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For information about articles or advertising in the
Texas Psychologist, please contact Lauren Witt at
(888) 872-3435 or tpa_lwitt@att.net
1464 E. Whitestone Blvd., Suite 401
Cedar Park, TX 78613
(888) 872-3435 • (888) 511-1305 fax
www.texaspsyc.org
There is a lot for Texas psychologists to be excited about! Good things have been happening in our state, and TPA has been at the vanguard of increased momentum and visibility for our profession. At the same time, the roles and opportunities for psychologists are shifting rapidly as the health care environment struggles for new efficiencies. This issue of the Texas Psychologist speaks to both sources of excitement.

We’ve had unprecedented success in promoting and protecting the profession of psychology during the last legislative session. Check out President Ray Brown’s discussion of our growth as THE voice for psychology in the Capitol. Executive Director David White’s report will clue you in about the many specific victories we enjoyed in the legislature. We have a lot to crow about, so don’t miss these articles.

Are you ready for the numerous and inexorable changes coming to the health care marketplace? Many practitioners will need to change to accommodate the new realities. Drs. Charles Walker and Kathryn Wortz of UT Health Northeast (formerly known as UT Health Sciences Center in Tyler) discuss the forces that will push us toward integrative care models, and they outline some of the roles that will open up for psychologists in Affordable Care Organizations and other integrated care organizations. They follow this with a second article describing how a psychologist operates as an integrated part of the treatment team in the Family Medicine Residency; there are several concrete suggestions about how psychologists modify usual practices to maximize their impact.

Some psychologists have been involved in collaborative care for years. Dr. Andy Block of TPA’s Integrated Health Care Task Force describes his long experience with a collaborative team working with orthopedic surgery patients. I think you’ll find his experience is instructive.

Are you rested? In addition to developing some different skills, psychologists will be developing new services for the medical marketplace. There is a substantial need for psychologists in the area of sleep. Drs. Taylor, Roane, and Dietch, from the University of North Texas and the University of North Texas Health Sciences Center in Fort Worth provide us with an up to date, evidence-based overview of diagnosis and treatment options for insomnia. It is an exemplary tutorial on an area where we have opportunities.

Finally, there is a big push at APA to make sure that psychologists have parity with all the other doctoral health care providers. The Medicare definition of “physician” includes many non-MDs, but not us. Dr. Cheryl Hall, TPA’s Federal Advocacy Coordinator, provides a discussion of the context and the process for this ongoing advocacy issue. This is the most significant policy issue currently on psychology’s agenda and the outcome will be a game changer for psychologists nationally. Keep your eye on this as it develops!

INVITE A COLLEAGUE TO JOIN TPA! You can look for a lapsed member or find a newly-minted early career psychologist. Take ‘em to lunch. Contact TPA Staff and/or the Membership Committee to help build our ranks.
It is indeed a time of celebration for TPA! Just in case you have not been “tuned in,” I am referring to our success in the 2013 legislative session. The most obvious accomplishments in this process include the passage of, not one, but two bills (HB 807 and HB 808) that we wrote, introduced through strong legislative sponsors/representatives, and successfully promoted. The celebration that I reference is not however, limited to the passage of these two bills. The celebration relates also to something of a turning point involving the growing momentum that we are feeling in our relationships with elected officials at the Capitol. Along with this, the events of the session left many of us feeling that we, Texas psychologists, have clearly been recognized as leaders in the arena of mental health and that our opinions and our support have been solicited, perhaps as never before! Historically, it has not been unusual for us to introduce bills with no success, when measured by their passage. In fact, I have experienced great difficulty in finding anyone who can specifically remember a legislative session wherein we passed even one, much less two, bills. This probably our most successful legislative session ever—excluding the passage of our licensing law many years ago, the Sunset survival years, and later on, our inclusion within the ranks of those who can bill insurance. The latter of these milestones occurred in the early days of my professional career, perhaps 30-35 years ago!

You will read more about the details of our successful bills elsewhere in this publication (see David White’s article), but I am compelled to provide a brief summary of each. HB 807 serves to enhance the protection of the term and title of “Psychologist,” disallowing it to be used as a job title for any non-licensed person within a state agency. That restriction is rather inclusive, with the exception of institutions of higher learning. We believe that this will do much to reduce confusion within the public sector as to what a psychologist is, emphasizing that fundamental achievements to earn that title include a doctoral degree in psychology and a state license (TSBEP). HB 808 allows for individuals in their final stages of training (including, but not limited to, provisionally licensed individuals) to work under supervision and bill for those services through the supervising psychologist. In addition, this will allow a newly-licensed individual the option of continuing under supervision for a time beyond the legal requirement and billing for services while awaiting inclusion on insurance panels. Just imagine the positive impact of this change for increasing the interest in a career in psychology. Hopefully this eliminates that “no man’s land” related to the year of postdoctoral supervision when employment is difficult to find, and increases the positive impact on the ability of a new psychologist to begin to attack the student loans! I do, however, anticipate further fights with the insurance companies that may well resist payment under this law until they are forced to do such. So, there may well be more battles to fight, but Texas law will now be on our side. Where might such skepticism come from regarding the insurance industry?

In no way do I wish to dilute or understate the significance of the passage of these two bills. They are important, but, on their own, they do not radically change the landscape of the practice of psychology. The real accomplishment, and the greatest reason to be excited and to be in a celebratory posture, relates to the mood and tone of this legislative session, the reliance on us for advice, the seeking of direction, and the requests for clarification when issues came up related to mental health and psychology. The success relates to us being heard when we spoke out against bills that were either bad for the profession of psychology and/or bad for the general public whom we serve. The apparent momentum, in my opinion, is what this is all about. It is what can keep us advancing, and help us to shore up our profession.

I will clarify from the onset that this momentum did not begin, and certainly should not end, with the efforts of this one legislative year and one legislative team. Just two years ago, under the strong leadership of Dr. Rob Mehl, we came very close to passing bills that would have accomplished our same goals—one of those bills simply not being brought to committee in the Senate for testimony and a vote, thus dying. The work in that last legislative session and the leadership involved were every bit as powerful, as diligent, and as meaningful as what went into this successful legislative session. If we would look back, the impetus from years of work served to energize and provide a foundation for us to build upon. The tenacity and the growing sophistication of TPA have expanded and such have made the work of all of us involved in the last session look very good. However, this momentum has yet to take us where we need or want to be. But it can take us there if, and only if, we build from where we are now and expand what we have accomplished. Maintaining the ongoing commitment of Texas psychologists who are willing to step up and do battle for TPA, the only organization that will ever promote our causes and help keep us professionally safe, is critical.

Perhaps what I am trying to say here has been best said in the comments shared with me by colleagues and I will share a sample of those. Dr. Catherine Lanham said it well in a message to me, stating that, “…this is the accumulation of so many years’ work and so many people’s efforts. What a
Returning to the notion that our legislative efforts are ongoing, cumulative, and demanding of tenacity that is sometimes hard to maintain in the shadow of perceived failure, allow me to share some brief history. Almost immediately after the end of the 2011 legislative session, TPA board members and committee members assessed our successes, failures and needs, and began to make plans, almost two years before the next session would begin. The Legislative Committee that worked was appointed early on, and they began to meet (teleconference) every other week. This turned into weekly meetings once the 2013 session opened. Concurrently, we began to draft/revise the bills that we planned to introduce. Sponsors were courted, and David White began to spend more and more time at the Capitol. As the 2011 legislative session ended, we crafted our legislative agenda for 2013. We focused on issues of mental health care. We hoped to increase the access to care, to improve the continuity of care, and to improve the quality of care in the mental health domain. We spoke ideally of joining hands with other disciplines to support these “quality of care” goals, getting behind any and all bills that might impact such. We made a strong commitment to work in the legislative arena in support of the doctoral standard and to protect psychology. We were especially prepared to address anticipated movement by the behavioral analysts and we were thankful when, ultimately, they made no legislative moves. We anticipated new turf issues from the LPAs, but eventually had to deal with them largely in the sense that they chose to openly oppose most everything that we supported, even HB 808, that might well have enhanced their access to jobs and income under the supervision of a licensed psychologist through whom they might more extensively bill for services. At their request, we excluded them from this legislation. We attempted to open new avenues of service for psychologists in other ways. We seriously entertained a bill that we crafted in which psychologists could legally perform the duties and sign the certificates related to the likes of involuntary commitment cases. We learned that, because of the definition of “physician” and the wording of our law and our Texas Constitution, which would require a Constitutional revision. That is an undertaking that must be initiated behind

When the session began, David passed to his staff most of the routine aspects of his job and his hours of meeting, greeting and educating escalated as he reached out to elected officials and their key staff. The Legislative Committee reviewed bills that appeared to have any bearing on our profession, then rated them, and made choices to monitor, oppose or support each bill. That sounds rather easy, but this involved making some difficult decisions—decisions wherein all political implications, relationships, and cost-to-benefit assessments had to be made. As an example, we chose not to weigh in on a bill wherein an important, but controversial, social justice issue was prominent. This decision did not reflect an absence of support, but was made because we knew that in the current legislative atmosphere, the bill would not likely gain momentum and the controversial nature might have impacted
us negatively. While debate among our committee continued, the decision was made to remain silent so as to make no enemies unless unsuspected momentum somehow developed, but it did not. We avoided challenging one bill initially because the sponsor was authoring yet another bill that we were compelled to support. Eventually, we did oppose the bill that we thought would be bad for psychology and we caused it to fail. We took that risk and came out well on both sides, that is, stopping a bad bill, apparently without offending the supporting representative. This, of course, took some explaining and education on our part. I think that we learned/remembered that sometimes taking a strong position, be it for a certain bill or for a matter of principle, cannot be acted on without assessing the “big picture” and making calculated decisions of the likely gains and likely losses for psychology. Sometimes it simply is not prudent to “just fight that bill” when such might put us at risk in a greater sense. Fortunately, the legislative committee worked well together and performed an outstanding service. Most of the members missed very few, if any, of those teleconferences, sometimes keeping their commitments to service by talking in transit, while on vacation, or even during sick leave. Thank you all! To top this off, an outstanding grassroots committee worked diligently and consistently, largely unseen, promoting contacts, seeking out their elected officials, and requesting the same of many psychologists around the state. Several of us gave important testimony in both the House and in the Senate. There were frequent trips to Austin, but fortunately, we escaped the midnight testimony that some of our members endured in past sessions. I watched with pride and reassurance as David and I walked the halls of the Capitol and as it became real to me that many in the Capitol know David White, by face or by name, and they feel a connection to psychology. Most of all, I sensed much trust in TPA. I saw evidence that we are being sought out for education, ideas and input, and I saw that some lawmakers were attempting to go out of their way to do “no harm” to psychology as they worked on legislation because of the respect for David and for TPA.

I spoke earlier of our need to develop relationships with psychiatry, looking for common ground where we can occasionally join hands for the betterment of mental health issues in Texas. There will always be turf issues between these two disciplines, and I remain convinced that our best hope of moving forward, advancing our areas of service, and capturing new turf will come in small increments such as those that we saw in this legislative session. I have total conviction that our greatest commitment is to maintain the momentum that we have developed over recent years and I think that we could easily lose much of that if we appear greedy or totally committed to invade/conquer the perceived turf of psychiatry. Conversely, I believe that much can be gained with the “baby steps” approach that worked so well this time around. The greedy appearance piece of that reminds me of a decorative holiday pillow that I once saw. It simply said, “Santa, I want it all!” That, I believe, is a position that we must avoid, relying instead on slow and steady progression, taking the occasional “grand step” when the climate, the culture, and the momentum suggest that the “grand step” will come down on firm ground.

