Texas Society of Psychiatric Physicians
NEWSLETTER
APRIL / MAY 2002

New Mexico Falls

Martha Leatherman, MD, Chair, Government Affairs Committee

On March 5, 2002, the Governor of New Mexico signed a bill granting independent prescribing privileges to New Mexico's psychologists. It took the New Mexico psychologists only two legislative sessions to achieve their legislative goal of gaining prescribing privileges by legislative fiat. The landmark victory for psychology will be felt in all states, especially bordering states like Texas.

In a press release from the American Psychiatric Association, APAs President, Richard Harding, MD said, "The new law, signed March 5 by the governor, is the result of a cynical, economically-motivated effort by some elements of organized psychology to achieve legislated prescriptive authority without benefit of medical education and training. Psychology prescribing laws are bad medicine for patients. The American Psychiatric Association regrets this ill-advised decision in New Mexico which we believe has great potential to do harm to people with mental illness. We pledge to continue to oppose all efforts to jeopardize the public health by allowing persons without a medical education to practice medicine."

The psychologists in New Mexico argued that prescriptive authority for psychologists was needed to address a need in the state...providing services to the population living in rural areas of the state. They cited that psychologists outnumbered psychiatrists 170 to 18 outside of the urban areas of Santa Fe and Albuquerque. Yet, when a legislative compromise was offered to limit psychologists prescribing to only underserved areas, the psychologists flatly refused the compromise.

According to published accounts of the legislative victory for psychology (*Monitor on Psychology*, April 2002), the support of the New Mexico Medical Society "helped pass this landmark legislation, " according to Elaine LeVine, PhD, chair of the New Mexico Psychological Association committee on prescription privileges. "To further aid the RxP crusade, NMPA joined forces with the New Mexico Medical Society, previously an opponent, to develop a compromise. It worked. The Medical Society recognized that psychologists could fill a need in the state," said LeVine. "The Medical Society came out on psychology's side. In the end, ... psychologists and physicians agreed on a program that builds on psychologists' doctoral level training," added LeVine.

The real winning strategy was revealed by Mario Marques, PhD, of the New Mexico Psychological Association in the American Psychological Association's bimonthly publication, *Monitor on Psychology*: "To me, the bottom line is we developed relationships with legislators. We educated them about psychology and we made friends with them in some cases."

This is the first lesson in Politics 101. Legislative victories are won with relationships, not necessarily on the merits of the arguments. It has been reported that Pat DeLeon, PhD, a leading national advocate for prescribing privileges for psychologists, told a conference in the mid-1980's that the issue of psychologists prescribing is not training or competence, but political power. You get what you have the votes for.

Clearly, the arguments against granting non-physicians independent prescribing privileges far outweigh any argument made in support of non-physician independent prescribing when it comes to public safety and providing the highest standards of treatment for persons with mental illnesses. Allowing psychologists to prescribe medications is a PRESCRIPTION FOR DISASTER.

"To me, the bottom line is we developed relationships with legislators. We educated them about psychology and we made friends with them in some cases."

—Mario Marquez, PhD
New Mexico Psychological Association

TSPP, along with colleagues from the "House of Medicine," friends within the mental health advocacy organizations, and Texas psychologists who oppose this expansion in their scope of practice, soundly defeated a psychologist prescribing bill during the Texas Legislative Session of 2001. When victory was secured in 2001, TSPP predicted the psychologists would again attempt to pass their prescribing legislation in 2003 when the next Texas Legislature convenes. With the recent legislative victory in New Mexico, it is a certainty that the Texas Psychological Association will introduce their legislation in 2003. TSPP and our friends are committed to defeating their bill once again.

But the task has grown much more difficult. With the surprising victory in New Mexico, psychologists are predicting "a domino effect in neighboring states, such as Texas and Arizona where the RxP movement has been active." (Monitor on Psychology, April 2002). No longer can we argue that no state in the nation has allowed psychologists prescribing legislation to pass.

The in-coming President of the Texas Psychological Association, Dee Yates, PhD, was quoted in *Monitor on Psychology* (March 2002) as follows: "Getting psychologists on board was one our of most important efforts. Initially, we had a lot of resistence from within the field. But as we started educating people, it got better. After learning more about RxP, most psychologists in Texas were convinced to support it. The sentiment on prescriptive authority in Texas is about the same as what national surveys have found. About 70% of the field really goes for it."

The Texas Psychological Association has somehow convinced the Texas A&M College of Education to co-sponsor a psychopharmacology continuing education course. After completing the 405-hour didactic curriculum, psychologists will receive a certificate in Psychopharmacology from Texas A&M as well as Continuing

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Texas A&M University Co-Sponsors Pharmacology Course with the TPA

Joseph Castiglioni, MD, PhD

Billed as a training program for doctoral level psychologists, a course in psychopharmacology is being created by the Office of Continuing Education in the Texas A & M University College of Education. The course, which is co-sponsored by the Texas Psychological Association, leads to a Certificate in Psychopharmacology. According to information packets describing the program, it will satisfy one requirement for psychologists to obtain prescription-writing privileges in Texas. The Texas Psychological Association has set the goal of acquiring the privilege of prescribing psychotropic medications for psychologists during the coming 2003 Legislative Session.

The course is open to any psychologist who has "engaged in the provision of health services in psychology" for at least two of the last five years. Eligible degrees listed on the course application form include the Ph.D., Psy.D., and Ed.D. The course is planned to consist of 405 hours of instruction on 34 weekends over a two-year period, and will be taught via distance education at sites in College Station, Dallas, Houston and San Antonio. Tuition for the course is $6,500.

Twenty-one participants started in the first class, which began in early April, 2002. Discussions with the course organizers revealed that the course program and content had not been finalized as of mid-April. Instructors were still being sought for many of the later modules, and the organizers have approached faculty members of the TAMU College of Veterinary Medicine and basic sciences faculty of the TAMU Health Science Center to teach components of the course.

Is this a photo of the Texas Capitol, home of the Texas Legislature, or is this a photo of the Medical School for some psychologists who want to obtain prescribing privileges by legislative fiat?

INSIDE...

President's Message

Charles L. Bowden, MD

Farewell...

A year is a moment in time, but even a moment has many events, and this year has certainly been event filled. My main theme as President of TSPP for 2001-02 was to improve the public sector funding of treatment for the mentally ill. This is now embodied in our on-target slogan, 26th by 06. This would bring state funding for treatment of mental illness by 2006 to the per capita rank that we have for income among the 50 states. This has positioned the long term commitment of TSPP on this issue so that we can clearly articulate the justification of this goal to legislators, and work collaboratively with our alliance partners to move the state toward that commitment. This will be no easy task, as we knew when we started. We live in a state, which, though prosperous and growing, has woefully inadequate, and inequitable revenue sources. Democrats as well as Republicans have been afraid of stating that new revenues based on corporate and individual incomes, not just property taxes, will be needed. Texas ranks last in amount of state funds raised as a proportion of state product. One consequence is that Texas has an inordinately high rate of uninsured, and that more care of the mentally ill now takes place in penal settings than in public mental health settings.

We effectively carried our message to legislators about the threat to public health if psychologists advanced their scheme to obtain prescriptive authority. Indeed, the leadership on this by Martha Leatherman and John Bush made Texas the leading example among all states on how to effectively organize an educational campaign on a medical issue. However, the Texas Psychological Association will return in force in the next legislative session, in part consequent to the sole state, our neighbor, New Mexico, passing prescriptive authority for psychologists in March 2002.

We have responded to the tragic murders by Andrea Yates with a planning effort for a program on the insanity defense, and related issues.

