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TSPP President's Message

It Takes a Physician . . . .

"Businessmen go down with their businesses because they like the old way so well they cannot bring themselves to change. One sees them all about–men who do not know that yesterday is past, and who woke up this morning with their last year's ideas." — **Henry Ford**

Members of TSPP recently received letters and enclosures from Michelle Riba, MD, APA President, and James Nininger, MD, Speaker of the APA Assembly. The letters were written in regard to the "future of organized psychiatry" in Texas, and the concerns of the APA Board of Trustees regarding the restructuring of organized psychiatry in Texas. The enclosures were copies of a letter written to the TSPP Executive Council.

These letters were written without knowledge of the facts regarding the restructuring. Neither of the signatories contacted me or any other member of the Executive Council to let us know of their concerns prior to sending these letters. Over the past few months, TSPP submitted written responses to two inquiries from Marcia Goin, MD, appointed by the APA Board to "oversee" TSPP. TSPP received absolutely no response from APA leadership, positive or negative, regarding any concerns of any kind. I will reiterate the facts, of which TSPP members are already aware.

TSPP did not establish the new Texas Academy of Psychiatry. The Academy is a completely separate, non-profit corporation established under Texas corporate law with its own structure, its own governance, and its own finances. In no way is the Academy a "subsidiary" of TSPP. Last year, TSPP desired to establish an affiliates' program, a membership-driven attempt to reach out to unrepresented Texas psychiatrists so as to allow them a voice in Texas psychiatry. APA threatened TSPP with dissociation as a District Branch of the APA unless we gave up this idea. We were informed, however, that we could allow it to be implemented instead as a separate entity–a corporation over which TSPP would have no control and which would therefore be beyond the purview of both TSPP and the APA. This is exactly what has occurred. TSPP was assured at our April Executive Council meeting by then-APA President Marcia Goin, MD, and our Area V Trustee, Jack Bonner, MD, that this solution would cause no conflict with APA. The solution itself was originally proposed by then-APA Assembly Speaker Prakash Desai, MD, and TSPP embraced it as the "Desai Plan."

The nature of the Texas Legislature (e.g., large membership numbers are necessary to have clout, and an organization's message must be simple, to-the-point, and capable of discourse in a very short period of time) must be taken into account in any dealings with that august body. A number of different psychiatric organizations now exist in Texas (TSPP, the Academy, the child and adolescent/forensic/geriatric organizations, the Texas Foundation for Psychiatric Education and Research, to name a few), and all have important issues deserving of legislative representation and legislative advocacy. **The Federation of Texas Psychiatry emerged as an umbrella organization for all of these professional entities so as to more effectively represent psychiatry's interests to the state legislature.** TSPP was the first to apply for membership, and we are the first to have been accepted. We hope that the other organizations (including the Academy) will also join, if they have not already done so. Individuals do not "join" the Federation, only organizations. Each professional organization will send a number of delegates to a Federation Assembly which will elect its own officers, which will develop policy with the input and influence of all of its member societies, and which will then serve as the single voice of Texas psychiatry to the legislature in the same effective way for which TSPP has always been recognized.

As with any Texas corporation, each member society is free to choose to administer itself or to choose to contract with an administrative entity. The Federation offers administrative services, and TSPP has chosen to contract with the Federation for these services. The administrative staff of the Federation will only provide administrative services to its member organizations. Most importantly, the Federation will not "mingle" the financial resources of these societies, and will not determine policy for its member entities.

None of these developments would have been necessary if APA had recognized **the major problem continually identified in multiple surveys behind the chronic loss of TSPP members: APA dues**. This problem makes the dual membership requirement (i.e., that members of TSPP must also be members of APA) financially untenable for many Texas psychiatrists. The major changes in APA's malpractice insurance program from the mid-1990s means that high APA dues are no longer an acceptable buy-in to a major member benefit that is itself no longer as valuable. **APA's dues are among the highest of the professional medical associations, yet income for psychiatrists is among the lowest of all specialties and continues to drop.** Ten years ago, over 85% of TSPP members insured themselves through the APA-associated malpractice insurance program. Today, only about 15% do so.

In the letters, the APA listed among its benefits the ability to save a District Branch money by acting as a central collecting agent for all dues. TSPP took part in that arrangement until three years ago, when we discovered that our members were paying their TSPP dues and APA dues to APA, but much of the TSPP dues money was not being returned to TSPP. We have collected our own dues since that time, an option which is open to any District Branch. The major increase we immediately experienced in cash flow has itself been of tremendous benefit. Dues income is the lifeblood of any District Branch — for TSPP, this income comprises 70-80% of our annual budget. In contrast, dues income accounts for only 16-18% of APA's annual budget.

