I

HB 1128 by Rep. Coleman (anorexia and bulimia nervosa); HB 919 by Rep. Eissler

community and instead, there will be a call word “parity” will be de-emphasized because benefits for mental illnesses. As a result, the efforts to pass legislation calling for equal

EEOC, the Equal Employment Opportunity Commission, which is the major purchaser of health insurance and can be the business community, which is the major purchaser of health insurance and can be a strong ally on this issue.

One tool that will be used in making the case for “equal benefits” is a recently published “Employer’s Guide to Behavioral Health Services.” The guide was published by the National

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

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

Key Findings

1. Mental illness and substance abuse disorders are serious, common, and expensive health problems. In 2001 mental health and substance abuse treatment cost was $414 billion and represented 7.6% of total healthcare spending in the United States ($1.4 trillion). Unlike other medical conditions such as heart disease or diabetes, the indirect costs associated with mental illness or substance abuse disorders generally are not included in the direct treatment costs.

2. Research has conclusively shown that depression and other mental illness and substance abuse disorders are a major cause of lost productivity and absenteeism. Mental illness causes more days of work loss and work impairment than many other chronic conditions such as diabetes, asthma, and arthritis. Approximately 217 million days of work are lost annually due to productivity decline related to mental illness and substance abuse disorders, costing United States employers $17 billion each year. In total, estimates of the indirect costs associated with mental illness and substance abuse disorders range from a low of $79 billion per year to a high of $105 billion per year (both figures based on 1990 dollars).

3. Disability costs related to psychiatric disorders are high and continue to rise. Mental illness and substance abuse disorders represent the top 5 causes of disability among people age 15-44 in the United States and Canada (not including disability caused by communicable diseases). (Note: includes employed and unemployed populations). Further, mental illness and substance abuse disorders, combined as a group, are the fifth leading cause of short-term disability and the third leading cause of long-term disability for employers in the United States.

4. The efficacy of treatment for mental illness and substance abuse disorders is well documented and has improved dramatically over the past 50 years. For most mental illnesses there is a range of well-tolerated and effective treatments. Current research suggests that the most effective method of treatment is multi-modal and combines pharmacological management with psychosocial interventions such as psychotherapy.

5. A significant proportion of individuals with behavioral health problems are treated exclusively in the general medical setting, which has become the “default mental healthcare system.” Among patients diagnosed with a mental illness, 43% of those with clinical depression and 47% of those with generalized anxiety disorder (GAD) were first diagnosed by a primary care physician. Approximately 22.8% of individuals treated for a mental illness or substance abuse disorder, and half (51.6%) of patients treated for depression, are treated by a general medical provider such as a primary care physician. Further, it is estimated that 11%–30% of patients presenting at primary care have a mental illness. Numerous studies over the past two decades have found that the adequacy and quality of mental healthcare delivered in the general medical setting is suboptimal. In fact, the National Co-morbidity Survey Replication (NCS-R) found that only 12.7% of individuals treated in the general medical sector received minimal adequate care compared to 48.7% of patients treated in the specialty mental health sector.

6. Primary care physicians (PCPs) and other general medical providers are — and will continue to be — an integral part of behavioral healthcare in the United States. However, significant quality problems have been found with general medical providers screening, treatment, and monitoring practices. Numerous studies have shown that patients with mental illness or substance abuse disorders are the most complicated and costly cases. For example:

• Healthcare use and healthcare costs are up to twice as high among diabetics and heart disease patients with co-morbid depression, compared to those without depression, even when accounting for other factors such as age, gender, and other illnesses.

• Patients with mental illness and substance abuse disorders are often less responsive to treatment. For example, depressed patients are three times as likely as non-depressed patients to be non-compliant with their medical treatment regimen.

• The presence of type 2 diabetes nearly doubles an individual’s risk of depression and an estimated 28.5% of diabetic patients in the United States merit criteria for clinical depression.

• Approximately one in six patients treated for a heart attack experiences major depression soon after their heart attack and at least one in three patients have significant symptoms of depression.

Access to specialty behavioral healthcare services is constrained due to benefit design with higher co-pays, visit limits, and most mental healthcare spending in the United States (including expenditures from private insurance, Medicare, Medicaid, etc.) by 2001, psychotropic drug spending was responsible for 21.0% of total mental health spending. In 2001, private employers spent approximately 17% of their total healthcare expenditures on prescription medications.

While employers have focused their attention on the management of high cost chronic medical conditions (e.g., heart disease and type-2 diabetes), such management efforts have not fully addressed the significant additional burden of co-morbid mental illness. Access to specialty behavioral health-care services is critical to delivering effective disease management services for chronic medical problems. Therefore, limitations on behavioral healthcare benefits may limit the efficacy of disease management programs for individuals with co-morbid medical and behavioral health conditions. Disease management programs will not realize their full potential without fostering better coordination between the general medical healthcare system and the specialty behavioral healthcare system. Research has shown that individuals with chronic medical conditions and untreated co-morbid mental illness or substance abuse disorders are the most complicated and costly cases. For example:

• Healthcare use and healthcare costs are up to twice as high among diabetics and heart disease patients with co-morbid depression, compared to those without depression, even when accounting for other factors such as age, gender, and other illnesses.

