Parents Beware of New Mexico
Karen Dinene Wagner, MD, PhD

On March 5, the governor of New Mexico signed a house bill (HB 170) that, in my opinion, opens the door for substandard treatment to be provided to children suffering from psychiatric disorders. This law will allow psychologists to prescribe psychotropic medications. A major rationale for the bill was that psychologists would provide needed mental health care in underserved rural areas of New Mexico. However, there is no provision in the law that states a psychologist must practice in underserved rural areas. The transition of this bill to a law created considerable controversy that has polarized the fields of psychiatry and psychology.

I believe that I can comment on this issue without bias since, as you may know, I am both a psychologist and a psychiatrist. I have a doctorate in clinical psychology and am a board-certified child and adolescent psychiatrist. Therefore, I have a good appreciation of the fundamental differences in training experiences. The low states that psychologists cannot prescribe any medications, other than psychotropics, or engage in the practice of medicine. I always viewed prescribing psychotropic medications as part of the practice of medicine. This is a frightening time for the mental health of both children and adults who are suffering from psychiatric disorders.

What and how much didactic instruction will be necessary to obtain prescribing privileges? Didactic instruction includes the following areas: neuroscience, pharmacology, psychopharmacology, physiology, pathophysiology, physical and laboratory assessment, and clinical pharmacotherapeutics. The amount of instruction is at least 450 classroom hours. The psychologist must complete pharmacological training from an institution of higher education. No provision about the required content or required hours are specified.

What is the content and amount of clinical training? The psychologist must complete a practicum in clinical assessment for at least 80 hours. In addition, a supervised practicum of at least 400 hours treating at least 100 patients with mental disorders needs to be completed. The practicum will be supervised by a psychiatrist or other appropriately trained physician. Is there a national certification examination? The psychologist must pass an examination that tests knowledge of pharmacology in the diagnosis, care and treatment of mental disorders.

What are the terms of the prescription privilege? There are two types of prescription certificates: a conditional prescription certificate and a prescription certificate.

The conditional prescription certificate is granted after completing the aforementioned training and is valid for two years. During this two-year period, the psychologist may prescribe psychotropic medication under the supervision of a licensed physician. The physician who supervises a psychologist is individually responsible for the acts and omissions of the psychologist while under their supervision. However, this provision does not release the psychologist from liability for their own acts and omissions.

Upon successful completion of this two-year period, the psychologist is eligible for a prescription certificate. This certificate allows the psychologist to prescribe psychotropic medication independently. A minimum of 20 hours per year of continuing education is required to maintain certification.

Psychologists with either the conditional prescription certificate or prescription certificate may order and review laboratory tests in conjunction with the prescription. The psychologist, when prescribing psychotropic medication, is expected to maintain an ongoing collaborative relationship with a health care practitioner who oversees the patient’s general medical care to ensure that medical examinations are conducted and that the psychotropic medication is appropriate for the patient’s medical condition. The details and process of this ongoing collaborative relationship are not specified in the bill.

Who is responsible for oversight of the program and subsequent clinical practice? The New Mexico state board of psychologists and New Mexico board of medical examiners will provide oversight of the didactic and clinical training. After a psychologist obtains a prescription certificate, only the New Mexico state board of psychological examiners is responsible for disciplinary action such as suspension or revocation of the prescription certificate.

To summarize, a doctoral-level psychologist must complete 450 hours of classroom instruction, have some psychopharmacology training and total practicum experience of 480 hours. The clinical practicum only specified the number of patients (100) with mental disorders. Age range, type of mental disorder, severity of disorder, treatment setting (inpatient/outpatient) and treatment duration are not specified.

What is a possible outcome of psychologists’ prescription privileges for children with mental disorders in New Mexico? This law presents a danger to the children of New Mexico. Sowhere in the law are there any requirements for pediatricians or clinical training specific to children. Therefore, children may be treated by a psychologist who has no expertise with children.

There is no comparison between a child and adolescent psychiatrist’s training and the New Mexico prescribing psychologist’s training. Child and adolescent psychiatry requires four years of medical school, three years of general psychiatry residency and two years of child and adolescent psychiatry residency. Unfortunately, most parents will not know the difference in the training of psychiatrists and psychologists when they seek an evaluation for their children with psychiatric disorders. They will trust that the “doctor” who can prescribe medication will be well-trained and competent to treat their children.

The law states that psychologists cannot prescribe any medication, other than psychotropics, or engage in the practice of medicine. I urge you to support TSPP to prevent Texas from allowing psychologists to prescribe psychotropic medications. It is also important to alert your legislators of this situation.

Reference:
Mickey Mouse, Fantasia, and the Prescribing of Medications

"A little learning is a dangerous thing" - Alexander Pope (1711)

The indomitable cartoon hero Mickey Mouse and the famous poet Alexander Pope immediately came to mind when I first learned that the Governor of New Mexico had signed off on a bill giving prescribing rights to psychologists. The same two associations continued to clung together as I later read the bill itself. This parallel plot is best presented granted upon scantly classroom and clinical work, little supervision, and virtually random access to medical resources. Nastiness of the most leathal and pernicious type laid in language that seemed completely unaware of a myriad of potential problems, such as the complexities of drug addiction and the medical/legal ramifications thereof. I could not rid myself of these two associations hammering at the back of my mind. Why? What was behind my strange combination of thoughts hammering at the back of my mind? 