The new Federation stands to save even more scarce TSPP resources by spreading administrative costs among several professional societies instead of TSPP bearing these costs alone. For this reason, former TSPP Executive Director John Bush and former TSPP Assistant Director Debbie Sundberg are now employed by the Federation, and, as previously noted, TSPP has chosen to contract with the Federation for administrative functions. **Any District Branch of the APA has the right to contract with whomever it wishes for these functions.** As an example, the Washington State Psychiatric Society recently entered into a new contract with an administrative firm, a contract which caused no concern with APA — even though this firm has no experience in administering a medical society. TSPP chose instead to contract with an experienced team which has already proven its effectiveness, and its integrity, countless times.

The APA Board listed other concerns in their letters which also have no basis in fact. Over the years, TSPP leaders have tried valiantly to work with the APA to find **new** alternative solutions to shared problems. All of these new alternatives were advanced by TSPP (including a dues reduction to $100.-$150./yr for APA dues) and all were rejected by APA. APA's suggestions included only those which have already been tried by all District Branches (we are not alone in this situation!). These solutions have failed not only to attract new members, but also have failed to retain current members. Now, TSPP has been threatened yet again with dissociation from APA, **this time for doing exactly as APA suggested**. This threat, and other slanderous and libelous accusations, distract us all from the much more important work at hand (including, but certainly not limited to, the work of ensuring that Texans are not prescribed medications by non-physicians, that the Texas Medical Practice Act be rewritten fairly and meaningfully, that the continued downward trend in public mental health spending be reversed, that the State Board of Medical Examiners be reformed so that Texas physicians are ensured due process, that the recent decimation of public health/public mental health state services be effectively addressed, that scientologist-inspired legislative initiatives are defeated, and many others). **We cannot allow this divisive effort on the part of the APA Board to lead to any legislative defeats in Texas!**

J. Clay Sawyer, MD, DFAPA
President, TSPP

I agree fully with APA's position that we need a strong national voice, and I intend to always be a member of the APA in support of working toward that end. However, the APA Board must be honest with itself about the true source of its problems, and these problems cannot be allowed to decimate any of its 70+ District Branches (of which TSPP is the fourth largest). Reality dictates that the APA cannot be everywhere at once. **All politics is local — only strong District Branches can fully and effectively advocate with state and local legislative bodies.** TSPP cannot allow what happened in New Mexico and in Louisiana to happen in Texas, but we cannot assure that premise if we represent only a minority of the psychiatrists in Texas. Currently, only 48% of all psychiatrists in Texas belong to TSPP/APA. One year ago, that figure was 52%. (In contrast, 82% of all Texas physicians belong to the highly-effective and nationally-recognized Texas Medical Association.) The number of member psychiatrists in both TSPP and APA has dropped, with few exceptions, nearly every year for about a decade. During that time, the malpractice climate has certainly changed and has already been identified by members, former members, and never-members as the number one reason that high APA dues are no longer acceptable since the dues no longer serve as a buy-in to what was the best membership benefit APA was ever able to offer. **Other valuable APA benefits are certainly offered, but APA members in Texas and across the nation have been voting with their checkbooks as to the value they place on these benefits.**

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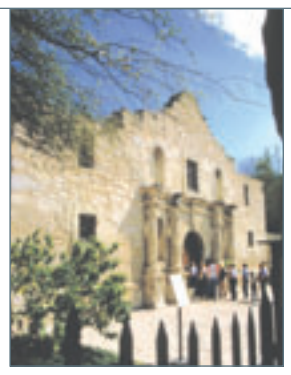

TSPP Annual Scientific Program

Beyond Essentials: Excellence in Texas Psychiatry

See page 7 for Schedule and Registration Form

New Choices in Membership

The Federation: A United Voice for Texas Psychiatry

Conway McDanald, MD, Chairman, Federation Delegate Assembly

Numerous challenges confront psychiatrists in the delivery of quality care to patients. These challenges emanate from the Texas Legislature, State regulatory agencies, practices of third-party payors, the myths and stigma of mental illness, just to name a few. For practicing psychiatrists, organized psychiatry provides the means of effectively addressing these challenges, preserving the patient-physician relationship and the quality of psychiatric care available to Texas citizens.

THE FEDERATION

For these reasons, the Federation of Texas Psychiatry (Federation) was formed this summer. The primary mission of the Federation is to encourage psychiatrists to participate in organized psychiatry, to unite and coordinate the activities of the state's professional psychiatric organizations, and to represent psychiatrists and their patients in the Texas Legislature and State regulatory agencies. The Federation offers membership to the state's professional psychiatric associations and is governed by a Delegate Assembly, composed of representatives from each member organization.

