Psychologists Sharply Divided Over Prescribing Privileges

John Winston Bush, PhD

Psychiatrists and other medical professionals are not alone in opposing bills that would grant drug-prescribing authority to clinical and counseling psychologists. The psychological profession itself is sharply divided over the issue. If such a bill is again brought before the Texas Legislature, psychologists will join their medical colleagues in opposing it — just as they have done in every state where similar bills have been introduced since 1985.

The very existence of opposition within psychology to prescribing privileges — colloquially known in our profession as “RxP” — is an open secret that the American Psychological Association (APoA) and its state affiliates have tried to sweep under the carpet. Spearheaded by a group of moderates at APoA, the campaign for RxP has been portrayed to psychologists as a “done deal” that is futile — and in fact a bit seductive — for them to oppose or even question.

Normal parliamentary rules in APoA’s elected Council of Representatives have been suspended in order to push through resolutions supporting RxP. The association’s most widely-read membership publication, Monitor on Psychology, carries frequent articles promoting RxP but rarely permits even a reader letter opposing the scheme to appear in its columns. Events such as the “Murta Convention on Prescribing Privileges” featured at APoA’s 2000 national convention have been one-sided presentations, with dissenting viewpoints systemically excluded. Its press releases and other public pronouncements show the same disregard for objectivity. Perhaps worst of all, state legislators and executive officials are given to understand that their psychologist constituents are united in support of RxP when in fact they are not.

By doing an end run on its membership and going directly to state legislators, APoA is trying — in the words of Prof. Elaine M. Herby, director of the clinical psychology training program at the University of Hawaii — to overhaul our discipline by legislative fiat. A matter that should have been settled within psychology — through transparent information policies and thorough, open debate — has been taken public without the consent of APoA’s rank-and-file members.

Having fostered ignorance and misinformation among its own membership, APoA and its state affiliates are able to get away rather easily with feeding legislators a grossly distorted picture of its proposed training model. The model has been falsely represented as being based on the Department of Defense Psychopharmacology Demonstration Project — a largely successful program (ACNP, 2000) in which 10 military psychologists were trained between 1993 and 1997 in prescribing psychotropic medications at the Uniformed Services University of the Health Sciences and Walter Reed Army Medical Center. It has also been falsely portrayed as reflecting the recommendations of a 1994-95 Blue Ribbon Panel of the California Psychological Association and the California School of Professional Psychology (CPA/SSP Task Force, 1995), which was funded by APoA itself and convened by its then-chairman.

Both the DoD program and the Blue Ribbon Panel report indicate a need for medical training lasting a minimum of two years — similar to that of advanced-practice nurses and physician assistants. But the APoA model, even with a generous estimate, a one-year program. Worse still, it permits its requirements to be met in weekend continuing-education workhops and “distance learning,” i.e., electronic correspondence schools.

Even a two-year, on-campus training program — i.e., one genuinely based on the DoD experiment — would not be fully adequate for civilian prescribing. The DoD trainers did not treat children or the elderly. Because military enlistment and discharge criteria select for the physically and mentally fit, they also did not see the proportion of medically and psychopathically complex cases that can be expected to present in civilian settings. Finally, working as they did in military team-practice settings, they had much easier access to psychiatric and other medical consultation than is available to most civilian psychologists.

By far the safest option for psychologists who want prescriptive authority is to complete medical school. Short of that, advanced-practice nursing or physician assistant training would seem a reasonable minimum — though some would dispute the adequacy of even those forms of abbreviated preparation. In any case no new legislation or state regulatory oversight is required by any of these options. Medical training specifically designed for psychologists is also a possibility — but that would mean an expanded DoD model program lasting about two and a half years, not one year as APoA is proposing.

Why has APoA embarked on such a reckless course of action? Reckless, because considerations of public safety are dismissed in cavalier fashion. Reckless, because it seeks prescriptive authority on the basis of a short-cut training model that is supported by neither the DoD precedent nor its own expert consensus. Reckless, because it entails misrepresentations to state legislators and other officials that are easily exposed by informed opposition. Reckless, because it undermines constructive collaboration between psychology and medicine, especially psychiatry. And reckless, because it leaves APoA and the psychological profession open to inseparable discredit once the facts become more widely known.

Reasonable people may differ in their explanations for this odd behavior on APoA’s part, but here are my own conjectures.

• Psychology has seen its share of the mental health care market eroded by the entry of other professions — social work and various kinds of counseling — and is looking for ways to recoup. Additionally, the incomes and administrative burdens of psychologists just like those of many other professionals — have been impacted by managed care, and adding prescriptive services seems to some to be a promising solution.