We dealt with one particularly troublesome component of the national APA's organizational difficulties by assuming the billing and collection of TSPP dues, which had previously been bundled with payment of national dues. We were able to accomplish this quickly and efficiently, principally because the excellent information systems in place, thanks to the efforts of John Bush and Debbie Sundberg, gave us most of the tools we needed. This step has put us in a better financial position than we would have been in had we continued to rely on the national billing apparatus.

I believe that we have dealt with problems at the national level of the APA as best as we can. However, there remains a mismatch between the financial resources of the APA and their excessive number of components, both in structure and function. Both individually, as well as organizationally, we must keep up the positive pressure on the Board of Trustees to effect the needed changes. Otherwise, not only the APA but state associations will be weakened by their operational limitations. An urgently needed restructuring must also entail further strengthening the corporate interaction between the national APA and state societies.

Whereas we have had a strong input on public sector funding, psychologist prescribing efforts, and APA relationships, we have done less about privately funded mental health care access. The deplorable coverage that passes for psychiatric insurance has made every city in Texas inadequately served with inpatient beds. This is a crisis. George Santos wrote eloquently about it in this newsletter a few months back. Managed care companies have squeezed psychiatric coverage more than almost any other component of medical care. We need to be equivalently pro-active in educating the public and legislators on the consequences of this sham, and the means to correct it. Equivalent efforts need to come also from our advocacy partners on this issue.

Although we are in much better financial shape than we were a year ago, for reasons of the dues handling described above, but also for external factors, we have operated at a small net deficit for the year. Historically, our stimulating and successful annual meeting has contributed a substantial profit toward our annual budget. This year's meeting also was adversely impacted by the aftermath of reduced travel following September 11. The annual meeting has had substantial support from research pharmaceutical corporations for many years. However, due to mergers within the industry, the number of companies has been substantially reduced, and, in turn, their contribution to the fiscal results of the annual meeting, and consequently our positive budgets, much lower. This situation is unlikely to be reversed. Our reserves are substantial, and we are projecting a balanced budget next year. I have asked the Budget Committee to continue to evaluate all possible measures to ensure that TSPP remains financially healthy, maximizing areas of success and identifying any areas of inefficiency, so that TSPP will continue to be responsive to the needs of the membership in these financially difficult times.

I believe we have well addressed the needs of our members this year. Participation in meetings of committees, the Executive Council, the annual meeting and, importantly, our summer leadership conference, has been broad and enthusiastic. When we faced the unexpected, such as the realization that having local chapter members who were not members of TSPP was not feasible, everyone came up with workable solutions that served the interests of the chapters and the TSPP. However, membership satisfaction is an individual issue, and my successor, Sandy Kiser, needs to hear from you if you want more of/less of any of our current offerings.

Thanks to literally hundreds of you who either volunteered, or responded favorably to my requests, or who simply continue to contribute to TSPP year in and year out. Special appreciation goes to Clay Sawyer, Sandy Kiser, and David Axelrad, as well as Martha Leatherman and Bob Denney. John Bush and Debbie Sundberg operate with a remarkable level of professionalism and dedication. There is no way that I could have accomplished a fraction of what I have done on your behalf as President without their support, and often their leadership . Even residing relatively close to Austin, the number of details that needs to be taken care of is far beyond my available time, or on some matters, understanding of the issue. John always supplies both the time and the perspective.

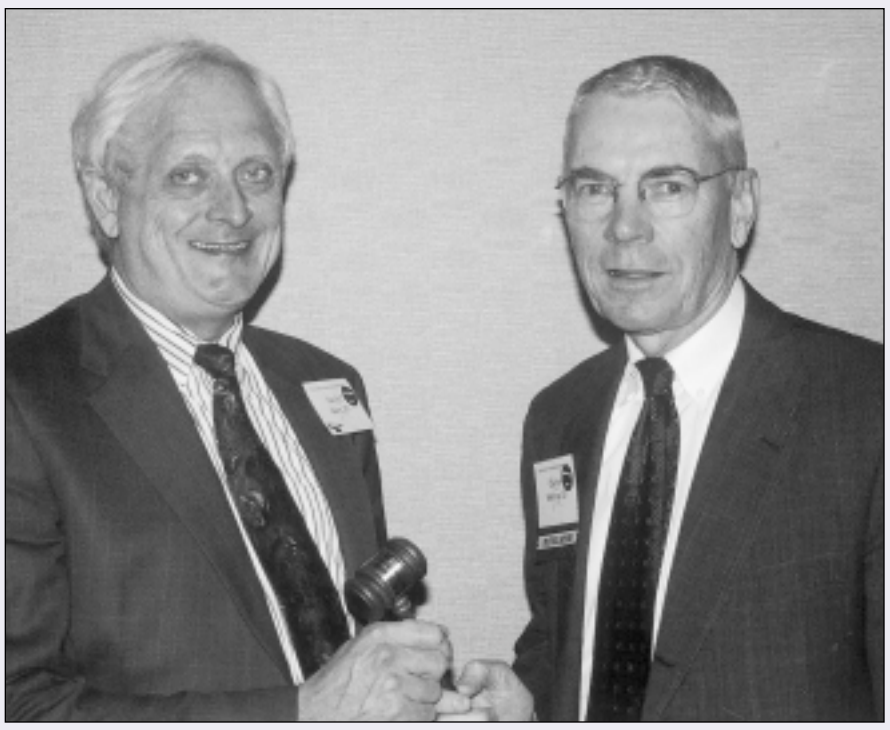
We are now engaged in an effort to contact all psychiatrists in the state who are not members of TSPP, and encourage their joining. You probably know a few in your community. Help us to help them, by encouraging their becoming members. TSPP will be the stronger for their participation. I chose the term Farewell to entitle this editorial. I did it not to emphasize the goodbye, but to wish that each of you fare well in the year ahead, and that we all work for TSPP to help us to fare well, as it does so as an organization. Thank you for your confidence in electing me to serve as your President.

In Memoriam

David A. Freedman, MD — Houston

Jacob Schut, MD — El Paso

Kiser Inducted as President



R. Sanford Kiser, MD (left) receives the TSPP President's gavel from Charles Bowden, MD during his induction ceremony as TSPP President at the Executive Council meeting on April 21, 2002. Dr. Kiser will serve as President during FY 2002-2003 and during the upcoming Legislative Session. Dr. Kiser is in private practice in Dallas.

Austin Chapter — The speaker at the March meeting of the Austin Chapter was W. Lawrence Fitch, JD, Director of Forensic Services for Maryland's Mental Hygiene Administration, Clinical Associate Professor of Psychiatry at the University of Maryland Medical School and Instructor of Law at the University of Maryland Law School where he teaches "Mental Disability Law" and "Mental Disability and Criminal Law." The topic of his presentation to the Chapter was "Current Issues in Forensic Psychiatry." Pictured with Mr. Fitch are Emilie Becker, MD, Chapter Past President (left) and Linda Taylor, DO, Chapter President.

Congratulations...

The American College of Mental Health Administration has awarded the Saul Feldman Lifetime Achievement Award to **H. G. Whittington, MD**, at its annual meeting in Santa Fe, New Mexico. Dr. Whittington, of Houston, Texas, is a psychiatrist who over a long and varied career has provided leadership and administration to public, private, and voluntary behavioral health agencies and programs.

Your Committees at Work...

TSPPs committees met in Dallas on April 20, 2002 and conducted their business, as follows:

Budget Committee: The committee reviewed financial reports and approved the Budget for FY 2002-2003. Dues waiver requests from members were reviewed. The committee discussed efforts to reach members who are delinquent in 2001 dues and whose memberships in APA and TSPP will be terminated by the end of June if dues are not paid. The committee discussed APAs dues amnesty proposal and decided more clarification is needed.