One thing that I think has been very good for us, and something that many of you may not have known, is that the three individuals who carried our two bills all the way to the governor’s desk are all physicians. Dr. John Zerwas is the Representative who carried both of the bills in the House and, on the Senate side, 807 and 808 were each picked up by a physician, specifically Dr. Robert Deuell and Dr. Charles Schwertner. I personally think that it is both noteworthy and significant that these three gentlemen, all from the medical community, gave us the support necessary to pass these bills. In fact, I cannot help but believe that their support was persuasive and validating in the eyes of their colleagues. I would wish that everyone who reads this article might consider dropping a note to these gentlemen, thanking them for their support.

Even before the celebratory atmosphere waned, TPA Board members, Legislative Committee members, and Grassroots Committee members were invited to participate, at their own expense, to a day of review, assessment and planning with the 2015 legislative session in mind. This occurred in Salado on June 27 and marked the beginning of our efforts to accomplish even more in the next legislative session. During the two days that followed, your Finance Committee met and worked to develop next year’s budget. Among the budgetary issues, there was discussion about the need and the value of a paid legislative consultant. Opinions differ on this role for TPA, but it is my plan to recommend a modest monthly commitment so that we can again (as in the session just ending) employ Shannon Noble, or the person best suited for this role, or at least have dedicated monies available to pay for consultation in legislative matters. I witnessed David White take on the real role of “lobbyist” for TPA, just as we had planned, but I also had the opportunity to see the value of an attorney/legislative consultant who could do research, clarify points of law, and occasionally address one of the lawmakers from a different position than could either David or one of us as TPA members. The results of this session led me to believe that we have found the best model for us.

In trying to summarize all this, allow me to simply say that we collectively did well and met success that cannot be explained in any way other than it resulting from a pattern of continued commitment, being able to come back after being “knocked down,” knowing how to build relationships, and demonstrating that we, the psychologists of Texas, are in second place to nobody, no profession, when it comes to expertise in the field of mental health care. This speaks to the message that I have delivered in redundant, probably boring, fashion for the last six months. That is, that if anything occurs to protect psychologists in Texas, TPA is probably behind it and that was certainly the case with regard to our legislative success. All of us as psychologists can thank TPA for the protection and support it brings to our profession. This current momentum must be maintained! I plead with you, yes once again, to maintain or even upgrade your membership with TPA. Additionally, please make it your personal goal to recruit no less than one or even upgrade your membership with TPA. Additionally, please make it your personal goal to recruit no less than one psychologist who is already receiving the benefits of TPA, but please make it your personal goal to recruit no less than one psychologist who is already receiving the benefits of TPA, but who has not yet joined in through membership and service. I would agree with Lane Ogden’s comments wherein he wanted to name every single person who has been a part of this successful legislative year. We simply cannot do that because we do not even know everyone who sent in money, made a call, turned in a card of support at a legislative hearing, or whatever. If you know someone who did any of those things, please thank them and especially communicate your appreciation to the outstanding efforts of your Legislative and Grassroots Committees. I am proud to be a part of TPA, and I am honored to be a part of the TPA leadership! I thank you all!
We all will agree that our world is changing. Change is good but many of us are not comfortable with change. You are keenly aware that changes are happening within your profession. But even with all the change you are experiencing, TPA is undergoing a metamorphous. From a legislative perspective, TPA will never be same.

Over the 22 years I have had the privilege of working as your Executive Director, I have shared with you that TPA is the only organization that represents your profession in the state legislature. Every session TPA’s representatives have monitored, testified and advocated on issues that affect you as a psychologist. This year TPA did the same thing, however, what we experienced was different. We have finally “grown up” as an organization. We have earned the respect of legislators and have become a player when it comes to mental health legislation. We had legislators seeking the advice from TPA on pending legislation. When we had concerns, bills were changed. We had laws we wanted changed, and legislators made it a priority to get that legislation passed. We were getting priority hearings and were constantly being summoned to explain our position on bills. We garnered the support from the leaders in the House and Senate to assure that our legislation was passed or killed. TPA will never be the same, which means you and your practice will never be the same.

Let me share with you some highlights of our 2013 legislative session.

HB 807 - The use of the title ‘Psychologist’

Under current law, certain persons employed by a government agency are exempt from licensing requirements for psychologists. This means that an agency may call a mental health service provider a “psychologist” even if the person does not have the appropriate doctoral degree or any of the required training and expertise associated with a license to practice psychology. These discrepancies can be confusing to consumers and to the general public.

TPA lead the effort to get the law changed and modified the exemption clause of the Psychologist Practice Act to limit who can call themselves psychologist. One of TPA’s primary missions is to protect your professional and your title! HB 807 is a big step in making that happen. Check TPA’s website for a Q&A on HB 807 and see who is effective by this legislation.

HB 808 - Employment of Provisional and Newly Licensed Psychologist

Currently, licensed psychologists may employ and/or supervise provisionally licensed psychologists (PLPs) but often times they are not eligible for insurance reimbursement. These individuals have completed their doctoral program and are satisfying their requirements for individual practice, however, many insurance companies’ managed care panels will not reimburse them because they are not an independent practitioner. Furthermore, many insurance companies will not reimburse newly licensed psychologist because they have not had enough experience as an independent provider. Even when these individuals are supervised insurance will not reimburse their supervising, licensed psychologist for the work they performed.

HB 808 makes clear that a licensed psychologist employing a PLP or a newly-licensed psychologist may delegate to these individuals, so that insurance companies’ managed care panels will reimburse the psychologist for the work performed by these folks. This bill will not only increase mental health services to the citizens of this state but will increase the opportunities for a PLP to obtain his or her required supervised practice hours and will help newly-licensed psychologists who currently have to be licensed up to three years before some managed care panels will reimburse for their services. Check TPA’s website for a Q&A on HB 808 and see how this new law can change your practice and your revenue stream.

HB 646 - Composition of TSBEP (PASSED)

Currently the Texas State Board of Examiners of Psychologists (TSBEP) is comprised of four licensed psychologists, two licensed psychological associates and three public members. The current demographics of the Board’s licensees are:

<table>
<thead>
<tr>
<th>License Type</th>
<th>Licensees</th>
</tr>
</thead>
<tbody>
<tr>
<td>Licensed Psychologist</td>
<td>4414</td>
</tr>
<tr>
<td>Provisional Licensed Psychologist</td>
<td>173</td>
</tr>
<tr>
<td>Licensed Psychological Associate</td>
<td>1091</td>
</tr>
<tr>
<td>Licensed Specialist in School Psychology</td>
<td>3059</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>8737</strong></td>
</tr>
</tbody>
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While licensed specialists in school psychology (LSSPs) are under the purview of the board, state law does not require that any member of the board be an LSSP. HB 646 ensures that LSSPs are represented on TSBEP by requiring that at least one LPA or licensed psychologist must be dually-licensed as an LSSP.

*Editorial note - as of this writing, there are currently three LSSP’s serving on the Board.*
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HB 746 – Health Practitioners Volunteering in a Disaster (PASSED)

In response to the problems that arise in the deployment of health practitioners during devastating natural disasters and because of the lack of uniformity in state laws regarding the scope of practice and licensing of such practitioners, the Uniform Law Commission (ULC) developed a model uniform law to regulate volunteer health practitioners providing services during emergencies. This bill provides a system whereby health practitioners in any state can be deployed to health care facilities and disaster relief organizations in another state in which an emergency is occurring.

HB 746 amends the “Uniform Emergency Volunteer Health Practitioners Act” and requires the Texas Department of State Health Services (DSHS) to administer a volunteer health practitioner registration system that accepts applications for the registration of volunteer health practitioners before or during an emergency.

HB 2392 - Mental Health Services for Veterans (PASSED)

Peer-to-peer mental health services for veterans are based on a model of formal and informal discussions that allow combat veterans to talk to other combat veterans. HB 2392 establishes a new subchapter within the Health and Safety Code for the provision of the Mental Health Program for Veterans. It creates definitions for “peer” to include family members and allows veterans of any discharge status, other than dishonorable, to be eligible for these services. Furthermore, the bill incorporates required elements of the program such as access to licensed mental health professionals and financial grants to regional and local organizations providing these services.

HB 1657 – The Use of NCSP Title (DID NOT PASS)
Currently, Texas statute states that only individuals with a doctoral degree and who are licensed by TSBEP can use the title ‘psychologist’. HB 1657 would have changed current statute and allowed individuals with a terminal master’s degree and who have obtained the national certification, “National Certified School Psychologist (NCSP)” to use this title in their professional setting. TPA opposed this legislation as we maintained the title “psychologist” is reserved only for doctoral-trained, licensed psychologist. HB 1657 did not pass but this debate is not over. We need you to continue to educate your legislators about the qualifications of a psychologist.

HB 1561 - Availability of Mental Health Records of Deceased Individuals (DID NOT PASS)

Currently, only a patient’s personal representative may have access to the deceased person’s confidential mental health records. There was a movement by certain groups that other individuals should have access to the deceased’s records. These groups asserted that, if a personal representative has not been named, the family should have access to the records. HB 1561 sought to amend the Health and Safety Code to authorize certain health care professionals to disclose confidential mental health information to the executor or administrator of a deceased patient’s estate or, if an executor or administrator has not been appointed, to the deceased patient’s spouse or an adult related to the deceased patient within the first degree of consanguinity for a deceased patient who was not married. TPA, along with other mental health groups, strongly opposed this bill as we felt access to confidential information, even from a deceased individual, would be extremely harmful to other individuals.

Other bills we worked on for you:

HB 144 (PASSED) – HB 144 allows a judge to order, in addition to psychological reviews, a screening for chemical dependency for any juvenile in the juvenile justice system to determine whether a child has any chemical dependency.

HB 1205 (PASSED) - HB 1205 modifies current laws where a professional does not adequately address circumstances when they believe that a child’s well-being has been or may be adversely affected by abuse or neglect but fails to report that abuse or neglect with the intent to conceal the abuse or neglect.

HB 1661 – (DID NOT PASS) Under current law, evaluations of children and adults for purposes of child custody determinations and adoptions are addressed in the same provisions, even though the processes are often different depending on the purpose of the evaluation. Interested parties asserted that the terminology used and standards established in current law that was applicable to the professionals who perform such evaluations, including provisions relating to training, standard practices, and testimony, needed to be updated to conform to current professional standards. HB1661 addressed these issues by amending current law relating to such evaluations and establishing separate provisions for child custody and adoption evaluations.

HB 3276 (PASSED) - Current law requires insurers to cover expenses for enrollees diagnosed with autism spectrum disorder from the date of diagnosis until the enrollee completes nine years of age. However, interested parties asserted that a critical oversight existed with respect to insurers’ coverage of screening for autism spectrum disorder; even though coverage of treatment begins on the date a child is diagnosed. HB 3276 seeks to address this oversight by requiring a health benefit plan to, at a minimum, provide coverage for screening for autism spectrum disorder at 18 and 24 months.

