

Bulletin of the American Academy of Clinical Psychology

PRESIDENT'S COLUMN



IN HONOR OF OUR FOUNDING MEMBERS AND A FOCUS ON OUR FUTURE

Eugene J. D'Angelo, PhD, FAACP

I bring sincere hope for a wonderful New Year to all of you from the Board of Directors of the American Academy of Clinical Psychology, of which I am the current president. I would like to begin by briefly introducing myself. I am the Chief of Psychology and Co-Director of the Outpatient Psychiatry Service at Children's Hospital in Boston, Massachusetts and have been board certified since 1988. I joined the Board in 2003. I know that we are quite fortunate to have a very talented and committed Board who are working tirelessly on your behalf on a number of projects. It is a true pleasure to work with them.

The current composition of the Board reflects a new era in the history of the American Academy of Clinical Psychology. In December 2004, Dr. Howard Cohen completed his term as AACP president. His leadership, wisdom, and unbridled enthusiasm for our organization serve as both an inspiration and a high standard to which all of us should aspire. However, Howard's stepping down from the presidency also represents another important transition, since he is the last representative of the founding members of AACP to serve on the Board. It is to Drs. Ernst G. Beier, Mary Cerney, Howard M. Cohen,

George G. Katz, Crystal Kelley, Martin I. Kenigsberg, Philip S. Pierce, Joseph G. Poirier, and Carl N. Zimet that we owe tremendous gratitude for their tireless efforts in the creation of this organization back in 1993. The founding members of the Academy were committed to the development and expansion of AACP as a critical arm of the ABPP experience, serving as an association which represented advocacy, continuing education, and a source of camaraderie among board certified clinicians. They worked hard to make AACP a legitimate voice within the ABPP community and in their efforts to expand the recognition of board certification for the public and profession at large. These psychologists were individuals of vision, of boundless energy, and uncompromising commitment. We thank them for their efforts, their energies, and for an Academy to which we can all be proud to claim membership.

For those of us who are now members of the Board of Directors, we are inspired by the efforts of these founding members. We aspire to carry forth their good works and to expand their initiatives into new venues. The current initiatives of the Board fall into three categories, namely, expanding our educational efforts, increased collaboration in advocacy, and the enhancement of our communication with members. Educationally, the desire is to provide an increased array of continuing educational offerings. We plan to do so in a couple of ways. First, we anticipate hosting a number of regional continuing education meetings throughout the country, to spread the message about the importance of board certification to non-members, and to provide educational offerings that are of the highest quality. Second, we will be offering, for a nominal fee, continuing education credits for reading and

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simply completing an evaluation form about selected articles in the Bulletin. There is also an additional way in which you might be able to participate in an educational activity which directly supports the expansion of board certification to more psychologists. AACP members are invited to participate in the "Mentoring Program" in which board certified psychologists in a particular region provide mentoring support to a candidate for examination by the American Board of Clinical Psychology.

Advocacy on behalf of ABPP and AACP includes expanding the marketing effort about the relevance of board certification to psychologists on a more regional basis. In addition to the regional continuing education events, our emphases will be on distributing materials about board certification to graduate students and postdoctoral fellows in clinical psychology in an effort to inform them early in their careers about the importance of board certification. We also plan on collaborating with members of the examining board, the American Board of Clinical Psychology, to host informational meetings for psychologists who are early in their careers. AACP has also joined with other academies that are associated with the ABPP specialties in efforts to more clearly define specialty training, to reinforce the importance of consistent standards of examination, and to try to thwart the incursion of vanity boards into the certification process. Collaboration with other board certified colleagues in other academies appears to be a potentially effective way to advocate on issues of common concern. Finally, AACP is an organization that is deeply committed to the welfare of all in our society. As such, diversity must be one of its important goals. This diversity should be reflected at the leadership level in the organization, among its membership, and for those communities in which we serve.

The third area of focus for AACP will be on enhancing communication within the organization. In this era of rapidly increasing information technology, we believe that our academy can become more responsive to the needs of our members and provide important and timely information through the use of electronic communications. To that end, we are in the process of enhancing and further developing our website, where we will be able to post important academy information, continuing education home study offerings, and make announcements of interest to our members. In particular, the Board has decided to begin publication and distribution of the Bulletin through both e-mail distribution to all members and by posting it on the website. In this way, this document, the central means by which the Academy has communicated, will be published electronically. This method also allows for larger editions with a greater number of articles, continuing education offerings, and the capacity for members to respond quickly and easily on topics of interest. The

next issue of the Bulletin will be distributed electronically to you. As such, it will be essential for all members to keep the AACP Central Office informed about any changes in e-mail address so that communications with you are uninterrupted. In most communications that you will receive from AACP, you will see reminders to update any changes in e-mail addresses.

AACP remains a strong organization with a clear mission and sense of purpose. We both thank and honor our founding members who have developed an organization which is well-respected and has many initiatives underway. Based on their solid foundation, we continue to look forward in our planning and initiatives. On behalf of the Board, I ask you to consider becoming involved in any way that you deem of interest or appropriate. This is your academy...it is an organization that requires your involvement in order to continue to foster its growth. Consider participating in the Mentoring Program, attend a regional continuing education event, write an article for the Bulletin, and/or run for a position on the Board of Directors. The Board wants to hear from you and invites your ideas and comments.

I would like to conclude by taking this opportunity to recognize and to thank Drs. Ira Stamm and James Carpenter for their leadership as both members of the Board of Directors and as co-editors of the Bulletin. It is through their generous efforts that the Bulletin has evolved into a thoughtful source of communication which will continue into the future, riding on the latest in information technology. We are now in search of new editors to take their place as they have completed their terms as both Board members and co-editors, hence, if anyone is interested in participating in taking on this exciting challenge as an editor or has any comments or concerns, please feel free to contact me. I can be reached at: Eugene.dangelo@childrens.harvard.edu

FROM THE EDITORS

**IRA STAMM,
PhD, FAACP**



This will be the final printed issue of the Bulletin and the last issue that Jim Carpenter and I will edit together. This issue appears in print and on-line, as well. Future issues will appear only on-line.

This transition to on-line publishing reminds me of another transition I experienced in my adolescence. My parents founded and owned a book store in lower Manhattan, New York City that was a fixture in the city for forty years. Stamm's for Books – Booksellers in the Old Tradition was located at 172 Broadway – a few blocks north of Wall Street and a few blocks south of New York City Hall.

My father came to the book business through his degree in Journalism. He was a lover of books. My mother was a high school graduate who had labored in the sweat shops of the Lower East Side at age 12 after she emigrated from Russia. She, too, loved books but was very much aware that the book store also paid our bills.

In the 1950s, the first paperback books began to emerge in bookstores. My father, as a lover of books, felt that the only self-respecting book had a hard cover and a hard binding. My mother understood that if the content of a \$5 dollar hard back book was available for fifty cents in paperback, there would be a strong market and future for these paperback books.

I recall the animated and heated discussions between my parents about the placement of these paperback books in their store. In the first year, the paperback books were relegated to a single rack in the back of the store. A decade later the store was evenly divided between paperback and hard cover books.