Children and Adolescents Committee: The committee reviewed the TMA Resource Guide for Physicians on Child and Adolescent Mental Health and found it to be a useful guide but suggests that additional information be provided about how primary care physicians could access child psychiatrists in their community. Psychiatric evaluations for children in foster care was discussed. The committee reviewed strategies being employed by psychologists who want to achieve prescribing privileges through the legislative process.

Continuing Medical Education Committee: The committee reviewed the 2002 TMA Section on Psychiatry and finalized the program for the TSPP 2002 Annual Scientific Program. The committee began planning for the coordination of the 2003 TMA Section on Psychiatry Program and the 2003 TSPP Scientific Program which will be conducted in Houston. The committee also began planning for the 2002 membership needs assessment.

Early Career Psychiatry Committee: The committee discussed ways to involve more early career psychiatrists at the Annual Meeting and a program for ECPs. Also discussed were ideas for the website and a mentoring program. Membership and practice issues were also discussed.

Ethics Committee: The committee discussed the APA Ethics Process and the format of ethics hearings.

Forensic Psychiatry Committee: The committee reviewed the status of the legislative task force on trial competency and the insanity defense. The committee approved a proposal for TSPP to host a conference on the Insanity Defense and for the appointment of a task force to develop and define TSPPs legislative position on the insanity defense.

Government Affairs Committee: A presentation by TMA outlined TMAs legislative priorities. Spokespersons for the Nurse Practitioners and Physician's Assistants addressed the committee on hospital admission practices. State legislative issues were discussed including restraint and seclusion, mental health parity, suicide prevention, psychologists' prescribing initiative, guardianship hospital admission authority, malpractice reform and the insanity defense. The committee endorsed the proposal of the Forensic Psychiatry Committee to conduct a conference on the insanity defense and that a task force be formed to develop TSPPs legislative position on the insanity defense. The committee was briefed on Federal issues, including suggested changes in the HIPPA privacy rules and mental health parity. The committee endorsed the distribution of educational alerts to members about the HIPPA privacy rules. A pharmacology course for psychologists at Texas A&M was reviewed.

Long Range Planning Committee: The committee discussed ways to improve the linkage between APA and TSPP, suggesting that APA leadership inform TSPP of Texas psychiatrists appointed to APA committees and components; assigning each TSPP member appointed to an APA committee or component to a corresponding TSPP committee; and conducting annually a meeting involving TSPP members appointed to APA committees and components with TSPP leadership. The committee also discussed an APA Task Force which is reviewing possible changes in the APA ethics process.

Managed Care Committee: The committee discussed a TMA workgroup reviewing Medicaid drug management protocols and ways to help psychiatrists navigate through the utilization review process with the development of an algorithm to guide a psychiatrist through a conversation with a reviewer. The committee also discussed the issue of formalizing complaints about managed care companies, including compiling information from hospitals about complaints and outcomes. The committee discussed developing a survey of specific managed behavioral health organizations, providing a rating system.

Members-in-Training Section: New Officers for the MIT Section were elected as follows: Chairman - Trina Cormack, MD (UTMB Galveston); Vice Chairman - Paul Carlson, MD (UT Southwestern, Dallas); and Secretary/Treasurer - Tiffany Ballard, DO (UT San Antonio). The committee discussed assignments for Newsletter articles, the Resident Paper Competition, and the use of the MIT listserv. The committee also discussed ideas about involving more residents in the work of TSPP.

Membership Committee: Changes in membership status were reviewed and approved. Responses to TSPPs membership recruitment letter were reviewed and discussed. The committee approved a recommendation that the TSPP Assembly Representatives pursue with APA dues reductions and other membership incentives. The committee also discussed several ideas for membership retention and recruitment. The committee reviewed the status of members who are delinquent in 2001 dues and who may be terminated by June 30 if dues payments are not received.

Professional Practices Committee: The committee reviewed Guidelines for Office-Based Outpatient Withdrawal Techniques for Alcohol, Anxiolytic/Sedative/Hypnotic Drugs, and Opiates developed by the Task Force on Addictive Disorders. The Guidelines were approved with amendments.

Public Mental Health Services Committee: The committee reviewed a draft report produced by a TXMHMR task force to respond to Rider 66 of the Budget. The committee took strong exception to a section of the report which addressed prescribing privileges of psychologists. The committee adopted the position that TSPP express its opposition, wherever possible, to independent prescribing privileges by non-physicians. The committee reviewed the funding for public mental health, noting increasing costs and increasing demand for services. The committee developed principles to guide discussions regarding eligibility for services: first, treat the most seriously ill and those most likely to respond to treatment; adopt an Oregon model of obtaining broadly based citizen consensus on ranking of illnesses based on cost benefit analysis; provide treatment to those least able to pay and deny admission when such admission would exceed a hospital's capacity.

Task Force on Addictive Disorders: The task force began preparing to develop guidelines for the following classifications of substances: stimulants, hallucinogens, cannabis and inhalants.

UR Complaint Service Committee: The committee discussed the continued publication in the Newsletter and other educational material information about utilization review laws. The committee endorsed inviting the Commissioner of the Texas Department of Insurance, or designee, to speak at an upcoming TSPP meeting.

EXECUTIVE COUNCIL ACTIONS...

The Executive Council met in Dallas on April 21, 2002 and approved the following actions:

- ★ At the request of the Budget Committee, the budget for fiscal year 2002-2003 was approved.
- ★ Upon recommendation of the Budget Committee, the Council approved dues waivers for three members.
- ★ The Council approved a recommendation of the Budget Committee that a 5% late fee will be assessed for current year dues that are not paid by July 1 of each year.
- ★ Upon the recommendation of the Executive Committee, bonuses were approved for the Executive Director and Assistant Director.
- ★ The Executive Council approved an amendment to Chapter Two. Membership Categories, Section XIII of the Bylaws. Bylaws amendments are considered by the membership at the Annual Business Meeting.
- ★ Upon the recommendation of the Constitution and Bylaws Committee, the Council approved changes in the Constitution to comply with APA Bylaws. The changes in the Constitution will be submitted to the membership by mail ballot.
- ★ The Council approved a recommendation of the Forensic Psychiatry Committee for TSPP to host an educational conference on the Insanity Defense. Invited speakers for the conference to be conducted in Austin will include nationally recognized authorities in the general area of psychiatry and law, qualified either by academic publication or by trial experience. The content of the conference will be balanced in terms of the various insanity defense formulations. A program chairman and committee will be appointed to develop the content of the conference.
- ★ Upon recommendation of the Forensic Psychiatry and Government Affairs committees, the Council approved a request that a task force be appointed to develop policy on the Texas Insanity Defense to guide legislative deliberations expected in 2003. Members of the task force will include members from the following committees: Forensic Psychiatry, Government Affairs, and Public Mental Health Services. The task force is to report its recommendations at the TSPP Summer Leadership Retreat.
- ★ The Council approved a recommendation of the Government Affairs Committee to send informational alerts to members about the changes in the HIPPA privacy rules.
- ★ The Executive Council approved a request of the Long Range Planning Committee to ask the APA President-Elect and Assembly Speaker-Elect to inform TSPP about appointments they make to committees and components that involve Texas members.
- ★ The Council approved a request of the Long Range Planning Committee that TSPP invite each TSPP member appointed to serve on APA committees/components to serve as members of corresponding TSPP committees.
- ★ Upon the request of the Long Range Planning Committee, the Council approved a recommendation that TSPP establish a coordinating committee, which will meet annually, to facilitate TSPP/APA issues. The committee will be composed of TSPP committee chairs, APA committee/component members, Assembly Representatives, and members of the Long Range Planning Committee.
- ★ Upon the recommendation of the Membership Committee, the Council approved membership applications for 17 new members.
- ★ The Council approved a recommendation of the Membership Committee to charge the TSPP Assembly Representatives to pursue dues reductions or other membership incentive programs with the APA.
- ★ Upon the recommendation of the Nominating Committee, the Executive Council approved the following TSPP Awards for presentation at the 2002 TSPP Annual Convention: Distinguished Service Award - Alex K. Munson, MD, Georgetown/Lubbock; and, Robert L. Zapalac, MD, Austin; Psychiatric Excellence Award - Edward S. Furber, MD, Fort Worth; Margo K. Restrepo, MD, Houston; and, Madhukar Trivedi, MD, Dallas; Special Service Award - The Honorable Mike Moncrief.
- ★ The Executive Council approved a recommendation of the Professional Practices Committee to adopt Guidelines for Office-Based Outpatient Withdrawal Techniques for Alcohol, Anxiolytic/Sedative/Hypnotic Drugs, and Opiates. These evidenced-based guidelines will be submitted to the membership in the TSPP Newsletter for review and comment before they are ratified in final form.
- ★ Upon the recommendation of the Public Mental Health Services Committee, the Executive Council approved a request for TSPP to direct appropriate persons and representatives to present, wherever possible, TSPPs opposition to independent prescribing privileges for non-physicians.
- ★ The Council approved a request of the UR Complaint Service to invite Texas Department of Insurance Commissioner, Mr. Montemayor, to speak to an upcoming TSPP meeting.
- ★ The Executive Council approved a recommendation to merge the function of the UR Complaint Service into the Managed Care Committee.