First, the above famous quotation by Alexander Pope is well known to most of us. In our modern times we usually invoke that quotation in some amusing fashion to convey the idea that “ignorance is bliss.” We thus propose that we are better off when left in a state of benight ignorance, rather than hastening to face the heavy consequences potentially involved in knowing too much. One of the great ironies of the history of literature is that Pope meant just the opposite when he wrote these lines. What he actually wrote was: “A little learning is a dangerous thing.” There shallow draughts intoxicates the brain, whilst drinking deeply sobers it again.”

We today have probably forgotten the rest of Pope’s verse because we have absolutely no idea of the meaning of “Pierian springs” or “shallow draughts,” although we are still pretty lighthearted about intoxication and sobering up again. Pope lived in an age in which the glories of classical Greece and Rome were being “recovered” by European culture. All things Greek and Roman were held in high and idealized esteem and considered to be paragons of perfection. For poets and others in the creative arts, the Muses of ancient Greece held a particular enchantment. In the myth of the Muses, any inspired inspiration for their admirers could supposedly travel to Pierta, a region in ancient Macedonia. There, at the foot of Mount Olympus, was a sacred fountain, whose spring was said to be the source of inspiration for all sorts of creativity and genius. By drinking directly from their spring itself, one could supposedly, by going to the source, get an especially strong jolt of knowledge and creative inspiration. In Pope’s verse above, he was thus conveying the idea that, if one went to all the trouble to travel to that exotic, mistic, far-off font of inspiration to partake of its waters of knowledge, then full and deep draughts (“draughts”) were required, otherwise problems would develop. Shallow samples of the Muses’ waters were dangerous, in that they would create a state of intoxication, in which the world could appear different than it truly was. In the bill from New Mexico providing for prescriptive authority without medical training and in similar bills proposed for Texas, small sips of knowledge (e.g. 400 hours of Continuing Education) are the only requirements for the authority to place foreign chemicals into the bodies of human beings. Those who have drunk deeper from that Pierian spring shudder at the consequences that are inevitably resultant from the intoxicated sense of power bestowed by such tiny tastes from that immensely deep well of knowledge. I found myself wondering whether Pope was chuckling in his grave at the irony that we modern human beings are now so shallow that we only remember the first line of his verse, and have forgotten the deeper meaning of the remaining lines.

I also found myself “musing” about how Pope might have written these lines to apply to our current situation. Would he have penned such words as:

"A little learning is a convenient thing; To obscure big problems I’ll be facing In giving drugs to treat the brain. Causing enigmas I can’t explain."

Or would he have preferred more profound verse, such as:

"A little learning is an OK thing. Just so it provides some quick prescribing I want no stuff to tax my brain. Cause over thinking gives me pain."

As I considered the above concepts, it seemed to me that I had solved the riddle of the origin of the association to Alexander Pope, but where in the world was the source of the thoughts of Mickey Mouse? As I pondered deeper and deeper upon this mystery, I remembered one of my favorite Mickey Mouse cartoons – the Sorcerer’s Apprentice from the Disney classic Fantasia. In fascinated wonder, I re-watched the cartoon, and the answer to my question unfolded before my eyes.

I started wondering how Walt Disney might have re-done "The Sorcerer’s Apprentice," using a plot involving Mickey Mouse, not as a sorcerer’s apprentice, but as a 400 hour prescribing sorcerer. On the previous page, in the left hand column of the table are brief descriptions of scenes from Fantasia, and in the right-hand column are the notes I jotted down while watching, to suggest to Mr. Disney the outline of a plot of a parallel cartoon in which Mickey plays the part of a new character, “The 400 Hour Prescribing Sorcerer.”

I really don’t know how to summarize my thoughts on these strange associations. Instead, I will turn to our two friends, Alexander Pope and Mickey Mouse, for their final comments on the matter.

"Fools rush in where angels fear to tread." — Alexander Pope

"Take two magic spells and call me in the morning." — Mickey Mouse

Mickey, the Sorcerer’s Apprentice

Mickey, bucking hackers of water into the house basin, looks across the room in fascination as his boss, the Sorcerer, waxes his arms to transform misty clouds into scary bats, then into beautiful butterflies.

The Sorcerer becomes deep, and sets his hat on the table before retiring for the night.

Mickey tries the hat on. It feels great. With the power of the magic hat, he finds he can waggle his fingers and waves his arms to induce the broom to come to life to carry water, to sprout arms, and pick up the water buckets.

Mickey shows the broom how to load the water for him. With very little tutoring, the broom goes to work. Mickey is very excited about how easy his life will be from now on.

Mickey sits down in the big chair of his boss and puts his feet up on the table. He only has to wave his arms gently to induce the broom to do all his water-hauling work for him.

Mickey finds this whole affair so easy that he gets relaxed and dozy. He falls asleep.

Mickey dreams that he is a great sorcerer, standing on a giant stone pedestal. With his newfound power, he orchestrates the stars into a splendid display of fireworks, the clouds into a gorgeous cascade of thunderstorms, and the ocean into massive waves of power.

Unfortunately, the waves of power awaken Mickey as they turn out to be actual waves from the Disney classic Fantasia. Mickey is now all over.

Mickey wishes he knew more ways to undo this disaster, but the 400 hours didn’t have time to adequately address those techniques. Abrupt chemical backing out of a bad pharmacological problem can be a real nightmare. Mickey wishes he could have some quick prescribing to treat the brain. Causing enigmas I can’t explain.

The Parallel Plot of Mickey Mouse, the 400 Hour Prescribing Sorcerer

Magic does so easy to vary a distance from. (By the way, could Mickey bring this water from the Pierian spring?)

Carelessness and lack of vigilance is dangerous for those entrapped with responsibility and authority. (The medical community?)