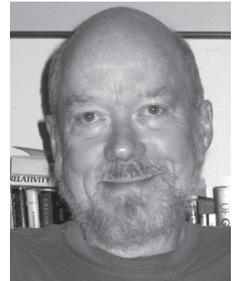
So much for change and paradigm shifts. Who Moved My Cheese?

There are many people to thank for the wonderful years I have spent as Academy Board member, and Editor, and Co-Editor of the Bulletin. I do want to thank Jim Carpenter for serving as co-editor with me these last few years. It has been a wonderful journey.

At this season of redemption and renewal, I wish all of you and your families the very best.

Ira

**JIM CARPENTER,
PhD, FAACP**

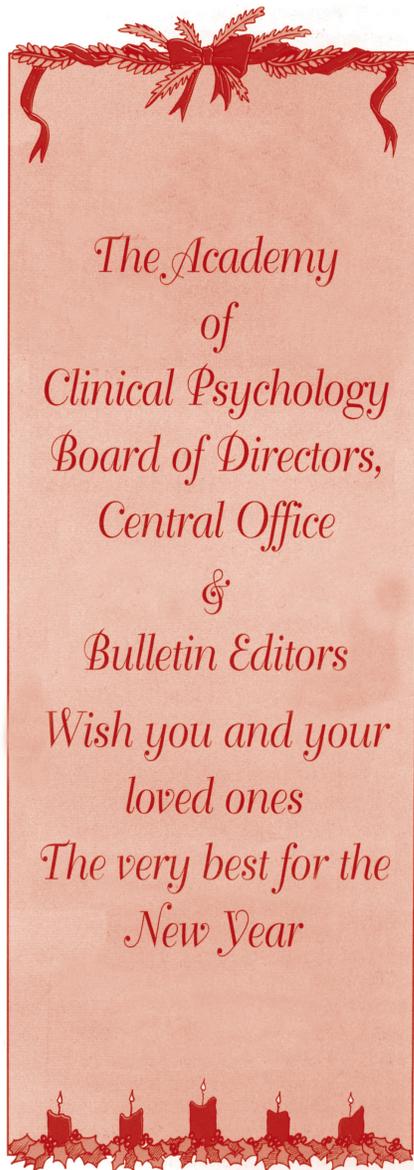


Like Ira, I am saying goodbye to the fine experience of co-editing this bulletin. The time moves me to reflect upon my relationship with ABPP altogether. I believe I first decided that I would try to achieve diplomate status the day I understood how much the idea meant to George Kelly. Kelly was a professor of mine in graduate school whom I greatly admired. Consciously, I chafed at his high standards a bit, but unconsciously I was finding a model I wished for. Kelly was one of the founders of ABPP, and conveyed a clear commitment to its importance. Looking back over some of his collected essays, I remember that he enjoyed poking fun at a few things over and over – at behaviorism, at psychoanalysis, and at the medical model. Perhaps especially at the medical model. It wasn't the implicit relegation of psychologists to second-class status in medical settings that bothered him primarily, it was the de-humanizing reduction of human nature to a collection of psychiatric fictions. I wonder what he would think today, decades later, to see how predominant that model has become. The noble profession of psychiatry has somewhat devolved into a trade of applied psychopharmacology. Psychotherapy, the adventure of co-creating human life that Kelly celebrated, has become ancillary to drug treatment. Of course huge forces are at work in all this. Drugs relieve suffering and change behavior, they are easy to take and give, and they are marketed with heavy financing. And like the hysterics of 19th Century Vienna, many current-day sufferers prefer to have an impersonal "disease" to the alternative of speaking clearly and even thinking clearly about things that have hurt them.

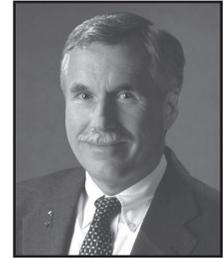
As I exit this little stage, I wish to make a couple of purely personal observations for which no one else is responsible. One is that I have come to believe that psychiatric medications, for all the good they sometimes do, act primarily by diminishing some aspect of consciousness. These emotional analgesics may make life more bearable, or even capable of continuing. The dimensions of consciousness they reduce in a given case may be ones that we are delighted to be without. But the drugs do not cure anything. Psychotherapy, I believe, also does not primarily result in a cure – when it works, it enhances the development of wisdom. This enhancement of consciousness, greater wisdom, also makes life more livable, and continuable, as well as enormously richer. The research comparing the benefits of drugs and psychological treatment makes it clear that in terms of immediate behavioral outcome, the two are quite comparable. The main advantages of

the meds are that they are less expensive in the short run, and may act more quickly. The main advantages of psychological treatment are that it implies no meta-message of defectiveness, and its benefits last after the treatment has ended.

So if I am right, and psychological treatment aims at the enhancement of wisdom (always a work in progress), then Kelly was right, and ABPP is very important. The client will have more luck in getting help with wisdom from persons who are themselves committed to excellence, to high standards of practice. Clinicians who have achieved board certification have demonstrated their personal commitment to excellence. When I have to refer to some clinician in a city I don't know, I always choose members of this Academy. It is a good bet they will tend to be wiser than the alternatives. To all of you colleagues, I join with Ira in wishing you the best of luck.



Policy and Process: The President's New Freedom Commission on Mental Health



Michael F. Hogan, Ph.D.

Director, Ohio Department of Mental Health

Introduction. President George W. Bush announced formation of the President's New Freedom Commission on Mental Health, in April, 2002. An Executive Order signed by the President outlined the Commission's charge: "The mission of the Commission shall be to conduct a comprehensive study of the United States mental health services delivery system, including public and private providers, and make recommendations to the President (Executive Order 13263 of April 29, 2002). This was the first presidential commission on mental health since the Carter Commission a quarter century earlier.

The framework for presidential Commissions has three elements. Members and a chair are appointed by the White House, an Executive Order is issued by the President to define the charge, and an Executive Director is also appointed by the White House. I was named chairman.

The record of any such effort is to some extent defined by its products, e.g. reports and recommendations. But there are many versions of the record. If one is focused on results, a full story cannot be told for years, until the overall impact and degree of implementation of recommendations can be assessed. Another story is that of the public process: was it open or closed? Were all viewpoints accommodated? How did the Commission relate to shareholders, whether they represent powerful interests or simply individuals with personal concerns? I appreciate this opportunity to provide one narrative: some reflections on the process of leading the Commission.

There are many possible perspectives on the task of leadership. There are technical dimensions of bringing any task to successful closure. However, any work involving a group of people who must perform as a team is by definition a group process. And crucial aspects of successful group processes are pretty obvious—if all too frequently ignored in our organizations. Group cohesion is essential. Norms for group interactions and decision making must be established. There are stages of group formation. Some conflict is essential; it can be productive or destructive. Most members of any group will not be consciously and not explicitly aware of these dynamics. And success in accomplishing formal tasks is contingent on effective process—although often in my experience the importance of process is denigrated. The story of the President's Commission thus has dimensions of human interactions and processes and of technical tasks.