For Review and Comment

Treatment Guidelines

On April 21, 2002, the Executive Council tentatively approved Guidelines for Office-Based Outpatient Withdrawal Techniques for Alcohol, Anxiolytic/Sedative/Hypnotic Drugs, and Opiates developed by the TSPP Task Force on Addictive Disorders. Below is a draft of the Guidelines submitted for review and comment by TSPP members. Please send your comments to TSPP by August 1, 2002. The Executive Council will consider all suggestions for changes in the Guidelines during its meeting on November 16, 2002.

Office-Based Outpatient Withdrawal Techniques: A Guide

Alcohol

Inpatient hospital treatment provides the best and safest treatment for withdrawal from alcohol. However, in selected cases as indicated by these Guidelines and with the express consent of the patient, office-based outpatient withdrawal can be recommended. Detoxification is only the introduction to addiction treatment and a treatment plan for continuing rehabilitation should be implemented.

The psychiatrist practicing in an office-based setting can expect to encounter patients with alcoholism. According to The National Comorbidity Study 14% of adults develop alcohol dependence over the course of a lifetime.

There are several reasons why a patient may prefer office-based outpatient detoxification and refuse inpatient or partial hospitalization:

- Has no insurance or has used up previous benefits
- Fear of stigma if hospitalized or enrolled in a formal treatment program
- Does not want to lose time from work or wants to minimize time away from work
- Prefers or needs to stay with family

The appropriateness, safety, and effectiveness of this procedure will depend on several variables. First, those variables which favor office-based outpatient detoxification:

- Cooperative patient
- Lives with or can be monitored by a responsible adult
- No acute medical conditions that in and of themselves would require hospitalization.
- No coexisting psychiatric disorders (Axis I or II) which in and of themselves would require hospitalization

Variables which weigh against office-based outpatient detoxification:

- A history of being uncooperative with medication schedule
- Lives alone and has no social network available for assessment
- Has acute medical problems (e.g. infections, pain symptoms) or unstable chronic medical problem (e.g. hypertension, diabetes mellitus)
- Has a co-occurring psychiatric disorder that may compromise judgment or that requires close monitoring.
- Past pattern of life threatening complications of alcohol withdrawal (for example: repeated seizures; emerging delirium tremens; hyperthermia; hepatic failure; esophageal varices)
- Likelihood of additional withdrawal syndromes due to other substance dependencies.
- Physical and laboratory tests must be available and used as indicated

I. The decision to proceed with office-based outpatient detoxification is a judgment the psychiatrist must make. Knowledge of the patient, consideration of the variables listed above, and ability to monitor the course of treatment will influence the decision. Please keep in mind, detoxification is only the introduction to addiction treatment and a treatment plan for continuing rehabilitation should be implemented. Office-based withdrawal treatment should only occur after a current physical examination and laboratory assessment has been performed.

Initiation of Detoxification – Look For:

Physical Exam:

Infections	Gastro-intestinal bleeding	Heart disease(arrhythmia, congestive heart failure)
Liver disease	Pancreaticis	Nervous system impairment (e.g., signs of head injury, stroke, subdural hematoma)

Laboratory:

Complete blood count	Liver Enzymes	Urine drug screen
Blood alcohol level	Electrolytes including potassium, calcium, magnesium, phosphate	

II. Educate patient and family member or other supportive persons regarding alcohol withdrawal symptoms and time course (see chart below).
- Need for hospitalization if symptoms of delirium tremens (DTs) occur (disorientation, confusion, persistent hallucinations)
- Possibility of seizures
- Lay frame work for need for further rehabilitation treatment following detoxification

Table 1. Symptoms of Alcohol Withdrawal (AW)*

Time of Appearance	Symptoms (mild to moderate AW)	Symptoms (Severe AW)**
Start: 6-8 hours	Nausea, Insomnia, Vomiting, Decreased Appetite, Tremor, Pulse increase	Same as mild-to-moderate AW plus: Visual and auditory hallucinations
Next 1-2 Days: intensifies, then diminishes	Anxiety, Headache, Irritability, Agitation, Sensitivity to light and sound, Concentration & orientation problems	Seizures ***
2-4 Days		Seizures *** Delirium Tremens (DTs): Increase agitation, tremulousness and disorientation Large increases in BP, pulse, and breathing rate Autonomic instability Hyperpyrexia Persistent visual and auditory hallucinations Disorientation
Up to 6 days		Seizures ***

* From Anton and Myrick, 2000
** Emergence of severe AW indicates hospitalization rather than outpatient detoxification
*** Seizures may not warrant hospitalization but Neurology consultation is indicated

Any relapse with alcohol or other illicit substances during this process is an indication for inpatient care.

- Advise against driving or operating dangerous equipment; Assess safety of patient's work situation

III. Physician supervision of the withdrawal regimen should be available at all times; Patient should be seen as needed in office; Access to physician must be available.
- Daily monitoring of symptoms by responsible adult (pulse, temperature, blood pressure); blood pressure monitoring is possible through pharmacy and super-markets which have blood pressure machines; blood pressure monitoring equipment can be purchased inexpensively; or visits to primary care office for determination of vital signs
- If pulse, temperature or diastolic blood pressure exceed 100 report results to a physician.