It does seem so very cool to dispense pills with the sure of a pen. It looks easy and straightforward.

A small sip from the Pierian pool will get you intoxicated, and make you believe that all your troubles are now all over.

Treating patients with pills is a piece of cake. Give them the prescription, and the head part is all over. Just sit back and take it easy after that.

Medicating prescriptions is so very, very easy that you can totally neglect. You don’t really have to pay much attention to the other things going on in your patient’s life or psyche.

Fraid would have been a field day with the material in this scene, but we need to get back to a summary of the theme at hand. PIERIAN INSTRUCTION?"
The Insanity Defense

A. David Axelrad, MD

On June 20, 2001, Andrea Yates drowned her five children over a period of 30 minutes while her husband was at work and before her mother-in-law arrived at the home to assist her in the care of her children. This tragedy was preceded by an eight-year history of psychiatric and psychological treatment for recurrent episodes of postpartum depression. In her subsequent trial from February 14, 2002, until March 12, 2002, the jury was pro- vided psychiatric testimony that the patient was suffering from recurrent episodes of postpartum depression. In the trial, a clinical psychologist provided psycho- logical test data supporting a diagnosis of schizophrenia. The jury heard testimony that the patient was delusional. Despite these delu- sions, she did notify the police immediately following the drowning of her children. She also made a statement to police that she had drowned her own children.

In the course of the trial, the jury had been made aware that Ms. Yates was a patient of a clinical psychiatrist in the Houston area. During the trial, the jury was informed that the patient had been hospitalized as recently as May of 2001 for psychiatric symptoms of both depression and psychosis. The patient was treated with an antipsychotic medication, Haldol, during her last hospitalization. The jury was informed that her psychiatrist withdrew Ms. Yates from Haldol over a three to four day period of time beginning on June 4, 2001. During the trial, the patient's husband and other members of her family and close friends testified that she was experiencing continuing psychiatric and psychological problems up to the time of the drowning of her children.

The jury heard opposing testimony from both treating psychiatrists and forensic psychi- atrists. The "battle of the experts" has created significant controversy throughout the country. Andrea Yates was found to be not guilty by reason of insanity.

The Insanity Defense

The insanity defense incorporated in the Insanity Defense Reform Act is as follows:

A defendant is not responsible for criminal conduct if at the time of such conduct he was insane. Insanity means a condition of mind such that at the time of such conduct, the actor did not know that his conduct was wrong, or was incapable of conforming his conduct to the requirements of the law as he was bound to know.

The Texas Insanity Defense

The Texas Insanity Defense Reform Act is as follows:

A defendant is not responsible for criminal conduct if as a result of severe mental disease or defect he is unable to appreciate the wrongfulness of his acts.

The Insanity Defense in Texas

During the trial, the jury was informed that the patient was suffering from severe postpartum depression. The insanity standard that applied was the M‘Naghten Standard. The M‘Naghten Standard subsequently created by the State of Texas, was used a more liberal standard than the M‘Naghten Standard currently utilized in most jurisdictions in the United States. The M‘Naghten Standard originated in England when it was promul- gated by the judges in the House of Lords in 1843 following a request by Victoria to address the firestorm that developed following the finding of insanity in the trial of Daniel M‘Naghten. M‘Naghten was prosecuted for the murder of the private secretary of Sir Robert Peel, the Prime Minister of England. The sec- retary had been killed in an attempt to assassi- nate Sir Robert Peel. At the time of the M‘Naghten finding of insanity in England, the judge in this matter used a more liberal standard than the M‘Naghten Standard subsequently uti- lized in most jurisdictions in the United States. The M‘Naghten Standard was the standard at the time of the trial of the Mally trial in 1982 was the following:

A person is not responsible for criminal conduct if at the time of such conduct a result of mental disease or defect he lacks substantial capacity either to appreciate the wrongfulness of his acts or to conform his conduct to the requirements of the law. It is to be noted that, prior to the trial of John Hinckley, the State of Texas also had a more liberal standard. The Texas standard incorporated the volitional element of the ALI test of sanity. The State of Texas standard was at that time:

A defendant is not responsible for criminal conduct if at the time of the conduct charged, the actor, as a result of a mental disease or defect, other than knew that his conduct was wrong, or was incapable of con- forming his conduct to the requirements of the law as he was bound to know.

The Parallel Plot of Mickey Mouse, the 400 Hour Prescribing Sorcerer

Mickey gets swept into the torrential waters. As he desperately tries to keep his head above the surface, he sees, floating in the flood, his friends. As he frantically flips through its pages, searching for ways to save his friends, he finds a broom. The broom to use it as a life raft, and he frantically flips through its pages, searching for ways to save his friends. As he frantically flips through its pages, searching for ways to save his friends.

The sorcerer awakens and comes downstairs to survey the havoc his assistant has created. He is able to dissemble the broom.

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In 1997 the Texas Legislature created an independent medical review process that consumers could use when their Health Maintenance Organizations (HMOs) denied coverage for treatments and procedures. It has been close to five years since the Texas Legislature passed the law, and Consumers Union believed that it was time to evaluate its effectiveness. In general we find that Texas consumers benefit from independent review because the reviewers overturn the worst kinds of insurer denials but also allow doctors to a standard of medical necessity that discourages unnecessary hospitalization or therapies. Consumers Union evaluated 263 review decisions (without any information identifying a patient). We divided the cases into various categories based on the medical issue in question and looked for patterns of care denied or care made available as a result of independent review. Overall, the independent review system appears to work for both consumers and the larger health finance system. Consumers receive an independent assessment of their medical treatment needs. The process concerns us not that is not supported by the medical record or where reasonable alternatives are available.

