Texas Society of Psychiatric Physicians
NEWSLETTER

JUNE / JULY 2002

Parents Beware of New Mexico

Karen Dineen 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.

The law 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.

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 law states that psychologists must receive didactics and supervised clinical experiences. Before drawing conclusions about the adequacy of this training to treat children with psychiatric disorders, let's take a closer look at the provisions of HB 170, which will go into effect on July 1.

What is the definition of a psychotropic medication in this law? A psychotropic medication includes medication as well as controlled substances (Schedules I through V) that require a prescription and whose primary indication is for the treatment of mental disorders.

Which psychologists will be eligible to prescribe psychotropic medications to children? Those psychologists who have completed a doctoral program in psychology and hold a current license to practice psychology in New Mexico are eligible.

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 details about this training 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 practica 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 privileges? There are two types of prescription certificates: a conditional prescription certificate and a prescription certificate.

The conditional prescription certificate is granted after completing the afore mentioned 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 relieve 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 psychological examiners 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 practica 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. Nowhere in the law are there any requirements for didactics or for 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 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. I urge you to support TSPP to prevent Texas from allowing psychologists to prescribe psychotropic medication. It is also important to alert your legislators of this situation.

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Reference:

House Bill 170 (2002), An Act Relating to Psychologists; Granting Prescriptive Authority to Certain Psychologists; Providing Qualifications and Limitations; Requiring Malpractice Insurance. 45th Legislature. State of New Mexico.

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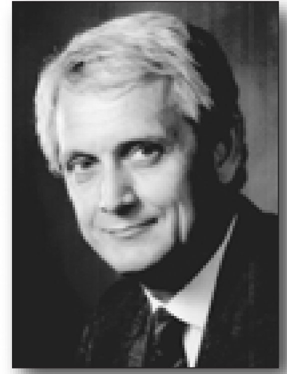
PRESIDENT'S MESSAGE



R. SANFORD KISER, MD

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 clang together as I later read the bill itself. There, prescriptive authority was granted based upon scanty classroom and clinical work, little supervision, and virtually random access to medical resources. Naivety of the most lethal and pernicious type lay hidden 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. What was behind my strange combination of disparate thoughts? In the best psychoanalytic tradition, I set out to explore the basis of this strange duo.

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 benign ignorance, rather than having 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;
Drink deep or taste not the Pierian spring.
There shallow draughts intoxicate 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 knowledgeable about intoxication and sobering up again.

Pope lived in an age in which the glories of classical Greece and Rome culture were being "rediscovered" 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, anyone desiring inspiration for their endeavors could supposedly travel to Pieria, a region in ancient Macedonia. There, at the foot of Mount Olympus, was a sacred fount, whose spring was the home of the nine Muses — goddesses who were the offspring of Zeus and the goddess of memory, Mnemosyne. The Muses were held 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, mysterious, far-off fount of inspiration to partake of its waters of knowledge, then full and deep drinks ("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 requirement 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 will inevitably result 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 re-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 Mouse, the Sorcerer's Apprentice	*The Parallel Plot of Mickey Mouse, the 400 Hour Prescribing Sorcerer*
Mickey, hauling buckets of water into the house basin, looks across the room in fascination as his boss, the Sorcerer, waves his arms to transform misty clouds into scary bats, then into beautiful butterflies.	*Magic does look so easy from a distance. (By the way, could Mickey be bringing this water from the Pierian spring?)*
The Sorcerer becomes sleepy, and sets his hat on the table before retiring for the night.	*Carelessness and lack of vigilance is dangerous for those entrusted with responsibility and authority. (The medical community?)*
Mickey tries the hat on. It feels great. With the power of the magic hat, he finds he can wiggle his fingers and wave his arms to induce the broom to come to life, sprout arms, and pick up the water buckets.	*It does seem so very cool to dispense pills with the wave of a pen. It looks easy and straightforward.*
Mickey shows the broom how to haul 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.	*A small sip from the Pierian pool will get you intoxicated, and make you believe that all your troubles are now all over.*
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.	*Treating patients with pills is a piece of cake. Give them the prescription, and the hard part is all over. Just sit back and take it easy after that.*
Mickey finds this whole affair so easy that he gets relaxed and drowsy. He falls asleep.	*Medication prescribing is so very, very easy that you can totally relax. You don't really have to pay much attention to the other things going on in your patient's life or psyche.*
Mickey dreams that he is a great sorcerer, standing on a giant stone pinnacle. With his new-found power, he orchestrates the stars into a splendiferous display of fireworks, the clouds into a gorgeous cascade of thunderstorms, and the ocean into massive waves of power.	*Freud would have had a field day with the material in this scene, but we need to get back to a summary of the theme at hand: PIERIAN INTOXICATION !!*
Unfortunately, the waves of power awaken Mickey as they turn out to be actual waves from the gigantic mess of a flood created by the unattended, out-of-control broom filling up the basement with the water it has been hauling.	*Crashing back to reality can be a terrible thing. With water this deep, Mickey may have to take some big gulps of the Pierian spring he has unexpectedly fallen into, before he can get sober up enough to get a grip on things. (Alexander Pope would have loved this cartoon!)*
As Mickey frantically tries to stop the broom, it disregards his best efforts. The broom is so disrespectful of Mickey, its creator, that it even sweeps him into its bucket as it tosses him and the rest of the bucket contents into the basin.	*The dang problem with a drug molecule is that, in real life, it is a three-dimensional structure, whose stereochemistry determines critical features of its physical chemistry, which in turn establishes its fit, affinity, and potency at multiple receptor sites throughout the body. That boring, but critical fact produces effects and side effects in virtually every body organ system in the body. Unfortunately their physiology and pathology were not covered in the 400-hour course. (Things that Mickey initially disregarded or trivialized are starting to get out of control and look scary. He and his fantasies of sorcerizing are not getting proper respect from reality. Waking up to a Pierian spring this deep is no fun at all).*
In desperation, Mickey tries to solve the problem by destroying his creation. He gets an axe and chops the broom into smithereens.	*Backing out of a bad pharmacological problem can be a real nightmare. 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 withdrawal is his only way out, which unfortunately destroys the intended beneficiary of his magic.*