• Patients with mental illness and substance abuse disorders are often less responsive to treatment. For example, depressed patients are three times as likely as non-depressed patients to be non-compliant with their medical treatment regimen.

• The presence of type 2 diabetes nearly doubles an individual’s risk of depression and an estimated 28.5% of diabetic patients in the United States merit criteria for clinical depression.

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Volunteers Make the World Go Around
Leslie H. Secret, MD, President, Texas Society of Psychiatric Physicians

As your President, I have been impressed by the contributions made by TSPFP members and the members of our Chapters. Members not only provide the financial support for our infrastructure but also become the energy and muscle that moves our organizations forward. Meeting together as Psychiatrists we talk about and find ways to support our communities, our patients, and our profession through volunteer activities. The vitality of Organized Psychiatry and Organized Medicine relies on our volunteer activities. Quite often volunteers and their contributions each day are overlooked unless those activities happen to solicit our collective attention.

Unfortunately, some of the most important contributions go unnoticed because they become part of the structure and expectations of the organization.

The committee work in TSPFP and the Chapters can be overlooked because it is part of our expectation. If the list of committee members is scattered, the contribution made by any one member will not be readily apparent. The discussions that transpired may be known only by those in attendance. Occasionally there will be an action item which will spring forth to move another committee and ultimately an action or position will be taken. Throughout this process each contribution is extremely valuable as the dialogue brings clarity and consideration. Often the individuals who contributed their expertise, experience and point of view can never be fully and formally acknowledged. Scanning the committee list again with the question what has this committee done lately, an answer quickly emerges. The work of committee members have provided the structure and the process that create what we are. Members are the fabric and without them and their contributions we would not be strong, effective, and efficient.

In fact without even one of them, we would see a blinding in the fabric until a new member arrives and contributes to the dialogue. Being a part of the fabric the year after year can be tiring and at times disheartening as the energy and contributions may seem to be unappreciated or unacknowledged.

The amazing part of all this is that members return year after year and can spend a life time being the fabric with very little acknowledgement and yet quickly spring forward when there is a need that requires the expenditure of more volunteer resources. A legislative year is often a time when there is a sudden need for the recruitment and expenditure of volunteer resources. Not to say that the off year doesn’t often demand a quick mobilization of resources. Our individual resources are the most precious ones we have, our time, our intellect, our creativity, our emotions and our energy. The return on our expenditure is the satisfaction that by combining our unique individual contributions, public policy is affected, patient care and access is advanced, patient safety is improved, and our profession is invigorated. Often the enrichment, the enjoyment, the humor, the affection, the good times and the growth as individual members working together is placed in the background and is overlooked by the urgency of situations or the boredom of the routine. Experiencing our membership and our volunteerism as enjoyable brings a certain serenity that invigorates, that energizes, that excites, and that returns us again. Focusing on and fostering satisfaction is some of our challenge. The satisfaction and serenity that members experience in their daily volunteering nurtures the strength in our organizations.

TSPFP and the Chapters are leaders locally, leaders in the state and leaders nationally. At times we fail to give our selves credit for what we achieve. As an organization we are a valued resource, providing leadership and thoughtful vision. Now that we are in the midst of the legislative session, please plan to attend our Capitol Day, February 28th. This allows our legislators to know that we are a special resource and readily available. Lastly, thanks to each of you the unsung heroes and heroines who give of yourselves and quietly make TSPFP and the Chapters a leader and a resource to our nation, to our state and to our communities. You do make the world go around.

MEMBERSHIP CHANGES
TEXAS SOCIETY OF PSYCHIATRIC PHYSICIANS
The following membership applications have been approved by the TSPFP Executive Committee and have been transmitted to the APA.