- The reviewers overturned slightly more than half of the HMO denials. Out of the 263 cases reviewed by Consumers Union, 144 (55 percent) were either completely or partially overturned and 119 were upheld.
- About 74 percent of the requests for review handled by the Independent Review Organization (IROs) were overturned more frequently than the general overturn rate. TMF overturned only 36 of its 89 cases, about a 42 percent overturn rate. TMF overturned much more frequently than the general overturn rate (70 percent overturned or partially overturned).
- In contrast, independent reviewers only rarely overturned an HMO’s decision not to pay for brand drugs. For the most part, reviewers supported alternatives proposed by the health plan.
- IRs: A Closer Look IROs: A Closer Look

Many decision-makers and interest groups, including the growing pharmaceutical industries, now pay attention to the outcome of independent review process. Consumers may be subject to medical judgment by their doctor, the health plan, or Health Maintenance Organization (HMO) from which the treatment was denied or by a system of independent review, and slightly lower than TMF. For example, of the 54 reviews dealing with substance abuse treatment, TMF overturned only 16 of its 49 cases, an overturn rate of 40 percent. TMF is the oldest review company, but Envoy joined the system in February, 1998. TMF added IR in December, 1999.

During a six-month period, from March 22 through September 12, 1999, we looked at 21 of these, overturned 13. Of the 16 cases Envoy reviewed, TMF overturned 54 cases each, about a 62 percent overturn rate. TMF overturned only 16 of its 49 cases, an overturn rate of 40 percent. TMF is the oldest review company, but Envoy joined the system in February, 1998. TMF added IR in December, 1999.

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accessing independent review. Moreover, the independent review process is no longer avail- able for all details.

In early 1999, TDI began sending letters to certain patients requesting independent review that had been done to cover their stay. A medical performing a review of medical necessity or appropriateness was after health care was received, the IRO process is not available to you. "TBI interpreted the statute to cover "prospective" or "concerned" denials and not those done "retrospectively." Since some of the cases cited in this report appear to address care retrospectively (care that has already been provided), it is unclear how TBI determines whether care is appropriate to send on to independent review. Without the benefit of inde- pendent review, many people end up having to pay for care they believe should have been cov- ered by their health insurance. More than half of appeals are fully or partially overturned. Consumers who cannot access or who do not pursue their full appeal rights may not be receiving adequate health care. Without either ensuring that more consumers challenge their HMOs’ decisions or making some struc- tural changes within the HMO industry itself, patients may fail to get medically necessary treatment and their frustration with the health care industry will only continue to grow.

Mental Illness

HMOs frequently arrive at different conclusions than the HMOs concerning mental illness. Out of the 265 reviews performed, 55 involved treatment for mental illness. Eleven of the cases all related to eating disorders. Of these, 46 (70 percent) were either fully or partially overturned. For the most part, the dispute cen- tered on the duration of an inpatient or urgent resi- dential treatment facility stay. Without access to the underlying documentation, Consumers Union could not fully evaluate the HMOs’ denials, but there are some basic standards that courts use when regularly during the IROs’ reviews of these cases.

IROs upheld HMO denials that involved patients undergoing a change in medication that could have been handled on an outpatient basis. In addition, if the patient showed obvious improvement and demonstrated a desire to get better, the IRO was likely to uphold the HMO denial of continued inpatient care. Lastly, a few denials involved patients whose medical records were inadequate. For example, in one case, a reviewer held that while it did appear that the patient had "significant medical and psychiatric problems, including dementia with memory impairment, a history of depression, substance abuse, and violent threats and behavior," there was "grossly inade- quality documentation" supporting the need for inpatient care.

Most HMO denials were at least partially overturned, but the standards are a little cloudier. If the patients’ records indicated they were still having suicidal thoughts, had under- gone many medicative changes within a short period, were lethargic, confused, violent, or showed remorse in an attempt to an unexpected situation, the IROs overturned all or part of the HMOs’ denials.

IROs denied residential treatment for an adolescent female with an IQ of 69 who had been living with his mother. The reviewer concluded that the patient’s history of violence toward her family and self-destructive acts clearly indicated that she was entirely out of control. In this instance, as in many others, the reviewer could find no responsible explanation for the HMO’s denial of residential care.

During a woman’s hospitalization for severe depression, United Healthcare refused to grant her a therapeutic pass. The independent reviewer found it inappropriate that the insur- ance covered that her hospitalization covered to me, that, if she were healthy enough to go on a pass, that she were healthy enough to be dis- charged. The patient had passed the patient to spend time with her mother, the reviewer held, an essential step in her recovery.

Sometimes the HMO wanted to move the patient to a lower level of care (residential treat- ment, partial hospitalization) instead of issuing a deci- sion concerning a young boy who had previously tried a long-term program. He complained of voices telling him to harm others and had a plan to murder her mother and stepfather as they slept and then kill himself. TBI found that because the boys was so young, the HMO should have allowed a longer hospitalization. “It is a well known fact among child psychiatrists that chil- dren have more difficulty dealing with transitions than adults and then assigned an IRO for the dis- charge,” the reviewer concluded.

In another example, Private Healthcare Systems agreed to cover only four days of inpa- tient treatment for a patient admitted by police in four point restraints with bipolar, seizure and cognitive disorders. At the time of proposed discharge, the patient was still suffering from seizures, was agitated and required restraints. In Evergreen, the HMO had stated that this patient could not be safely cared for at any other level than “acute inpatient care,” and should not be trans- ferred. Still in the hospital at the time of the review three weeks later, the reviewer felt that she should remain an inpatient until her physi- cian was ready to move her.