• Any thoughtful psychologist is aware of dubious prescribing practices on the part of some physicians, including psychiatrists. (As no doubt is any thoughtful psychiatrist.) Some of my colleagues, curiously, have taken this to mean that they could do as good a job or a better one without any great amount of medical training. This puts them in the strange position of implying that seven years of medical training is not enough to make every psychiatrist competent, somehow one year would do the job for psychologists.

An interesting application of Mes van der Rohe’s architectural dictum, “Less is more.”

• Perhaps because it is not part of their everyday experience, some psychologists fail to appreciate the difference between knowing what drugs and dosages are most likely to prove helpful to patients — which many do — and having medical responsibility for the consequences of prescribing them. One former APoA president is on record as saying that prescribing psychotropics is no more difficult to learn than the use of a desktop computer.

• Twenty years ago, when APoA began looking seriously into prescribing privileges, many of today’s highly efficacious psychological treatments did not exist, or were still in the early stages of development, or had not yet developed a strong evidentiary base in the research literature. It was easy for some to imagine that biological psychiatry would be the wave of the future, without much effective competition from psychological treatments. Today the picture is very different — but in the meantime APoA’s drive for prescriptive authority has acquired a momentum that it will not be easy to reverse.

In any event, despite APoA’s claim to speak for clinical and counseling psychologists, many of us are deeply skeptical of our organization’s pre-prescribing-privileges campaign in anything like its present form. I recommend that all state psychiatric and medical societies make a point of actively partnering with their allies in psychology to defeat these bills in any state where they are introduced. There don’t have to be any more New Mexico — and won’t be if we stick together.

References


Dr. Bush is Chairman of the Committee Against Medicalizing Psychology and is in the Private Practice of Clinical Psychology in Brooklyn, New York

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[2] In addressing psychiatric patients, I use the acronym “APoA” to refer to the American Psychological Association and “APs” to the American Psychiatric Association. This nicely distinguishes our “ologists” from your “iatrists” — and avoids the one-upmanship of terms such as “ApA” and “Apa” that are sometimes used by clinical and counseling psychologists, many of us psychologists, many of us

[3] Here’s one to keep an eye out for: the claim that APoA’s one-year training curriculum merely embodies cuts that had already been made in the well-vetted Defense Department project. Not so. The DoD program began in 1991 as a three-year program, and was cut in 1993 (apparently without untoward consequences) to a two-year program. The further reduction to a one-year program was done, not by the DoD project, but by an APoA “working group” whose proceedings APoA has not opened to outside scrutiny. (For details, see the RxP Truth Squad site at http://www.RxPfacts.com.)
You may be among some members who are frustrated with the mounting problems facing the practice of psychiatry and our patients. I firmly believe that the problems would be worse if it were not for the Texas Society of Psychiatric Physicians and the involvement and participation by its members.

Most of our members are modest, quiet, unassuming, yet dedicated volunteers, who never tire of their own chores about which they have been able to accomplish by utilizing TSPP as a springboard for serving their patients. As a result we see no data about the lives that have been saved; the suffering that has lessened; the potential that has been realized in lives that otherwise would have been left dormant. Often we see the difference only in things that might seem small or trivial.

I have been astounded by the openness, honesty, diligence, and dedication on the part of the TSPP members and staff involved in addressing the many problems we face.

One of those small things occurs for me virtually every week. I see it in the children of my patients. Sometimes when I open the door to my waiting room to get a new patient, I see the entire family sitting there. Before shutting that door to take that new patient back, I am often haunted by the haggard, unkempt, leprous appearance of the children. “Children shouldn’t have to look that way,” is a thought that frequently lingers in my mind as we walk back to my office. Inside I boil with fury, yet ache with despair, over my helplessness to save the children then and there. As I work thereafter to treat the patient who is the mentally ill parent who cannot function for their children, time and time again I have found that my struggles have already been broken and my hands have already been untied by the activities of TSPP members who have volunteered their time and sweat to remove roadblocks that otherwise would have rendered all my efforts useless.

So often the situation is different when I open that door a few months later. The children then are more likely to be well-groomed, laughing, cutting up, and bragging about their new toys. They are happy! They have their parent back! I can’t tell you enough how on those occasions I have thought to myself, “Thank you for TSPP!”

Those thoughts are silent events. No one hears them but me. They are kept in no data bank. I don’t even tell the TSPP stuff or the TSPP members who did the work to make those good things possible. Instead I find myself thinking about what it will be like when those children grow up and have kids of their own. I think about how they will be better parents, because they themselves were able to have parents. I think about how the subsequent generations will multiply with more and more children, and how this benefit will grow. I am thankful that at this point in time we have been able to make a difference for them, even though they will never know of it. I am aware that no one will be able to calculate the multiplying benefits that TSPP has had and will have for those children of the future, but I am convinced that, invisible as our joint efforts generally are, they will be present, long after we are gone.