Member in Training
Afzal, Khalid, MD, El Paso
Garcia-Pittman, Erica, MD, Dallas
Gonzalez, Sylvia, MD, Spring
Larsen, Christant, MD, Galveston
McAdams, Cairena, MD, Plano
Moore, Audrey, MD, Houston
Nail, Cheryl, MD, Houston
Opalach, Thaddeus, DO, Mansfield
Park, Evan, MD, San Antonio
Patel, Nishant, MD, Houston
Perejillo, Heather, MD, Houston
Regan, Arif, MD, Spring
Regan, Heather, MD, Houston
Rex, A, MD, El Paso
Shah, Rubina, MD, Austin
Siebert, Jordan, MD, Temple
Vaughn, Lissette, MD, Missouri City
Vimal, Kiral, MD, Lubbock

General Member
Budzisz, Craig, MD, Richardson
Houston
Lynn, Alfred, MD, Houston

Member in Training
Debby, Robert, MD, Austin
Foggia, Owen, MD, Amarillo

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

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

In applying, you must submit an Fellowship Application form and the three letters of recommendation to the APA by September 1, 2007. Members who apply and are approved for the category of Fellow this year will officially become Fellows on January 1, 2008 and will be invited to participate in the Convocation of Distinguished Fellows during the 2008 APA Annual Meeting in Washington DC. To obtain a Fellow Application form, please contact the APA Membership Department, 1000 Wilson Blvd., Suite 1825, Arlington, VA 22209 or call 1-888-35-PSYCH.

In Memoriam...
Bruce H. Beard, MD, Dallas
George A. Constant, MD, Victoria

The Access to Care program is a mental health and substance abuse program for people who were impacted by Hurricanes Katrina, Rita and Wilma, and their family members. Survivors are able to receive financial assistance for mental health counseling, medication and substance abuse treatment during their recovery. The program can be used to pay for services with licensed providers and clinics anywhere in the country and is retroactive to August 30, 2005. Anyone who resided in a FEMA designated pre-disaster hurricane zip code prior to landfall and suffered significant impact is eligible. Anyone who lost a close

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Texas Society of Psychiatric Physicians
Committee Meetings/CME Dinner Program/Executive Council Meeting
April 28-29, 2007 • Adolphus Hotel • Dallas

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

TSPP's committee meetings have been scheduled in conjunction with the TexMed Annual Convention in Dallas and members are also encouraged to attend TMA's Section on Psychiatry Program Friday, April 27, 8:00am-5:00pm, at the Hyatt Regency Hotel.

Following the conclusion of committee meetings on Saturday, the TSPP CME Committee has arranged a 2-hour Category 1 CME Dinner Program “Practical Clinical Applications of the CATIE (Clinical Antipsychotic Trials of Intervention Effectiveness) Studies” by noted speaker, Michael Schwartz, MD. To confirm your meeting attendance and/or register for the CME Dinner Program, please complete the enclosed RSVP & Registration Form and return to the Texas Society of Psychiatric Physicians’ Office, 401 West 15th Street, Suite 875, Austin, TX 78701 (fax 512/478-5223) by March 28. For additional information, visit our website at www.txpsych.org or contact our office at 512/478-0605; e-mail tsppofc@aol.com. We look forward to seeing you at the TSPP meetings in April.

TELECOMB SOCIETY OF PSYCHIATRIC PHYSICIANS
Committee & Executive Council Meetings &
CME Dinner Meeting “Practical Clinical Applications of the CATIE Studies”
April 28-29, 2007 • Adolphus Hotel
R E G I S T R A T I O N
FAX ADDRESS FOR MEETING CONFIRMATION:
E-MAIL ADDRESS FOR MEETING CONFIRMATION:
YES, I will attend NO, I will not attend COMMITTEE/EXECUTIVE COUNCIL
YES, I will attend NO, I will not attend CME DINNER MEETING
__ Attending Lunches - NO CHARGE If pre-registered before meeting. Underwritten by Acadia Healthcare
☐ ☐ Academic Psychiatry
☐ ☐ Children and Adolescents
☐ ☐ Constitution and Rights (NOT MEETING)
☐ ☐ Continuing Medical Education
☐ ☐ Ethics
☐ ☐ Ethics Fellowship
☐ ☐ Finance
☐ ☐ Forensic Psychiatry
☐ ☐ Foundation Board of Directors
☐ ☐ Government Affairs
☐ ☐ Members-in-Training Section
☐ ☐ Norming (NOT MEETING)
☐ ☐ Physician Advocacy
☐ ☐ Professional Practices
☐ ☐ Public Mental Health Services
☐ ☐ Sociörneuropsychology
☐ ☐ Strategic Planning & Coordinating
☐ ☐ Texas Academy of Psychiatry Membership

$35.00 Per Person
__ Attending CME Dinner Program: “Practical Clinical Applications of the CATIE Studies” - Michael Schwartz, MD $35.00 Per Person Prior to 3/28 $45.00 AFTER

__ Attending (stands Executive Council Meeting)

M E T H O D O F P A Y M E N T : ☐ Check ☐ VISA ☐ MasterCard ☐ American Express
Credit Card # Exp. Date

Name of Cardholder (as it appears on card)

Zip Code Where Identification Credit Card Statement

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

REGISTRATION FEE: $35.00 PRIOR TO MARCH 28 / $45.00 AFTER MARCH 28
TSPP has arranged for a limited, discounted room rate of $139 single or $149 double occupancy at the Adolphus until March 28 or upon sell-out, whichever occurs first. For room reservations please contact the Adolphus Hotel at 1/800/221-9083.