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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 problems and psychiatric treatment for recurrent episodes of postpartum depression.

In her subsequent trial from February 14, 2002, until March 12, 2002, the jury was provided psychiatric testimony that the patient also had a diagnosis of schizophrenia. In the trial, a clinical psychologist provided psychological test data supporting a diagnosis of schizophrenia. The jury heard testimony that the patient was delusional. Despite these delusions, 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.

Over the course of her 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 psychiatrists. The "battle of the experts" has created significant controversy throughout the country.

Andrea Yates was found to be sane at the conclusion of her trial following a three-hour deliberation. In the penalty phase, the jury also underwent a short deliberation leading to a sentence of life without parole. The sanity verdict created significant controversy, both in Texas and throughout the country, because of the limited nature of the M'Naghten standard in Texas.

The insanity defense in Texas is found in Section 801 of the Texas Penal Code:

A. It is an affirmative defense to prosecution that, at the time of the conduct charged, the actor, as a result of severe mental disease or defect, did not know that his conduct was wrong.

B. The term "mental disease or defect" does not include an abnormality manifested by repeated criminal or otherwise antisocial conduct.

This standard, the M'Naghten Standard, originated in England when it was promulgated by the judges in the House of Lords in 1843 following a request by Queen 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 secretary had been killed in an attempt to assassinate 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 created by the House of Lords.

It is important to clarify that this standard was initially utilized in most jurisdictions in the United States until the 1950s, when the American Law Institute formulated the Model Penal Code, which did include a new test for insanity (the ALI test), which significantly modified the M'Naghten Standard previously utilized in most jurisdictions in the United States. The ALI test was the standard at the time of the attempted assassination of President Ronald Reagan by John Hinkley. The insanity standard at the time of the Hinkley trial in 1982 was the following: "A person is not responsible for criminal conduct if at the time of such conduct as a result of mental disease or defect he lacks substantial capacity either to appreciate the criminality of his conduct or to conform his conduct to the requirements of law." It is to be noted that, prior to the trial of John Hinkley, 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 at that time was:

(A) It is an affirmative defense to prosecution that, at the time of the conduct charged, the actor, as a result of mental disease or defect, either did not know that his conduct was wrong, or was incapable of conforming his conduct to the requirements of the law he allegedly violated.

(B) The term "mental defect" does not include an abnormality manifested by repeated criminal or otherwise antisocial conduct.

Following the Hinkley trial, the State of Texas dropped the volitional element in the insanity test, leaving the State of Texas with the more restrictive cognitive standard contained in the M'Naghten standard, requiring the jury to base its findings solely on the defendant's capacity to distinguish right from wrong.