IV. Pharmacotherapy: This is an example regimen only and this regimen should be tailored individually for the patient's specific needs.
1. Vitamins:
   a. Thiamin 100 mg daily x3 days
   b. Multivitamin, one daily
2. Benzodiazepines (BZ's) are the most commonly used agent

Advantages:
- Well tolerated
- Proven efficacy
- Can be used to treat break-through sxs
- Can prevent seizures

Disadvantages:
- Dangerous if mixed with alcohol
- Side effects include amnesia, sedation, motor incoordination
- Potentially addictive if used for long periods

a. Chlordiazepoxide: (preferred regimen)

Advantages:
Long-acting
Unlikely to be abused

Day 1: 50 mg po q 6 hours
Day 2: 25 mg po q 6 hours
Day 3: 25 mg po q 6 hours
Day 4: 25 mg po bid (if necessary)
Supplement with 25 mg to 50 mg every one hour if symptoms of withdrawal are not abating. Decrease dose if patient is over-sedated.

or

b. Lorazepam:

Advantage:
Can be given even if cirrhotic liver disease present

Disadvantage:
Short-acting

Day One: 2 mg po q6h
Day Two: 2 mg po q6h
Day Three: 1 mg po q6h
Day Four: 1 mg po q6h
Day Five: 0.5 mg q 6h
Day Six: 0.5 mg q 12h
Supplement with 0.5 to 1.0 mg every one hour if withdrawal symptoms are not abating.
Decrease dose if patient is over-sedated

c. Oxazepam:

Advantage:
Can be given with liver disease
Intermedicate acting
Unlikely to be abused

Day One: 30 mg q 6h
Day Two: 30 mg q6h
Day Three: 15 mg q6h
Day Four: 15 mg q6h
Day Five: 15 mg q12h
Supplement with 15-30 mg every hour if symptoms of withdrawal are not abating.
Decrease dose if patient is over-sedated.

To avoid benzodiazepine abuse or dependence, prescribe only enough for the number of days of expected use; no refills.

Other Agents that May be Used for Detoxification:

1. Carbamazepine (Tegretal):

Advantages:
No adverse interaction if alcohol ingested

Disadvantages:
Efficacy not as well documented as BZ's
Break-through symptoms must be treated with BZ's
Cannot be given if LFTs>3 x normal
Not effective for DT's

Day 1-2: 200 mg qid
Day 3-4: 200 mg tid
Day 5-6: 200 mg bid
Day 7-8 200 mg daily

2. Divalproex Sodium (Depakote)

Advantages:
Can prevent seizures

Disadvantages:
Efficacy not as well documented as BZ's
Break-through symptoms must be treated with BZ's
Not effective for DT's

Day 1: 500 mg po start loading dose, followed by 500mg po 6 hours later
Day 2: 500 mg po bid
Day 3: 500mg po bid
Day 4: 250 mg po bid
Day 5: 250 mg po one dose

Other potentially useful medications:
- Neurontin – for anxiety or sleep disturbance
- Phenergan suppository (25 or 50 mg), prn, for nausea or vomiting
- Over the counter (eg. Kaopectate) or prescribed (Lomotil) anti-diarrheals.

References: Available from the Texas Society of Psychiatric Physicians

Office-Based Outpatient Withdrawal Techniques: A Guide

Anxiolytic/Sedative/Hypnotic Drugs

Nearly 2% of adults develop a dependence on anxiolytic, sedative, or hypnotic drugs. Benzodiazepine (BZD) dependence is the most common, but barbiturates and musculoskeletal relaxants need to be considered as well.

The same guidelines, as with alcohol, apply in determining whether office-based outpatient detoxification is appropriate. Also, obtain a physical exam and laboratory studies; and educate the patient and significant others as to the symptoms and course of withdrawal.

Physiological dependence on BZDs can be expected if BZDs are used for more than six months. Short-acting BZDs will have an earlier onset of withdrawal symptoms, longer-acting BZDs will have a later onset. Table 1 lists discontinuance or withdrawal symptoms

Table 1. BZD

Discontinuance Symptoms:

Timing:
Appear within 24 hours for short-acting BZDs; Within 2-3 days for intermediate-acting BZDs and up to one week for long-acting BZDs.

Maximum intensity is from three days to two weeks

Usually subside by four weeks: occasionally lasts up to three months

Very Frequent:

Anxiety	Irritability	Agitation	
Restlessness	Insomnia	Muscle Tension	

Common But Less Frequent:

Nausea	Depression	Lethargy	Ataxia
Blurred vision	Diaphoresis	Hyperreflexia	Aches and pain
Coryza	Nightmares	Hyperacusis	

Uncommon:

Psychosis	Confusion	Paranoid Delusions	
Persistent Tinnitus	Seizures	Hallucinations	

Withdrawal Techniques

These techniques are best suited for the chronic BZD user; that is the patient who has been on a relatively stable dose continuously for six months or more. These techniques are examples of care that must be individualized to the patient's needs.

The patient who has been on a continuous but very variable dose (e.g.;, 15-20 mg of alprazolam on Sunday but 2-4 mg on Monday and perhaps 6 mg on Tuesday, then 2 mg on Thursday, etc.) may be withdrawn using lower doses (preferably at least one-half) of those doses described below.

Sporadic or intermittent use of anxiolytic/sedative/hypnotics may not require a withdrawal regimen.

Withdrawal from the muscle relaxant Soma is necessary because meprobamate is a metabolite of Soma.

Diazepam (Valium) Substitution

- Determine the equivalent dosage of diazepam from Table 2.
- The longer-acting Clonazepam (Klonopin) can be used rather than diazepam. (5 mg of diazepam = 1 mg of Clonazepam).

Table 2

Drug Being Discontinued/Dose Equivalency of 10 mg of Diazepam (mgs):

Barbiturates:

Amobarbital - 100	Butobarbital - 50	Butalbital - 50
Pentobarbital - 100	Phenobarbital - 30	Secobarbital - 100

Other sedative-hypnotics:

Chloral hydrate - 500	Ethychlorvynol - 350	Glutethimide - 30
Meprobamate - 400	Methyprylon - 300	

Benzodiazepines:

Short-acting (half-life less than three hours)
- Triazolam (Halcion) - 1

Intermediate-Acting (half-life 12-20 hours)

Alprazolam (Xanax) - 1	Lorazepam (Ativan) - 1
Oxazepam (Serax) - 30	Temazepam (Restoril) - 30

Long-Acting (half-life greater than 100 hours)

Chlorazepate (Tranxene) - 15	Chlordiazepoxide (Librium) - 25
Clonazepam (Klonopin) - 2	Diazepam (Valium) - 10
Flurazepam (Dalmane) - 30	

Divide the daily dose by 5. For example, the diazepam equivalent for a patient taking 10 Fioracet (10 x 50 mg) per day is 100 mg of Valium (10 mg diazepam is equivalent for withdrawal purposes to 50 mg of butalbital). Divide daily dose by five: 100 mg of Valium divided by five is 20 mg (the dose which is decreased each week). To further illustrate- the diazepam equivalent for a patient taking 6 mg Ativan (lorazepam) per day is 60 mg. 60 mg divided by 5 is 12 mg (the dose which is decreased each week).

The daily dose of diazepam is divided into three doses per day (last dose at hs) For example, when 60 mg of diazepam is the determined equivalent; the weekly dose will be decreased by 12 mg per week. Week one of withdrawal can start with a daily dose of 48 mgs. This is 12 mgs/day less than the 60 mg/day calculated to be the pre-detox level. Therefore, the first week of detox incorporates the first weekly decrease (12 mg in this example).

	7:00 AM	1:00 PM	HS	Daily Doses
Week 1	16 mg	16 mg	16 mg	48 mg
Week 2	12 mg	12 mg	12 mg	36 mg
Week 3	8 mg	8 mg	8 mg	24 mg
Week 4	4 mg	4 mg	4 mg	12 mg
Week 5	2 or 3 mg	2 or 3 mg	2 or 3 mg	6 to 9 mg

Weeks 6, 7, and 8 may require very gradual 1/2 to 1 mg taper per week. There is no need to hurry the tapering schedule. A small (2 to 5 mg) dose may be necessary daily, on a pm basis, for some patients as they taper. (Tapering can be slowed as necessary.)