Patients covered by PacifiCare of Texas appealed five decisions related to mental ill- ness. The IRBs overturned three of the five. The reviewer upheld one of these because the psychiatrist did not provide enough informa- tion. All of the overturned cases involved records that the reviewers believed demon- strated that the patients were still in the midst of treatment and had not shown much improvement. In one case, a patient was admitted on suicide watch and the HMO warned her transferred to residential treat- ment two days later. The reviewer believed that her two unsuccessful prior admissions indi- cated that it was not safe to discharge her. Some advocates for people with mental ill- ness contend that managed care companies have gone too far in their efforts to write unnecessary inpatient care out of the mental health system. Studies based on the national household survey, Health Care for Communities, find that respondents seeking treatment for mental health and substance abuse problems report delays in treatment or a lower level of treatment are less likely to report no treatment under managed care plans. Although we could not review and categorize a large number of cases, our research identified several individual examples of overly aggressive discharge from inpatient mental healthcare that were corrected through access to the indepen- dent review process.

Substance Abuse

More than a fifth of all the cases related to substance abuse treatment (54 cases). IRBs overturned more HMO denials related to substance abuse than the average “overturn rate” (60 percent or 32 cases).

Like mental illness cases, these appeals dealt mostly with the patient’s length of stay in an inpatient care or residential treatment facility or their removal from inpatient care to a lower level of care (outpatient, residential, partial hospitalization). Reviewers identified a number of criteria when they examined cases of level of documentation, level of home support, level of patient commitment to drug treatment, years of drug addiction, and level of withdrawal and fre- quently overturned HMO decisions for the most severe cases.

Of the 22 HMO decisions upheld by the IRBs, some supported the HMOs’ determina- tions primarily because the patients’ families appeared supportive and non-chaotic. They tended to uphold the HMO if the patient showed little or no withdrawal or had no complications.

Finally, reviewers tended to uphold an HMO determination if the patient was making good progress with good motivation (and therefore could successfully move to outpatient care) or if the patient was making little or no progress. In some cases, the time to make a full time re-admission (or a higher level of care) for patients with other complicating mental ill- ness, those with a severe detoxification, and those with serious family conflict at home. In some cases, the time to make each case at home was a critical determinant for an HMO time to make a pass from inpatient care to a lower level of care. In one case, a patient was admitted on suicide watch and the HMO overturned, but the standards are a little cloudier. If the patients’ records indicated they were still having suicidal thoughts, had under- gone many medicative changes within a short period, were lethargic, confused, violent, or showed remorse in an attempt to an unexpected situation, the IRBs overturned all or part of the HMOs’ denials.

Leadership Recommendations

The TSSP Nominating Committee will meet in early August to consider nominations for the following elective positions: President-Elect; Secretary-Treasurer; Councilor-at-Large; APA Assembly Representative; Rep to APA Division of Government Relations; Rep. to APA Division of Public Affairs. If you or your Chapter wishes to recommend an individual for consideration for one of the positions, please submit your suggestions to the Nominating Committee, Texas Society of Psychiatric Physicians, 401 West 15th Street, Suite 675, Austin, Texas 78701 by July 31, 2001. The Nominating Committee’s slate of candidates will be pub- lished in the October/November Newsletter. Following the announcement, additional nomi- nations may be submitted by individuals or Chapters in writing to TSSP or made during the TSSP Annual Business Meeting on November 16 in Fort Worth.

Congratulations...

Irvin M. Cohen, MD, Houston, was the recipient of the APA LIFERS organization’s 2002 Harold E. Bronson Award presented in Philadelphia on May 21, 2002 during the recent Annual Meeting of the American Psychiatric Association. Dr. Cohen, Chair of the APA Committee on Senior Psychiatrists, was cited for his “long-term commitment to psychiatry and research on the impact of retirement on physicians.” The APA LIFERS is the association of APA Life Members and Life Fellows.

Also in Philadelphia, APA Assembly Speaker Awards were presented to Joel S. Feiner, MD (Dallas) recognizing his outstanding service to public and community psychiatry, and to John Bush (Austin), recognizing his contributions in his dual roles as Executive Director of TSSP and President of the National Depressive and Manic-Depressive Association. The APA Warren Williams Award was presented to Byron L. Howard, MD (Dallas) by Area 5, recognizing his outstanding contributions to psychiatry.
Parity: Definitions vary. Some say it is equal insurance coverage of “mental illnesses” at the same level as “medical” and “surgical” illnesses. Some say, it is equal, quality, comprehensive health care for all types of clinically significant illnesses and diseases such as cancer and mental illness for all Americans, with and without insurance. A work in progress, mental health parity legislation advances incrementally through Congress and the state legislatures. Passage of a more comprehensive federal bill this year received a significant boost on April 29th when President Bush announced his commitment to end the stigma surrounding mental illness, his support for mental health parity in insurance coverage, and the launch of the New Freedom Commission on Mental Health. A majority of members in both houses of Congress have now signed on as sponsors of the mental health parity bills: 66 Senators and 220 members of the House. As the legislative process unfolds on this proposed legislation, there will certainly be attempts to kill the bills or limit their scope significantly. Parity advocates anticipate strong opposition at every step of a long walk to true parity by any definition.