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

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

OBJECTIVES: At the conclusion of this presentation participants will be able to:
- Specify the evidence for differences in efficacy between first and second generation antipsychotics, and among the different second generation agents.
- Discuss the comparative side effect profiles for these classes of medications.
- Describe to patients the current rationale for use of antipsychotics in specific clinical situations.

ACCREDITATION STATEMENT: The Texas Society of Psychiatric Physicians designates this educational activity for a maximum of two AMA PRA Category I Credits ™. Physicians should only claim credit commensurate with the extent of their participation in the activity. The Texas Society of Psychiatric Physicians is accredited by the Texas Medical Association to provide continuing medical education for physicians.

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

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

S C H E D U L E
SATURDAY, April 28
7:30 AM - 8:00 PM Registration / Information Mezzanine Foyer
7:30 AM - 8:35 AM Foundation Board of Directors Breakfast Mtg Directors
8:00 AM - 9:00 PM DBSA Sam Houston C
8:30 AM - 4:00 PM Committee Hospitality Sam Houston AB
9:00 AM - 10:30 AM Socratic O’Day - 11:00 AM Texas Academy of Psychiatry Membership PATRICK NEFF
10:30 AM - 12:00 PM Professional Practices Fellowship W. Lee O'Daniel
11:30 AM - 12:00 PM Strategic Planning & Coordinating Executive Sam Houston C
12:00 PM - 1:30 PM Complimentary Refreshments & Light Hors D'oeuvres Committee Member Luncheon John Neely Bryan
** No Charge for Pre-Registered Prior to Meeting **
Underwritten by Acadia Healthcare (See Registration Form to Register)
1:30 PM - 3:00 PM Public Mental Health Services Executive Patrick Neff
3:00 PM - 4:30 PM Continuing Medical Education Sam Houston C
3:30 PM - 4:30 PM Forensic Psychiatry Executive Patrick Neff
4:30 PM - 6:30 PM Children and Adolescents Executive W. Lee O’Daniel
4:35 PM - 6:00 PM Members in Training Executive Patrick Neff
6:30 PM - 8:30 PM CME Dinner Program “Practical Clinical Applications of the CATIE Studies”, Michael Schwartz, MD Sam Rayburn AB
$35.00 Per Person Prior to 3/28/2007; $45.00 After 3/28 and On-Site (See RSVP/Registration Form to Register)
SUNDAY, April 29
9:00 AM - 12:00 PM Executive Council Official Complimentary Continental Breakfast for Council Members
Dan Moody

Texas Psychiatric Times
TSCAP Summer Conference  

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

T he Texas Society of Child and Adolescent Psychiatry will hold its annual meeting July 27–29, 2007 at the Moody Gardens in Galveston, Texas. The theme of the meeting is “Psychiatric Directions in Child and Adolescent Psychiatric Treatment.” We plan to delve into new advances in clinical neuroscience that may shape the practice of psychiatry in the next five years: pharmacogenetics, brain stimulation methods and the ethics of pharmacogenetics, and psychopharmacology in children and adolescents. Our keynote speaker will be James McCracken, MD, the Chief of the Child Psychiatry Division of the University of California at Los Angeles. Dr. McCracken and his collaborator were the leading researchers in the world in the genetics of psychiatric disorder. In the future, pharmacogenetics will allow us to help predict response to treatment and identify patients vulnerable to side effects. In the last few years, brain stimulation tasks such as magnetic stimulation or deep brain stimulation (DBS) have been developed. The potential use of these methods in the treatment of psychiatric disorder. VNS is currently approved for treatment of adult depression and epilepsy. We will review the basic principles of these techniques and have a case presentation of a child with comorbid major depression and epilepsy whose depression responded when his epilepsy was treated with VNS. Finally, we will have a presentation and panel discussion on psychiatric polypharmacy in children which will highlight the ethics credit of your continuing medical education (CME) annual requirement. There is great public concern about the use of psychotropics in children who are taking multiple medications. There is an increasing number of children and adolescents on multiple medications. There is an increasing number of children and adolescents on multiple medications. The medical literature, including (1) multi-class polypharmacy, i.e. use of drugs of different classes to treat one condition, (2) adjunctive polypharmacy, i.e. the use of a second medication for side effects of another medication, and (3) augmentation, i.e. use a low dose of a second medication to enhance the benefits of another medication. The brass tacks bottom line for polypharmacy is that it is a word that can be used loosely and inappropriate to foster confusing generalizations. Polypharmacy can come in multiple forms, some of which emerge from ignorance. So, the use of multiple medications, derived from a thoughtful, knowledgeable understanding of drug pharmacodynamics and pharmacokinetics, is not just polypharmacy. It is rational polypharmacy.
Texas Society of Child and Adolescent Psychiatry Summer Meeting and Scientific Program
“New Directions in Child and Adolescent Psychiatric Treatment”
July 27-29, 2007 • Moody Gardens Hotel • Galveston