Trazodone 50- 150 mg hs, is a useful adjunct.

As the drug taper ends *rebound symptoms* may appear. Rebound is a mixture of prior anxiety symptoms and withdrawal symptoms. These will typically abate after two weeks of being drug free. *Relapse* symptoms, which are the re-emergence of an anxiety disorder, may also appear. Two months of being drug free is sufficient time to determine if re-emergence of an anxiety disorder has occurred.

Table 3

Predictors of Increased Severity of BZD Withdrawal

Drug Variables

High Dose	Longer Duration of Treatment
Shorter Half-life	More Rapid Taper

Clinical Variables

Higher pre-taper anxiety and depression	Personality Disorders
History of Alcohol and Drug Abuse	Panic Disorders

References: Available from the Texas Society of Psychiatric Physicians

Office-Based Outpatient Withdrawal Techniques: A Guide

Opiates*

Withdrawal from Opiates

Hospital inpatient treatment is often best for detoxification from opiates, but in selected cases, detoxification may be on an outpatient basis. Evaluation of other drugs of abuse and assessment of the patient's physical status should be performed prior to initiating outpatient withdrawal regimens for opiates.

The duration of withdrawal will depend on the half-life of the opiate: symptoms will appear 4-12 hours after last dose.

	Peak Withdrawal Symptoms:	Most Symptoms Over:
Meperidine (Demerol)	8-12 hours	4-5 days
Heroin	36-72 hours	7-10 days
Hydromorphone (Dilaudid)	36-72 hours	7-10 days
Codeine	36-72 hours	7-10 days
Hydrocodone (Vicoden)	36-72 hours	7-10 days
Oxycodone (Oxycontin)	36-72 hours	7-10 days

Signs and Symptoms of Opiate Withdrawal

Early Symptoms

Anorexia	Anxiety	Craving	Dysphoria
Fatigue	Headache	Irritability	Lacrimation
Mydriasis (mild)	Perspiration	Restlessness	Rhinorrhea
Yawning	Piloerection (goose flesh)		Increased respiratory rate

Later Symptoms

Abdominal cramps	Broken sleep	Hot or cold flashes
Increased pulse	Low-grade fever	Increased blood pressure
Muscle & bone pain	Muscle spasm (hence the term kicking the habit)	
Mydriasis (with dilated fixed pupils at the peak)	Nausea and vomitting	

Clonidine-Aided Detoxification

1. Oral
   Day 1: 0.1-0.2 mg orally every 4 hours up to 1 mg
   Day 2-4: 0.1-0.2 mg orally every 4 hours up to 1.2 mg
   Day 5 to completion: Reduce 0.2 mg/day; given in divided doses; the night-time dose should be reduced last; or reduce total dosage by one-half each day not to exceed 0.4 mg/day

2. Patch

The clonidine patch comes in three strengths (#1, #2, #3) and delivers over one week the equivalent of a daily dose of oral clonidine (e.g., #2 patch = 0.2 mg oral clonidine, daily, etc.).

One technique is to apply one #2 patch for patients under 100 lbs, two #2 patches if they weigh 100-200 lbs and three #2 patches for those over 200 lbs. Also, on day one (the day the patch is applied) oral clonidine may be necessary- 0.2 mg q 6hours for 24 hours, then 0.1 mg q 6 hours for the second 24 hours.

The patches should be removed if systolic pressure falls below 80 mm hg or diastolic below 50 mg hg.

Advantages of patch:

- Patients don't have to take pills several times a day
- Even blood levels of medication
- Buildup of withdrawal symptoms during night is prevented

Blood pressure monitoring is important as hypotension can occur especially in thin patients. Advise patient to take blood pressure before and 20 minutes after a dose of Clonidine. If "lightheaded" or dizzy, patient should lie down. Adequate fluid intake is important. Contact physician if dizziness continues.

Useful Medications for Symptom Control During Opiate Withdrawal

Provide medications the patient is allowed some control over:

Lomotil, 2 tablets qid, prn diarrhea
Kaopectate 30 cc prn after a loose stool
Pro- Banthine, 15 mg or Bentyl 20 mg q 4h prn abdominal cramps
Tylenol, 650 mg q 4h prn for headache
Feldene, 20 mg daily or Naprosyn, 375 mg q 8h for back, joint, and bone pain
Mylanta, 30 ml q 2h prn for indigestion
Phenergan suppositories, 25 or 50 mg, prn nausea
Atarax, 25 mg q 4h prn nausea
Librium, 25 mg q 4h prn for anxiety
Benadryl, 50 mg or temazepam 30 mg hs prn sleep
Doxepin 10 to 20 mg , po, hs, for insomnia, anxiety, dysphoria

A patient has a right to be informed that alternative treatments to the withdrawal procedure described above are methadone maintenance or outpatient withdrawal using methadone. These procedures can be carried out in licensed Texas Department of Health approved opioid agonist treatment programs.

References: Available from the Texas Society of Psychiatric Physicians

APA Warren Williams Award

Paul Wick, MD, APA Representative

Area 5 Council of APA will present the Warren Williams Award to Byron L. Howard. M.D. of Dallas and Jack W. Bonner III, M.D. of Greenville, South Carolina at the APA Assembly May 17-19, 2002, in Philadelphia.

The Assembly Warren Williams Speaker's Awards were established in 1984 and are administered by the APA Area Councils to recognize outstanding recent or current contributions in the field of psychiatry. The Awards were named in honor of Warren Williams, MD, as past speaker of the Assembly.

Dr. Howard is being honored for his outstanding leadership as a psychiatrist in organized medicine having served in the Texas Medical Association as Board member, Chairman of the Board, member of the Council on Legislation and currently Vice-Chair of the Texas Delegation to the American Medical Association. He has previously served on the APA Assembly as a Texas Representative. Additionally he had leadership roles at Timberlawn Psychiatric Hospital in Dallas and in teaching where he is a Clinical Professor of Psychiatry at the University of Texas Southwestern Medical School.

As a Texas native and previous psychiatric administrator in Texas, Dr. Bonner is known to many in Texas. He currently serves on the APA Board of Trustees as the Area 5 Trustee. He is current President of the American College of Psychiatrists and previous president of the North Carolina Psychiatric Association, Southern Psychiatric Association, Southern Psychiatric Association and the National Association of Psychiatric Hospital Systems.

Last years' co-recipient of the Area 5 Warren Williams was John Bush, TSPP Executive Director.

Letters...

Dear Dr. Santos:
It was with great interest that I read your article entitled "A Crisis of Capacity" in the February/March issue of the *TSPP Newsletter*. In the article you stated that El Paso has suffered a 76.3% decline in available psychiatric beds between the years of 1996 to 2000. I thought I'd update you on the situation here. It is unimaginably bad and in the words of our State Senator Elliot Shapleigh, it "...has gone beyond the point of crisis and is now a matter of civil rights."

The El Paso Psychiatric Center is the public psychiatric hospital built a few years ago for the El Paso area. It was originally opened in 1995 (I think) as an 80 + bed facility. I wish to point out that this did not represent a net gain in beds for the community, but rather a net loss, because with the opening of EPPC came the closing of the State Psychiatric Center which had many more beds. In 1999, due to financial constraints, the entire third floor of EPPC was shut down with a resultant decrease to 52 operating beds. Most recently, due to a nursing shortage, the hospital's Crisis Stabilization Unit located in the emergency area had to be shut down.