Many dimensions of human process were simple. To congratulate people on their appointment, begin to get to know them and assess their interests, I scheduled individual telephone conversations before the group met for the first time. People were appreciative and forthcoming. All shared enthusiasm and personal commitment; many asked how they could be helpful. Another set of human concerns was addressed by planning the initial meetings so that they would center around group meals, with the chance for people to talk informally and begin to build a sense of teamwork. These meals became a group tradition; the Commission had a private group dinner at almost every meeting, and breaking bread together became a valued opportunity for informal conversation, working through problems, and celebrating progress. It was important that the SAMHSA (Substance Abuse and Mental Health Services Administration) staff identified a scheduling/logistics contractor with good “concierge” qualities, given the hassles and demands of travel.

Although every member of the Commission played a crucial role in the group, a few individuals played particularly significant roles behind the scenes. SAMHSA Administrator Charlie Curie put his stamp on the Commission’s charge, membership and credibility through his role within the Administration. He also provided resource support for everything the Commission needed. Perhaps one of his most crucial and skillful tasks was to play a deliberately low-key role for most of the groups discussions, assuaging concerns that the Administration would try to limit or control the Commission’s work. He also recruited Stan Eichenaur from retirement to serve as the Assistant staff director for the Commission. An accomplished manager and community mental health center director, Stan managed all of the Commission’s consultant experts and timelines. His low-key detail oriented management abilities provided an effective compliment for staff Executive Director Claire Heffernan, an experienced Washington attorney and public policy staffer.

Some of the Commission’s group norms began to be established very early. Asking California mental health director Steve Mayberg to chair part of an early meeting established an informal leadership role for Steve, which positioned him to assume a strong leadership role later, when the Commission reached its inevitable “storming” stage. Having our White House liaison attend an early meeting to talk about the importance of the task, and an attorney brief us on the rules for decision making of federal advisory committees established “boundaries” for constructive work. And providing for a briefing on the development and logic of the Surgeon General’s Report on Mental Health (Office of the Surgeon General, 1999) by its scientific editor (and policy insider), Howard Goldman was helpful in establishing that the Commission would work to build on—not revisit—the broad directions of the Surgeon General’s work.

A strategic perspective. While the membership, charge and broad parameters for the Commission were set by the White House, a game plan to complete the task within a mere 12 months was essential. I felt that the strategy would need to be informed by both the experience and impact of the 1978-1979 Carter Commission. From the perspective of hindsight, “what worked” and what was less successful, and what could be learned to help shape the current work? Additionally, the commission would need to consider the current context of mental health care, and how the field has evolved in the last quarter century. The changes have been dramatic: deinstitutionalization, devolution, the creation of Medicare and Medicaid, the emergence of managed care, development of new treatments, emergence of advocacy groups, and the contributions of Surgeon General David Satcher, represented by the various Surgeon General’s reports.

Much was learned about the Carter Commission from conversations with Executive Director Tom Bryant. There were many differences. The field was far less developed in 1978; perhaps the world was simpler. The Carter Commission had two years to do its work, not one, its mission was broader (covering research as well as policy), and certainly having First Lady Rosalyn Carter as honorary chair said something about the status of the effort within the administration. (By comparison, it became clear that The New Freedom Commission—which the President had pledged to create during the election campaign—was something that President Bush supported personally. On the other hand, considering the overall policy/political environment of a post 9/11 world, it seemed unlikely that our commission would lead to major new legislative or budget initiatives.)

Considering the years following the work of the Carter Commission, several paradoxes emerged. A major legislative proposal followed (The Mental Health Systems Act), but its enactment was followed by the Reagan election, and the legislation was essentially written out of the law in the budget reconciliation process. Thus, highly visible, “powerful” recommendations were ill-fated, and the immediate impact of the Carter Commission’s recommendations was limited. On the other hand, one can credibly argue that the commission’s indirect and long-term impact was substantial. Koyanagi and Goldman (1991) reviewed the impact of the National Plan for the Chronically Mentally Ill that indirectly emerged from the work of the Carter Commission. They concluded that changes crucial to improving mental health occurred primarily via staged, incremental, mid-range changes in major federal programs (e.g. Medicaid, Medicare, Social Security), not via change in mental health programs or policy per se. Additionally, the path of change was incremental and not due primarily to “big bang” reforms (e.g. national legislation, major new programs).

These experiences of an earlier Commission shaped strategy. Because “big bang” immediate changes following a report were perhaps unlikely, it seemed equally important to conduct the process in a fashion that would motivate the field, as to recommend federal actions. With respect to policy recommendations, we saw that follow-along to the earlier commission was both delayed (indeed, occurring in subsequent administrations) and incremental. Many policy actions did not flow directly from commission recommendations, but grew from indirect effects such as the involvement of federal staff in a way that motivated subsequent action.

Bridging strategy and process. One tactic that followed from this learning was to develop not just a single report to the President, but to develop work products on many components of mental health care. In the end, 16 subcommittees were formed on topics ranging from Medicaid to Consumer Issues. The idea was that the subcommittee reports could be published later as working papers, helping to create an agenda for future advocacy. Although this tactic went beyond the charge to the Commission, it was supported by SAMHSA Administrator Curie. Left for later was the question of how these reports would be reviewed and released; 30 months after the Final Report was submitted, 5 of the 16 subcommittee reports have been published by SAMHSA.

Forming multiple subcommittees served other purposes as well. They would also help the Commission cover many aspects of a complex field efficiently, and facilitate development of diverse recommendations for the report to the President. Not entirely coincidentally, creation of 16 subcommittees meant that each of the 15 appointed members would chair one. This gave each member a piece of the action, and reinforced a feeling that each member was in a valued position of leadership. And finally, most members were cast more in the mold of front-line clinicians, advocates, administrators—not policy wonks. Engaging experts to advise the Commission subcommittees would provide a deep level of knowledge on each issue, balancing the practical and clinical experiences of Commissioners.

Another strategic implication emerged from considering the status of the field: the boost provided by Dr. Satcher’s work, the complex shareholder environment, and the likelihood that follow-through by the administration would be incremental. Both the process of the Commission and its report would be as much for the field itself as for the inside-the-beltway crowd. Because of this, we sought to nurture a good relationship with the advocacy and professional organizations that would need to carry the torch after the time-limited Commission was gone. We met early with the Mental Health Liaison Group (MHLG), which includes all of the national organizations with a mental health public policy presence. Following

this, informal meetings with core members of the MHLG continued for the life of the Commission. Lead members of the MHLG developed shared recommendations for the Commission to consider, and as the Final Report was being prepared, took steps to create a new advocacy coalition, the Campaign for Mental Health, to “speak with one voice” on the Commission’s recommendations and other mental health advocacy issues.

We also determined it was crucial to have the Commission process be very accessible and open. Time was set aside in every meeting for public comment. Additionally, an interactive website was set up to receive public comments; over 2,300 individuals submitted concerns and ideas via e-mail (Azrin, Moran, and Myers, 2003). Finally, in addition to the Commission’s working meetings, which included invited expert testimony and presentations, subcommittee deliberations and public comment, the Commission held two meetings “on the road,” one in Chicago and one in Los Angeles.