In contrast to the more restrictive standard in Texas, Congress passed the Insanity Defense Reform Act in 1984, establishing a new Federal insanity defense. The relevant committees in Congress heard testimony from the American Psychiatric Association and other mental health organizations. The Federal insanity defense incorporated in the Insanity Defense Reform Act is as follows:

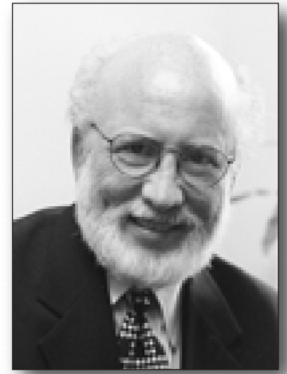
> A defendant is not responsible for criminal conduct if as a result of severe mental disease or defect he is unable to appreciate the nature and qualityor the criminality or wrongfulness of his acts.

Further, Congress also modified the Federal standard to provide for the defendant to have the burden to prove his insanity by a preponderance of the evidence. This same burden of proof exists in the current insanity defense in Texas.

The Texas Alliance for the Mentally Ill (TEXAMI), as well as other mental health organizations, have provided opinions regarding the need to modify and change the Texas state standard. Representative Garnet Coleman, a past recipient of the TSPP Special Services Award and the Jacob Javits Award from the APA, has publicly stated that he will be introducing a bill, refining and liberalizing the insanity defense statute in Texas, in the upcoming session of the Texas Legislature. In a personal communication with me, Representative Coleman also indicated that he had an interest in the involvement of both TSPP and other psychiatric organizations in this process.

It is important to clarify that at the present time the State is involved in the study of both competency and insanity as a result of the passage of Senate Bill 553, authored by Senator Robert Duncan. This bill did create an interim task force which will be providing a report to the Legislature in the upcoming session. TSPP has been actively involved in this process, and the task force does include the following TSPP members: Joseph Black, MD, Victor Scarrano, MD, Ross Taylor, MD, and George Trapp, MD.

In the most recent TSPP meeting, on April 20 and 21, 2002, both the Forensic Psychiatry Committee and the Government Affairs Committee of TSPP discussed fully major concerns regarding insanity that have been forwarded to TSPP by Texas psychiatrists and other mental health organizations in Texas.



A. DAVID AXELRAD, MD

The Executive Council of TSPP approved a proposal by the Forensic Psychiatry Committee to convene a State Conference in the Fall of this year. This educational conference would include nationally recognized authorities in both forensic psychiatry and criminal law. The presenters will provide both technical and scholarly reports regarding insanity. Numerous points of view will be addressed by the invited speakers. The invitational conference will be open to psychiatrists, attorneys, public policy makers, and the public. The conference will be educational in nature and broad in scope. TSPP will invite other State organizations, including the Texas Association for County and District Attorneys, the Texas Association of Criminal Defense Attorneys, the Texas Trial Lawyers Association, and the Texas Bar to participate in both the planning and financial support of the conference. In the recent meeting of the Board of Directors of the Texas Foundation for Psychiatric Education and Research on April 20, 2002, the Foundation approved a grant to help support this planned statewide invitational conference.

The Executive Council also approved an action item establishing two task forces: one to plan the conference and a second to develop a policy concerning insanity for TSPP. Representatives of the Forensic Psychiatry Committee, Government Affairs Committee, and Public Mental Health Services Committee will participate in the task force leading to the development of a TSPP policy concerning insanity which will be presented to the TSPP Executive Committee for approval by the first week in August 2002. In view of the actions of the TSPP Executive Council, TSPP will play an important educational role in assisting the public policy makers of the State of Texas as they address this most complicated area of insanity reform.

President's Message — Mickey Mouse, Fantasia, and the Prescribing of Medications continued from page 2