The situation in the community is just as bad. There is only one other facility set up to handle psychiatric patients: NCED. This is a private non-profit facility that is barely managing to hang on by its fingernails. They have about 18 active beds and have at times closed to admissions with fewer than 18 patients because of the inability to staff the unit appropriately. A major source of their admissions is overflow from EPPC when our beds are filled.

In sum, we have a total of 70 psychiatric inpatient beds in El Paso for a city with a population of 700,000 or one bed per 10,000 people. Some of the local psychiatrists admit their patients to medical units in the general hospitals, put them on one-to-one coverage and treat them there. This is a less than ideal solution, but it is workable since lengths of stay have gotten so ridiculously brief.

I generally dislike complaining without having a proposed solution to offer, but in the face of the apathy of the psychiatrist community in this city, I'm not sure what can be done. We have a tiny local branch that seldom has meetings. Most of the local psychiatrists fail to show up when it does. We seldom do anything in a coordinated manner. As a result, we have little clout.

In sum, I think the situation in El Paso is even worse than you described it in your article. I don't foresee it getting any better in the near future.

Frank L. Giordano, MD
Associate Professor of Psychiatry
Director of Psychiatric Residency Training
Texas Tech University Health Sciences Center
at El Paso

MEMBERSHIP CHANGES

New Members

The following membership applications were approved by the Executive Council on April 21, 2002.

Member in Training

Cyriac, Thomas V., MD, Galveston
Doddakashi, Veena R., MD, Austin
Doongerwala, Quddusa, MD, Houston
Gunawardana, Asini E., MD, Sugar Land
Hawkins, Germaine B., DO, Fort Worth
Johns, Jeffrey F., MD, San Antonio
Lulla, Kiran S., MD, Austin
McIntyre, Shelly, MD, Lubbock
Stonedale, Judi, DO, Dallas

General Member

Borck, Vicky K., DO, Dallas
Litle, Marc, MD, Dallas
Samad, Zahida, MD, Lubbock

MIT Advancement to General Member

Garza, Robert E., MD, Houston
Mallett, Robin, MD, Galveston
Martini, Sharon R., MD, San Antonio

Transfers from Other District Branches

Maldonado, Jorge, MD, GM, Wichita Falls (Eastern Missouri)
Vache, Marilyn J., MD, Austin (Arizona)

New Mexico Falls

continued from page 1

Education credits for each course. According to the *Monitor on Psychology* (March 2002), task forces have been formed by state psychological societies to develop training programs as preparation for prescribing legislation successes. It was reported in *Monitor on Psychology* that "more than 100 psychologists have been trained to prescribe" in Texas. The article also reported that "in Texas and other states, psychopharmacology students and graduates pledge necessary financial resources for legislative efforts. "We try to really involve our graduates of the training program and keep them prominent in our legislative efforts," said Marsha Sauls, PhD, past-president of the Georgia Psychological Association. She also noted that graduates of these psychopharmacology courses "make the most convincing advocates" for the psychologists' prescribing legislative agenda.

According to Walt Cubberly, PhD, President of the Texas Psychological Association, a major effort of "TPA involves pursuing prescriptive authority for appropriately trained psychologists. President-Elect Dr. Dee Yates and President-Elect Designate Dr. Alan Hopewell and others are heading up this effort, which will involve a major push in 2003. Many psychologists who have completed the psychopharmacology training are already contributing $2,000 per year into a fund to support passage of this legislation." (*Texas Psychologist*, Spring 2002).

In *Texas Psychologist* (Spring 2002), Dee Yates, PhD said: "The question was *once*, should psychologists prescribe? The question now is when? The momentum is here. The time is now!"

Redistricting of legislative districts will also add to the burden of defeating the prescribing legislation in Texas in 2003. As a result of redistricting, a large turnover of legislators is expected, some estimate a 40%-60% turnover. With the loss of members who served in the Legislature in 2001, the institutional memory about this and other issues of importance to psychiatrists and patients will be lost.

To counter this legislative threat to patient safety and quality care for persons with mental illnesses, TSPP has once again implemented its Political Action Task Force. Political Action Coordinators have been appointed in each of TSPPs 16 Chapters. The primary objective of TSPPs Political Action Task Force is to encourage members to educate their legislators about the issues and form relationships during the current election cycle, which will conclude with the General Election in November, 2002. If TSPP members wait to become involved with legislators and political issues when the Legislature convenes in January, 2003, it will be too late. Once the Legislative Session begins, relationships and issue education must have already been accomplished. To help measure the success of the TSPP Political Action Task Force, TSPP will again send to all members in December a Key Contact Form, which will provide a means for members to report on their relationship-building during the election cycle.

The time to act is NOW. Contact your Chapter's Political Action Coordinator or TSPP and get involved. Your help is needed and vital to preserving and protecting quality medical care for persons with psychiatric illnesses in Texas.

Chapter Political Action Coordinators

Austin Chapter . . . . . Emilie Becker, MD
Bexar County Chapter . . . . . Linda Rhodes, MD
Brazos Valley Chapter . . . . . Joseph Castiglioni, MD
Corpus Christi Chapter . . . . . Raul Capitaine, MD
East Texas Chapter . . . . . Joseph Arisco, MD
Paul Wick, MD
El Paso Chapter . . . . . Gerardo Gregory, MD
Galveston-Jefferson Chapter . . . . . Grace Jameson, MD
Heart of Texas Chapter . . . . . Suresh Durgam, MD
Houston Chapter . . . . . George Santos, MD
Jacquie McGregor, MD
Lone Star Chapter . . . . . Clay Sawyer, MD
North Texas Chapter . . . . . Bill Lynch, MD
Nicole Cooper, MD
Red River Chapter . . . . . Joseph Black, MD
South Texas Chapter . . . . . Jose Igoa, MD
Tarrant Chapter . . . . . Edward Furber, MD
Victoria Chapter . . . . . George Constant, MD
Wayne Goff, MD
West Texas Chapter . . . . . Lynda Parker, MD
Shirley Marks, MD
Ralph Hodges, MD

Register Now

TSPP Leadership Retreat

Take a break and bring your family to TSPPs 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 TSPPs 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 reception hosted by TSPP.

On Sunday morning, TSPP members will meet and participate in briefings on TSPPs Political Action Task Force and various organizational projects.

The Resort is family-friendly, featuring: a 4-acre water park with two pools, waterfall, sundeck and a 950 foot Ramblin 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 TSPPs 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

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:_____

Please Print Name As You Would Like It To Appear on Name Badge

Guests/Family: _____

Please Print Name(s)

Your Preferred Mailing Address: _____

Daytime Telephone #_____ 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
Coalition Legislative Priorities
Luncheon Presentation by a State Legislator
$45.00 Per Member *$25.00 Per MIT Member*

☐ Coalition Reception, August 3, 6:30 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

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 _____

Name As It Appears on Card _____

Signature *(Required for Credit Card Charge)* _____

CANCELLATION POLICY: In the event of cancellation, a full refund will be made if **written notice is received in the TSPP office by July 24, 2002, less a 25% handling charge. No refunds will be given after July 24, 2002.**

REGISTRATION DEADLINE JULY 24, 2002

Return to: TSPP, 401 West 15th Street, Suite #675, Austin, TX 78701
(512) 478-0605 ★ FAX (512) 478-5223 ★ E-Mail: TSPPofc@aol.com

Texas Society of Psychiatric Physicians
Annual Convention and Scientific Program

NEW FRONTIERS IN PSYCHIATRY

November 15-17, 2002 • Worthington Hotel, Fort Worth, Texas
Room Reservations: $135.00 Single/Double Room Rate
817-870-1000

DAILY SCHEDULE

Friday, November 15, 2002

8:00 am-8:00 pm	Registration and Information
9:00 am-5:00 pm	TSPP Committee Meetings
12:00 pm-1:00 pm	Membership Luncheon
6:00 pm-7:30 pm	Reception with Exhibitors
7:30 pm	Free Evening in Fort Worth

Saturday, November 16, 2002

7:00 am-7:00 pm	Registration and Information
7:00 am-8:00 am	Continental Breakfast w/Exhibitors
8:45 am-5:00 pm	Scientific Program
12:15 pm - 2:00 pm	Annual Business Luncheon
5:00 pm-6:30 pm	Executive Council Mtg
6:30 pm	Awards Banquet Reception
7:00 pm	Annual Awards Banquet

Sunday, November 17, 2002

8:00 am	Continental Breakfast
8:00 am-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, 401 West 15th Street, Suite #675, Austin, Texas 78701 by October 26 to receive 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.**

If you require any special assistance to fully participate in this conference, please contact TSPP at (512) 478-0605.