Both of these meetings proved crucial to the Commission’s success. We arranged receptions with local and state mental health leaders in each case. In California especially—in part because of Steve Mayberg’s efforts—the support and enthusiasm for the work by local leaders was very warm. Visits to well-chosen local programs were strongly motivating: members saw examples of excellence. And testimony from local people—especially a panel of youth in Chicago—reinforced the importance of the work.

A core message: Recovery. Throughout the Commission’s deliberations, the theme of recovery kept emerging. Often thought of as an end state of complete remission, a broader idea of recovery emerged from testimony from individuals with mental illness, who described recovery as a process of positive adaptation to illness and disability, linked strongly to self-awareness and a sense of empowerment. In a visit with the Commission, former First Lady Rosalyn Carter commented on what she described as “the biggest single difference in mental health now, compared with the time of our Commission—today, we know that recovery is possible for every person with a mental illness.” The hope of recovery became a core theme.

The Final Report. Each of the subcommittees submitted its top recommendations to the full Commission. Then, the Commission turned its sights to overarching issues and cross-cutting ideas that would respond to the President’s charge, motivate the field, and inspire an agenda for change. The problem of a fragmented system was identified in the Executive Order; it had also hit home during the Commission’s deliberations. No less than 42 different federal programs that might be used by individuals with mental illness were identified in our review (New Freedom Commission on Mental Health, 2003).

Many of the federal programs that are most crucial to individuals with a mental illness are mainstream in auspices (e.g. Medicare, Medicaid, Social Security programs, vocational rehabilitation, housing, and special education) where mental illness is just one of a wide range of concerns. Often, individuals with mental illness fare poorly in these programs (perhaps because of the complexity of serious mental illness: extended course, episodic nature, and high levels of disability). The scope of many of these mainstream programs is many times greater than that of the only major federal program supporting mental health care specifically—the Mental Health Block Grant. Faced with this reality, the Commission sought a change approach that would be both aggressive—because of the scope of the problem—and realistic—given the inherent challenges of change. As the Commission considered how to describe and frame needed change, a consensus emerged. In the words of the Final Report, “mere reforms are not enough. A fundamental transformation is required (Commission, 2003).” By this, the Commission implies that many changes at many levels, over time, are required to achieve substantial change.

Although the Commission would make many recommendations for change across multiple federal programs, we sought an approach to motivate action at every level. This was to propose six goals for mental health care, to create a “short list” of benchmarks to be tracked and monitored. The goals describe desired conditions for mental health and mental health care in a transformed, future mental health system.

Will the Commission’s work make a difference? The members of the Commission are under no illusion that their report, no matter how responsive and well received, will achieve deep change



Academy President Eugene D’Angelo greets former Academy President Carl Zimet at the Denver Meeting. Fall 2005.

by itself. We have hope that the rare opportunity of Presidential attention to mental health will make a difference. Although many advocates were frustrated by the slowness of the initial federal response, SAMHSA (2005) has now released an “Action Agenda” for change that reflects substantial collaboration on mental health across many agencies and the Campaign for Mental Health Reform (2005) has published its recommendations. Just as significantly, we are encouraged by the shared desire for change that emerged from consumers, family members, providers and advocates.

A concern we heard frequently was the hope that the “Commission’s report must not sit on a shelf.” Our view is that the Commission’s report is a diagnosis and treatment plan for a system of care that is sick in many ways, but also has great resilience. Our experience suggests that developing a good treatment plan is necessary—but certainly not sufficient—for progress and recovery. We urge our elected officials and all members of the mental health community to commit to that goal.

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THE FALL AND RISE OF EXPERTISE

Roger Brooke, Ph.D., FAACP



Something remarkable has happened this past year in professional psychology. It can give comfort to all our unassuming and quietly competent colleagues: the kinds of colleagues, mostly in private practice, who had little time for funded research into their work; colleagues who often did not like

labels, diagnostic or otherwise; the kind we went to for our own therapy; people in whose hands we entrusted, with trepidation and increasing confidence, our own psychological well-being and even our lives.

Diplomates of the ABPP have cause to celebrate. Expertise is once again recognized by APA as essential to professional competence. For most readers of *The Bulletin*, the importance of expertise is too obvious to need mention. Without expertise there would be no need for an ABPP. All psychologists would be equal, as long as they had received training in manual-based interventions specific to certain diagnostic categories. It is not surprising that many of us have felt alarmed at the rising scientific status of psychological interventions that treat a psychologist's expertise as a confounding variable.

A brief recap. In 1993 Div. 12 proposed that clinical psychology demonstrate its treatment efficacy in a way that would be persuasive to our colleagues in psychiatry and medicine. There was good empirical reason to believe that we psychologists would knock our medical colleagues' socks off when it came to the treatment of conditions such as anxiety and depression. Ironically, however, Div. 12's Report endorsed the culture of medical and pharmaceutical hegemony. Psychological treatment research adopted medicine's definitions of psychopathology and its method of controlled trial comparisons as the measures of scientific credibility and therapeutic effectiveness. Treatment objectives became defined solely by the DSM; recruited "subjects" were carefully screened to exclude "comorbidities," after which they were randomly assigned to different treatment modalities, or placebo groups or waiting lists as controls; "therapists" in outcome studies were trained to implement treatments according to precisely written treatment manuals. Div. 12 produced an initial list of "well established treatments," together with a list of "probably efficacious

treatments," for certain disorders. Psychologists were encouraged to support treatment research that would either validate their approaches or would show them to be no better than placebo. In the latter case, those psychologists would need to be retrained in approved manual-based procedures.

Especially alarming for many of us was that this policy was explicitly meant to assist the health care insurance industry (*ibid.* p.1). Thus there was a realistic concern that EVT's (empirically validated treatments) might become the insurance industry's measure of professional legitimacy. There were even occasional hints that practicing within a tradition not listed for specific diagnostic categories might be incompatible with best practice and therefore make one vulnerable to malpractice charges. (Mercifully, I do not know of a case in which this actually happened.)

Expertise had not explicitly been rejected, but it had been effectively abolished as an undesirable treatment variable. As the Div. 12 Report stated: "Such standardization and precise definition of treatment through treatment manuals and other procedures reduce the methodological problems caused by variable therapist outcomes and lead to more specific clinical recommendations" (*ibid.* p. 1). Competence had been implicitly redefined as knowledge of the research literature, diagnostics, appropriate patient selection, and the precise implementation of manual-based treatments. Expertise was worse than irrelevant; it was unscientific and confounding.

The demise of expertise was one of the unintended consequences of clinical psychology's adoption of the medical model as its standard for measuring therapeutic efficacy. The pressure on our good colleagues was felt as an accusing professional atmosphere. We were on the defensive, such as when filling out those interminable insurance forms asking us what specific symptoms we planned to target over the course of the next ten sessions and what treatment model we planned to implement.

Many of our colleagues felt abandoned by APA. Its *Template for Developing Guidelines* (APA, 1995) effectively endorsed the assumption that practice guidelines should be based upon research in which controlled clinical trials formed the standard of professional legitimacy. But then, what would become of those who identified themselves as eclectic, multimodal, feminist, social constructivist, psychoanalytic independent, Jungian, Kleinian, existential or humanistic, and what would become of the various types of family therapists? How could one of my colleagues possibly make time in her practice so as to hustle an experiment that would put her approach--Jungian, with large doses of attachment theory and feminist sensibilities--on some approved list? What insurance check box would not be misleading?