Mickey Mouse, the Sorcerer's Apprentice	*The Parallel Plot of Mickey Mouse, the 400 Hour Prescribing Sorcerer*
As Mickey leaves the room and breathes a sigh of relief, each broom splinter comes back to life, reconstitutes itself into a whole broom, and starts hauling more water. The flood, which was bad enough to begin with, now becomes immense.	*Medication side-effects and drug-drug interactions have a bad habit of compounding themselves, one upon the other, until the prescriber and the patient can find themselves in deep do-do (in this case, water). The stupid drugs also refuse to stay put in the intended target organ. Instead they get out of control and circulate throughout the entire extent of the 60,000-mile long circulatory system. That pathway courses throughout places completely irrelevant to the treatment at hand – places such as the integumentary, lymphatic, immune, reproductive, musculoskeletal, cardiovascular, respiratory, nervous, endocrine, digestive, and urinary systems. A 400-hour prescribing sorcerer doesn't need to know all that stuff – it's too medical.*
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 possible salvation – the sorcerer's Book of Magic! He scrambles on board to use it as a life raft, and he frantically flips through its pages, trying to find a last-minute way out of this mess.	*Don't you think it's a little bit too late to start really learning about how to do this prescribing stuff? Besides, it won't work, because the book is filled with worthless mumbo-jumbo, such as "medication receptor mechanisms produce actions based upon the hydrophilic/hydrophobic characteristics of the drug molecule, which in turn influence whether the medication acts at receptor sites which are intracellular, channel-linked, catalytic, G-protein linked, or on the cell surface." All Mickey really wants to do is write impressive prescriptions quickly and exit from this chaos. Who needs this superfluous molecular biology junk?*
The sorcerer awakens and comes downstairs to survey the havoc his assistant has created. He is able to dispel the flood.	*Fortunately, in this case, the responsible and knowledgeable authority awoke in time to save the situation. What will happen in real life if the medical community dozes too long?*
Mickey sheepishly returns the sorcerer's hat and returns to hauling water. As he turns to leave the room, the sorcerer splats him on his bottom with the broom.	*In real life, the 400-hour prescribing sorcerer will likely get more than a splat on the hinny as a response to his/her misadventures. Even now, the personal injury lawyers are probably licking their chops at the lawsuits that loom as their windfall profits from the adventures of Mickey Mouse, the 400 Hour Prescribing Sorcerer.*

An Assessment by Consumers Union

Independent Review Organizations

In 1997 the Texas Legislature created an independent 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 hold 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 individual medical needs, but reviewers do not approve care 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. We call this the "overturn rate." In all the overturned cases, consumers were able to get more care covered by their health plan.
- About 74% of the requests for review handled by the Independent Review Organizations (IROs) consistently concerned: a handful of contested prescription drugs (19 cases), surgical treatment for obesity (16 cases), mental illness (46 cases), substance abuse (54 cases), and the number of days (if any) required for hospital care for physical illness (60 cases).
- HMOs consistently deny and are overturned on the same issues-mental illness treatment, gastric bypass for obesity, and substance abuse treatment. This raises concerns about HMOs' practices with respect to these conditions, especially when there are clear guidelines that indicate how an IRO will decide.
- Mental health and substance abuse treatment constitute only 8% of the nation's medical care costs, and private insurance only pays 27% of the price. Yet, these conditions together accounted for 38% of care denials sent for independent review in our sample. Mental health treatment denials were overturned much more frequently than the general overturn rate (70 percent overturned or partially overturned).
- Independent reviewers only rarely overturned an HMO's decision not to pay for certain drugs. For the most part, reviewers supported alternatives proposed by the plan.
- Envoy and Independent Review, Inc. (IR) overturned HMO denials more frequently than Texas Medical Foundation (TMF). The variance could reflect material differences in approach to treatment worthy of additional investigation.
- Despite the strong likelihood of additional treatment, the number of reviews remains relatively small. Insurance companies make thousands of coverage decisions each week, yet only 587 cases were settled by independent review last year.

This may be because health plans are making better coverage decisions now that someone can take an independent look. The same statute that created independent review also authorized consumers to sue a health plan for care denials.

But the low level of use could be because few consumers have the time and energy to pursue independent review after a discouraging internal review process. (They must be denied twice before accessing an independent reviewer.) Other consumers (those covered by employer based ERISA plans) are not guaranteed access to the system at all. Federal changes to ERISA proposed in the Patient Protection Act would ensure that more consumers could get an unbiased look at their health plan's treatment decisions.

IROs: A Closer Look

Many decision-makers and interest groups, including the growing pharmaceutical industry, now intervene in the medical care delivery process. Consumers may be subject to medical judgement by their doctor, their health plan or Health Maintenance Organization (HMOs), and their Utilization Review Agent. Consumers also seek to make their own decisions and respond to advertising by drug companies.

Most of the decision-makers are subject to financial incentives. These include incentives to doctors to reduce referrals. Utilization review agents get paid to reduce over-utilization of services by denying treatments that are not "medically necessary." But overly aggressive denials may become a barrier to the care people really need.