PROGRAM AT A GLANCE

Friday, July 27, 2007
10:00 am - 10:30 am Welcome and Announcements Floral Hall A-3
10:30 am - 10:50 am Pharmacogenetics in Child and Adolescent Psychiatry Floral Hall A-2
10:50 am - 11:50 am Brain Stimulation Technologies in Psychiatry Sanofi Sachs, DO
11:50 am - 12:00 pm Break / Lunch Set-Up Floral Hall A-2
12:00 pm - 2:30 pm Lunchatoon: Case Presentation of VNS Break Floral Hall A-2
2:30 pm - 3:30 pm Use of Multiple Psychopharmacological Agents in the Child with Severe Aggression and/or Mood Lability Steven Pilzka, MD
3:30 pm - 4:30 pm Exhibitors Depart Floral Hall A-1

Sunday - July 29, 2007
4:00 pm - 5:00 am Membership Business Meeting Break Floral Hall A-1

Scientific Program:

NEw DIRECTIONS IN CHILD AND ADOLESCENT PSYCHIATRIC TREATMENT
8:15 am - 8:30 am Welcome and Announcements Floral Hall A-2
8:30 am - 9:00 am Pharmacogenetics in Child and Adolescent Psychiatry Floral Hall A-2
9:00 am - 10:00 am Brain Stimulation Technologies in Psychiatry Sanofi Sachs, DO
9:00 am - 10:30 am Pharmacogenetics in Child and Adolescent Psychiatry Floral Hall A-2
10:30 am - 10:50 am Brain Stimulation Technologies in Psychiatry Sanofi Sachs, DO
10:50 am - 11:50 am Brain Stimulation Technologies in Psychiatry Sanofi Sachs, DO
11:50 am - 1:15 pm Break Floral Hall A-2
12:00 pm - 1:15 pm Lunchatoon: Case Presentation of VNS Break Floral Hall A-2
1:15 pm - 2:15 pm Panel Discussion: Medical-Legal Issues Surrounding the Use of Multiple Psychopharmacological Agents in Children and Adolescents Steven Pilzka, MD and Randall Sellers, MD Floral Hall A-2
2:15 pm - 3:30 pm Use of Multiple Psychopharmacological Agents in the Child with Severe Aggression and/or Mood Lability Steven Pilzka, MD
3:30 pm - 4:30 pm Exhibitors Depart Floral Hall A-1

Program Information

LOCATION: Moody Gardens Hotel, Galveston, Texas, 1/800/582-4673.

Sponsored by: Texas Society of Child and Adolescent Psychiatry

CME / SCIENTIFIC PROGRAM / LUNCHEON
Fax Back (512) 478-5233 or Mail: 401 West 15th Street, Suite 8705, Austin, TX 78701; Questions or Special Assistance: Call Debbie Sundberg (512) 478-4065 or E-mail: tscapofc@aol.com

PAYMENT INFORMATION

Never pay more than the discounted room block, whichever occurs first.

AXA\n
NAME OF SPOUSE/GUEST(S) ATTENDING WELCOME RECEPTION

NAME DEGREE

PAYMENT INSTRUCTION

Method of Payment - Make checks payable to “TSCAP”

DIRECTOR OF ADMISSIONS AND REGISTRATION

Name of Attendee: ____________________________
Tel: ____________________________
Fax: ____________________________
Email: ____________________________

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DIRECTOR OF ADMISSIONS AND REGISTRATION

Name of Attendee: ____________________________
Tel: ____________________________
Fax: ____________________________
Email: ____________________________
and management of utilization. These additional financial limitations are not applied to psychotropic drug benefits or to many behavioral health interventions delivered in the general healthcare setting. This practice is poorly motivated by incentive for patients to a) access mental healthcare from general healthcare providers (where there are no visit limitations and co-pays are significantly lower) and b) rely upon medication as an exclusive method of treatment.

10. Limiting behavioral healthcare services can increase employers’ non-behavioral direct and indirect healthcare costs. One study found that limiting employer-sponsored specialty behavioral health services increased the direct medical costs of beneficiaries who used behavioral healthcare services by as much as 37%. Further, the specialty behavioral health service limitation substantially increased the number of sick days taken by employees with behavioral health problems. The study concluded that savings attributed to limiting behavioral health benefits were fully offset by increased use of other medical services and lost workdays.