SB 718 (PASSED) - Texas law is clear that the age of consent for inpatient mental health services for an individual is 16 years of age or older, but it is silent on the age of consent for outpatient mental health services. Because outpatient services can be used earlier in a mental health crisis, often avoiding the need for more costly and involved inpatient services, it should be made explicit in the Health and Safety Code that the age of consent is the same for both. SB 718 amends the law allowing an individual 16 years of age to voluntarily be admitted to outpatient facility.

If you have any questions on any of these bills, please give me a call.
The Physician Definition Bill: Why Pursue It?

Cheryl L. Hall, PhD, MS PsyPharm
Federal Advocacy Co-Coordinator for Texas

During the past few years at State Leadership Conference we have been talking to U.S. Senators and Representatives about the importance of including psychologists in the definition of “physician” in the Medicare program. You may ask, “Why is that important for our patients and for psychology as a profession?”

A little background is in order. Psychologists are key Medicaid mental health providers, delivering nearly half of the psychotherapy services to Medicare beneficiaries in the hospital outpatient setting and more than 70% of the psychotherapy services in the hospital inpatient, partial hospital, and residential care settings. Psychiatrists also provide the vast majority of mental health testing services, many of which are unique to their training and licensure. Medicare’s physician definition (1861(r) of the Social Security Act) already encompasses non-physician providers such as dentists, podiatrists, optometrists and chiropractors. We are the only doctoral-trained health care practitioners not in the definition. Those doctoral providers are included in the Medicare physician definition so that they may provide services to the full extent of their licensure. Including psychologists in the Medicare physician definition does not make us physicians, just as dentists do not become “physicians” by their inclusion in the definition. It doesn’t expand our scope of practice; only state licensure law can do that. Most importantly, it does remove barriers to the services we provide. The way things stand now we are hampered by the requirement to have a physician sign off and “supervise” our work. Without a physician’s order, a referral for therapy has to wait. Continuation of needed therapy has to be suspended when an order expires, until a new one can be obtained. Day treatment or partial hospitalization programs, especially in rural areas, are generally run by psychologists but have to have a physician to “supervise” by signing off treatment plans and program decisions. Inclusion of psychologists in the physician definition will provide for a long-overdue reassessment of the services psychologists may provide within licensure without supervision. In partial hospital programs, if physician barriers were removed, beneficiaries would have better access to partial hospital services they need. In hospital settings, this overdue change would help clarify clinical oversight for hospital patients under the care of psychologists and reduce the administrative burden on hospital staff.

As a result of this exclusion, the Medicare program has fallen behind the private insurance market. Many insurers already define “physician” to include not only medical doctors and doctors of osteopathy, but also psychologists and other non-physicians currently in the Medicare physician definition.

During the last session a bill including psychologists was co-sponsored by Sen. Olympia Snowe (R-ME) in the Senate and Rep. Jan Schakowsky (D-IL) in the House. Senator Snowe recently left the Senate, but the good news is that we have obtained a new co-sponsor in Sen. Sherrod Brown (D-OH). Senate bill 1064 and House bill 794 will dispense with unnecessary physician supervision requirements in the Medicare program. Both sponsors are Democrats and the challenge now is to build more co-sponsors because legislators want to see bipartisan support before they sign on. Obtaining those initial co-sponsors so that other legislators can see bipartisan support will be an uphill battle. As of June of this year, we have 31 in the House and seven new members are supporting the bill that were not before, only one of which is a new representative. If this bill gets enough co-sponsors it’s likely to be patched to a larger health care vehicle package like payment reform of the SGR. If the bill doesn’t pass before December 2014 it will die and a new process will have to begin after that.

Fortunately there are many consumer and provider organizations supporting the Brown/Schakowsky bill in addition to the American Psychological Association, including the American Federation of Teachers, American Foundation for Suicide Prevention, American Group Psychotherapy Association, Association for Ambulatory Behavioral Healthcare, Center for Medicare Advocacy, Inc., Mental Health America, and the National Council for Community Behavioral Health.

The Brown/Schakowsky bill will allow psychologists to be treated like all other non-physician providers already included in the Medicare physician definition, thereby ending unnecessary physician supervision without increasing Medicare costs. An actuarial analysis of the Brown and Schakowsky bill has determined that including psychologists in the Medicare physician definition will not increase Medicare claims costs. Psychologists already provide their services in settings throughout the program, and sufficient provisions will remain in place to ensure that the services psychologists provide are medically necessary and appropriate. In fact, this bill would allow Medicare to actually save money because they will not be paying physicians for unnecessary supervision of psychologists.

Including psychologists in the physician definition will particularly help Medicare beneficiaries in rural areas where psychiatrists are not available to provide supervision. Based on a 2007 APAPO study prepared by the Center for Health Policy, Planning and Research at the University of New England, there are 2,943 psychiatrists in non-Metropolitan areas.
David Schnarch chosen for esteemed award by American Psychological Association (APA)

Dr. David Schnarch will receive the 2013 APA Award for Outstanding Contributions to Independent Practice. He is also previous recipient of the 2011 AAMFT Award for Outstanding Contribution to Family Therapy and the 1995 AASECT Award for Professional Excellence. Dr. Schnarch is the author of the best selling Passionate Marriage and most recently Intimacy & Desire: Awaken the Passion in Your Relationship.

Discover why his approach is receiving so much recognition in these upcoming events:

**Professionals:**
- **APA Annual Convention Award Recipient and Speaker**
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  - Honolulu, Hawaii: July 31 - August 4, 2013
    - Understanding Mind Mapping, July 31
    - Understanding Sexual Desire and Personal Development in Love Relationships, August 3
  ```

- **Colorado Association for Marriage and Family Therapy (CAMFT) Annual Conference Keynote Speakers**
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  www.ccamft.org
  - Denver, Colorado: September 20, 2013
  ```

- **Crucible Intimacy and Desire Clinical Workshops**
  ```
  - Alexandria, Virginia: September 27-28, 2013
  - Dallas, Texas: October 25-27, 2013
  ```

**Public:**

Therapists, these are excellent resources for your clients and colleagues and many therapists also attend to enhance their own personal development.

- **Passionate Marriage Couples Enrichment Weekend**
  ```
  - San Francisco, California: October 4-6, 2013
  - Dallas, Texas: March 28-30, 2014
  - Denver, Colorado: May 2-4, 2014
  ```

- **Intensive Therapy Program for Couples / Individuals**
  Available throughout the year.
Statistical Areas in the U.S.—a rate of 5.2 psychiatrists per 100,000 population. There are three times as many psychologists in these areas—8,867 psychologists or a rate of 15.7 psychologists per 100,000 population. Even more striking is the state of Texas data:

- In the state of Texas, psychologists outnumber psychiatrists 3 to 1.
- In 60 rural counties where at least one psychologist provides services, psychiatrists are not available to provide the supervision requirement.
- In some counties with a senior population around 20%, well above the state average of 10%, psychologists outnumber psychiatrists 7 to 1!!

The lack of psychiatrists to supervise treatment in the various Medicare settings has stilled the development of mental health services delivery in rural areas. If, for example, a physician is not available to supervise partial hospital services in a rural area, then such services are not provided. Removing unnecessary physician supervision requirements will help remedy rural access to mental health services. Psychologists will be able to provide partial hospital services within their licensure without unnecessary physician oversight, while still working with physicians regarding medication and other services beyond their current licensure.

The importance of mental health services has been highlighted in the past few years, by unfortunate violent incidents committed by individuals with serious mental illnesses. In fact, Congress references the Medicare physician definition in enacting laws to improve beneficiary access to services, but since psychologists are not included, mental health services are too often left behind.

For example, Medicare “physicians” (including podiatrists, etc) receive a 10% bonus payment for providing services in Health Professional Shortage Areas. By excluding psychologists, mental health services are mostly left out of bonus payments designed to improve Medicare beneficiary access in underserved areas. Also, the Health Information Technology for Economic and Clinical Health Act provides for incentive payments to Medicare “physicians” (including chiropractors, etc) when they adopt electronic medical records into their practices. With the exclusion of psychologists from these payments, mental health is essentially left out in the development of electronic medical records in the Medicare program.

A candid appraisal of the likelihood of this bill passing is that it will be an uphill battle, but that it IS possible. The opposition would have the legislators believe that patient safety is called into question, especially for patients with comorbidities. But again, we are not asking to do anything that we aren’t already licensed to do that is within our scope of practice. We are already providing these same services WITHOUT physician supervision within the Veteran’s Administration and in private practice. The opposition’s case seems weak on the face of it, but legislators are sensitive to alienating any of their constituent groups, including physicians, and let’s face facts; the physicians provide important medication and physical illness management and are paid appropriately for it. But they would also like to continue to be paid to unnecessarily supervise us!

You can see there are many compelling reasons why inclusion in the physician definition is important: for patients’ access to mental health services, for continuity of care, to decrease administrative burden with unnecessary oversight by physicians, and for inclusion of mental health records in health care records as we transition to electronic medical records.

The statistics on Texas are striking, and it’s important that we continue to talk to our U.S. Senators and Representatives from Texas on the need for their constituents to benefit from this bill. Currently, there are no Texas co-sponsors for the Brown/Schakowsky bill. As psychologists, we have to educate our legislators about why this is important to their constituents, especially as the aging population explodes and with vast rural areas in Texas. Whether or not you are a member of the American Psychological Association (APA), consider writing your U.S. Representative and Senator about the importance of this bill. If you can visit their district office or Capitol Hill office and meet with them or their health care aide, educate them about this issue and how it has specifically affected you and your patients or those of your colleagues. When talking to fiscally conservative members, remember to also emphasize the cost-neutrality of this bill, and the possibility that it will actually save Medicare money. Finally, if you are an APA member, respond to action alerts from the APA Practice Organization to email or call when the timing is critical and they ask that we rally with a deluge of calls/emails about this bill. Take a few minutes even on a hectic day because it truly makes a difference!
Surely by now the word is out. Currents of change are flowing, if not rushing, through the U. S. health care system. We psychologists are floating in that current of change, carried along in the wake of the health care reform movement. Over the next few years, many clinical psychologists along with other mental health providers will be significantly impacted in terms of how we practice and, most likely, how we are paid for the services we perform. The purpose of this article is to provide background information and some thoughts about the transformation of health care service delivery to integrated care models, to urge our colleagues to contribute time and money to earn psychology its rightful place within those models, to challenge psychologists as they consider their practices in the future, and to suggest opportunities that exist for psychologists within the restructured health care industry of the 21st century.

With years of mounting evidence that the health care system in the United States is expensive, inefficient, insufficient and inequitable, the need for change is clear: Growth in U. S. health costs exceeds the rate of growth for the GDP and inflation (U. S. Department of Health and Human Services, 2005), the quality of care is lower than in many other industrialized nations (Fox, M., (2010), and there has been no trend for improvement. Between 2010 and 2011, “[health care] costs were up sharply, access to care deteriorated, health system efficiency remained low, disparities persisted, and health outcome failed to keep pace with benchmarks” (Commonwealth Fund Commission on a High Performance Health Care System, 2011). Furthermore, the fact that more than 130 million U. S. citizens suffer from chronic diseases that account for 70% of deaths (Kelly & Coons, 2012) attests to massive failure to address issues of disease prevention.