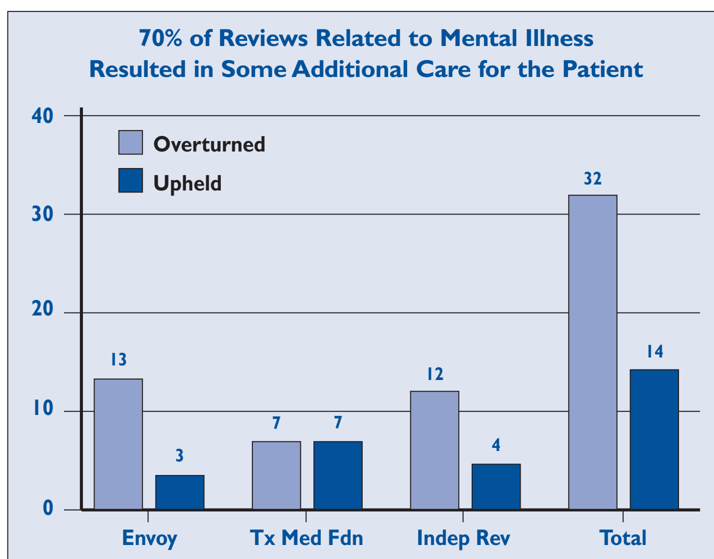
In 1997, the Texas Legislature made an effort to provide consumers a system to address this dilemma. The law developed a system of accountability for HMOs and health care professionals completely independent of financial incentives. The independent review process allows patients to question their HMOs' determinations and offers insight into doctors' decisions. Similar legislation is currently a topic of debate in Congress.

When a health plan denies access to care, the consumer must first appeal the decision to the HMO itself before seeking a ruling by an Independent Review Organization (IRO). A Utilization Review Agent (URA) will conduct an "internal review" and determine whether the original denial was valid. If the internal reviewer also denies care, the consumer may then request an independent review.

TDI assigns the case on a rotating basis to one of three independent review organizations in Texas and checks for any conflict of interest between the IRO and the insurer. The IRO then decides whether the HMO's original finding was appropriate. The IRO decision is binding.

Consumers Union Study

The Texas Department of Insurance (TDI) receives about 500 requests for independent review each year, and distributes them among three independent review organizations (IROs). Consumers Union analyzed every IRO decision completed during a six-month period, from March 22 through September 26, 2001. The sample (263 decisions) included all three review organizations and 63 health plans. We compared this time period to statistics maintained by TDI and found that the sample we used is representative of the kinds of disputes reviewed over the past five years.



With all identifying information about consumers and physicians removed, Consumers Union read the reviewer's narrative for every decision, categorized them by illness and procedure, and summarized the relevant medical issues in dispute. The amount of information varied. Some IRO decision letters offered great insight into the medical condition and the decision-making process, while others only included a few sentences with few details. Despite these limitations, Consumers Union could determine the key medical issues in most cases, as well as the standards used by IROs when evaluating these issues.

The "overturn rate" is the number of cases where treatment denials are overturned compared to the total sample. We use the term "partially overturned" for cases where the IRO agrees with the health plan on some issues but disagrees on others or where the IRO approves coverage for some additional treatment days but fewer than requested by the consumer.

General Findings

Five years after the law's passage, Consumers Union found that the independent review process is working for consumers. More than half of those who presented their case to an independent reviewer received some additional treatment (55 percent of denials were fully or partially overturned). This is a slightly higher rate than found in nationwide studies of independent review, and slightly lower than the overturn rate in Texas since inception of the system (59 percent overall).

About 74 percent of the requests for review handled by the IROs consistently concerned: a handful of contested prescription drugs (19 cases), surgical treatment for obesity (17 cases), mental illness (46 cases), substance abuse (54 cases), and the number of days (if any) required for hospital care for physical illness (60 cases). The remaining disputes involved a wide array of other treatments (including chiropractic, physical therapy, occupational therapy, durable medical equipment, experimental treatments, and miscellaneous surgeries) from which it was difficult to discern any patterns of care.

For some conditions with similar details — including mental health problems and severe obesity — IROs consistently overturned treatment denials. This raises concerns about HMOs' practices with respect to these conditions, especially when there are clear guidelines that indicate how an IRO will decide.

Mental health and substance abuse treatment constitute only 8 percent of the nation's medical care costs (and private health insurance pays very little of that cost). Yet, these conditions together accounted for 38 percent of care denials sent for independent review in our sample. Mental health treatments denials were 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 name brand drugs. For the most part, reviewers supported alternatives proposed by the health plan.

TDI is distributing the cases evenly among the reviewers as required by law, but Envoy and Independent Review, Inc. (IR) overturned HMO denials more frequently than Texas Medical Foundation (TMF) in our sample. Envoy and IR overturned 54 cases each, about a 62 percent overturn rate. TMF overturned only 36 of its 89 cases, an overturn rate of 40 percent. TMF is the oldest review company, but Envoy joined the system in February, 1998. TDI added IR in December, 1999.