Ironically, what treatment successes of hers, perhaps checked in the "Psychodynamic" box, would not further delegitimize her true orientation and skills? (And what failures would not be an undeserved black eye for main stream psychodynamic therapists?)

Energetic research and scholarship over the past ten years threw the clarity and mission of the purely medical model for clinical psychology into some disarray. Critiques of validity as an impossible standard softened the term to "empirically supported treatments." The notions of empirical support, and of treatment manuals, became increasingly flexible. While controlled clinical trials remained the gold standard of efficacy studies, case lore and clinical practice outcomes were slowly accepted as relevant and supportive. The definition of "manuals" broadened to include a range of psychoanalytic texts, such as Clarkin et al's (1999) book on the psychoanalytic treatment of borderline conditions. What I found particularly interesting was that these books were hardly manuals in any simple sense. To practice in accordance with these "manuals" requires years of training and probably one's own analysis.

A number of intellectual criticisms and research findings led to the decline of the EST movement and the return of expertise as a desirable variable in professional competence. Space precludes detailed argument, but here are some markers for the significant changes that had been occurring.

Different persons with the same DSM diagnosis need to be treated differently because of individual and cultural differences, including expectations about what kind of therapist or treatment might be helpful. Treatment goals are collaboratively formed, and are often adjusted as treatment proceeds. As Seligman (1995, p. 997) noted, therapy in the real world is of variable duration, with self-correcting improvements, and is aimed at improving the quality of life as well as symptom relief for patients who have multiple problems and who select their own therapists. Because of this, controlled clinical trials have insurmountable external validity problems.

Comorbidity and lack of diagnostic specificity are more common than not. The quest for diagnostic purity can be so far removed from clinical practice as to be utterly absurd. In one report of CBT for generalized anxiety disorder, an astonishing 450 of over 500 applicants were rejected from the study for not meeting the diagnostic criteria for GAD. Apparently the study showed treatment to be efficacious (Borkovec and Costello, 1993). But as Todd and Bohart (1999) comment: "[O]ne can ask how useful such information is to a practicing clinician given that nearly 90% of the clients referred for the study (presumably because they were anxious) were not included" (p. 459).

Treatment outcomes in controlled clinical trials tend to be disappointing. In one meta-analysis of 34 outcome studies for treatment of depression, panic disorder, and PTSD, fewer than 36% of potential study participants were included in the studies, the large majority being rejected because they had "comorbid conditions." More than half of the patients accepted into treatment dropped out. Of the fewer than half of the one third who were both selected and completed treatment, most continued to have mild symptoms after treatment and gains were only partly maintained after two years. Over 50% of these patients who had completed these courses of treatment went on to other therapies (Westen and Morrison, 2001). In other words, fewer than a half of a half of one third (< 8.3%) did not pursue treatment elsewhere, and it is difficult to believe that those few were all fine. With outcomes like that most of us would have given up years ago.

Brand names for treatment approaches are poor descriptors for the processes that are effective in those approaches. In one major study (Ablon and Jones, 1998), it was shown that the sessions of effective CBT therapists met the defining templates for competent psychodynamic therapy, and that the sessions of most psychodynamic therapists met the defining templates for competent CBT sessions.

There is increasing evidence that adherence to treatment manuals is negatively correlated with treatment outcome. In the Ablon and Jones study (*ibid.*), those cognitive behavioral therapists who had adhered to their manuals were not effective. In a study of CBT for depression, better outcomes were found when therapists did not adhere rigidly to a manual (Castonguay et al, 1996). (I once asked a group of committed EST enthusiasts whether any of them would choose a therapist because of his or her reputation for adhering strictly to a manual. The cognitive dissonance set up was funny to watch, but they did laugh.)

The nonspecific factors--that is, factors shared by effective therapists of different orientations--are arguably more significant in treatment outcome than specific techniques (Wampold 2001). In particular, it is once again generally accepted that "empirically supported therapeutic relationships" (Norcross, 2002, 2004) are non-specific, complex, and necessary to positive treatment outcomes.

Evidence from the insurance industry suggests that there is no correlation between theoretical orientation and treatment outcome, even controlling for diagnosis or severity of psychopathology (Brown, Dries & Nace, 1999). Good, indifferent, and bad therapists come in all colors. Differences in competence, measured in outcomes, are greater within treatment modalities than between modalities (Wampold, 2001, p. 212).

It should be noted that APA had been fairly responsive to these developments. Its revised Criteria for Developing Treatment Guidelines (APA, 2002) was significantly more subtle and sophisticated than its 1995 version. In many respects it astutely anticipates some of the themes of the Policy and Report that were produced in 2005.

In late 2004, incoming APA President, Ronald Levant, Ed.D., ABPP, hit the ground running with a Task Force reviewing the question of competence in evidence based practice in psychology (EBPP). This Task Force comprised scientists and practitioners of various theoretical persuasions, reflecting the diversity of the field. They were given the task of formulating a Policy and a Position Paper that would describe “the best possible care based on the best available evidence” (APA, 2005b, p.3). A provisional report was made available for comment in March 2005. The final Policy Statement on Evidence-Based Practice in Psychology was approved as APA Policy and the accompanying Report of the 2005 Presidential Task Force on Evidence-Based Practice was accepted by the Council of Representatives of APA in August 2005.

The Policy and the Report discuss three areas: the question of best available evidence, clinical expertise, and patients’ characteristics. In my reading, clinical expertise is the pivot around which the questions of evidence and patient characteristics are organized.

It is up to the practicing clinical psychologist to evaluate different forms of evidence in the context of the patient’s characteristics, circumstances, and values. This means that our good colleagues are advised not to submit their expertise to the results of controlled clinical trials, but to use their critical thinking and good judgment in their assessment of various sources of evidence as well as the needs and circumstances of each particular patient.

Expertise is operationally defined and discussed in considerable detail, and readers are encouraged to read the Policy and Report for themselves. I would simply like to highlight a few of the statements (all from APA, 2005b) that go to the heart of why we can celebrate--and why we can extend our thanks and congratulations to Ron Levant and his colleagues on the Task Force. We can start with their summary statement:

“Experts recognize meaningful patterns and disregard irrelevant information, acquire extensive knowledge and organize it in ways that reflect a deep understanding of their domain, organize their knowledge using functional rather than descriptive features, retrieve knowledge relevant to the task at hand fluidly and automatically, adapt to new situations, self-monitor their knowledge and performance, know when their knowledge is inadequate, continue to learn, and generally attain outcomes commensurate with their expertise” (p. 10).

“Psychological practice is a complex relational and technical enterprise that requires clinical and research attention to multiple, interacting sources of treatment effectiveness” (p. 8).

“Expert clinicians revise their case conceptualizations as treatment proceeds” (p. 11).

“The goals of therapy are developed in collaboration with the patient” (p. 11).