One of the major changes in the structure of health care service delivery systems is reflected in the notion of “integrated care” or “integrated primary care.” Traditionally health care services have been delivered by a consultative network of otherwise isolated primary providers and specialists that typically operate in a standalone fashion (Kelly & Coons, 2012). They are reimbursed on a fee-for-service basis, and problems with communication and coordination of care reportedly abound (Kelly & Coons, 2012). Such a system can lead to fragmented, rather than coordinated, conceptualization of patient conditions, redundancy in diagnostic procedures, and after-the-fact intervention rather than preventative care. The inclusion of psychologists in these traditional networks, in our experience, is largely based on the success of psychologists in developing professional relationships with the medical providers involved and maintaining those relationships. At this point in time, these relationships are generally with physicians who already understand and value the work of psychologists. In a manner, these “psychology advocates” open the door to participation that can allow other physicians to gain positive regard for the utility of the psychological work they witness. It is hoped that integrated care systems will more uniformly recognize the value of psychological services within such models, based on empirical evidence that psychological needs abound in primary medical care settings, and will codify such services as essential. However, a guaranteed place for psychology in the system remains to be seen and, as will be discussed later in this article, professional psychology will face continued competition from other provider groups related to mental health.

What does an integrated health care delivery system look like? The concept of “integrated care” has been defined by the Institute of Medicine as health care comprehensive, continuous, coordinated, culturally competent and consumer centered (Institute of Medicine, 2001, as cited in Kelly & Coons, 2012). The term as used in the literature usually describes a group of primary care providers, specialists, and support staff sharing a common electronic medical record, providing on-going staff training and education, and engaging in continual process and outcome improvement efforts. All involved providers usually practice at the same location, although in some cases there may be participating providers who have part-time involvement or are housed in another, preferably nearby, location. Transformation of health care service delivery systems into integrated models is already evident within federal health systems such as the Department of Veteran Affairs, the Department of Defense, Federally Qualified Health Centers, and the Indian Health System (Kelly & Coons, 2012). Kaiser Permanente and the Mayo Clinic are two private sector systems that are embracing integrated models (Kelly & Coons, 2012; Kaiser Permanente, n.d., Mayo Clinic, n. d.). Notably, the Mayo arrangement stipulates a role for mental health as a participating specialty.
The Organizational Models. Two overlapping, integrated care entities or models that are prominent concepts in the reform to integrated health care will be briefly reviewed in this paper. The first is the Accountable Care Organization (ACO). The concept of the ACO was codified in the passage of the Patient Protection and Affordable Care Act (PPACA) and has been defined by the Centers for Medicaid and Medicare Services (CMS) as “groups of doctors, hospitals, and other health care providers, who come together voluntarily to give coordinated high quality care to their Medicare patients” (Centers for Medicaid and Medicare Services, n.d.); in other words, an entity that meets CMS service integration requirements and enters a contracted arrangement with Medicare. Medicare began making payments to ACOs in 2012 via shared risk payment arrangements such as capitation and shared savings plans (Goodman, 2013). “Capitation” refers to a fixed payment to a provider entity for each covered life, regardless of service utilization (American Medical Association, n.d.). Increased profits are realized when patients remain healthy and do not utilize health care, and losses accrue when expensive or protracted treatment is required. Shared savings programs provide financial incentives derived from savings to the Medicare program obtained when provider entities meet targets for reducing growth in expenditures while maintaining quality benchmarks (Centers for Medicaid and Medicare Services, 2012). This will hopefully lead to a focus on preventative medicine, better quality and lower health costs (c.f. Goodman, 2013).

The second model reviewed is the Patient Centered Medical Home (PCMH), which likely will describe most ACOs. The PCMH is a model of integrated health service delivery developed and jointly endorsed by the American Academy of Family Physicians (AAFP), the American Academy of Pediatrics (AAP), the American College of Physicians (ACP), and the American Osteopathic Association (AOA) in 2007. The PCMH has been described as a system that puts patients at the center of the health care system and provides primary care that is “accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective” (American Academy of Pediatrics, 2007, cited by MacClements, J., 2012, slide 2). Ideally, the PCMH is supposed to be “anticipatory” of patient needs (O’Donnell, Williams, Eisenberg, & Kilbourne, 2013).

In 2011, the National Committee for Quality Assurance (NCQA), a non-profit organization dedicated to promoting quality in health care, acting in concert with the aforementioned medical bodies, published a set of standards and a three-tiered recognition process to assess the degree to which health care organizations are functioning as a PCMH. According to the NCQA, NCQA-recognized PCMHs will provide patients after-hours advice and access, education about their medical home, team-based care, and resources for self-care management; they will collect and use data for patient management and evidence-based guidelines for preventative, acute, and chronic care management; finally, they will engage in ongoing program improvement using performance and patient experience data and track and coordinate tests, referrals, and changes to level of care (NCQA, 2011).

Changes in Mental Healthcare. Currently mental health services are not a required component in ACOs/PCMHs, but a recent position paper has urged incorporation of such services in the PCMH (O’Donnell, Williams, Eisenberg, & Kilbourne, 2013). In that paper, O’Donnell and colleagues acknowledge that mental disorders are leading causes of disability worldwide, are associated with increased health care and employer costs, and are associated with premature mortality. They conclude that, for ACOs and the medical home to achieve the triple aim of improved care for patients and populations at lower cost, mental health care must be integrated with PCMHs (O’Donnell et al., 2013). O’Donnell et al. further note that performance analyses of the Chronic Care Model (CCM), one model that incorporates mental health services, have shown that the model demonstrates improved physical and mental outcomes with little to no increased costs. Unfortunately, sometimes what one hand gives the other takes away. In the same paper, O’Donnell and colleagues note that, in the absence of a fee-for-service structure, some mental health needs might be met by nursing or paraprofessional staff given some training.

That psychology should play a central role in a comprehensive, coordinated, culturally competent integrated system should surprise no one; for many years there has been ample evidence that psychological factors contribute to a large volume of presenting complaints in primary medical care (e.g., Fries et al., 1993; Gatchel & Oordt, 2003; Wang et al., 2005). Governmental recognition of the need to include mental health services as part of integrated health care was insightfully and plainly expressed in 1974 by Marc LaLonde, then Canadian Minister of National Health and Welfare, in a detailed report (LaLonde, 1974, cited in Kenkel et al., 2012). Five years later, the U. S. Surgeon General issued a report on health and disease prevention that, according to Kenkel et al. (2012), indicated that psychological expertise needs a major role in the prevention of disease and death.

Unfortunately, barriers to inclusion for psychology in integrated health care are also longstanding. Perhaps the greatest barrier to date has been the historical separation of mental health and medical services in U. S. payer systems. Belar and Deardorff (2011) noted that this division is perhaps a reflection of the mind-body dualism that pervades our culture and language, making it difficult to conceptually integrate the psychological, physiological and sociocultural. Also there is in some cases a professional barrier. In our experience, a number of physicians maintain a noticeable professional distance between themselves and psychologists, even psychiatrists; they do not understand the science present in psychology; they show little interest and see little need involving themselves in the mental health services for their patients. This
dualism may in fact have been promoted by our profession as well. In our experience, physicians sometimes complain that they receive little or no communication from psychologists when they refer patients out for care. Our sensitivity to confidentiality may have created an unintended barrier to coordinated care. Further, our profession has offered little or no training in understanding how to interface effectively with physicians (Dickinson & Miller, 2010).

Where does this leave psychology and/or mental health care in the integrated care scheme as realized in the overlapping ACO and PCMH models? Unfortunately, at the present time, not as well off as psychologists might hope. To date, mental health services are not explicitly incorporated into the ACO rules. The only ACO performance measure under the Medicare Shared Savings Program that is related to mental health requires screening for depression and documentation of a follow-up treatment plan (O’Donnell et al, 2013) that can be met by administering a screening tool followed by medication. It rests with the profession of psychology to work through political means and educate policymakers of the value of mental health services in achieving the aims of health care reform. Furthermore, with lower costs being of paramount importance, psychologists face the need to clearly distinguish themselves from lesser trained professionals, identifying or clarifying the uniqueness of those services that can only be provided by psychologists, and guarding our professional turf from encroachment by other groups who attempt to carve out parts of mental health to be performed either additionally or exclusively by holders of newly invented certifications or licenses, as has happened in Texas. In short, we must differentiate ours from other mental health professions and be able to offer evidence that our high level of training and expertise remains relevant in an extremely cost-conscious care environment.

Implications for Practice. Nevertheless, it seems that much, if not all, of primary health care will move to integrated care. Psychologists planning to work in the integrated care system who are not already versed in time-limited, problem-focused treatment approaches need to consider whether their services are in fact marketable to a PCMH. Also, clinicians who have confined themselves to the role of “mental health service provider” will find themselves needing to broaden their scope of practice to that of a “health service provider” through additional education and training. For example, psychologists working in medical settings will need to be prepared to address problems traditionally seen as mental health issues, but often in the context of a medical illness that will require a broad understanding (e.g., depression in a middle-aged woman diagnosed with diabetes or an adolescent with cystic fibrosis engaging in acting out behaviors and refusing to take medications or undergo daily chest percussion treatments). In short, such psychologists will need to be able to integrate Axes I, II and III. They also will likely find themselves participating either as W-9 employees of a PCMH or as contracted providers, perhaps contrary to long-held, cherished notions of working forever in a private practice. Furthermore, some psychologists may find it uncomfortable and challenging to adapt to a work setting dominated by the medical field with its own unique culture. New skill sets and knowledge as well as the ability to work in new environments will be of key importance. According to Kelly & Coons (2012), some of the skills and adaptations required of psychologists working in integrated care include the ability to collaborate as a team member, mastering communication via common medical record, team meetings/staffings, working in the same space as other providers (“collocated”), the likely need to shift treatment emphasis to brief assessment and intervention strategies, dealing with the demands of coordinated patient scheduling, mastering the “curbside consult” with providers across disciplines, referring elsewhere for longer term care, gaining a broader set of clinical skills and improving knowledge of psychopharmacology and medication issues in general.

Psychology as a profession has been evolving to meet new roles and new challenges in a changing health care system. A psychologist moving toward the type of integrated practice described in this article is not moving into uncharted territory by any means. Clinical health psychology has been established as a specialty in professional psychology by the American Psychological Association since 1997 (Belar & Deardorff, 2009). An excellent guide for graduate students and practicing psychologists considering this type of practice is C. D. Belar and W. W. Deardorff’s text, Clinical Health Psychology in Medical Settings: A Practitioner’s Guidebook, 2nd Edition, (2009), published by the APA.

There are ethical issues facing psychologists in collaborative primary care settings. As noted by Runyan, Robinson, & Gould (2013), other than some published information on shared record-keeping and confidentiality issues, little has been discussed or determined about other scenarios a psychologist might face in such a work setting. For example, how should a behavioral health specialist ethically and strategically treat several family members when family issues are a pressing problem? What about implicit and explicit informed consent in the context of delivering preventative health services via highly coordinated care? A 2013 special issue of the APA journal Families, Systems, & Health (Vol. 31, No. 1) was devoted to the identification of gaps in ethical standards for behavioral health clinicians and their primary care physician colleagues and is highly recommended.

Psychologists also may find a role in integrated health care because of their special training in psychometric theory and statistics. The need for outcome measures and methods to track patient data and determine trends and evidence for significant change is well within the scope of the PhD in psychology—perhaps after some brushing up with their statistics texts and notes.