Within certain condition categories, Envoy and IR overturned more health plan decisions than TMF. For example, of the 54 reviews dealing with substance abuse issues, Envoy reviewed 17 and overturned 13. IR, which looked at 21 of these, overturned 13. Of the 16 TMF reviewed, only six were overturned. These difference are only suggestive, however, because the number of cases in a specific treatment category is small, and the specific case histories differ. But the variance could reflcet material difference in approach to treatment worthy of additional investigation.

Finally, we find that the number of independent reviews remains low, although the system is now in its sixth year of operation. In 2001, consumers requested only 587 decisions. Since inception in November, 1997, IROs have conducted only 1,864 reviews.

This is consistent with national findings on the use of the available independent review systems around the country. A recent Kaiser study of the 41 states with independent review laws found that only about 4,000 patients appeal HMO treatment decisions each year nationwide.

People may get discouraged. A patient must be denied twice (an initial denial, then an internal review that upholds the first denial) before

accessing independent review. Moreover, the independent review process is no longer available for all denials.

In early 1999, TDI began sending letters to certain patients requesting independent review that "if the first time your health benefit plan performed a review of medical necessity or appropriateness was after health care was received, the IRO process is not available to you." TDI interpreted the statute to only cover "prospective" or "concurrent" 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 TDI determines which requests are appropriate to send on to independent review. Without the benefit of independent review, many people end up having to pay for care they believe should have been covered 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 encouraging more consumers to challenge their HMOs' decisions or making some structural 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

IROs frequently arrive at different conclusions than the HMOs concerning mental illness. Out of the 263 reviews studied, 46 involved treatment for mental illness. Eleven of the 46 cases all related to eating disorders. Of these 46, 32 (70 percent) were either fully or partially overturned. For the most part, the dispute centered on the duration of an inpatient or residential 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 come into play 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's denial of continued inpatient care. Lastly, a few decisions were upheld simply because the patients' 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 inadequate 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 undergone many medicine changes within a short time period, were lethargic, confused, violent, or showed no interest in committing to an unsupervised situation, the IROs overturned all or part of the HMOs' denials.

BCBS denied residential treatment for an adolescent female with an IQ of 64 who had assaulted her 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 unfortunate that "the insurance that covered her hospitalization conveyed to me that, 'If she were healthy enough to go on a pass, then she was healthy enough to be discharged.'" The pass had enabled 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 treatment, partial hospitalization). TMF issued a decision 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 his mother and stepfather as they slept and then kill himself. TMF found that because the boy was so young, the HMO should have allowed a longer hospitalization. "It is a well known fact among child psychiatrists that children have more difficulty dealing with transitions than adults and need more preparation time for discharge," the reviewer concluded.

In another example, Private Healthcare Systems agreed to cover only four days of inpatient 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. An Envoy reviewer found that this patient could not be safely cared for at any other level than "acute inpatient care," and should not be transferred. Still in the hospital at the time of the review three weeks later, the reviewer felt that she should remain an inpatient until her physician was ready to move her.

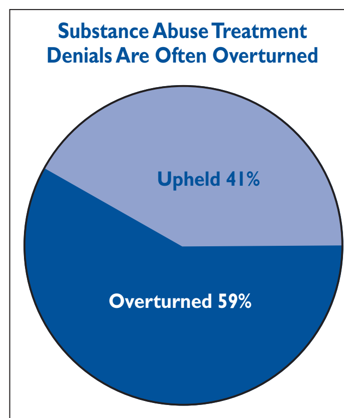
Patients covered by PacifiCare of Texas appealed five decisions related to mental illness. The IROs overturned three of the five. The reviewer upheld one of these because the psychiatrist did not provide enough information. All of the overturned cases involved records that the reviewers believed demonstrated 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 wanted her transferred to residential treatment two days later. The reviewer believed that her two unsuccessful prior admissions indicated that it was not safe to discharge her.

Some advocates for people with mental illness contend that managed care companies have gone too far in their efforts to wring 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 less treatment, but 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 independent review process.

Substance Abuse

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

Substance Abuse Treatment Denials Are Often Overturned



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-level of documentation, level of home support, level of patient commitment to drug treatment, years of drug addiction, and level of withdrawal-and frequently overturned HMO decisions for the most severe cases.

Of the 22 HMO decisions upheld by the IROs, some supported the HMOs' determinations 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.

On the other hand, reviewers approved additional treatment time (or a higher level of care) for patients with other complicating mental illness, those with a severe detoxification, and those with serious family conflicts at home. In some cases, we were surprised at how little inpatient treatment time a managed care company would provide for severe addictions. An alcoholic of 20 years with a history of depression entered the hospital for detoxification. After two days, he was discharged to finish his detoxification as an outpatient. The HMO denied coverage for the two days of inpatient care. The reviewer determined that his severe withdrawal symptoms warranted his two-day stay. Another patient with combined cocaine and alcohol dependence was granted only four days for inpatient detoxification, then moved. The reviewer noted his additional diagnoses of hypothyroidism and depression, and added another 5 days.