“Psychological practice is, at root, an interpersonal relationship between psychologist and patient. Each participant in the treatment relationship exerts influence on its process and outcome, and the compatibility of psychologist and patient(s) is particularly important” (p.12).

“Psychologists must attend to the individual person to make the complex choices necessary to conceptualize, prioritize, and treat multiple symptoms” (p. 16).

“Perhaps the central message of this task force report, and one of the most heartening aspects that led to it, is the consensus achieved among a diverse group of scientists, clinicians, and scientist-clinicians from multiple perspectives that [Evidence-Based Practice in Psychology] requires an appreciation of the value of multiple sources of scientific evidence” (p. 18).

“Treatment decisions should never be made by untrained persons unfamiliar with the specifics of the case” (p. 18).

It could not be clearer than that.

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Academy Vice President Larry Schoefield (L) and Eugene D'Angelo (R) welcome Academy Executive Director Lynn Peterson to the board meeting in Denver and thank her for all her work on the academy's behalf.

This is the last in our series of articles on Theory, Research and Clinical Practice. Careful research on temperament in humans has been going on longitudinally now for many decades, and the implications for clinical practice are considerable. Dr. Saposnek summarizes some core findings of this area and offers us some guidance for helping families deal with those varieties of our human nature that other varieties find vexing. Good science can be very practical.

The Use of Temperament in Clinical Practice



Donald T. Saposnek, Ph.D.

Among the concepts that I have found most useful in my three decades of clinical work as a clinical-child psychologist, parent educator, family therapist, and child custody mediator is the concept of temperament. The domain of temperament is best conceptualized as a subset of the more general arena of personality. This notion of inborn characteristics has been around in different forms for almost 2000 years, beginning perhaps with the Greek physician, Galen of Pergamon (Kagan, 1998), who posited four temperament types in adults (melancholic, sanguine, choleric, and phlegmatic) that were reflected in their personalities.

Research into the individual differences and temperaments of infants and children began in the 1920s and 1930s with the work of Gesell, Shirley, Escalona, and Schneirla, who documented the range of these characteristics. Then, in the 1950s, Thomas, Chess, and Birch (1968) began their seminal anterospective study of temperament—the New York Longitudinal Study (NYLS). Through factor analytic methods they identified nine dimensions of temperament, and they defined temperament characteristics as “styles” of behavior—the how rather than the why or what of behavior. These characteristics are present at birth, stable by 6-8 weeks after birth and present with strong evidence of a genetic basis. Thomas and Chess initially followed a group of infants through their childhood and adolescence, observing and rating the ways in which their temperament characteristics impacted and were impacted by their parents and caregivers through exquisite,

reciprocal interactions over time. Over the course of thirty years, with replication by other research samples, and having published hundreds of articles and numerous major books, they accumulated important findings that have made significant impact on our thinking about child rearing and the development of children’s behavioral problems. Additionally, numerous other contemporary researchers have explored and expanded our knowledge of temperament and have identified additional dimensions that are of comparable significance to child development.

Empirical research in temperament is difficult, and there continues to be considerable controversy over appropriate research methodologies, the number of dimensions that validly and reliably hold up to research scrutiny, and the exact nature of and interactions among the various contributing biological, genetic, and experiential influences on temperament (See Rothbart & Bates, 1998, for an excellent review of these issues). Indeed, these are exciting, promising, and important issues to sort out. However, as is the case in so many areas of applied psychology, clinical usefulness of a concept often precedes final validation by rigorous research. Some of the particular child temperament dimensions that are immediately important and useful to parents for understanding and modifying patterns of interactions within a relationship may not yet have attained high levels of validity and/or reliability when put under the scrutiny of strict research methods. Nonetheless, they can still serve as a basis for clinically helpful educative interventions.

Over several decades, I have accumulated and developed a profile of 17 dimensions that are documented in the research literature and have proved to be extremely useful in clinical assessments and educative interventions in both therapy and child custody contexts (Saposnek, 1998, 2004, 2005). I use the profile to help parents separate the portion of their child’s symptomatic behaviors that may be the result of life-long developmental processes (temperament) from that which is primarily related to stressors in a more time-limited period in the child’s life. Then, I help the clients to explore which dimensions may have led to a poor fit between a parent’s tolerance and the child’s temperament (see “goodness of fit” concept below) and develop strategies to correct the results of a poor fit. I also find the profile useful in helping couples identify and change aspects of conflict in their adult relationships that may have originated from style differences rather than motivated intent. These small educative interventions that lead clients to develop more constructive interactive strategies help shift the focus of therapy from pathology to health and competencies and can also significantly reduce therapy time.

The following dimensions are included on the profile:

1. **ACTIVITY LEVEL** (Sheer amount of movement—ranging from Low to High).
2. **RHYTHMICITY** (Regularity and predictability of bodily functions, e.g. eating; sleeping; elimination—ranging from Very Erratic to Very Regular).
3. **APPROACH TO NEW SITUATIONS** (comfort in warming up to new situations, people, toys, etc.—ranging from Very Slow to Warm up, to Very Quick to Warm up).
4. **ADAPTABILITY** (Flexibility; ease with which responses can be modified—ranging from Non Adaptable to Very Adaptable).
5. **INTENSITY OF REACTION** (Energy level of responses—ranging from Very Low Intensity to Very High Intensity).
6. **THRESHOLD OF RESPONSIVENESS** (Sensitivity threshold --Intensity of stimulation needed to get an orienting response—ranging from Low Threshold [Very sensitive] to High Threshold [Very insensitive]).
7. **QUALITY OF MOOD** (Overall mood most of the time—ranging from Very Somber and Serious to Very Joyful and Pleasant).
8. **DISTRACTIBILITY** (Ease with which extraneous internal or external stimuli will interfere with on-going behavior—ranging from Very Distractible to Non Distractible).
9. **ATTENTION SPAN/PERSISTENCE** (Length of time persisting at an activity without distractions—ranging from Short Time to Long Time).
10. **EMOTIONALITY** (Ease with which emotions are expressed—ranging from Non-Expressive to Very Expressive).
11. **SOCIABILITY** (Degree to which person enjoys contact with people—ranging from Non-Sociable to Very Sociable).
12. **FEARFULNESS** (Tendency to experience and express fear—ranging from Fearless to Fearful).
13. **SOOTHABILITY** (Ease with which person can be soothed when distressed—ranging from Not Easily to Very Easily).
14. **FASTIDIOUSNESS** (Tendency to need things to be neat and orderly—ranging from Non-Fastidious to Very Fastidious).
15. **CUDDLYNESS** (Degree to which person likes to be held closely—ranging from Non-Cuddler to Cuddler).

16. **RISK-TAKING (PHYSICAL)** (Degree to which person likes to take physical risks—ranging from Low to High).

17. **RISK-TAKING (MENTAL)** (Degree to which person likes to take mental and social risks—ranging from Low to High).