Psychologists also can look for opportunities to become part of the reform process itself. In 2011, Texas Health and Human Services was granted a five-year waiver of certain federal Medicaid requirements under Section 1115 of the Social Security Act that, among other things, created a pool of funds for Delivery System Reform Incentive Payment (DSRIP) projects that achieve certain goals intended to lower costs and improve the quality of patient care. Many DSRIP projects have been proposed throughout the state. At our institution, UT Health Science Center at Tyler, there is a large scale DSRIP behavioral health project attempting to make significant changes in the diagnosis and treatment of depression in primary medicine clinics through rural northeast Texas. Efforts include the creation of a mental health consultative
telenet system linking two major hospitals with mental health services to rural hospitals, the provision of regular education and training of primary care physicians by psychiatrists and psychologists, and the establishment of a network of referral sources for psychotherapy and counseling. While the goals defined for the project are related to outcome measures for the diagnosis and treatment of depression, the system being created will eventually impact all mental health problems presented in primary care in rural northeast Texas. This is one of a multitude of DSRIP projects being undertaken in our area. There may be roles for psychologists in similar projects elsewhere in the state, and some of these demonstration projects may have the potential to establish new roles for psychologists in the regional health care system. Finally, psychologists are finding roles in the early training of primary care physicians that can impact the relationships between those physicians and psychologists in the future (see Wortz & Walker, 2013, in this issue).

There are a host of studies showing the effects of unaddressed mental health issues on health outcomes (e.g., depression-related increased cumulative mortality rates for persons who have suffered heart attacks (Frasure-Smith, N., Lespérance, F., & Talajic, M., 1993; Murphy et al., 2013) or depression and stress as risk factors in the development of diabetes (Pouwer, Kupper, & Andriaan, 2010; Knol, el al, 2006; Cosgrove, Sargeant, Caleyachetty, & Griffin, 2012; Lloyd, Smith, & Weinger, 2005). With regard to the development of an evidence basis for the value of mental health services in improving health outcomes, the data are already available in convincing fashion for many important medical management issues with preventative behavioral health needs.

In sum, the time is ripe for psychologists to join physicians in reworking our health care delivery system. It is an uncomfortable and awkward time in traditional medicine, but psychologists are uniquely equipped to see this discomfort. Approaching not only physicians but also hospital administrators and medical program directors with the offer to help as clinicians and educators/trainers, outlining for them the kind of assistance we can provide, and how that assistance fits into the ACO and PCMH models, can open doors that may help secure our future as health service providers.

All in the Family: The Behavioral Science Role

Kathryn Wortz, PhD  & Charles R. Walker, PhD
University of Texas Health Science Center at Tyler

The time is right for psychologists to actively pursue roles within the medical field. Medicine is undergoing a Thomas Kuhn-style paradigm shift, with a huge overhaul in its payer and delivery systems (See Walker & Wortz, 2013, this issue). The skills psychologists offer are precisely those most needed now by the primary care medical field, and with the movement of the medical system into friendlier, more comprehensive modalities, medicine is searching for the answers that psychologists already hold.

Patient Centered Medical Home (PCMH) requirements, Medicare’s targeting of readmission rates, and the Affordable Care Act all direct the medical system to improve doctor-patient communication and understanding, encourage patient self-management of chronic illness, and promote comprehensive, one-stop care. All hope to make the practice of medicine both more effective, cost efficient, and personal.

To further the argument for psychologists’ increased involvement in medicine, primary care has become the de facto mental health system, with Primary Care Physicians (PCPs) providing more mental health care to patients than psychologists and psychiatrists combined (Regier et al., 1993). PCPs need our help, and want it, but few physicians have regular direct interactions with psychologists, and they may not fully comprehend what we can do or what skills we offer.

The roles a psychologist can fill in a medical setting are multitudinous and are not limited to the health psychologist. Cherokee Health Systems, located in eastern Tennessee, has long placed psychologists in the clinics of family practitioners and found the partnership to be highly effective (Freeman, 2013). The psychologist is available to see the patients a physician is concerned about, all within the context of the “doctor’s office.” Problems can range from the psychosomatic to mood disorder to marital problems. Seeing a psychologist at the doctor’s office reduces stigma and fits mental health into a physical health setting, a more palatable solution to the patient as well as to the physician and psychologist.
The model of psychological care in the primary care setting continues to shift. It is moving from that of separate offices or departments, to “co-location” in a primary care clinic, and finally to full collaboration and integration (Blount, 2003; Kelly & Coons, 2012). The role of the psychologist is thus becoming more and more integrated into primary care. For the physician, the psychologist is evolving from simply a professional to whom to refer patients, to a frequent consultant and then, ultimately, to a member of the same team.

**Medical Culture.** Each discipline has its own culture. Language, thinking style, values, problem solving, history, tradition and information are unique to each field. Boundaries, communication styles, even dress are different in psychology than in medicine. For example, it is not unusual for a physician to write a prescription for his friend or to treat a coworker. At the risk of overgeneralizing, physicians tend to be clean-shaven, psychologists have more beards. Internal Medicine docs tend to dress more formally than the earthier Family Medicine docs, but the flowing skirt of a psychologist is unmistakable. Above all else, it seems physicians are focused on active, faster lifestyles. “Work hard, play hard” is the motto quoted by more than one of our medical faculty. Even their work is more active: they stand all day; we sit. They make fast decisions that lead to action; we more often ponder and contemplate before acting.

“Vive la différence” but “when [working] in Rome” psychologists are challenged to adapt to the fast pace, flexibility and unpredictability of the environment. Another challenge is the process of molding into the team as a valued player, but not often the team captain (Vogel et al., 2012). Last but not least is the challenge of working in an environment in which you are outnumbered: there are a lot of nurses, a lot of doctors, a lot of physical therapists, but not a lot of psychologists, at least for now.

**Family Medicine.** One role psychologists already fill is found in the Family Medicine Residency. Residencies can be either freestanding or attached to an academic medical center. Family Medicine physicians are trained for three years (some programs are longer, some shorter) after completion of their medical degree. They see patients with a “Physician in Training” permit under supervision of a licensed physician. This allows their services to be billed under the license of the supervising doctor. Trainees need to develop both broad medical training and a strong emphasis on communication and good bedside manner; so many Family Medicine programs hire a “Behavioral Scientist” to train Resident doctors. The behavioral science role, introduced as many as 50 years ago (Fischetti & McCutchan, 2002), has traditionally been filled by psychologists and social workers.

The behavioral science position in Family Medicine incorporates functions that are both traditional and nontraditional to a psychologist’s training. However, the skills learned in our training, scientific thinking, cultural awareness, theory building, psychotherapy and the assessment of individuals serves us well regardless. In Family Medicine, there are components of the role to which we are accustomed. This includes the aspects of a traditional faculty appointment, with lectures, research and professional presentations, but without the demands of traditional teaching or the flexibility of a nine-month schedule. The behavioral science role also includes the traditional skills of the clinician: psychotherapy, consultations and assessment/evaluations. Compensation is typically higher than for traditional faculty positions. Benefits such as good health insurance and paid vacation are a luxury after private practice. Tenure is generally not offered (to physicians and psychologists alike), and contracts renew from year to year.

Nontraditional to psychology are the breakneck pace of the environment and the need for flexibility. The psychologist is generally working with two sets of clients: the patient and the medical team (Masters, 2010). Not only is the psychologist helping patients, she is also helping the doctors deal with patients and even learn to counsel them. Being available and flexible are paramount. Interruptions are common. The uninterrupted psychotherapy hour is a sacred cow that may need to be cattle-prodded from this environment. “Administrative time” disappears in an instant to meet the needs of a Resident with a problematic patient.

**Sharing information.** An essential aspect of integrated care, as well as of education and training, is sharing information. This takes place in various forms, many with which psychologists may be uncomfortable. It is important to remember that the patient is receiving the care of a treatment team and has already signed a form acknowledging that information will be shared for the purpose of care as well as training. At the Family Medicine program at the UT Health Science Center at Tyler, we reiterate this with our patients, ensuring they understand and agree to how information might be shared. Psychological notes are kept in the Electronic Medical Record (EMR), accessible to the physician and insurance companies. Therefore, they are kept brief and general, providing enough information to keep the treatment team informed without disclosing the most intimate details of the patient’s life. The same is true of verbal information sharing. Further, keeping verbal information sharing behind closed doors is essential, and important to model to trainees. In some settings, the EMR can be designed to reveal only the Assessment and Plan from the psychologist’s SOAP formatted notes (Steinfeld & Keyes, 2011), but it is our opinion that this level of information is less than optimal for the treating medical provider. Regardless, the degree to which psychological records are accessible by other disciplines in a shared digital record environment remains an ethical and practical issue of debate (Steinfeld & Keyes, 2011).

**Location, location, location.** It is absolutely essential that the counseling room be located within the Family Medicine Clinic. The clinic is the heart of the training of the family physician. Although often away completing rotations with specialists elsewhere in the hospital or off site, the Resident sees patients in clinic on a weekly basis. The saying “out of sight, out of mind” is particularly true in medicine, where problems are addressed in rapid succession. Being physically present in the clinic, either in a counseling room seeing patients (next door to an exam room), sitting in the precepting room offering suggestions, or wandering the halls announcing you are available is essential to this job. Physicians need the support and the reminder of an ever-present psychologist in order to continue to use one regularly. Otherwise, it is too easy to forget that psychological support is available. If readily available, it will be used; if used, it will be valued. Once valued, it will be promoted.
Co-precepting. If the clinic is the heart of the family medicine residency, then the precepting room is its soul. Residents come in to a work room or “precepting room” to speak to their clinic supervisor, or “preceptor,” about their patients as they see them in clinic. The first year Residents (aka Interns) are supervised for every patient; by the third year, supervision is largely a formality, and only the most difficult patients are discussed at any length. The psychologist’s role is to complement the supervision process. This is a prime opportunity for the psychologist to listen in and interject with a question to ensure that the psychological aspects of the patient encounter are also appreciated and addressed:

• “Why does this gentleman have so many seemingly small but separate complaints?”
• “What stress might this woman with headaches be experiencing?”
• “How can you gently address this diabetic’s obesity?”

The job includes guiding good treatment of the many psychological complaints that walk into the Family Medicine clinic:

• “Good job at identifying the depression; did you rule out Bipolar Disorder?”
• “Do you want to refer that child out for testing to make sure it’s ADHD?”
• “It sounds like there are a number of case management issues; should we call the Social Worker?”

And last but not least is addressing the needs of the Resident herself:

• “That patient really pushes your buttons. What do you think that’s about? How do you want to handle that kind of problem in the future?”
• This is also a good time to offer to help. Since physicians do not know all of the ways a psychologist can participate, it is up to us to make that clear:
• “Do you want me to come in with you (to observe, help diagnose, calm the patient down, etc.)?”
• “I have some time. Do you want me to see them in counseling now?”
• “You need to make a CPS report. Can I show you how?”

It is important to remember that this is the supervising physician’s opportunity to teach as well, and that she is the commander of this ship. Generally, preceptors are receptive to the psychologist jumping in, and they participate in the discussion. But it is important to hand the final decision back to and to make it clear to the Resident that you defer to the supervising physician. The decisions made are on her license.

Curbside consults. “Curbside consults,” or being available for questions, are an important part of working in this field. In the residency, this is a prime opportunity for education as well. Clarifying and asking questions about the Resident’s concerns allows the Resident to learn diagnostic skills, counseling skills, and the way that psychologists think about problems and people. Offering a few suggestions gives him something he can work with (doctors like answers), while still allowing for his independent judgment and decision making.