Reviewers overturned several denials because the patients had already been unsuccessful in outpatient treatment. For example, one patient addicted to multiple substances, complicated by chronic pain, entered inpatient detoxification. The HMO denied the care, and the reviewer overturned the decision because the patient's prior attempts to withdraw from opiates on an outpatient basis had failed. Inpatient detoxification was medically necessary.

At least 25 of the 54 substance abuse cases (46 percent) involved teenage abusers. About half these HMO decisions were overturned (13 of 25 or 58 percent). In most cases, the substance abuse was coupled with juvenile crime, running away, family conflict and other problems. In response, families most frequently requested residential treatment-programs designed to give the teens 24-hour supervision apart from other substance-abusing friends or family conflicts. Each of these cases presents a snapshot of a very troubled family seeking some kind of help that they believe is covered under their insurance-and not necessarily getting it.

These cases also illustrate the importance of a family advocate when faced with insurance denials for mental health and substancse abuse care. Parents, or some other advocate within the system, took the time to make sure their child got the care covered under the insurance plan (first asking for internal review, then for independent review). Individuals without strong family or other support may find this process difficult to navigate on their own.

The above are excerpts from a study of IROs performed by Consumers Union. For a copy of the complete report, visit Consumers Union website at www.consumersunion.org.

Congratulations...

Irvin M. Cohen, MD, Houston, was the recipient of the APA LIFERS organization's 2002 Harold E. Berson 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 APAs 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 TSPP 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.

Leadership Recommendations

The TSPP 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; and 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 published in the October/November Newsletter. Following the announcement, additional nominations may be submitted by individuals or Chapters in writing to TSPP or made during the TSPP Annual Business Meeting on November 16 in Fort Worth.

State of the Union and States

Mental Health Parity

Nicole Cooper, MD

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 erode 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 sunsetted in 2001. Two complementary 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. All apply to only a portion of the Americans with mental illness who need parity of care and access.

Like the 1996 act, the Domenici-Wellstone Mental Health Equitable Treatment Act of 2001 (S543) and the Roukema-Kennedy Mental Health Equitable Treatment Act of 2002 (HR 4066) apply only to federally regulated group health insurance plans or coverage for those plans if and while they offer mental health coverage, sold to businesses with 51 or more employees. The resolutions seek equal or comparable treatment for mental health as for so-called "medical and surgical" benefits. However, they do not overtly require such plans to have or retain mental health coverage. They do not address the adequacy of mental health delivery (quality of care) under the plan's managed care system but leave "medical necessity" criteria to the individual plan. Although both S543 and HR 4066 claim to cover all categories in the latest DSM, they do not include substance abuse and chemical dependency. The 1996 parity act requires equal lifetime and annual payment limits for mental and physical illnesses, if and while the plan provides mental health benefits. S543 and HR 4066 extend parity to include equality in deductibles, coinsurance, co-payments, cost-sharing and limits on the total amount that may be paid by a participant or beneficiary with respect to benefits under the plan or health insurance coverage. They seek equal limitations on frequency of treatment, number of visits or days of coverage.

Analagously, the Wellstone Fairness in Treatment: The Drug and Alcohol Addiction Recovery Act of 2001 (S595) applies to the same 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 contrast, 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 debilitated, 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 schizophrenia, 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 depression 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 ignorance about the place of mental illness in medicine and on the stigma of mental illness.

The insurance industry and business (along with traditional anti-psychiatry foes 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, playing to the fear of the business community, employees and legislators. S543 was derailed 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 passive-aggressively that patients receive suboptimal or little care. Parity does not ensure access. Patients ashamed of, or debilitated by mental illness may not pursue a complex, onerous appeal 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 noninsured 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 onerous 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. Worker 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 astutely and accurately reframed the issue as a civil rights, 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 the public realize 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 legislating 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.

TSPP Awards Banquet

The TSPP Past President's Council invites all members to attend the TSPP Awards Banquet to help honor the recipients of TSPPs Awards, scheduled for Saturday, November 16, 2002 at 7:00 pm at the Worthington Hotel in Fort Worth. A reception will precede the banquet beginning at 6:30 pm. Reservations for the Awards Banquet may be made by completing and returning the registration materials for the 2002 TSPP Annual Conference and Scientific Program, which will be in the mail soon. *Please plan to attend the TSPP Awards Banquet and help us honor these deserving individuals.*

TSPP Distinguished Service Award

ALEX K. MUNSON, MD

ROBERT L. ZAPALAC, MD

The **TSPP Distinguished Service Award**, established in 1975 to recognize individuals for sustained contributions to psychiatry, will be presented to **Alex K. Munson, MD** (Georgetown/ Lubbock), and **Robert L. Zapalac, MD** (Austin).