Federal Parity. In 1996 Congress passed the landmark Domenici-Wellstone Mental Health Parity Act of 1996. Due to strong opposition to subsequent parity bills, it was renewed for a year rather than sunsetting in 2001. Two complimentary bills now before Congress are designed to close some of its gaping loopholes. Apparently they have necessary Congressional support. A third resolution to cover substance abuse treatment does not exist. Inpatient and outpatient treatment were prohibited. Small businesses (less than 51 employees) were exempted. Group plans if and while they have substance abuse treatment benefits. Its parallel language applies to inpatient, residential, outpatient and prevention services for substance abuse and has the same constraints. Substance abuse was considered a sticking point and was removed from the other bills to ensure their passage. In 1999, by Presidential decree in 1999, all federal workers, retirees and their dependents enrolled in the Federal Employees Health Benefits (FEHB) Program have enjoyed full, so-called mental health and substance abuse parity with medical and surgical benefits since January 2001. Unfortunately, Medicare recipients, often on fixed incomes, unemployed, and entitled, pay 50% co-payments for mental health services but 20% for “medical and surgical” services. Many Americans have no coverage at all.

State Parity. States vary on parity, from no legislation to chemical and substance abuse mandates. Thirty-four states have some version of parity for different subsets of the population. TSPP has lobbied vigorously for parity in Texas to good effect. In 1991, Texas was one of the first to legislate parity, requiring parity for those with “serious mental illness” with other physical illness, applying to schizoaffective, paranoid and other psychotic disorders, bipolar disorders, major depressive disorder, and schizo-affective disorder. However, the parity law applied to only health plans providing coverage for state and local government employees. In 1997, the Texas Legislature passed the Mental Illness Parity Act, expanding the parity law to apply to health plans regulated by the state. The new law required coverage for serious mental illness, based on medical necessity, for 45 days of inpatient treatment and 60 outpatient visits per calendar year. Outpatient visits for medication management do not count toward the 60 visits. Lifetime limits on covered inpatient and outpatient treatment were prohibited. Small businesses (less than 51 employees) were exempted. Group plans could use managed care. Similar plan coverage for small employers must be offered. Pervasive developmental disorders, obsessive-compulsive disorders and psychosis in childhood and adolescence were added to the list of “serious mental illness.” Exempt from the state parity law are self-insured plans regulated at the federal level under ERISA. The federal parity bills discussed above seek to close the ERISA loopholes. Again, for those without insurance, parity may mean no care at all.

Parity opponents. Parity advocates describe a canny, well-funded opposition whose success depends on ignoring the place of mental illness in medicine and on the stigma of mental illness.

The insurance industry and business (along with traditional anti-psychiatry folks like the Scientologists) have opposed parity with three effective strategies:

1. Fear. They predict economic hazards for the insured, employers, insurance company solvency, and the economy at large, paying to the fear of the business community, employers and legislators. 5543 was derided in late 2001 for economic reasons; a Washington Post editorial warned it would increase company costs at a bad time. The fear flows to the public health funding debate as well.

2. Distorted language. The House of Medicine knows that mental illness is a medical disorder. Psychiatrists are physicians who specialize in one branch of medicine. Substance abuse and chemical dependency clearly have medical effects (and perhaps causes) and are coded in DSM. Health plans imply otherwise. They remove mental illness from “medical” and substance abuse/chemical dependency from mental illness. The language of the Congressional bills reflects and perpetuates this confusion. Scientologists, of course, question the medical nature of mental illness and psychiatry’s role in treating it and lobby to undermine our profession at the state and federal level.

3. Benefits in name only. Health plans may manage mental health benefits so strictly or passively-aggressively that patients receive suboptimal or little care. Parity does not ensure access. Patients ashamed of, or decried by mental illness may not pursue a complex, often appealed policy to get relief. Studies show they may not get mental health care or use their policies to pay for it.

Parity advocates respond.

1. Economic benefits of equitable, appropriate treatment. Studies quoted by the TSPP, APA and AMA demonstrate the efficacy and economy of treating mental illness in both the insured and uninsured setting. The prevalence of mental illness means society is dramatically impacted by the functional capacity and health care usage of those with mental illness. States with mental health parity have experienced no increase in premiums or usage. In fact, reduced premiums, decreased mental health usage and/or a compensatory decline in other health services have been the rule. Workforce productivity improves with optimal mental health treatment (including substance abuse and chemical dependency of course), saving companies billions in lost time through absenteeism or poor attention. Businesses, federal and state budgets benefit from treated individuals who are able to work, purchase products and services, and do not slide into crime, the prison system, and welfare programs. Studies also show that optimal outpatient treatment can save thousands per patient on more expensive, inpatient stays.

2. Truth in Language: Parity advocates have autonomy and actually reframed the issue as a civil right, antidiscrimination, equal treatment or equal insurance issue. In no other branch of medicine is the victim blamed for the disease and refused treatment for it arbitrarily, despite its origin. Smokers are covered for lung cancer, the obese for cardiovascular disease and type 2 diabetes, etc. In contrast, many mental illnesses (brain diseases) have little or no participatory component. The new emotional language seems to appeal and educate. The emerging use of the term “brain disease” rather than the stigmatized term “mental illness” may also help to publicize the medical nature and impact of mental illness.

Today. Rally behind the APA and TSPP and educate our patients, state and federal legislators, and the media about the medical illnesses of our patients and our medical training. Join your local TSPP political task force to meet and greet legislators. Use “parity” with colleagues and “equal treatment” with everyone else. Consider a “medical” alternative to “mental illness” (eg, I am a medical doctor trained to treat brain diseases which have both genetic and environmental components).