Warm handoffs. “Warm handoffs” also require flexibility. These often occur when the resident or faculty physician has a backed up schedule and someone becomes upset. Occasionally, a warm handoff is the result of the physician’s having enough time to suggest to the patient that she consider psychotherapy (always called “counseling” in our setting to lessen the threat), and realizing that the psychologist is in clinic. In any event, it requires the psychologist to break away from what he is doing and take a few minutes, if not several minutes, to help out. The first step for the psychologist is to determine the physician’s need or goal, be it to calm someone down while he sees the next patient, establish a therapeutic alliance for future “counseling,” or to help with diagnosis. The second step is to establish the physician’s limitations. Can he join the psychologist in the meeting with the patient or does he need to get to the next patient? If he can join in, this becomes an opportunity to better integrate the care, as well as to model counseling techniques. If not, the question becomes one of flow. Is the physician done with the patient for today, or will he come back in to the exam room to wrap up once the psychologist is finished? Does the physician need the patient to be removed from the exam room to open up more space, especially if this will become a longer interaction? At the end of the interaction, the physician is helped by the psychologist’s documentation of the interaction, no matter how brief and regardless of whether the interaction is billed or not.

Interrupting the sacred hour (or 45 minutes). Blasphemy, yes, but the psychotherapy hour must be interruptible in the Family Medicine setting unless the program is blessed with multiple behavioral science personnel. Patients are informed of this arrangement at the outset, and most are able to tolerate the inconvenience. Preferably, the interruption takes only a few minutes, but occasionally it may take several minutes away from a session. The session is then either prolonged or cut short and billed accordingly. Another interruption to psychotherapy is the need to train. At times, the patient must be able to tolerate a psychology intern or a medical resident sitting in on his session and participating. Again, this is discussed with the patient at the outset, and is a condition of treatment at the residency.

Brief Interventions. In this setting, therapeutic intervention is ideally brief (15-20 minutes), short-term, and solution focused (Vogel et al., 2012). It is important to remember that the patient is emotionally invested in medical care; he or she came to see the medical doctor, not the psychologist. Being asked to talk with the psychologist is highly threatening to many patients, either because they are afraid their medical complaint is not being validated or thoroughly assessed (“they think it’s all in my head”), or because they fear they are being labeled as a psychiatric patient (“they think I’m crazy”). The process can be disruptive to, and may be perceived to interfere with, the established relationship between patient and physician. Fortunately, patients are often tentatively willing to speak with the psychologist because it is what their physician wants them to do. But they are relieved when the intervention is short and limited (Vogel et al., 2012).

Milieu. To us one of the most pleasurable parts of the psychologist’s job in the medical setting, particularly with Residents, is fostering a warm milieu. Despite recent changes in duty hours, Resident doctors work a lot of hours, are sleep deprived, and are often tired. The stress of late hours, changing rotations every four weeks, constantly learning, and making life and death decisions is hard on a new physician. Bringing an encouraging smile or a nod of “Atta Girl/Boy” into a room are simple yet remarkable gestures from a faculty member that go a
long way with a trainee. Overtly stating that “it’s OK to make mistakes” engenders trust, openness and encouragement. Coming out of training that teaches physicians to appear confident even when they are not, simple interventions of this nature serve to promote the well-being of the Resident, in particular, and the Residency, in general. Furthermore, it is “contagious,” and the medical faculty members often adopt and reinforce this message.

**Staffing Model.** In an ideal setting, the Family Medicine residency has hired at least three psychologists. In this arrangement, at any given time, two psychologists are seeing patients, providing the income stream that will largely support all three. The third psychologist is then available to co-precept, do curbside consults, give a lecture, shadow residents, foster the milieu, and tend to administrative duties. A Family Medicine residency generates a huge number of psychological referrals, can easily support this arrangement, and will probably still be referring out to psychologists in the community.

**Ready to start?** Don’t wait for the position to be advertised. Likely as not, it won’t be. We encourage you to pick up the phone and put in a call to the Chairman of the Family Residency nearest you. If there is not a position currently available, we encourage you to ask for 15 minutes of the Chairman’s or Program Director’s time to discuss a self-supporting model for expanding their Behavioral Science program.

Further information on working as a “Behavioral Scientist” can be found at the Society of Teachers of Family Medicine website (www.stfm.org). They also have information on fellowships for behavioral science faculty who are new to the field. These year-long distance programs help behavioral science educators make the shift into this unique career.

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**Platinum Advocates**

TPA would like to thank its 2013 Platinum Advocate members for showing their commitment to being upholders of the profession of psychology.

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The integration of psychological services into medical treatment teams will take on great significance as the American health care system searches for means to improve efficiency and effectiveness. It has been estimated that less that 20% of patient visits to primary care physicians are for symptoms with discoverable causes (Kroenke and Mangeldorff, 1989), and it is clear in many of these cases that psychosocial factors influence symptom complaints. For example, about 75% of patients who are depressed present physical symptoms as the reason they seek health care (Unutzer, Schoenbaum, Druss & Katon, 2006; see also, Blount et al, 2007). While many physicians still do not recognize the roles that depression or other emotional issues may play in leading patients to seek medical care and in maintaining symptoms complaints, others have learned that integrating psychological services into their practices can both improve effectiveness and can avoid taking many patients down a long road of negative medical diagnostic procedures and even ineffective treatments. Such a physician is exemplified in a recent New York Times opinion piece by Dr. Abigail Zuger, (June 10, 2013), in which she describes the difficulties of a patient who had chronic multiple complaints—sinus attacks, pain, headaches and muscle cramping. Dr. Zuger relates how it took her a great deal of time, and a major change in her usual approach to patient care, before she stopped “expecting the worst of every symptom”, stopped doing “everything to diagnose and treat (symptoms) without regard for the destructive aspects of doing too much,” and convinced the patient to go for mental health evaluation.

I have been fortunate to be involved with forward-looking physicians who have come to recognize the value that psychological services can bring to their practices. In graduate school during the mid to late 1970s I conducted research on chronic pain patients at Dartmouth Medical School’s New Behavioral Medicine program, under the supervision of psychiatrists and psychologists. However, once I entered clinical practice in the early 1980s I began working as a member of multidisciplinary teams involving physicians of other medical specialties, including rehabilitation medicine (Physiatry), Neurology, and, most importantly Orthopedic Spine Surgery. It is my experience with this last group of physicians, particularly at the Texas Back Institute (TBI), that I will describe in detail.

Before coming to TBI I worked with a small group of spine surgeons in Indianapolis, beginning to systematically apply research on the psychology of pain to the evaluation of spine surgery candidates. When I arrived at TBI in 1990, the spine surgeons there recognized two important facts. First, although spine surgery was most often effective in providing pain relief and improved function, there was still a fairly large group of patients who did not obtain such positive results, even though the surgery was successful in correcting the apparent physical cause of the pain. Second, although not trained in mental health assessment, these surgeons recognized that prior to surgery many of their patients had significant psychosocial issues: depression, anger, anxiety, substance abuse, chaotic personal lives and many more.

Initially the surgeons with whom I worked with were supportive of my efforts, yet some were skeptical. When they referred patients for psychological assessment prior to surgery, in most cases I was able to either document that the patient had no major psychosocial issues or that I could address such concerns through brief cognitive-behavioral treatment, ultimately enhancing the patient’s chances of obtaining good results from the surgery. However, about 15%-20% of the time when I performed a presurgical psychological screening (PPS) I recommended that, if the surgery was not medically critical, then it should be either delayed significantly or avoided altogether, due to the patient’s extreme level of psychosocial concerns. Certainly the research on the topic of PPS for spine surgery was quite limited in the early 1990s, and perhaps it is no wonder, then, that my suggestions to delay or avoid surgery were rejected almost as often as they were accepted.

The situation gradually changed over the next few years. First, the surgeons had the opportunity to observe outcomes when they performed elective spine surgery on patients for whom a high level of emotional distress had been identified—and the results were certainly less than optimal for this group of patients. In addition, together with the surgeons I embarked on a prospective study examining the outcomes of elective spine surgery for patients with varying levels of psychosocial risk factors. For this study we developed a “scorecard”, assigning patients into a low, medium or high level of psychosocial risk (Block et al., 2001). We found that about 83.0% of high risk patients obtained poor surgical results, whereas only 17.7% of low risk patients failed to achieve good surgical response. I should add that these data were collected in the mid to late 1990s. Now it is impossible in our practice to replicate this study, as the surgeons are much more likely to follow the suggestions flowing from our PPS efforts. We continue to conduct collaborative research on the impact of psychosocial concerns on those who undergo spine surgery and to refine our treatment approaches based on the results.

My experience working with orthopedic surgeons has taught me some significant lessons. First, physicians need to understand the value of psychological services to their
Chronic insomnia is defined as difficulty initiating sleep, or maintaining sleep with daytime consequences (e.g., fatigue, attention problems), and symptoms persisting for more than three months (American Psychiatric Association, 2013). This disorder affects individuals across the lifetime, with nearly 16% of the adult population reporting chronic insomnia (Lichstein, Durrence, Riedel, Taylor, & Bush, 2004) and approximately 25% of young children exhibiting sleep difficulties (Kuhn & Weidinger, 2000). Although chronic insomnia does not present the same in different age groups, it has adverse effects across the lifespan. Insomnia is a risk factor for many medical and mental disorders (see Taylor, Lichstein, & Durrence, 2003 for a review). People with insomnia frequently have or develop comorbid depression, anxiety, and substance use disorders (Taylor et al., 2003). Additionally, they are 2.5 to 4.5 times more likely to experience accidents than people without insomnia. It is estimated that the direct cost of insomnia per year is $13.9 billion, with total costs reaching $30-35 billion annually (Walsh & Schweitzer, 1999). Current cognitive and behavioral therapies are efficacious in both adults and children (Morgenthaler, Kramer, et al., 2006; Morgenthaler, Owens, et al., 2006).

**Adult Insomnia**

**Psychological Treatments.** Though pharmacological treatments (see review below) can be useful in cases of acute insomnia, cognitive behavioral therapies are preferred for chronic insomnia, with demonstrated efficacy in both primary insomnia (Morgenthaler, Kramer, et al., 2006; Morin et al., 2006) and insomnia comorbid with other medical or mental disorders (Steers, & Rybarczyk, 2006). These treatments are research-supported, with meta-analyses showing that cognitive and behavioral therapies are significantly more effective than placebo in improving sleep (Irwin, Cole, & Nicassio, 2006; Morin, Kulbert, & Schwartz, 1994; Murtagh & Greenwood, 1995). Furthermore, randomized clinical trials demonstrate that psychological treatments as effective as pharmacological treatments in the short-term, and more effective in the long-term (Jacobs, Pace-Schott, Stickgold, & Otto, 2004; Morin, Colecchi, Stone, Sood, & Brink, 1999).

Etiology is commonly explained with the **behavioral model of insomnia** (Spielman, Caruso, & Glovinsky, 1987). This model (Figure 1) theorizes that underlying genetic and physiological mechanisms that put individuals at risk for insomnia are called predisposing factors. Precipitating factors are the life events, medical circumstances, environmental, or psychological factors that serve as a catalyst for the initiation of insomnia. Perpetuating factors are
those that maintain or exacerbate existing sleep difficulties (e.g., maladaptive beliefs and behaviors). It is believed that individuals with chronic insomnia have adapted to the original stressor and now perpetuate the insomnia through their own behaviors and cognitions.