Some members are impatient with our progress to eliminate problems. I am too. I have no belief that either TSPP or APA are perfect organizations, but I do not consider them to be the causes of the problems. For us to give them that type of blame is to say that fires are caused by firemen because we see firemen at every single fire.

Instead I believe we each can utilize our professional organizations as a means of unifying our voices to express our views for solutions to these problems. I have been astounded by the openness, honesty, diligence, and dedication on the part of the TSPP members and staff involved in addressing the many problems we face. I find only a multitude of compassionate and caring individual members who, although they might in all good faith disagree about certain matters, are willing to engage in vigorous and sometimes frank discussions, and then put differences aside and compromise as needed for the welfare of our society, our profession, and our patients.

In so many ways, our members’ feelings of frustration reminds me of the classic 1946 movie, “It’s A Wonderful Life, directed by George Cukor. In that movie Jimmy Stewart played the part of George Bailey. George was an idealistic fellow, who, while young, had big ideas of leaving his small home town, Bedford Falls, and going into the world to do wonderful things. But when his father died, George sacrificed his dreams and stayed in Bedford Falls in order to assume his father’s role as the manager of a small savings-and-loan company. That little company served as the town’s only protector against Henry Potter, a rich, villainous banker, whose only goal was to ruthlessly extract as much money as possible from the townspeople, regardless of how many lives or families were destroyed. In the movie Potter relentlessly mocked George for being a sentiment man, who cared more for serving the pathetic people of the town than he did for money, power, and prestige.

Although TSPP might seem like a small and helpless little endeavor like the Bailey Bros. Building and Loan Association of the movie, I believe TSPP has been able to make a big difference in improving the lot of our profession and our patients. Henry Potter had described the Bailey company as a losing proposition run by idealistic, starry-eyed dreamers like George Bailey and his father. He had no concept of the meaning of the message of the motto that George’s father had kept on his office wall – “All you can take with you is that which you’ve given away.”

Progress that we all want to achieve in addressing the many problems facing psychiatry and our patients depends upon active involvement and participation by all psychiatrists in the work of TSPP. Giving up and dropping out is not an option. “Each man’s life touches so many other lives, and when he is around he leaves an awful hole…”

R. SANFORD KISER, M D
The annual TSPP Summer Leadership Retreat, conducted on August 3-4 at the Hyatt Hill Country Resort in San Antonio, was entertaining, informative and inspirational. Over 100 members of TSPP and its partners in the Mental Illness Awareness Coalition (Mental Health Association in Texas, NAMI Texas, Texas Depressive and Manic-Depressive Association, the Texas Mental Health Consumers and the Texas Medical Association) attended.

On Saturday, Joe Gagen of Austin conducted an interactive program on legislative advocacy. Using role-playing, Mr. Gagen demonstrated how legislators view issues and how they make decisions. Throughout the presentation, the audience was reminded of Mr. Gagen's "Eight Advocacy Rules of Highly Effective Organizations": 1) All Politics is Local, or Why no one can explain a bill like a constituent; 2) Organizations: 1) All Politics is Local, or Why no one can explain a bill like a constituent; 2) Representative's constituency and is responsible for is in the best interests of the constituents; Senator Averitt said that advocates must communicate with legislators about their issues. He said that the effective advocacy from constituents does make a difference, citing how he was convinced to support mental health parity because of the effective communications he received from his constituents on this issue.

He urged the audience to seek out their elected representatives and educate them about the issues, keeping in mind that one must convince the representative that what is being advocated for is in the best interests of the constituents. He said that once the elections have been finalized, members of the Texas Legislature, Republicans and Democrats, sit down together in a non-partisan way to develop solutions that will help the citizens of Texas.

On Sunday morning, TSPP members were treated to an informative and inspirational interactive program by Joel Roberts, a media expert from Los Angeles. Speaking bluntly, Mr. Roberts began his presentation with the statement that "the image of psychiatry sucks." He went on to say that the potential of that image is dramatic. He said that the reality of the psychiatric profession is that psychiatrists make a tremendous contribution to people, but that the image of what psychiatrists do has not caught up with the reality. He cited many reasons for this problem, including: 1) many of the parties who define the image of psychiatry are not in the field itself (ie, movies, Scientology, TV shows etc); and, 2) psychiatrists who do go into the media do not tend to do as well as they could do. His presentation addressed two topics simultaneously, how to attract the attention of the media and how to excel when the media opportunity presents itself. Members learned media techniques by role playing, or as Mr. Roberts said, "we’re going to learn about media by doing media." He stressed the importance of making a good first impression, accomplished during the first 90 seconds of a media interview. He emphasized that persons who excel in the media can swiftly answer three things: 1) What’s the problem that you have the answer to? 2) Who has the problem? and 3) What’s the cost of getting it wrong? (ie, the risks and harmful consequences of psychologists’ prescribing medications to patients). Language used in a media interview that does not have impact will alienate an audience quickly. Mr. Roberts encouraged members to use concrete language, creating images by telling stories or vignettes. He emphasized that the characteristics of a good communicator, one who can influence others, is a combination of expertise as well as humanity. Mr. Rogers particularly urged psychiatrists to show their humanity when communicating with the media, not just their expertise.