Tomorrow. Urologists, nephrologists, and transplant surgeons all serve the same organ system with some overlap. Let’s share the brain with neurologists and clarify our job description so the lay public can understand our medical specialty. TSPP is well-named — let’s call ourselves psychiatric physicians rather than psychiatrists until the public catches on. That should help with psychology prescribing as well. Most important, address the deeper need for equal access and treatment to medically indicated care determined by trained physicians. Brainstorm with colleagues about a public and private mental health care system which we devise in the coming months to offer our Texas Legislature as a model for the nation. A Congressional Committee is now considering a resolution legislative access to comprehensive health care for all Americans in 2004. The time is now to send our solutions for parity and access to inform this legislation.
The TSPP Distinguished Service Award, established in 1975 to recognize outstanding contributions to psychiatry, will be presented to Alex K. Munson, MD (Georgetown/Ludlock) and Robert L. Zapalac, MD (Austin).

TSPP is pleased to acknowledge restricted educational grants from the following organizations in support of the TSPP Scientific Program “New Frontiers in Psychiatry,” to be conducted at the Wortington Hotel in Fort Worth on November 15-17.

PLATINUM
Eli Lilly and Company
Forest Laboratories, Inc.
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Pfizer, Inc.
Wyeth-Ayerst Laboratories

MARGO K. RESTREPO, MD
WALTER REIFSLAGER, MD
NANCY D. TRUSCINSKI, MD

The TSPP Psychiatric Excellence Award, established in 1991 to recognize individuals who have demonstrated sustained excellence in psychiatry, will be presented to Edward S. Furber, MD (Fort Worth), Margo K. Restrepo, MD (Houston), and Madhusudan Tripathy, MD (Dallas).

The TSPP Psychiatrist Award, established in 1991 to recognize outstanding individuals for sustained contributions to psychiatry, will be presented to Irvin M. Cohen, MD, Arlin Cooper, MD, Shannon Gwin, MD, T. Grady Baskin, MD, Robert Stubblefield, MD, James L. Knoll, III, MD, Grace K. Jameson, MD, Regis S. Stewart, MD, Walter Reifslager, MD, William Langston, Jr., MD, Stuart Nemir, MD, Howard Crow, MD, Hunter Harris, MD, Kenneth Z. Altshuler, MD, Betsy Comstock, MD, Dorothy Cato, MD, James W. Maas, MD, Madhukar Trivedi, MD (Dallas), and Madhusudan Tripathy, MD (Dallas).

The TSPP Special Service Award, created in 1975 to recognize outstanding service to community and to psychiatry, will be presented to The Honorable Mike Moncrief (Fort Worth). Former recipients of the award include Irvin M. Cohen, MD, Arlin Cooper, MD, Shannon Gwin, MD, T. Grady Baskin, MD, Robert Stubblefield, MD, James L. Knoll, III, MD, Grace K. Jameson, MD, Regis S. Stewart, MD, Walter Reifslager, MD, William Langston, Jr., MD, Stuart Nemir, MD, Howard Crow, MD, Hunter Harris, MD, Kenneth Z. Altshuler, MD, Betsy Comstock, MD, Dorothy Cato, MD, James W. Maas, MD, Madhukar Trivedi, MD (Dallas), and Madhusudan Tripathy, MD (Dallas).

The TSPP News Letter

Texas Society of Psychiatric Physicians
Annual Convention and Scientific Program
NEW FRONTIERS IN PSYCHIATRY
December 15-17, 2002 • Fort Worth, Texas

SCIENTIFIC PROGRAM SCHEDULE
Saturday, November 16, 2002
8:45-9:00 am Scientific Program Welcome
8:00–9:00 am Psychiatric Drug Development and the Human Genome Project: What is the Connection and the Implications?
Shelton R. Fierce, M.D.
Psychiatric Research Institute Within, Kansas
10:00-11:00 am Vagus Nerve Stimulation (VNS): A. John Bush, M.D.
Gale Gilles, M.D., Ph.D.
UT Southwestern, Dallas, Texas
11:00-11:15 am Refreshment Break
11:15-12:15 pm Treatments for Alzheimer’s Disease: A Research Update
Kevin F. Gray, M.D.
Dallas VA Medical Center, Dallas, Texas
12:15-2:00 pm Annual Business Luncheon
2:00-3:00 pm The Psychiatrist’s Role in the Criminal Justice System: Competency to Stand Trial and the Insanity Defense
Victor R. Szasz, M.D., J.D.
Baylor College of Medicine, Houston, Texas
3:00-5:00 pm Mental Health Models and Complex Emergencies: A New Frontier
Daniel L. Creson, M.D., Ph.D. and Panel
UT Southwestern, Dallas, Texas
Saturday, November 17, 2002
8:00-9:00 am Resident Paper Competition Presentation
Presentation to be determined
9:00 -10:00 am Advancements in the Diagnosis and Treatment of Multiple Sclerosis
Elliot M. Frohman, M.D., Ph.D.
UT Southwestern Medical Center, Dallas, Texas
10:00 -11:00 am Managing Schizophrenia While Emergencies: A New Frontier
Daniel L. Creson, M.D., Ph.D. and Panel
UT Southwestern, Dallas, Texas
11:00 am-12:00 pm Ethical Issues: The Simple Side of Complexity
Greg McQueen, Ph.D.
University of North Texas Health Science Center, Fort Worth, Texas

Sunday, November 17, 2002
8:00 am Continental Breakfast
8:00-12:00 pm Scientific Program
Conclusion of Program
Remainder of Day to Enjoy City of Fort Worth

TO REGISTER
Please complete the registration form and return it with your check, money order or credit card information for your registration and event fees to the Texas Society of Psychiatric Physicians, 148 West 4th Street, Suite 100, Austin, Texas 78701 by October 26 to reserve the discounted registration fee. Registration forms and payments by credit card may be FAXED to TSPP at 512/478-5223.