Former recipients of the award include Irvin M. Cohen, MD, Arlin Cooper, MD, Shannon Gwin, MD, Walter Reifslager, MD, William Langston, Jr., MD, Stuart Nemir, MD, Howard Crow, MD, Hunter Harris, MD, Spencer Bayles, MD, Frank Schuster, MD , Beverly Sutton, MD, Irvin Kraft, MD, Perry Talkington, MD, Jerry M. Lewis, MD, Pedro Ruiz, MD, W. Robert Beavers, MD, Thomas Paschal Clarke, MD, Victor J. Weiss, MD, T. Grady Baskin, MD, Robert Stubblefield, MD, James L. Knoll, III, MD, Grace K. Jameson, MD, Rege S. Stewart, MD, Harris M. Hauser, MD, William P. Moore, MD, Robert G. Denney, MD, Priscilla Ray, MD, Larry E. Tripp, MD, Tracy R. Gordy, MD, Paul H. Wick, MD, and Robert L. Williams, MD.

TSPP Special Service Award

THE HONORABLE MIKE MONCRIEF

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 E. Ivan Bruce, MD, Holland Mitchell, MD, James Peden, MD, James Black, MD, Frankie Williams, MD, Dennis Jones, Helen Trammell Carlton, Pete Palasota, MD, Agnes V. Whitley, MD, Helen Jacobson, Miriam Feaster, Byron L. Howard, MD, Jacqueline Shannon, Earl Campbell, Kathy Cronkite, Norma Henry, Anne R. Race, MD, and Joel S. Feiner, MD, Jules H. Bohnn, MD, Hal H. Haralson, Joe Lovelace, Peter A. Olsson, MD, James Swinney, The Hon. Garnet F. Coleman, Roy Fanoni, MD, David M. Keedy, MD, Steven B. Schnee, PhD, Adib R. Mikhail, MD and Jane Preston, MD.

TSPP Psychiatric Excellence Award

EDWARD S. FURBER, MD

MARGO K. RESTREPO, MD

MADHUKAR TRIVEDI, 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 **Madhukar Trivedi, MD** (Dallas).

Former recipients of the award include Betsy Comstock, MD, Dorothy Cato, MD, James W. Maas, MD, Robert L. Leon, MD , Harlan Crank, MD, Joseph Schoolar, MD, A. John Rush, MD, Kenneth Z. Altshuler, MD, KD Charalampous, MD, Donald R. Seidel, MD , Charles L. Bowden, MD,, Charles M. Gaitz, MD, Myron F. Weiner, MD, William E. Fann, MD, Edward L. Reilly, MD, David A. Waller, MD, Robert W. Guynn, MD, Keith H. Johansen, MD, James W. Lomax, MD, George A. Constant, MD, Ignacio Magana, MD, Mohsen Mirabi, MD, John Sadler, MD, and Roy V. Varner, MD.

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 Wortington Hotel in Fort Worth on November 15-17.

PLATINUM

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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

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	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
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#☐ Spouse	$ 95	$120
LUNCHEON PROGRAM		
#☐ Annual Business Meeting and Luncheon – Saturday	$15	$20
AWARDS PROGRAM - Saturday Evening		
#☐ Awards Presentations/Banquet	$25	$35

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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

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, 512/478-0605
Hotel reservations: 800/233-1234

OCTOBER

30-Nov 2 **38th Annual State Conference**
Learning Disabilities Association of Texas
Renaissance Austin Hotel, Austin, Texas
Contact: Registration 512/458-8234

NOVEMBER

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

TSPP MEMBER INFORMATION UPDATE

NAME ____________________

ADDRESS ____________________

CITY ________ STATE ____ ZIP ____

( ) TELEPHONE ______ ( ) FAX ______ E-MAIL ______

Send your update information to:

TEXAS SOCIETY OF PSYCHIATRIC PHYSICIANS
401 West 15th Street, Suite 675
Austin, Texas 78701
512/478-5223 (fax)/TSPPofc@aol.com (E-mail)

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 publication is determined on a case by case basis by the Editorial Board. The Editorial Board reserves the sole right to accept or reject any submitted advertising copy.

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