Psychological treatments of insomnia for adults typically target the behaviors and thoughts that perpetuate poor sleep patterns. Some common features of these treatments include collaboration, daily monitoring, homework and psychoeducation. Presented below are the methods that have substantial empirical support as determined by critical reviews by the Standards of Practice Committee of the American Academy of Sleep Medicine (Morgenthaler, Kramer, et al., 2006; Morin et al., 2006). These reviews indicate that multi-modal cognitive-behavioral therapy of insomnia, as well as the single interventions of stimulus control therapy and progressive muscle relaxation, are to be considered “Standard” treatments, indicating they have the highest level of empirical validation (i.e., at least two placebo-controlled randomized clinical trials).

Sleep restriction therapy, biofeedback, paradoxical intention and multi-component behavioral therapy are “Guideline” treatments, indicating they are effective but have a lower level of empirical validation (e.g., only one placebo-controlled randomized clinical trial, clinical case studies, or waitlist control studies). Treatment of insomnia typically integrates one or more of the following interventions, often tailored specifically to the patient’s individual needs. Therefore, it is important to consider comorbid conditions that may impact the course of treatment, such as medical (e.g., seizures, medication), psychiatric (e.g., anxiety), and other sleep disorders (e.g., sleep apnea) (see chapters in Morin & Espie, 2012 for more specific guidelines).

**Stimulus Control Therapy (SCT).** SCT is the most effective single component treatment method, focusing on breaking associations between the bed/bedroom and the experience of insomnia. Because the bedroom is often used for non-sleep activities, such as eating, watching television, and engaging in activities that disrupt sleep, SCT aims to strengthen sleep-compatible associations with the bed/bedroom and remove sleep-incompatible ones, and uses classical conditioning to break the association between the bedroom and insomnia. Patients are instructed to limit activities in the bedroom to sleep and sex, and to avoid any activating activities in the room (e.g., arguments, worrying).

Patients should get up at the same time every day and only go to bed when sleepy. They are to get out of bed any time (even in the middle of the night) that it takes more than 15-20 minutes to fall asleep. When this occurs, they should engage in a relaxing activity in another room, preferably in dim light, and only return to bed when sleepiness sets in. This process is to be repeated as often as necessary until they fall asleep. Patients are instructed not to watch the clock, but to get out of bed when they think 15-20 minutes have passed. This procedure allows patients to begin to recognize signs (e.g., yawning, tired eyes, nodding off) of “sleepiness” as opposed to fatigue.

**Progressive Muscle Relaxation (PMR).** Although there are several relaxation interventions, PMR has the strongest evidence base and has been demonstrated to be more effective than placebo, waitlist and no-treatment controls. PMR typically takes 10-30 minutes to complete, and patients are taught to alternate tense (4-7 seconds) and relax (20-45 seconds) various muscle groups throughout the body: hands, wrists, arms, shoulders, feet, ankles, thighs, buttocks, abdomen, neck, forehead, face and jaw. Patients are instructed to focus attention on the contrast between the feelings of relaxation and tension, which teaches them to recognize when they are tense and consciously relax (Jacobsen, 1929). Homework for this technique consists of practicing at home several times during the day and just prior to bedtime, as several weeks may be needed for mastery of this skill.

**Sleep Restriction Therapy (SRT).** The goal of SRT is to strengthen the homeostatic sleep drive by limiting time in bed to the patient’s true sleep need and eliminating naps (Spielman, Sarkin, & Thorpy, 1987; Wohlgemuth & Edinger, 2000). People with insomnia commonly have irregular sleep schedules (e.g., sleeping in later on weekends or after a bad night), and SRT seeks to regulate the sleep-wake cycle. In addition, SRT eliminates behaviors that perpetuate insomnia (e.g., excessive time in bed), and increases sleepiness, making the patient more likely to fall asleep when they get in bed.

In order to determine the patient’s average total sleep time (TST), they are instructed to keep a Sleep Diary for 2-3 weeks. The patient and therapist then collaborate to determine time in bed (TIB) for the next week. Typically this is equal to the TST, though some therapists allow an extra 30 minutes, and it should not be less than 5-5.5 hours for safety reasons. After the patient’s average sleep efficiency (i.e., [TST/TIB] x 100) reaches greater than 87%, their TIB is progressively extended by 15 minutes each week. In a given week if the sleep efficiency falls below 85%, the TIB is decreased by 15-30 minutes. This titration stops once the optimal TIB is achieved (i.e., TIB cannot be extended without sleep efficiency falling below 87%).

SRT quickly consolidates the sleep period and often produces sleepiness within the first week. However, it is important to include education about the benefits of this therapy, since the increased daytime sleepiness can be dangerous or unpleasant and may otherwise reduce adherence. A modification of this therapy, called sleep compression, can be used in risk populations (e.g., elderly, children, comorbid medical disorders, patients with high sleep anxiety) or with those who find the SRT procedures too drastic. Sleep compression gradually reduces TIB until the optimal TIB is reached (Lichstein, Riedel, Wilson, Lester, & Aguillard, 2001).

**Paradoxical intention.** Paradoxical intention instructs patients to get into bed and try to stay awake, which is intended to reduce performance anxiety. This technique is not typically recommended over other empirically-supported interventions or included in multi-modal therapies because research has produced mixed...
results about effectiveness. However, it may be a useful technique when patients do not respond to other methods (Broomfield & Espie, 2003).

**Biofeedback.** Biofeedback is a form of relaxation therapy that provides visual or auditory feedback either mechanically (e.g., thermometers) or with computers and amplifiers. This technique is intended to reduce somatic arousal by helping patients learn to control physiological parameters (e.g., finger temperature or muscle tension) that may otherwise be unobserved. Biofeedback is often combined with other relaxation techniques such as PMR (Freedman & Papsdorf, 1976), with results comparable to PMR alone, and may not demonstrate the additive benefits of its expensive equipment.

**Cognitive behavioral therapy of insomnia (CBT-I).** Although several individual therapies have demonstrated effectiveness as single-treatment modalities, in practice, multi-modal combinations are the most common. CBT-I is the combination of one or more of the above behavioral techniques (typically SCT, SRT, and PMR) with sleep hygiene and cognitive therapy. CBT-I is able to address the multi-faceted nature of insomnia and tailor treatment to each patient’s individual needs, and it is therefore becoming the treatment standard (Jacobs et al., 2004; Morin et al., 1999; Morin et al., 1994).

**Sleep hygiene.** Sleep hygiene is a compilation of recommendations aimed at educating the patient about reducing behaviors or factors that may interfere with sleep (e.g., irregular sleep schedules, using caffeine, alcohol, or nicotine before bedtime, taking naps, exercising too close to bedtime, uncomfortable sleeping environment). Sleep hygiene is an ineffective treatment on its own, mostly likely because individuals with insomnia already target poor sleep hygiene habits in attempts to treat their own insomnia. Sleep hygiene recommendations, sometimes confused with SCT, are often cited by the media and are the method with which most non-specialists are familiar. Because sleep hygiene is frequently the only treatment offered by non-specialists to their patients, psychological treatments of insomnia may be unfairly deemed ineffective (Steers & Wyatt, 2003).

**Cognitive therapy.** Cognitive therapy techniques in insomnia are similar to those developed by Beck and colleagues in the depression literature (Beck, Rush, Shaw, & Emery, 1979). Patients with insomnia often develop dysfunctional beliefs and attitudes about sleep, and cognitive therapy seeks to target and restructure these maladaptive thoughts (Harvey, 2002; Harvey, Tang, & Browning, 2005). Some individuals worry about the consequences of not getting enough sleep (e.g., 8 hours of sleep per night), and some think they will never sleep well again. These thoughts tend to escalate at bedtime, thus contributing to the arousal cycle that interferes with sleep. Cognitive therapy focuses on identifying these harmful thoughts, perhaps with a measure such as the Dysfunctional Beliefs and Attitudes about Sleep scale (Morin, Vallières, & Ivers, 2007), challenging their validity, and substituting more adaptive thoughts (e.g., functioning on less than 8 hours of sleep is possible), thereby reducing arousal.

Maladaptive thoughts about sleep are challenged in three basic ways. First, common myths are dispelled through basic sleep psychoeducation. For example, patients learn that 70% of adults sleep 6.5-8.5 hours per night, and the average person wakes up several times per night but does not typically remember these awakenings. Second, patients are instructed to keep logs about their sleep-related thoughts and use common cognitive therapy techniques (e.g., testing the evidence, survey method, behavioral experiments) to test their validity. Finally, some therapists combine these two methods by using these cognitive therapy techniques as they arise in session.

**Pharmacological Treatments.** Despite the well-demonstrated superiority of psychological treatments, pharmacological interventions are still the most commonly used treatment in patients with chronic and transient insomnia (Krystal, 2009). There are several likely reasons for this: (a) few clinicians are aware of or trained in psychological therapies for insomnia, (b) insufficient or insufficiently disseminated information regarding the utility and efficacy of psychological therapies, (c) increased time and effort necessary for psychological therapies, and (d) belief in the misconception that insomnia is merely a symptom of another disorder.

The three primary classes of hypnotic medication currently used in the treatment of insomnia are benzodiazepines, nonbenzodiazepine hypnotics and antidepressants (see Krystal, 2009 for a detailed review). However, there are many known potential side effects from use of hypnotics (e.g., short-term memory decrements, automatic sleep behaviors like sleep-eating disorder, depression, daytime sleepiness) and withdrawal effects following long-term use (e.g., rebound insomnia, irritability, increased tension and anxiety, panic attacks, hand tremor, sweating, difficulty concentrating, dry retching and nausea, some weight loss, palpitations, headache, muscular pain and stiffness, and perceptual changes). Knowledge regarding the safety and efficacy of long-term use of these medications is limited (Riemann & Perlis, 2009), but the reality is that these medications are often used indefinitely. Ultimately, requiring medication to achieve a normal physiological process is neither practical nor desirable in the long-term.

Over-the-counter medications (e.g., antihistamines) or home remedies (e.g., alcohol, herbs, dietary supplements) are also used frequently, with or without the consent of a treating clinician. However, the sleep-promoting efficacy, side effects, and potential for tolerance and dependence of these products have not been well-studied. The two most commonly used herbal supplements for sleep difficulties, melatonin and valerian, were not significantly better at improving sleep than placebo in two controlled trials. However, melatonin may be useful in patients with jet lag or severely delayed sleep schedules if used correctly. (See Morgenthaler et al., 2007 for practice parameters for treatment of circadian rhythm sleep disorders.)