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
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If you require any special assistance to fully participate in this conference, please contact TSPP at (512) 478-0609.
Register Now

TSPP Leadership Retreat

Take a break and bring your family to TSPP’s Summer Leadership Retreat on August 3-4, 2002 at the 200-acre award winning Hyatt Regency Hill Country Resort in San Antonio. The Leadership Retreat’s program on Saturday will once again involve TSPP’s advocacy partners in the Mental Illness Awareness Coalition (Mental Health Association in Texas, NAMI Texas, Texas Depressive and Manic-Depressive Association, and Texas Mental Health Consumers). In preparation for the 2003 Texas Legislative Session, the Saturday program will feature an interactive legislative training program facilitated by Joe Gagen; briefings from each coalition partner on legislative priorities, and a luncheon program highlighted by a presentation by a member of the Texas Legislature. After enjoying an afternoon of relaxation and fun with family and friends, join your colleagues at an evening of relaxation and fun with family and friends, join your colleagues at an evening of relaxation and fun with family and friends, join your colleagues at an evening of relaxation and fun with family and friends.

On Sunday morning, TSPP members will meet and participate in briefings on TSPP Political Action Task Force and various organizational projects. The Resort is family-friendly, featuring: a 4-acre water park with two pools, waterfall, sun-deck and a 950 foot Rambler River; an Arthur Hills designed 18 hole championship golf course, rated among the best in the US; and, the Windflower Hill Country Spa offering a full spectrum of massage and skin care treatments. The Resort is minutes from SeaWorld and Six Flags Fiesta Texas.

Space is limited for the Retreat, so register soon by completing the Registration Form below and returning it to TSPP. Take advantage of TSPP’s discounted room rate of $179 by calling the Resort to make your room reservations (800/233-1234).

SCHEDULE

Saturday, August 3
9:00 am Registration
9:30 am Legislative/Workshop led by Joe Gagen
12:00 pm Luncheon Program
2:00 pm Fun Time with Family and Friends
6:30 pm - 7:30 pm TSPP Reception

Sunday, August 4
9:30 am - 12:00 noon TSPP Organizational Planning

CALENDAR OF MEETINGS

JUNE
22 "Use of Buprenorphine in Pharmacological Management of Opioid Dependence”
American Academy of Addiction Psychiatry
Hyatt Riverwalk Hotel, San Antonio, Texas
Contact: Registration 913/262-6161

AUGUST
3-4 TSPP Summer Leadership Retreat
Hyatt Regency Hill Country Resort, San Antonio, Texas
Program Contact: Debbie Sundberg, 512/478-5605
Hotel reservations: 800/255-1254

OCTOBER
50-Nov 2 38th Annual State Conference
Learning Disabilities Association of Texas
Renaissance Austin Hotel, Austin, Texas
Contact: Registration 512/488-8234

NOVEMBER
15-17 TSPP Annual Convention and Scientific Program
"New Frontiers in Psychiatry”
Worthington Hotel, Fort Worth, Texas
Program Contact: Debbie Sundberg, 512/478-5605
Hotel reservations: 817/870-1000

15 TSPP Committee Meetings
Membership Luncheon
Reception with Exhibitors
16 Scientific Program
Annual Business Meeting
Executive Council Meeting
TSPP Awards Banquet
17 Scientific Program

TSPP MEMBER INFORMATION UPDATE

Name: ____________________________________________
Affiliation: ________________________________________
Address: ________________________________________
City: _____________________________________________
State: __________________ Zip: __________
Phone: __________________ Fax: __________________
E-Mail Address: __________________

Date: __________________

REGISTRATION DEADLINE JULY 24, 2002

TSPP Leadership Program, Sunday, August 4, 9:30 am - 12 Noon
No Fee

Total Registration Fee Enclosed: $________

METHOD OF PAYMENT: □ Check (Payable to Texas Society of Psychiatric Physicians)
□ Visa □ MasterCard

Card#: ____________________________ Expiration Date: ___________

Cardholder’s Billing Zip Code: ___________
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Texas Society of Psychiatric Physicians
MENTAL ILLNESS AWARENESS COALITION LEADERSHIP RETREAT
August 3-4, 2002 • Hyatt Regency Hill Country Resort, San Antonio, Texas

CONFERENCE REGISTRATION

Name: ____________________________________________
Address: ________________________________________
City: _____________________________________________
State: __________________ Zip: __________
Phone: __________________ Fax: __________________
E-Mail Address: __________________

Please register below for EACH event you will be attending
□ Coalition Legislative Program and Luncheon, August 3, 9:30 am-2:00 pm
Legislative Communications Training led by Joe Gagen
Contact: Registration 512/478-5605
□ Coalition Legislative Priorities
Luncheon Presentation by a State Legislator
$45.00 Per Member $90.00 Per MD Member
Contact: Registration 512/478-5605
□ Coalition Reception, August 3, 5:30 pm - 7:30 pm
No Fee but must pre-register to attend.
□ TSPP Leadership Program, Sunday, August 4, 9:30 am - 12 Noon
No Fee

The TSPP NEWSLETTER is published six times a year for its membership in February, April, June, August, October, and December. Members are encouraged to submit articles for possible publication. Deadline for submitting copy to the TSPP Executive Office is the first day of the publication month. Display advertising is available and 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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Edward L. Billy, MD

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