11. Employers have tightly managed behavioral health benefits delivered by the specialty mental healthcare system, but have not as yet implemented comprehensive and integrated management programs to address quality and costs of psychotropic drugs and behavioral health services delivered by general medical providers. Specialty mental healthcare services have been managed tightly by managed care systems over the past two decades. Utilization review techniques and other methods have reduced the percent of total healthcare dollars employers spend on mental healthcare benefits. In fact, private employers experienced a 50% decline in their mental healthcare premiums (not including the cost of psychotropic drugs) during the 1990s; the average cost of private employers’ behavioral health premiums dropped from 6% of total claims costs in 1988 to 2.2% in 1998. Employers have not adequately managed the cost or quality of behavioral healthcare services delivered in the general medical setting despite the high proportion of patients treated for behavioral disorders in the general medical setting. Further, employers are not receiving good value for their investment in psychotropic drugs.

12. The lack of coordination and integration among mental healthcare vendors of employers (MOOs, MBHOs, EMs, PBMs, and others) has created significant quality and accountability problems. Employers can address these problems by improving the design of their health insurance benefit structures, and by requiring their behavioral health vendors and managers to coordinate with one another.

Recommendations

1. Recommendations Directed at Health Plan Benefits and Services

The key findings described above guided the development of the Committee’s recommenda-
tions for the delivery of stan-
dardized and integrated behavioral health services. These recommendations are meant to guide employers as they develop their medical and behavioral health benefit plans. Employers are encouraged to adopt these recommendations as model language with Managed Care Organizations (MCOs), Managed Behavioral Health Organizations (MBHOs), Pharmacy Benefit Managers (PBMs) and/or Disability carriers as appropriate. The recommendations will require employers to change their vendor contract language and make changes to their benefit structures. Adoption of these recommendations regarding best-practice implementation and quality improvement measures will necessi-
tate that employers instruct their MCOs, MBHOs, PBMs to track patient and provider data. Wherever possible, the management vendors should incorpo-
rate these recommendations as part of their annual provider perfor-
man)

2. Recommendations to Improve the Delivery of Covered Behavioral Healthcare Services in the General Medical Setting

a. Document and Monitoring - Document diagnosis upon initia-
tion of treatment.

b. Referrals to the Specialty Behavioral Healthcare System - Coordination of care upon referral from primary care to specialty behavioral healthcare.

c. Improving the Coordination of Specialty Behavioral Health Services - Employers should require their disease management vendors, as part of their regular practice, to periodically screen all patients enrolled in their respective programs for common behavioral health conditions, and coordinate care with other providers as indi-
cated.

3. Recommendations to Improve Benefit Design for Behavioral Health Screening and Treatment Services


b. Reimbursement for Non-Psychiatrist Physicians - Reimburse primary care and other non-psychiatrist physicians for screening, assessing, and diagnosing mental illness and substance abuse disorders, rules and policies regarding the payment for non-
psychiatrist physicians (e.g., primary care physicians) for the treatment of mental illness and substance abuse disorders. Relevant guidelines should be published to primary care physi-
cians, other non-mental health providers, and their clinical/business adminis-
trators.

4. Recommendations to Improve the Accuracy and Quality of Prescribing Psychotropic Medications in the General Medical and Specialty Behavioral Healthcare System

a. Adoption of a national best-prac-
tice guideline for the prescribing and monitoring of psychiatric drug interventions - Require MOOs, MBHOs, and PBMs to annually assess their provider performance.

b. Annual assessment of provider behavior in relation to the nationally accepted standard best-practice guideline chosen - Require MOOs, MBHOs, and PBMs to annually assess their provider performance in relation to the nationally accepted standard best-practice guideline they have cho-

5. Recommendations to Improve Behavioral Healthcare Services for Individuals with Serious Mental Illness

a. Evidence-Based Treatment Modalities for the Seriously Mentally Ill (SMI) - Provide coverage for evidence-based treatment modalities for seriously mentally ill children and adults. Such evi-
dence-based treatment modalities include:

Targeted case management services;
Assessment community treatment (ACT) programs;
Therapeutic nursery services;
Therapeutic group home services.

b. Providers of Evidence-Based Treatment Modalities for the Seriously Mentally Ill (SMI) - Direct MOOs and MBHOs to add providers that can deliver the evidence-based treatment modalities described in section 5a.

c. Annual Review of Behavioral Health Treatment Modalities - Direct MOOs and/or MBHOs to annually review behavioral health treatment modali-
ties and make recommendations as to whether new treatment modalities should be added to employers’ benefit structures.

II. Recommendations Directed at Disability Management Vendors and Services

6. Recommendations to Improve Employer Management of Behavioral Health Disorders that Qualify for Short- and/or Long-Term Disability Benefits

a. Review short- and long-term disability management programs and instruct vendors to actively manage all behavioral health dis-
ability claims.

b. Involve a behavioral health spe-
cialist in certification of psychi-
artic disability and treatment planning.