SCIENTIFIC PROGRAM SCHEDULE

Saturday, November 16, 2002 (6 Hours Category I Credit)

8:45-9:00 am	**Scientific Program Welcome**
9:00-10:00 am	**Psychiatric Drug Development and the Human Genome Project: What is the Connection and the Implications?** Sheldon H. Preskorn, M.D. Psychiatric Research Institute Wichita, Kansas
10:00-11:00 am	**Vagus Nerve Stimulation (VNS)** A. John Rush, M.D. Cole Giller, M.D., Ph.D. UT Southwestern, Dallas, Texas
11:00-11:15 am	**Refreshment Break**
11:15am-12:15pm	**Treatments for Alzheimer's Disease A Research Update** Kevin F. Gray, M.D. Dallas VA Medical Center, Dallas, Texas
12:15 pm-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. Scarano, 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 Houston, Houston, Texas

Sunday, November 17, 2002 (4 Hours Category I Credit)

8:00–9:00 am	**Resident Paper Competition Presentation** Speaker 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 Switching Antipsychotics** Manuel Montes de Oca, M.D. Stony Point, New York
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

TSPP 2002 Registration

NAME PHONE

ADDRESS

CITY STATE ZIP

NAME(S) SPOUSE/GUEST(S) ATTENDING (for name badges)

Indicate the NUMBER of individuals who are registered for each event in the appropriate enrollment category listed below. Please note the enrollment fees are PER PERSON and your payment should reflect the proper fee for the number of individuals registered per event.

		Before 10/26	After 10/26
WELCOME RECEPTION - Friday Evening			
#☐	NOT Registered for Scientific Program	$40	$50
#☐	Registered for Scientific Program TSPP Members/Non-Members/ Spouse/Guest	No Chg	No Chg
SCIENTIFIC PROGRAM - Saturday and Sunday			
#☐	TSPP Member	$180	$220
#☐	TSPP MIT/Medical Student	$ 25	$ 35
#☐	Non-Member	$225	$275
#☐	Non-Member MIT/Medical Student	$35	$50
#☐	Allied Health Professional	$ 95	$120
#☐	Spouse	$ 95	$120
LUNCHEON PROGRAM			
#☐	Annual Business Meeting and Luncheon – Saturday	$15	$20
AWARDS PROGRAM - Saturday Evening			
#☐	Awards Presentations/Banquet	$25	$35

TOTAL REGISTRATION FEE ENCLOSED ☐

METHOD OF PAYMENT
Make checks payable to "Texas Society of Psychiatric Physicians"

Method of Payment ☐ **Check** ☐ **VISA** ☐ **MasterCard**

CREDIT CARD # EXP. DATE

CARDHOLDER (AS IT APPEARS ON CARD) SIGNATURE

CARD BILLING ADDRESS CITY STATE ZIP

Return to: TSPP • 401 West 15th Street, Suite #675
Austin, TX 78701 • (512) 478-0605 • FAX (512) 478-5223

MITs Do Make a Difference

Jacqueline C. McGregor, MD, Chair, MIT Section

Looking back over the past almost five years, I am both happy and sad that my tenure as a member-in-training (MIT) is coming to a close. I became a member of TSPP like most residents by filling out an application for membership to the APA. At the time I was not entirely clear what dual membership status meant. Soon I started to receive newsletters and mailings from TSPP; I kept getting confused about what the initials stood for. What could a resident have to contribute anyway? At first I used all of the same reasons that most residents have for not participating in organized psychiatry. I did not understand what organized psychiatry was in the first place; I was too busy; I could not afford the travel expenses; I was worried about going to meetings where I would not know anyone; I did not think that a resident could make a difference.

My introduction to TSPP came when a group of residents from my adult training program wanted to arrange a field trip during the 1999 Legislative Session. We called John Bush and asked for his assistance. He didn't just help us; he and Debbie Sundberg did all of the work. Essentially, all we had to do was show up. Mr. Bush personally gave us an orientation on the important issues that session, set up meetings, and had us attend committee hearings. It was quite an experience and I left Austin motivated to be more involved.

As a PGY 2, I became the MIT representative from my training program and tentatively began attending meetings. I was surprised to find out how easy it really was. General members came up and introduced themselves. John Bush and Debbie Sundberg made a point of checking in with residents. As a resident representative I was included in the Executive Council meetings and quickly became engaged in the workings and issues of TSPP. Some of these included maintaining ECT as a treatment option, gaining funding for new generation antipsychotics, establishing mental health parity, maintaining patient privacy, and preventing psychologist prescribing.

For the past two years, I have been the chair of the MIT Section. The committee has continued to struggle with trying to get residents more involved in TSPP. We surveyed residents to find out what was standing in their way and as a result established a TSPP MIT listserve to increase communication. I hope that residents will continue to try and overcome the obstacles because it is well worth it. It is the responsibility of each psychiatrist in this state — even resident psychiatrists — to advocate for our patients and our profession. We are the future of this organization.

I feel fortunate to have had this opportunity to be a TSPP member-in-training. Before I started working on this piece, I had not considered the significance of the words "member-in-training." It certainly never seemed like a second-class membership. I have worked on committees, participated at leadership retreats, and voted at Executive Council meetings. I have made acquaintances with residents and psychiatrists across the state; some I now count as friends and mentors. This time has been good preparation for general membership. Being involved as an MIT has given me an important perspective that I will carry with me. Looking forward, I know that my association with TSPP is just beginning.

JACQUELINE C. MCGREGOR, MD

Rep. Garnet Coleman Honored

Members of the TSPP Houston Chapter, along with other medical colleagues, recently hosted a reception given in honor of Representative Garnet Coleman of Houston. Representative Coleman has been a champion for mental health issues in the Texas Legislature. (Left to right, Spencer Bayles, MD, David Axelrad, MD, Representative Garnet Coleman, George Santos, MD, and James Lomax, MD).

CALENDAR OF MEETINGS

MAY

18-23 **APA Annual Convention**
Philadelphia, PA

AUGUST

3-4 **TSPP Summer Leadership Retreat**
Hyatt Regency Hill Country Resort, San Antonio, Texas
Program Contact: Debbie Sundberg, 512/478-0605
Hotel reservations: 800/233-1234

NOVEMBER

15-17 **TSPP Annual Convention and Scientific Program**
"New Frontiers in Psychiatry"
Worthington Hotel, Fort Worth, Texas
Program Contact: Debbie Sundberg, 512/478-0605
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

Scientific Program Contributors

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 Worthington Hotel in Fort Worth on November 15-17.

Platinum ($6,000 +)
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