Following Mr. Roberts’ presentation, Political Action Coordinators from each of TSPPs Chapters reported on their activities to involve members in the political process and to build a winning strategy against the initiative of psychologists to win prescribing privileges by legislative fiat. The Retreat ended with Political Action Task Force Chairman David Auldred, MD issuing the following challenges to TSPPs Chapters:

1. In every Chapter, the Political Action Task Force is to arrange one TV or radio interview to discuss TSPPs position against prescribing by psychologists.
2. In every Chapter, the Political Action Task Force is to arrange a meeting with the editorial board or medical writer of their local newspaper to discuss TSPPs position against prescribing by psychologists.
3. In every Chapter, the Political Action Task Force and members are to identify psychologists within their community who will join a coalition against prescribing privileges by psychologists.
Committee Leadership and Volunteers

President Sanford Kiser has completed the task of reviewing committee structure and requests from members for committee appointments. Dr. Kiser has merged four committees into existing committees in an effort to increase productivity in the areas covered by the committees and reduce redundancy. The Early Career Psychiatry Committee has been merged into the Membership Committee to provide early career psychiatrists a greater focus for the organization. The Public Affairs Committee has been merged into the Government Affairs Committee to enhance the Society’s public messages and their impact on public policy. The Task Force on Addictive Disorders has been merged into the Professional Practices Committee because of the scope of the Task Force’s objectives. And, the UR Complaint Service has been merged into the Managed Care Committee because of the close association of the two committee’s objectives. Sixteen committees will tackle the Society’s work during FY 2002-2003.

While some committees are still being formed, to date 306 committee appointments have been made involving 155 members. Committee appointments should be finalized by September 1. TSPP’s committees will meet twice this year: November 15, 2002 in Fort Worth and April 5, 2003 in San Antonio.

**TSPP Committee Leadership**

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<tr>
<th>COMMITTEE</th>
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<tr>
<td>Budget</td>
<td>Chair: Clay Sawyer, MD; Vice Chair: Conway McDonald, MD</td>
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<td>Children &amp; Adolescents</td>
<td>Chair: Linda Rhodes, MD; Vice Chair: Scott Woods, MD; Consultant: Grace Jameson, MD</td>
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<td>Constitution &amp; Bylaws</td>
<td>Chair: Bill Red, MD; Vice Chair: Franklin Redmond, MD</td>
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<td>CME</td>
<td>Chair: Rege Stewart, MD; Vice Chair: Joan Hebeler, MD; Consultant: Jef Nelson, MD</td>
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<td>Ethics</td>
<td>Chair: Michael Amschul, MD; Vice Chairs: Milton Amschul, MD and George Trapp, MD</td>
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<td>Fellowship</td>
<td>Chair: Patrick Holden, MD; Vice Chair: Adh Middhall, MD</td>
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<tr>
<td>Forensic Psychiatry</td>
<td>Chair: David Axelrad, MD; Vice Chair: J. Douglas Crowder, MD</td>
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<td>Subcommittee: Insanity Defense Conference Program Committee</td>
<td>Chair: David Axelrad, MD; Subcommitte: Insanity Defense Policy Development Committee</td>
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<td>Government Affairs</td>
<td>Chair: Martha Leatherman, MD; Vice Chair: Les Secrest, MD</td>
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<td>Long Range Planning Committee</td>
<td>Chair: Robert Demney, MD; Vice Chair: Richard Soel, MD</td>
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<td>Managed Care</td>
<td>Chair: George Santos, MD; Vice Chair: Ed Furber, MD</td>
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<td>MIT</td>
<td>Chair: Trina Cormack, MD; Vice Chair: Paul Carlson, MD</td>
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<td>Membership</td>
<td>Co-Chairs: Jacqueline McGregor, MD and Gary Etter, MD; Vice Chairs: Trina Cormack, MD and Shirley Marks, MD</td>
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<td>Newsletter &amp; Website</td>
<td>Co-Chairs: Edward Redly, MD and Joseph Castiglioni, MD</td>
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<td>Nominating Committee</td>
<td>Chair: Charles Bowden, MD; Vice Chair: Deborah Peel, MD</td>
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<tr>
<td>Professional Practices</td>
<td>Chair: Lynda Parker, MD; Vice Chairs: Estrella deForster, MD and Ed Nace, MD</td>
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| Public Mental Health Services | Society’s work during FY 2002-2003. The Public Affairs Committee has been merged into the Membership Committee to provide early career psychiatrists a greater focus for the organization.

