-level psychologist so these patients can receive the regular follow up care that cannot be provided in a primary care setting.

#5. The sale of psychostimulant drugs on school grounds by adolescents is a growing problem. NAPPP recommends that prescriptions for psychostimulant medications be closely monitored by physicians. One way to control this type of drug trafficking is to ensure that patients are not faking their symptoms to obtain these medications.

#6. The over-diagnosing of bipolar disorder is a real concern and public policy issue. Those appropriately diagnosed with bipolar disorder require intensive initial treatment and regular follow-up care that is long-term and costly. The problem of over-diagnosing appears to be a problem in psychiatry in that many psychiatrists make this diagnosis on subjective symptoms and do not seek or obtain a formal assessment by a doctoral level psychologist. The largest increase in this diagnosis is on children between the ages of five to nine years old. NAPPP recommends that before patients are prescribed any medication based on a diagnosis of bipolar disorder, there needs to be a formal psychological assessment by a doctoral psychologist.

VIII. Patients Deserve To Be Evaluated And Treated By Real Doctors

#1. NAPPP recommends that due to the complex nature of behavioral disorders and the need for collaboration with physicians, any behavioral disorder that requires an Axis I diagnosis, that is, any diagnosis found in the most recent version of the Diagnostic and Statistical Manual (DSM) published by the American Psychiatric Association, requires that the provider be a doctoral-level psychologist, psychiatrist or, when indicated, a licensed clinical social worker. Non-doctoral providers should be utilized for elective services such as marital

and relationship counseling, academic counseling, child-parent conflicts, and other non-problems not associated with those diagnoses specified in the DSM.

#2. With the passage of the Healthcare Reform Act, after which about 32 million people will be covered by insurance, managed care companies and third-party behavioral healthcare companies need to expand their panels of providers. Consistent with the provisions of the bill, NAPPP recommends that these companies adopt an "any willing provider" policy for doctoral level psychologists and psychiatrists. Failure to address this issue will result in many patients facing delayed treatment or being denied the right to quality care.

IX. The Treatment of The Elderly In Long Term Care

Given the barriers to effective care by psychologists in nursing homes, there are several recommendations that can improve the psychological well-being and quality of life of the residents in these settings, reduce the incidence of unnecessary psychotropic medications, and reduce health care costs. These recommendations include:

Expand the availability of psychologists in nursing homes: Just as facilities of a minimum bed size require the services of a social worker consultant, a comparable requirement for psychologists should be implemented in all state-licensed, Medicare-approved facilities. The scope of mental health issues among current and newly admitted residents, including the prevalence of mental disorders, warrants serious consideration of this requirement by the Centers for Medicare and Medicaid Services. Beyond patient care, consulting or staff psychologists can help with program development, crisis management, hiring and staff development activities, community outreach, and family education.

Psychological screening of all residents on admission: The federal government, as part of the Nursing Home Reform legislation, enacted programs that require pre-admission screening of new admissions to identify those with a primary psychiatric diagnosis and to locate other placement possibilities in lieu of the nursing facility. This is the PASSAR system. However, it does not necessarily identify patients who may have underlying subclinical depression or anxiety, a potential for behavioral acting out, or potential difficulty adjusting to placement or to their rehabilitation program.

Triaging new admissions will place individuals in three groups: Those who may need mental health services and will likely benefit, those who may need services but are inappropriate for treatment (and warrant alternative programming), or those who do not need services. Just as new admissions are currently screened to identify whether a rehabilitation program is indicated, the same benefits would accrue from use of triaging for psychological services. This process will be instrumental in ensuring that residents have access to necessary care, and also serves as a preventive measure to avoid more serious emotional disorders and behavior disturbances several months after admission.

Reimbursement for case conferences and staff training: A considerable amount of time spent by the behavioral health consultant is not billable to the patient's insurance. This professional time could be spent on case conferences, developing behavior management plans and supervising staff during the implementation of these plans, reviewing records for psychotropic medication management, and telephone consultation. It is highly recommended that insurance plans, especially Medicare and Medicaid, be expanded to include procedures that are reimbursable for these events.

Training for nursing home staff: As in any medical institution, there is a wide array of staffing and many levels of education among nursing home employees, from the nurses' aide who may have not completed high school to the department heads, with undergraduate and, often, graduate degrees. Directors of staff development are responsible to ensure that the staff maintain its required certifications and is trained in a core body of knowledge. Beyond these subject matter basics, however, there is a continued demand that more indepth information is taught on behavioral health topics, topics that address patient uniqueness and resistance to care, non-compliance, and complex behaviors that add an extra burden to staff caregiving practices. In addition to learning to better individualize care, added staff training has been shown to improve staff retention and reduce turnover. To the extent that psychologists can promote a greater understanding of the role that mental health assessment and treatment approaches play in nursing homes, and can integrate these approaches with the rest of the health care team, true comprehensive care can take place.

XI. References

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