6. Recommendations to Improve the Structure of Employee Assistance Program Services

7. Recommendations to Improve the Structure of Employee Assistance Program Services (EAPs)

a. Reduce redundancies between EAPs and health plans by re-
stucturing EAPs. EAPs should not duplicate services offered through the health plan (MCOs and MBHOs), but should be re-
structured, if necessary, to pro-
vide the following functions:

- Support management in addressing issues of productivity and absenteeism that may be caused by psychosocial prob-
lems.

- Assist in the design and develop-
ment of a structured program to deliver health promotion and healthcare education tools that significantly affect employee and beneficiary health and pro-
ductivity and lead the effort to deliver behavioral healthcare education programs.

- Functionally coordinate with other health services including disability management, health, and promotion.

b. Based on an analysis of current EAP services, the NCESBHS found that an important function that EAPs provide is assessment and short-term counseling for individ-
uals at risk of mental illness and substance abuse disorders and those with problems of daily living (e.g., divorce counseling, grief processes). In the restructuring of EAP as recommended in 7a, it is essential that these services be retained and provided by an EAP or other entity.

c. Conduct periodic organizational evaluations to assess the effectiveness of work organization on employee health status, productivity, and job satisfaction.

Substance Abuse

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

HB 574, Ruth Ann Jackson — PATIENT'S BILL OF RIGHTS IN PAIN TREATMENT: A patient who suffers from severe chronic or acute pain is not required to reject the use of any or all modalities to relieve the pain; choose from the appropriate pharmacologic treatment options to relieve the pain, including opiate medications, without first having to submit to surgery or a medical procedure that results in the destruction of a nerve or other body tissue or the implantation of a drug delivery system or device; and ask the patient's physician to provide a patient identification number to the health care provider that is not fully reimbursed by the patient's health benefit plan.

Legal

HB 1334, Elizavette Nashed — MEDICAL USE OF MARIJUANA: Provides a defense to prosecution for the possession of marijuana that the person possessed the marijuana as a patient or physician licensed to practice medicine in this state pursuant to the recommendation of that physician for the amelioration of the symptoms or effects of a bona fide medical condition. A physician may not be denied any right or privilege or be subject to any disciplinary action solely for making a written or oral recommendation to the patient for use of marijuana for a particular purpose.

SB 249, Rodney Ellis — DEATH PENALTY: Prohibits a death sentence of a defendant, who at the time of the commission of the capital offense, was a patient under the care and treatment of a mental hospital.

Other

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

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

in full agreement with and to a health care provider that is not fully reimbursed by the patient's health benefit plan.

ECONOMIC

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

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

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

HB 344, Danessa Duker — HMOs: All covered services offered by an HMO must be sufficient in number and location to be readily available and accessible within the service area in all enrollees. An HMO shall make special, general and hospital psychiatric care available and accessible 24 hours a day, seven days a week, within the HMO service area. An HMO must arrange for covered health care services, including referrals to specialists, to be available to enrollees on an outpatient basis. A physician or provider who submits a claim and accepts payment from an HMO may not bill the enrollee for the services for which the claim was made.

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

HB 380, Leticia Van de Putte — BALANCED BILLING: Each benefit plan that provides health care coverage for an enrollee shall provide a non-network health care provider’s fee for service received by the enrollee from the health care provider that is not fully reimbursed by the enrollee’s health benefit plan.

HB 1128, John Davis; SB 419, Eddie Lucio, Jr. — MH INSURANCE: Requires health benefit plans to provide coverage for a psychiatric hospital for a preliminary examination within the facility after the person is committed by the court.

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

ALLIED HEALTH

HB 1196, Rob Orr — ADVANCED NURSE PRACTITIONERS AND PHYSICIAN ASSISTANTS: Increases from 3 to 6 the number of advance nurse practitioners and physician assistants that may be supervised by a physician for prescribing privileges and removes the requirement that the supervising physician be on site.

HB 1346, Jodie Laubenberger — PSYCHOLOGY: A psychologist may delegate to a qualified and properly trained person acting under the psychologist’s supervision any psychological test or service that a reasonable and prudent psychologist could delegate within the scope of sound psychological judgment if the psychologist determines that: the test or service can be delegated safely and proficiently by the person; the person does not report to the public that the person is authorized to practice psychology; and the test or service will be performed in accordance with laws and regulations in compliance with any other law. The delegating psychologist remains responsible for the psychological test or service performed by the person to whom the psychologist delegates the service. The psychology licensing board may not adopt a rule that operates as an absolute prohibition or restriction on the delegation of psychological acts.

MENTAL HEALTH

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

HB 452, Paul Moreno — LOCAL MENTAL HEALTH AUTHORITIES: Allows a local mental health authority to contract for services from a) a subsidiary of the local mental health authority; b) an entity formed or owned by a subsidiary of the local mental health authority; c) an entity affiliated with a subsidiary of the mental health authority; d) an entity to which a facility is not a part of the local mental health authority; e) any entity that has on its governing board a member of a governing board of the local mental health authority or its subsidiary; or f) any entity that has on its governing board a member of a governing board of the local mental health authority or its subsidiary.