**TSSP Committee Volunteers**

TSPP appreciates the participation of its member-volunteers.

**MEMBERSHIP CHANGES**

**NEW MEMBERS**

The following membership applications were approved by the Executive Committee following the last Executive Council meeting of April 21, 2002.

**Member in Training**

- Babber, Vidushi, MD, Waco (South Carolina)
- Katic, Alain, MD, Bellaire (Massachusetts)
- Schuenemeyer, Aneta, MD, San Antonio
- Wallace, Christopher, MD, San Antonio

**GENERAL MEMBER**

- Aeschliman, Sofia, MD, Dallas
- Alper, Joseph, MD, Austin
- Arfa, Kenneth, MD, Dallas
- Armas, Joel, MD, San Antonio
- Amschul, Milton, MD, Fort Worth
- Amschul, Milton, MD, Fort Worth
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Mental Illness Awareness Week 2002

Mental illness awareness Week, scheduled for October 6-12, affords TSPR members to join community leaders and mental health advocates and provide public education about mental illnesses and psychiatric treatments. TSPR affiliated foundation, the Texas Foundation for Psychiatric Education Research, provides grants to support MIW activities in TSPR Chapters. The following is a summary of MIW activities planned for each Chapter that has submitted a grant request to the Foundation.

Austin
Along with the Mental Health Association of Austin, the Austin Chapter plans to participate in National Depression Screening Day. Austin Psychiatric Association members and other mental health professionals will perform screenings and provide information to the public. They hope to reach 50 people from the site at Book People. Byron Stone, MD will be the site clinical director. The event will be covered by KLBK-FM and the National Health Public Service Network.

Bexar
The Bexar Chapter with NAMI San Antonio South will sponsor a fashion show at Peacock Valley Golf Club with clothes provided by J. Penney. Approximately 150-200 people attended last year, including 15 physicians. Both organizations will also host a legislative breakfast at Mi Tierra. Approximately 80 people will attend.

El Paso
The El Paso Chapter, NAMI El Paso, La Familia del Paso, Texas Tech Residency Staff, El Paso Community MIMM Center, El Paso Psychiatric Center and UTEP will distribute a letter to approximately 1,000 people highlighting the mental health situation in El Paso; issue a joint press release announcing MIW activities; present a proclamation to County Commissioner’s Court, conduct a Candlelight Vigil; conduct a program at Texas Tech; sponsor a consumer art exhibit; and participate in National Depression Screening Day.

Galveston-Jefferson
The Chapter with NAMI Gulf Coast and Gulf Mental Health Consumers will host a luncheon program to educate the public about mental illnesses.

Heart of Texas
The Scott & White Clinic, Department of Psychiatry and NAMI Temple will host a Department of Psychiatry Grand Rounds “Advocacy for the Needs of the Mentally Ill.”

Houston
The Houston Psychiatric Society, Baylor College of Medicine Psychiatry Department, UT Psychiatry Department, HIND, Obstetrical and Gynecology Society, and MD Anderson Cancer Center will sponsor Depression Screening as part of Women’s Health Fair organized by the Houston OB/GYN Society; design, print and distribute a brochure for new mothers on baby blues, postpartum depression and postpartum psychosis; and design, print and distribute a brochure to address mental health care of cancer patients.

North Texas
The North Texas Chapter, with NAMI Dallas, MHA of Greater Dallas, DMDA of Dallas, and SMU School of Theology will attend a city council meeting for a mayoral proclamation and present members of the council with a book about mental illness; walk to the city jail and conduct a rally at the jail; and conduct a program at the Perkins School of Theology on “Mystics in Our Midst.”

National DMDA Opposes Psychologists Prescribing

O n August 8, 2002 the Board of Directors of the National Depressive and Manic-Depressive Association reaffirmed its position against legislation allowing psychologists to prescribe medications, first published in the Wall Street Journal on April 30, 1998: “...the National Depressive and Manic-Depressive Association (National DMDA) opposes allowing psychologists to prescribe medication. We believe it is in the patient’s best interest to restrict medication prescription to medical doctors.” The Board’s action provided additional rationale for its opposition to the initiatives of some psychologists to gain prescribing privileges by legislative means: The National Depressive and Manic-Depressive Association (National DMDA), the nation’s largest patient-directed, illness-specific advocacy organization, believes it is in the patient’s best interest to restrict psychotropic medication prescription to medical doctors.