Some of the more important findings from temperament research are as follows:

Temperament characteristics tend to remain relatively stable over time. This means that, for example, a child who has a high activity level at birth is likely to maintain a high activity level throughout childhood, regardless of what is done to try to slow him or her down. While it is possible to teach a child to change his behavior somewhat against his temperament, it is not likely that you could change his behavioral style significantly and permanently in its opposite direction. Adults, when adopting social roles, and adolescents, as a result of hormonal and peer influences, often learn to temporarily adjust their behavior to specific situations in ways that may give the appearance of a temperament style change. But, once out of the situation, the previously expressed patterns usually re-emerge. Children, however, are much more consistent in their temperament expressions across time and situations.

While the relative stability of these characteristics is significant and interesting, the most important influence of these temperament characteristics on development is embodied in the notion of "goodness of fit" (Thomas & Chess, 1968), which is the interaction of these characteristic styles of behavior with the tolerances and expectations of caregivers and other significant people in the child's life (i.e. parents, siblings, teachers); the better the fit between a child's temperament and his caregivers' tolerance, the healthier development of the child, the poorer the fit, the worse the outcome. For example, consider what might happen if a child with a high activity level were born to a couple who could only tolerate low active behavior of children. Perhaps the mother and father both love to sit and read peacefully for extended periods of time. As their child moves about the house frequently and rapidly, the parents begin to yell at the child to "Slow down," "Stop disrupting the household," "Stop being such a trouble-maker!" Regularly hearing such negative comments, the child feels increasingly stressed (since she actually cannot help herself), begins to develop self-doubts and a negative self-image, and perhaps begins to live up to the prophecy of a "trouble-maker," or one who "cannot control herself." By the time she is of school age, she is already set up to fail socially, and perhaps academically as well.

Or, think of a child who is temperamentally slow to warm up to changes, resists transitions, and is born to parents who have a very active social life and are constantly on the move. Each time the parents try to get the child out the door, he resists, whines, and protests. The parent increasingly feels exasperated and pressured by time and begins trying to force the child out the door. Family conflict will predictably blossom. When parents' tolerances and their child's temperament characteristics are poorly matched (a poor fit), there is a significantly increased chance of the child developing behavior problems over time. However, if parents are aware of these mismatched variables, they can structure their environment and expectations for their child so as to minimize conflict and negative interactional patterns from developing.

There are no intrinsically "good" or "bad" temperament characteristics. And, a good fit does not necessarily occur even when the parent has the same temperament characteristics as the child. There are only good or bad attitudes towards a child's particular temperament characteristics and helpful or unhelpful expectations about them. For example, the parent who just likes to read quietly might view an active child as unbearably annoying, whereas, another parent (who is a sports enthusiast) might view the same active child with delight—"... at last, a child who can keep up with my needs for active play!" Or, one parent might view a child who in temperament is very intense and loud in his responses as a constant source of harshness and irritation, while another parent might positively and proudly see this same child as an assertive, strong young man who stands up for his rights, lets himself be heard, and does not cower to anyone. These interactions between particular temperament characteristics and the reactions of others to them continue as a subtle but powerfully influential on-going process throughout a child's development.

While there is strong evidence for a genetic influence, a temperament characteristic is not inherited as a single gene, such as it is for eye color. Rather, it is the result of the complex influences of multiple genes with significant variation of their expression. This means that a child may have a very different temperament profile from his or her parents or siblings. Of particular significance, a lesson from behavioral genetics is that genetically-loaded behavioral characteristics will exaggerate towards the extreme to which they are inclined, when the organism is under stress. This means that a parent with a moderately high active child who creates stress by yelling at him to slow down (an intervention that would seem intuitive to many parents) will likely generate in the child an even higher activity level. Bringing this counter-intuitive phenomenon to the awareness of parents can be very helpful in persuading them to use more playful strategies in managing their child's expressions of temperament characteristics.

Historically, we have attributed behavior problems of children to psychological problems within the child. In contrast, the concept of temperament offers an interpersonal, interactive view—that such problems can often be the result of an on-going mismatch between parents' tolerances and their child's particular temperament. As parents persistently struggle to change their child's genetically determined style of behavior that resists change and is programmed to exaggerate under stress, the child feels frustrated, discounted, and eventually develops symptomatic behaviors.

With knowledge of temperament characteristics and the dynamics that lead to goodness of fit, therapists can help parents effectively minimize long-term, destructive interactional patterns that lead to emotional and behavioral problems in their children.

FOOTNOTES:

1 Copies of the Profile and supporting questionnaire that focuses the ratings can be obtained by contacting the author.

2 Dimensions 1-9 are adapted from Thomas, A., Chess, S., and Birch, H.G. (1968).

Dimensions 10 and 11 from Buss and Plomin, (1975)

Dimensions 12 and 13 from Rothbart, et al. (1994; 1998)

Dimension 14, from Graham, Rutter, & George, (1973)

Dimension 15 from Schaffer and Emerson, (1964)

Dimension 16-17 from Farley, (1986)

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Lifelong Professional Development Project Request For AACP Member Input

The Executive Board of your Academy is sponsoring an investigation into long-term professional learning and growth. Much effort is put into training to enable persons to enter the profession, but relatively few resources are available to help the practicing psychologist to continue to grow and learn. Continuing education for re-licensure is the most common method, but everyone who has participated knows that it has varying effectiveness. Some psychologists will continue to read professional literature, and some will join others in peer consultation efforts, but there are no systematic approaches to lifelong professional development.

As a first step in this project, we would like to identify, with your help, the internal processes and changes that take place as a part of growth and development, as well as find out what activities you have engaged in to promote those changes. Examples of internal changes that take place over time that enable you to provide more effective services might include gaining a deeper capacity for empathy or developing your own system for describing behavior and its problems. Examples of activities promoting change might be peer consultation groups or participating in your own therapy.

With this input from you, we will construct a model of development and an inventory of processes that lead to improvements in skills, as well as a list of activities that facilitate those processes. We hope you will share our enthusiasm for the potential of this project, which we hope will lead to an improved understanding of professional growth, which can be published and available to all psychologists (and other mental health professionals as well). You may reply to the following questions with a hard-copy mailed to Christopher Ebbe, Ph.D., 943 Scripps Dr., Claremont CA 91711 or e-mail your answers to cebbe@alum.mit.edu.

Christopher Ebbe, Ph.D., ABPP, FAACP

Eugene D'Angelo, Ph.D., ABPP, FAACP—President, AACP

1. Please list improvements in skills and competencies that you have noted in yourself or others after the point of licensure--any new or changed behavior that has made you a better therapist, assessor, supervisor, consultant, etc. Don't limit yourself just to things we already have concepts for—your attempts to articulate something vague or relatively ineffable will be appreciated!

2. For the changes and improvements you listed above, what brought them about? This might be interactions with other people, reading, or supports. It could have taken place with others or by yourself, and the purely internal processes might have been attempted consciously or occurred relatively unconsciously.

Thank you for your contributions!

Testimony to the Special Committee on Financial Institutions and Insurance - Kansas Legislature – September 26, 2005

Ira Stamm, Ph.D., FAACP

Good morning. My name is Dr. Ira Stamm. I am a psychologist in private practice in Topeka. Before entering private practice I was with the Menninger Clinic in Topeka from 1972-1995. It is a privilege and an honor to address this Special Committee. My testimony reflects my own professional views as a psychologist in private practice and not those of any organization.