HB 518, Elliot Naishtat — EMERGENCY DETENTION: PRELIMINARY EXAMINATION: Extends the time period allowed for detaining a person for a preliminary examination from 24 hours to 48 hours. SB 261 Judith Zaffirini EMERGENCY DETENTION: Specifies that jails or nonmedical facilities used to detain persons charged with or convicted of an offense were committed.

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

MEDICAL MARIJUANA

HB 1131, Sylvester Turner — TEXAS YOUTH COMMISSION: The TVC may not allow a child committed to it to participate in a medical, psychiatric or other type of research programs.

HB 1131, Sylvester Turner — JUVENILE PROBATION SYSTEM: The juvenile probation system may not allow a child within its system to participate in a medical, psychiatric or other type of research programs.

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SB 30, Jane Nelson — TEXAS MEDICAL BOARD: A license applicant who is not
Past columns have dealt extensively with the fact that, as physicians in general and as psychiatrists in particular, we all have a duty and a responsibility to take steps necessary to ensure that we offer both the best quality of care to our patients and reasonable access to that care. Maintaining our high educational standards, and continuously updating our own theoretical and practical knowledge, meets part of that standard; TSPP’s annual scientific program is a primary means of achieving that goal. But further steps are necessary: an active role in advocating for our profession and for our patients is an effort we should all undertake, an effort at which we have been, and can continue to be, successful. Past experience reveals proof of that success. If not for the efforts of TSPP members in the past on individual and collective bases, non-physicians would not even perform psychiatric admissions and prescribing psychotropic medications. For the good of our present and future patients, we cannot allow that to happen. We must also carry the message of the House of Medicine regarding other efforts by non-physicians to assume physician roles without the benefit of proper and complete medical training. All of these messages are interrelated and centered on quality patient care. Performing this mission is one reason why the Federation of Texas Psychiatry exists. In an effort to begin the process of accomplishing these many and worthy goals during the current Texas legislative session, the Federation is sponsoring our latest Capitol Day later this month on Wednesday, February 28, 2007. The program will begin at 10 am in the Thompson Auditorium of the Texas Medical Association Building in Austin at 401 West 15th Street. We will hear legislative updates from Federation and TMA lobbyists as well as news from other mental health advocacy organization partners. We will then visit with various legislators and reconvene in the afternoon for debriefing. Complete registration information and legislative contact information will have been mailed to TSPP members, to Academy members, to TSCAP members, and to other psychiatrists by the time this column appears in the Texas Psychiatrist, the Federation newsletter. For now, through, all participants should contact their state representatives and state senators as soon as possible for appointments between 11 am and 4 pm on the 28th. A small fee will be charged for physicians to participate, but residents can attend for free and are heartily encouraged to do so. White coats are recommended for all physicians to attendize to maximize impact. Wear them if you have them! This work is not particularly hard, but it is necessary. Legislators want to see their constituents, and they have great respect for busy physicians who take the time and make the effort to go to Austin to see them. Let’s not disappoint them! The Federation speaks with the power of the voices of the nearly 46,000 physicians who belong to its member organizations. Let’s not let this clout go to waste! See you in Austin on the 28th. 

2007 Texas Legislature continued from page 7

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

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

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

CALENDAR OF MEETINGS

FEBRUARY

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

APRIL

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

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

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

JULY

27-28 TSCP SUMMER CONFERENCE
“New Directions in Child and Adolescent Psychiatric Treatment”
Moody Gardens Hotel
Galveston, Texas
Contact: Debbie Sundberg, 512/478-0605

NOVEMBER

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

FEDERATION OF TEXAS PSYCHIATRY

The Federation was established on July 1, 2004 with the following purposes:
A. to promote the common professional interests of psychiatrists;
B. to facilitate the coordination of and work in concert with state professional psychiatric associations and state professional subspecialty psychiatric associations, to unify programs that advance public and professional education and advocacy for psychiatry and persons with psychiatric illnesses;
C. to provide centralized services to state professional psychiatric associations and state professional subspecialty psychiatric associations;
D. to make psychiatric knowledge available to other practitioners of medicine, to scientists, and to the public; and,
E. to promote the best interests of patients and those actually or potentially making use of mental health services.

The TEXAS PSYCHIATRIST is published 5 times a year in February, April, June, August, and October. Members of Federation member organizations are encouraged to submit articles for possible publication. Deadline for submitting copy to the Federation Executive Office is the first day of the publication month. Copy must be edited, acceptable for publication. Display advertising is available and publication is determined on a case by case basis by the Editorial Board. The Editorial Board reserves the sole right to accept or reject any submitted advertising copy.

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