To safely prescribe psychotropic medication, extensive education of the physiology of the entire body is necessary. Safe and effective use of medications to treat brain disorders requires medical training to ensure a thorough understanding of physiology, chemistry, drug interactions and medical problems that can mask symptoms of mental illnesses. An understanding of the entire body and how systems interact with each other can only be achieved through a rigorous medical education involving undergraduate and graduate medical training, and an extensive residency.

• Prescriptions for psychotropic medications should be written and monitored only by someone trained in assessing all adverse physical reactions, drug-induced physical side effects, and drug/drug interactions.

We advocate that physicians and mental health professionals work together to provide the best treatment possible for patients, and call for psychotropic prescription authority to remain the purview of medically trained physicians and only by other professionals when under the supervision of a physician. The experience, broad knowledge base, standards of care, and expertise make medical doctors the only professionals National DMDA believes should be sanctioned to prescribe psychotropic medications.

To better reflect the mission and purpose of the organization, the Board also approved a name change for the organization at its meeting in Orlando, Florida. The new name for the National Depressive and Manic-Depressive Association is the Depression and Bipolar Support Alliance (DBSA). The new name better communicates the mission of the organization as ratified by the Board of Directors in February 2002:

The Mission of the Depression and Bipolar Support Alliance is to improve the lives of people living with mood disorders:

• by improving recognition, early detection, and diagnosis of mood disorders as treatable medical illnesses;

• by helping people successfully manage their illness;

• by working with people with mood disorders, families and health care professionals to improve care;

• by expanding the ability of people to receive treatment;

• by continuing research to improve mood disorder treatment options; and,

• by increasing acceptance and understanding of mood disorders so that the rights of people with mood disorders are protected.

Psychologists Against Prescribing Privileges

Many Texas psychologists oppose the legislative initiative of the Texas Psychological Association to obtain prescribing privileges by legislative fiat. It is important that their voices be heard when this issue is debated in the Texas Legislature in 2003. To help facilitate effective legislative communications on this issue, TSPR is forming a coalition with Texas psychologists. Please identify psychologists in your practice or community who are interested in joining this coalition to ensure that their positions are accurately communicated to members of the Texas Legislature by returning the form below to TSPR.

SURVEY TO RECRUIT PSYCHOLOGISTS WHO DO NOT SUPPORT THE LEGISLATIVE PROPOSAL TO GRANT PSYCHOLOGISTS PRESCRIBING PRIVILEGES

Name: ____________________________
Phone: ____________________________

Chapter: ____________________________

Submit by: ____________________________

Issue / Year: August / September 2002

NOT ALL PSYCHOLOGISTS SUPPORT THE LEGISLATIVE PROPOSAL TO GRANT PSYCHOLOGISTS PRESCRIBING PRIVILEGES

Please identify psychologists in your Chapter who do NOT support the legislative proposal to grant psychologists’ prescription privileges and indicate their willingness to help defeat the bill.

Submitted by: ____________________________

Chapter: ____________________________

Telephone: ____________________________

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<thead>
<tr>
<th>Psychologist Name</th>
<th>Address</th>
<th>City, State, Zip</th>
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Return to: TEXAS SOCIETY OF PSYCHIATRIC PHYSICIANS, 401 WEST 5TH STREET, SUITE 675, AUSTIN, TEXAS 78701, 512/478-5225 (FAX)
TMA, Texas AFL-CIO Sue to Stop Illegal Workers’ Comp Plan

Rule would deplete injured workers’ access to quality medical care

The working men and women of Texas and the physicians who care for them when they’re hurt on the job asked a state district judge on July 10 to invalidate a new state workers’ compensation rule that hinders injured workers’ access to quality medical care.

The Texas Medical Association and the Texas AFL-CIO jointly filed suit to block the Texas Workers’ Compensation Commission from implementing the medical fee guideline rule it adopted earlier this year. The fee guidelines cut reimbursements by 17 to 41 percent for surgeons, radiologists, pathologists, internists, and physical medicine specialists who treat injured workers.

“The law requires these guidelines to be fair and reasonable and designed to ensure quality medical care,” said TMA President Fred Merian, MD, a family practitioner from Victoria who treats injured workers. “What the commission came up with is patently unfair and unreasonable and seems designed to keep injured workers away from the care they need.”