In 2001 the Kansas legislature in a moment of its finest wisdom and kindness passed a piece of landmark legislation, the Kansas Mental Health Parity Act. This act guarantees to individuals suffering from mental illnesses which have a biological basis that they can have 45 days of inpatient care and 45 outpatient sessions for treatment of their illnesses

INPATIENT TREATMENT

Unfortunately, some, but not all, insurance carriers doing business in Kansas have found ways to undermine and thwart the good intent of the mental health parity act passed by the Kansas legislature. Teenagers who have made suicide attempts are allowed no more than three to five days in a psychiatric hospital following an attempt. The parents of one teenager who needed re-admission to a hospital for a longer stay were denied that request by the insurance company. Instead, the insurance company case manager suggested that the parents contact SRS, have their son declared a "child in need of care", relinquish custody to SRS, and have treatment paid for by SRS; or, they were advised they could call the sheriff, have the teenager arrested, and treated within the juvenile justice system. The State of Kansas and not the insurance

company eventually paid for this boy's treatment in a residential facility.

This vignette highlights two problems:

1. Are some commercial insurance carriers in Kansas routinely engaging in "breach of contract" by denying to policyholders health care benefits for which they have paid premiums?
2. By denying consumers use of their purchased benefits some insurance companies are "cost shifting" their fiduciary responsibility to the public ledger.

OUTPATIENT TREATMENT

Patients seeking outpatient mental health services encounter a different set of problems. Although the mental health parity act entitles many Kansans to 45 outpatient sessions, these sessions are meted out by some carriers in series of 3 or 6 or 9 sessions. Some companies require the patient to obtain authorization before seeing the therapist for the first time. Some companies then require the therapist to fax a one or two page report to the company requesting authorization for additional sessions. Therapists are sometimes discouraged by the insurance company from continuing to see the patient. The case manager of one company told me "to wind down the treatment in the next several months."

Utilization review for outpatient therapy highlights several problems:

1. The erosion of confidentiality – the therapist must share with the insurance company private and confidential material. Some companies store this information in national data banks outside of Kansas.
2. The utilization review practices of some insurance companies threaten and disrupt the emotional connection between patient and therapist. Continuity of the patient-therapist relationship is the basis for therapeutic healing. The patient and therapist no longer direct the patient's treatment. Treatment is directed by the insurance company.
3. Mental health patients are subject to different standards of utilization review from patients who undergo medical and surgical treatment. Patients with asthma, diabetes, high blood pressure, etc. are not told they can only see their doctor for three sessions at a time. In this way mental health parity is more illusion than reality.

ALLOWABLE FEE SCHEDULES

In 2004 one of the largest insurance carriers in Kansas notified its non physician health care providers that their allowable fee schedules would be reduced 10-30%. This included community mental health centers, outpatient substance abuse facilities, licensed clinical social workers, clinical psychologists, nurse practitioners (ARNPs), physician assistants, chiropractors, physical therapists, occupational therapists, and speech language pathologists.

The insurance company was asked for financial data demonstrating that it was losing money on services offered by these practitioners. The insurance company said they had no such data. The insurance company explained that its plan simply was to reduce the fee schedule to these providers until providers begin to drop out of the network – this would indicate that a bottom or floor had been reached – and no further reductions would be made.

An audit requested by the Kansas legislature showed that mental health costs to the insurance carriers increased by less than 1% a year from 1999 through 2002. The aggregate increase in costs during the first year of mental health parity in 2002 was also less than 1% - no more than it had been prior to the mental health parity act. Other studies, referred to as the “cost offset data”, suggest that when adequate mental health services are available and funded, the costs of health care on the medical and surgical side decreases by 20%. In spite of this data this one insurance carrier reduced its payments to mental health providers 15-30%.

KANSAS INSURANCE DEPARTMENT

The Kansas Insurance Department has been made aware of the problems with utilization review and the allowable fee schedule changes. To my knowledge the Kansas Insurance Department has taken no steps to protect vulnerable adolescents or others with mental illness from the dangerous utilization review practices of some insurance carriers. It is just a matter of time before one or more adolescents or other mental health patients take their life in a suicide that is preventable if these patients could have had access to treatment denied by their insurance carrier.

On the matter of fee schedules, the Kansas Insurance Department has taken the position that it does not have the authority to intervene in what it views as a dispute between an insurance company and its providers.

I am a member of a group of concerned health care professionals who have been meeting on a regular basis over the past two years to study problems with health care insurance in Kansas. Our group has concluded, regrettably, that the Kansas Insurance Department functions more as a Review Agency than as a Regulatory Agency. The Kansas Insurance Department needs to function more like the Kansas Corporation Commission.

It would be helpful if the Kansas Insurance Department would pick up the phone and ask the insurance companies to apply the same standards of gatekeeping and utilization review to patients with mental illnesses as they do to patients who seek medical and surgical treatment.

It would be equally helpful if the Kansas Insurance Department would ask the insurance company that arbitrarily decreased the fee schedule for certain providers, “Why are you reducing fees to mental health centers and individual non-physician providers while increasing them for doctors and hospitals? This has the appearance that you are trying to take advantage of those small providers who do not have the financial or political resources to oppose those changes.”

RECOMMENDATIONS TO THE KANSAS LEGISLATURE

What might the Special Committee and the Kansas legislature do to help all Kansans with commercial health insurance?

1) Gather data. As a start, request that the Kansas Insurance Department conduct an audit of the treatment of all adolescents with a diagnosis of Major Depression and who have been hospitalized for that depression. Study the benefits offered in the insurance contracts of these patients and compare them with the lengths of stay in the hospital for these teenagers.

2) Amend the mental health parity law in three ways:

- First, require that patients accessing mental health services have the same co-payments and deductibles for mental health services as they do for medical and surgical services. For examples, if medical services have a \$15 or 20% co-pay mental health services cannot have a 50% co-pay.

- Second, add to the law that the gatekeeping and utilization review requirements and thresholds for mental health services be the same as for medical and surgical services.

- Third, expand the illnesses to be covered by mental health parity to all mental and emotional disorders.

3) The Kansas legislature might also amend the statutes governing the work and responsibilities of the Kansas Insurance Department to include making sure that all patients are getting full access to their insurance benefits, and give the insurance department the authority and mandate to intercede in disputes between insurance companies and hospitals and providers.

4) Lastly, ask the Office of the Attorney General to rule on whether it is legal for an insurance company to deny benefits to patients that are a written part of the insurance contract or whether failure to do so constitutes a "breach of contract?"

Thank you for listening to these remarks. I will be pleased to answer any questions.

Ira Stamm, Ph.D., ABPP

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Enc. 40-2, 105a – Kansas mental health parity act

40-2, 105 – General provisions fornervous and mental conditions

Chiles, C., et.al. (1999) The Impact of Psychological Interventions on Medical Cost Offset: A Meta-analytic Review, American Psychological Association, pp. 204-220 (page 204 attached)

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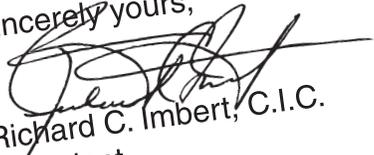
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