**Childhood Insomnia**

Complaints of bedtime struggles and nighttime awakenings are common in pediatric and child psychotherapy offices (Kuhn & Weidinger, 2000). Because childhood sleep difficulties are influenced in large part by parental behaviors and environmental factors, examination of cultural practices, parental expectations, and the child’s developmental stage are crucial for successful treatment. Children may be using bedtime and sleep as a way of exercising control over their own lives. Alternatively, sleep difficulties may arise as a function of misalignment between the child’s internal clock and his or her imposed bedtime. It is important to note a distinction between childhood and adolescent insomnia: while younger children may actively resist sleep, older children and adolescents present more similarly to adults in that they typically have genuine difficulty falling asleep despite their best efforts. (For a more in-depth review of childhood insomnia and treatment considerations, see Wolfson & Montgomery-Downs, 2013.)
Most frequently, childhood sleep complaints fall under the umbrella diagnosis of Behavioral Insomnia of Childhood (BIC), which is comprised of three types: 1) Sleep Onset Association, 2) Limit-Setting, and 3) Combined. Sleep Onset Association Type is characterized by bedtime struggles stemming from the child’s desire for a specific item or person in order to fall asleep and throughout the night. Limit-Setting Type includes children who exhibit stalled or refusal behaviors at bedtime or throughout the night, paired with parents that have difficulty setting limits. Combined Type is characterized by exhibition of both of these behaviors. As in adult insomnia, it is important in childhood sleep difficulties to assess for comorbid conditions that may affect the course of treatment, such as medical (e.g., seizures, medication), psychiatric (e.g., anxiety), and other sleep disorders (e.g., sleep apnea).

**Psychological Treatments**

Behavioral therapies are the preferred method of treatment for childhood insomnia, with one estimate of efficacy reaching 94% (Mindell, Kuhn, Lewin, Melzer, & Sadeh, 2006). These treatments employ the principles of learning to change unwanted behaviors through changes in both child and caregiver behaviors. The success of behavioral therapies is largely attributed to a family-level change, as opposed to the expectation that the child will change independently. One of the most important tenets of treatment is the introduction of predictability and consistency through bedtime routines that always have the same result. The specific use of reinforcement aids the child in learning by providing a contrast in experience. For example, parents are instructed to use differential attention to create this contrast by attending to (reinforce) desired behaviors (e.g., praising the child for getting ready for bed), and not attending to (extinguish) undesired behaviors (e.g., actively ignoring the child crying in bed).

Presented below are the treatment methods for BIC that have substantial empirical support, as determined by reviews by the Standards of Practice Committee of the American Academy of Sleep Medicine (Mindell et al., 2006; Morgenthaler, Owens, et al., 2006). These reviews found that preventive parent education, unmodified extinction, and extinction with parental presence were all “Standard” interventions. Graduated extinction, bedtime fading/positive routines, and scheduled awakenings were all “Guideline” treatments.

**Preventative parent education.** Preventative parent education is a proactive intervention that aims to educate and prepare caregivers before sleep problems arise. This intervention focuses on establishing positive sleep habits by helping caregivers to learn appropriate expectations and establish limits for the child, as well as establish favorable conditions for infants to learn independent sleep initiation skills. These interventions typically target caregivers during the prenatal period to up to six months postnatal, and focus on topics like bedtime routines, establishing a consistent sleep schedule, caregiver handling during sleep initiation, and caregiver responses to nighttime awakenings. Caregivers are also taught to separate feeding and bedtime, how to discriminate infant wakefulness, and how to minimize response to nighttime awakenings. Independent infant sleeping initiation is encouraged by teaching caregivers to put infants in bed “drowsy, but awake,” which provides infants the skills to re-initiate sleep if nighttime awakenings do occur. Numerous studies identify prevention is not only effective, but also the most economical and time-efficient intervention available (Mindell et al., 2006).

**Unmodified extinction.** This technique, also known as “systematic ignoring” or “crying it out,” is the most effective behavioral intervention for existing BIC (Kuhn & Elliott, 2003; Mindell et al., 2006). Unmodified extinction removes the reinforcement (i.e., caregiver attention) that results from an unwanted behavior, thereby reducing the frequency of this behavior over time (Lerman & Iwata, 1996). In this treatment, parents place the child in bed and do not attend to him or her until the next morning unless absolutely necessary (e.g., legitimate illness, danger of self-harm, or property destruction). These basic instructions are frequently modified to incorporate further instructions (e.g., establishing a regular bedtime and bedtime routine, handling refusals to stay in bed, and preparing the parent for the potential extinction burst) that increase the chances of treatment success. Some consider this treatment to be least palatable to caregivers, and therefore several alternative extinction-based treatments (e.g., extinction with parental presence, graduated extinction) have been developed.

**Extinction with parental presence.** Extinction with parental presence requires parents to leave sleep in a separate bed or cot in the child’s bedroom while actively ignoring unwanted behaviors. Parents maintain this pattern for up to one week or until the child successfully initiates and maintains sleep on their own, whichever occurs first. Once parents are out of the child’s bedroom, they use unmodified extinction for any further unwanted behaviors. This modification can successfully allay caregiver fears about child safety, and has been demonstrated to produce less crying than unmodified and graduated extinction techniques (France & Blampied, 2005).

**Graduated extinction.** Graduated extinction is an alternative modification of the extinction procedure that incorporates caregiver check-ins. These check-ins consist of a 15-60 second period during which caregivers are instructed to go into the child’s room to briefly check on the child with minimal attention (i.e., no excessive talking, touching, or looking at the child). This technique primarily uses one of two schedules: fixed interval schedule (i.e., a specific length of time between check-ins) or graduated fixed interval schedule (i.e., interval between check-ins gets progressively longer in a systematic way [e.g., 5 minutes, 10 minutes, 15 minutes]). Graduated extinction has been shown to be associated with improved parent-child interactions compared to no intervention, and may generalize to improving overall parenting skills (Mindell, 1999).

**Bedtime fading.** Bedtime fading is comparable to sleep restriction therapy, a widely-used treatment for insomnia in adults, adolescents and older children. The child’s bedtime is initially moved later in order to more closely match their actual sleep onset time, and a consistent morning wake time is established. Once the child is falling asleep quickly and reliably, the bedtime is slowed moved earlier until the child’s sleep period falls within an age-appropriate range (Piazza & Fisher, 1991).

Two further components are often added to the above procedure: response cost and positive routines. Similar to stimulus control therapy, response cost involves removing the child from the bed for one hour if sleep onset does not occur within 15-20 minutes of bedtime. This technique uses the reinforcing quality of sleep to outweigh the reinforcement of caregiver attention. Positive routines establish a nightly bedtime routine that consists of enjoyable pre-bedtime activities and positive praise for the child following the bedtime routine. These components employ differential attention, which helps the child learn the sleep compatible behavior and cues for sleep onset that are supported.
by the rapid initiation of sleep due to the bedtime fading procedure.

Scheduled awakenings. This protocol, originally developed for use with BIC, is most often used with the treatment of pediatric parasomnias. Scheduled awakenings seek to dissolve the association between middle of the night awakenings and parental attention (Rickert & Johnson, 1988). Caregivers establish a timeline for likely spontaneous middle of the night awakenings and then preemptively wake the child 15-30 minutes before they would occur. The time of each awakening is gradually delayed to allow the child to sleep for longer periods without interruption. Scheduled awakenings are successful in the reduction of nighttime awakenings, but they do not affect bedtime struggles because they target disruptions that occur after sleep onset. This procedure does negatively impact parental sleep schedules and takes longer than extinction-based protocols (e.g., 8 weeks versus 1-3 weeks). However, this treatment is still considered effective and is indicated in situations in which extinction is contra-indicated due to child resistance, self-harm or poor caregiver adherence.

Pharmacological Treatments
Although behavioral therapies are the most effective for treating BIC, the National Sleep Foundation and the Best Practice Project Management, Inc. (Mindell et al., 2006) collaborated to explore the potential utility of pharmacological treatments. A panel of experts convened for two days and drew two primary conclusions: research supporting or refuting the use of pharmacological treatments in the management of BIC is scarce, and there is a need for effectiveness and efficacy studies to evaluate use of hypnotic medications in pediatric populations. Despite these findings, Owens, Rosen and Mindell (2003) found that 58% of pediatricians prescribed medication and 77% reported they recommended over-the-counter medication for the treatment of BIC during a 6-month period. The Food and Drug Administration has not approved the use of hypnotics in the children, and current pharmacological interventions are off-label and not empirically supported. In sum, caution is warranted in pharmacological interventions for BIC until further studies can provide well-defined guidelines that ensure the safety and appropriateness of treatments.

Resources for Providers
Training. Although the effectiveness of psychological treatments for insomnia in both children and adults has been empirically demonstrated, the use of these practices is still limited. This is due, in part, to the lack of clinicians trained in behavioral sleep medicine (BSM) (Pigeon, Crabtree, & Scherer, 2007). BSM practitioners can operate in many settings (e.g., sleep disorders centers, private practice, hospitals, medical centers), and can see sleep patients on a part- or full-time schedule. Because of the paucity of providers, services are in high demand and affiliation with a local sleep clinic typically provides an abundance of patient referrals. To find local sleep disorders centers, visit the American Academy of Sleep Medicine sleep disorders center location website (www.sleepcenters.org). These centers are often overwhelmed by demand for psychological services for sleep disorders and typically unable to provide them.

Training opportunities in BSM are growing, and there are many benefits to specializing in this area. We encourage practitioners to familiarize themselves with the empirically-based psychological treatments described above, as they can often be seamlessly integrated with other therapeutic practices and theoretical orientations, and to consider offering these services in their own practice. Books with more detailed descriptions of psychological treatments for insomnia are listed below. In addition, several continuing education courses are available. For instance, the American Psychological Association (APA) offers an introductory online continuing education course in BSM (http://www.apa.org/education/ce/aoa0012.aspx). There are also intensive 2-3 day CEU courses offered on a frequent basis (e.g., http://www.pesi.com/insomnia/). These treatments are so effective that the Veterans Administration is currently disseminating them across the nation for those working in VA settings.

For practitioners interested in obtaining certification in behavioral sleep medicine (CBSM), there are two pathways offered by the accrediting body, the American Board of Sleep Medicine (ABSM). The first is a route for practitioners who have been a part of a BSM training program enabling them to obtain the necessary 1,000 hours of direct BSM training and client contact. The second option is for practitioners who have not previously been part of an accredited BSM training program. Instead, certification can be obtained by acquiring 500 hours of direct BSM training and 500 hours of behavioral medicine training. Both require a passing score on the CBSM exam, which is offered annually around the country. Direct BSM training can be obtained through training programs accredited by the SBSM; for a list see the SBSM website (http://www.behavioralsleep.org/FellowshipPrograms.aspx). There are also a number of postdoctoral and fellowship training opportunities provided at various universities and centers.

Billing. Billing for BSM services can be challenging for individuals unfamiliar with the field, although it presents no more difficulty than billing for other health psychology services. Psychiatric codes for clinical interview, testing, individual and group psychotherapy, as well as Health and Behavior Codes for assessment, testing and intervention are the same as for a typical health psychology intervention. Indications allowed for BSM billing purposes are diagnoses of insomnia, hypersomnia, circadian rhythm disorders and CPAP compliance. The earnings potential for BSM providers is relatively high. The starting salary for a licensed psychologist working with a sleep disorders center is approximately $60,000-$80,000 a year, and they can expect to make 20-30% more than they would in a undergraduate psychology department (DeAngelis, 2007).

Summary and Conclusions
Psychological treatments of sleep disorders, particularly insomnia, have been demonstrated effective through decades of research and clinical practice. The treatments reviewed above have been examined experimentally, and regularly shown to be superior to placebo, no treatment, and waitlist controls, and in some cases medication. For further reading on the techniques presented above, several treatment manuals are available with specific instructions on the delivery of these interventions (M. Perlis, Aloia, & Kuhn, 2010; M. L. Perlis, 2005; M. L. Perlis & Lichstein, 2003).
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