On April 25, 2002, TWCC adopted — over the objections of TMA, the Texas AFL-CIO, and Governor Rick Perry — an arbitrary new fee schedule for physicians who treat injured workers under the state’s Workers’ Compensation System. The rule, which is effective September 1, illegally ties workers’ compensation reimbursement to the fees that Medicare pays for similar medical services to elderly Texans.

“The rule cut reimbursement, physicians across Texas are deciding to stop seeing workers’ compensation patients,” TMA Vice President and Governor Rich Perry said. “This new fee schedule, if allowed to stand, will further force good doctors out of the system.”

Why it needs to be stopped:

• TMA wants the rule invalidated because it violates the law, the constitution, and the Texas Legislature’s mandate to ensure quality medical care.

• TMA wants the rule overturned because it violates the Texas Constitution, and the Texas Legislature’s mandate to ensure quality medical care. Unfortunately, the commission’s guidelines to be “fair and reasonable and designed to ensure quality medical care.”

• TMA disagrees with the way the TWCC adopted the rule. The rule violates the Texas Constitution, and the Texas Legislature’s mandate to ensure quality medical care.

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What TWCC did:

• On April 25, 2002, the Workers Compensation Commission adopted — over the objections of TMA, the Texas AFL-CIO, and Gov. Rich Perry — a new fee schedule for physicians who treat injured workers under the state’s Workers’ Compensation System. The rule is effective September 1, illegally ties workers’ compensation reimbursement to the fees that Medicare pays for similar medical services to elderly Texans.

• TMA disagrees with the way the TWCC adopted the rule. The rule violates the Texas Constitution, and the Texas Legislature’s mandate to ensure quality medical care.

What TMA wants: What TMA wants:

• First: A temporary injunction stopping TWCC and Executive Director Richard Reynolds from “implementing or enforcing, directly or indirectly” the Medical Fee Guidelines rule.

• Then: An order declaring the Medical Fee Guidelines rule “void and unenforceable.”

The Centers for Medicare and Medicaid Services (CMS) has ordered Medicare carriers to suspend printing and mailing bulletins and newsletters between July 1 and September 30. CMS says funds for ongoing provider education and training, including newsletters, will be reduced by 11.35 percent to support implementation of the Health Insurance Portability and Accountability Act (HIPAA).

Why it needs to be stopped: HIPAA Causes Suspension of Medicare Newsletters

Conquer New Heights @ TMA Summit 2002

TMA’s fall conference presents a new, issue-driven interactive session that allows members to focus on 2002-03 TMA strategic priorities and help shape association policy for the upcoming session of the Texas Legislature.

TMA Summit 2002 is Sept. 20-21 at the Renaissance Austin Hotel. As always, TMA members register for free. The fee for nonmember physicians is $200. To register online for TMA Summit, go to www.texmed.org, click “About TMA,” and don’t forget that TMA councils and committees will meet, and Category 1 CME credit will be offered.

Make your hotel reservation early to receive the special meeting rate of $129 single and $139 double. Call the Renaissance Austin Hotel at (800) 228-9290 or (512) 343-2626 to reserve a room, or fax your request to (512) 343-6364. You must ask for the TMA Summit 2002 rate to receive the discount. The housing reservation deadline is Thursday, Aug. 29.

For more information, call (800) 880-1300, ext.1346, or (512) 370-1346, or visit the TMA Web site at www.texmed.org.

Note: Not all speakers listed are confirmed.
Annual Convention and Scientific Program

NEW FRONTIERS IN PSYCHIATRY

November 15-17, 2002 • Worthington Hotel, Fort Worth, Texas

Meeting Location

The Annual Convention and Scientific Program will be held November 15-17, 2002 at the Worthington Hotel, 200 Main Street, Fort Worth, Texas. Located in the heart of downtown’s entertainment district, Sundance Square, is the newly remodeled Worthington Hotel. Performing arts venues, movie theaters, restaurants, museums, quaint shops and outdoor stores are all within easy walking distance.

TSP has negotiated a special discounted meeting rate of $135.00 single/double for convention attendees. Hotel reservations may be made by calling the Worthington Hotel at 1-888/767-1000 and identifying themselves as an attendee of the Texas Society of Psychiatric Physicians’ convention. Cut-off date for discounted rates is October 24.

Discounted Airfare

Southwest Airlines is offering a 10% discount on most of its already low fares for air travel to and from the event. You or your travel agent may call Southwest Airlines Group and Meetings Reservations at 1-800-435-5366 and reference the assigned I.D. Code #F1532. Registrations are available 7:00 a.m. – 8:00 p.m. Monday-Friday, or 8:30 a.m. – 5:30 p.m. Saturday and Sunday. Central Standard Time. You must make reservations five or more days prior to travel to take advantage of this offer.

Airporter Bus Service (Yellow Checker Shuttle – 817/213-1500)

The Airporter Bus Service is provided via a contract with the Yellow Checker Shuttle and is the most convenient and affordable ride to and from the DFW International Airport and the major downtown Fort Worth Hotels. Seven days a week, service to DFW begins at 6:16 am and continues until the last departure at 9:45 pm. One way fare is $15. Contact Yellow Checker Shuttle at the number above for additional information.

Discounted Registration Fees

Attendees who register before October 26 will receive significant savings on their meeting registration fees. Mail or Fax your registration form and payment using your VISA or MasterCard to make reservations and payment. Mail or FAX your registration form and payment by credit card may be FAXED to TSPP at 512/478-5223. The Simple Side of Complexity”, has been designated by the Texas Society of Psychiatric Physicians for 1 hour of education in medical ethics and/or professional responsibility.

Exhibits

Members are encouraged to visit with exhibitors and program contributors in the Elm Fork & Elm Foyer Friday evening during the TSPP Welcome Reception and during the continental breakfast on Saturday. Exhibits will feature the latest information on new pharmaceutical research, products and services pertaining to Psychiatry. If you require any special assistance to fully participate in this conference, please contact TSPP (512) 478-0605.

Method of Payment

- Make checks payable to “Texas Society of Psychiatric Physicians”

Method of Payment

Check  VISA  MasterCard  Credit Card # ___________________________ Exp. Date ______________

Name of Cardholder (as it appears on card) ___________________________

Signature ___________________________

Credit Card Billing Address

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CANCELLATION POLICY: In the event of cancellation, a full refund will be made if written notice is received in the TSPP office by October 26, 2002, less a 25% handling charge. No refunds will be given after October 26, 2002.

Return to: TSPP • 401 West 15th Street, Suite #675 • Austin, TX 78701 • (512) 478-0605 • FAX (512) 478-5223
I was a typical busy weekend call for me as a first year psychiatry resident in a county hospital. After having admitted ten to twelve patients and running from one unit to the other taking care of emergencies and some not so urgent things, I had almost reached the end of my call and was going to see my last patient for the night. She was a middle-aged lady who walked with the help of a cane as she had suffered a stroke a few years ago. She had been admitted to our hospital a number of times and was known to be loud, demanding and considerably aggressive. She was cooperative in the admission interview. I completed the physical exam and asked her to return to her room. I started to go back to the conference room in the opposite corner to complete my admission note. As I was about to enter the room, I heard a sound behind me. I turned around and saw that the patient had followed me to the conference room. I asked her to go back pointing to the direction of her room, but she did not move and kept staring at me. Seeing that she was not following my instructions, I called out to the psych tech on the unit to remove her. He was some distance away and did not hear my call. I was about to call at him again, when I felt a sharp pain on my right arm and I howled in anguish. The patient had stricken me with her cane. She was quickly brought under control and removed from there. My arm was black and blue for the next few days, but I was thankful that the cane did not pierce my skin.

The incident left me in shock and disbelief because the thought that this patient could strike me had never crossed my mind. I am on my guard with patients who appear aggressive, but this patient did not seem like that. I had never actually taken the time to find out some quantitative measures. The answers were just a “google” away. I found some interesting statistics published by the U.S. Bureau of Justice regarding violence in workplaces. What percentage of the mental health workers (including physicians, nurses and technicians) in the U.S. are victims of violence at workplace per year? Take a guess before you read on. The answer is one in every twenty or 5% in 1999. It was much higher earlier. Look at the chart below for some comparative analysis. The data shows that the mental health profession was second only to the law enforcement profession in the rate of violent victimization expressed as number of annual cases per thousand professionals. Although, there has been a decrease from 1995 to1999, the percentage of reduction in the rate of victimization is the least (28%) in the mental health profession compared to all the other professions.

As physicians in charge of our units we are responsible for ensuring safety not only of ourselves and our fellow workers but also, more importantly, of the patients who depend on us for their care. It is important for us to be aware of the telltale signs of aggression and be prepared to deal with it. The bibliographic lists references that discuss “The Aggression Continuum” – the progressive emergence of physical and behavioral signs that foretell the possibility of violence and thereby present an opportunity to institute appropriate preventive measures before acts of violence are actually committed. I learned a lot from reading this material. If I had followed the foregoing measures of safety it would have reduced the odds of me getting hit without compromising patient care in any way.

1. Never turn your back to patients; one can control the situation much better when one is facing them.
2. Give choices to patients rather than orders; nobody likes taking orders especially agitated patients.
3. Be uplaid for signs of physical agitation like twitching of facial muscles, darting eye movements or fixed staring.
4. Maintain a non-threatening body posture and keep a buffer zone.

References