The work of the Federation begins with encouraging psychiatrists to be members of professional psychiatric organizations. Membership affords psychiatrists numerous opportunities to advocate and participate in efforts to influence healthcare policies in our State. To borrow a line from President Kennedy, "Ask not what your psychiatric organization can do for you, but what you can do for your psychiatric organization." Our medical and psychiatric associations depend on member-volunteers to develop policy, to set standards for quality care for our patients, and to advocate. Not only do our psychiatric organizations need the talents and experiences of psychiatrists from all segments of the healthcare delivery system to be effective, we need every psychiatrist in our State to be involved. Because when it comes to effective advocacy, particularly in the Texas Legislature, strength is in numbers.

Texas is now virtually surrounded by states that have passed laws allowing psychologists to prescribe medications. For the third consecutive Legislative Session, the Texas Psychological Association will attempt to convince the Texas Legislature to pass their bill authorizing prescriptive privileges for psychologists. Organized psychiatry that is strong and united will again defeat this legislative initiative that poses a danger to our patients. But, we need every psychiatrist in our state to be on our legislative advocacy team to be successful.

MEMBERSHIP CHOICES

Psychiatrists in Texas now have a choice of membership options in organized psychiatry.

Choice 1. The Traditional Alternative - TSPP/APA

The Texas Society of Psychiatric Physicians (TSPP) has a long and proven track record in its advocacy for patients and the profession of psychiatry. TSPP has been a District Branch of the American Psychiatric Association (APA) since 1956, serving as Texas' voice in the national organization. Because of APAs dual membership policy, psychiatrists must be members at both the national and District Branch level. This dual membership policy affords members benefits and services from both TSPP and the APA.

Choice 2. The Texas Only Alternative - The Academy

Responding to a growing number of Texas psychiatrists who prefer membership in only a state psychiatric organization, the Texas Academy of Psychiatry (Academy) was established this summer. The Academy is entirely independent from TSPP and has its own governing body, committees and programs. Membership categories and services of the Academy are comparable to those offered by TSPP, except for the services and benefits provided by the APA. Academy dues are comparable to TSPP dues, but of course, there are no dues for national membership.

Conway L. McDanald, MD

PARTICIPATION IS VITAL — CHOICES MAKE IT EASIER

With this restructuring of organized psychiatry in Texas, the Federation is hopeful that every psychiatrist will find a professional home, either TSPP or the Academy. The Federation will provide the means for TSPP and the Academy to share programs and work together. Thus, by uniting the two major psychiatric organizations in Texas, the voice and influence of psychiatry will be strengthened. Becoming a member in either organization is critical to secure quality care for patients as well as to assure that the future of Texas psychiatry rests in the hands of Texas physicians. How you choose to participate is your choice. TSPP and the Academy are both outstanding organizations working for Texas psychiatry. If you are already a member of TSPP or the Academy, THANK YOU!. If you are not yet a member, please choose to become involved. With the membership choices and options now available, every psychiatrist in our State should be a member and contribute to our profession through organized psychiatry. ■

Advocates for Patients and Quality Psychiatric Care

Texas Academy of Psychiatry: A New Way to Participate

R. Sanford Kiser, MD, President, Board of Trustees

I am pleased to inform you about a new professional organization, the ***Texas Academy of Psychiatry***, which offers Texas psychiatrists an additional way to participate in organized psychiatry at the state level.

ESTABLISHMENT

The Texas Academy of Psychiatry was organized this summer in response to a growing demand of psychiatrists in Texas for an opportunity to be involved in organized psychiatry without the requirement of a mandatory dual membership requirement in a national organization.

According to surveys distributed by the Texas Society of Psychiatric Physicians in 2003-2004, 40% of TSPP members and over 80% of non-members expressed an interest in belonging to a single professional psychiatric association, rather than a mandated dual membership arrangement. The Academy was therefore established to meet this need and desire of Texas psychiatrists. The Academy will expand the choice of membership options in organized psychiatry and hopefully, allow our profession to expand the strength and influence of psychiatry in Texas.

GOVERNANCE

The Academy is entirely independent and will have its own Board of Trustees, committees and programs. While independent, the Academy will work with other professional medical organizations on programs of mutual interest in order to effectively advocate for our patients and our profession.

MEMBERSHIP STRUCTURE

Membership is available to any psychiatrist having a current medical license to practice medicine without restrictions and who has a residency training certificate from an approved psychiatric residency program. Categories of membership include: **Member-in-Training** (physicians who have been accepted into an approved psychiatric residency program); **General Member** (physicians who have completed acceptable training and who have either a valid license to practice medicine or hold an academic, research, or governmental position that does not require state licensure; **Fellow** (Academy members who have been members for at least eight years and who have made significant contributions to the field of psychiatry. Applicants who have held the position of Fellow or Distinguished Fellow in other recognized professional psychiatric associations may be granted the recognition of Academy Fellow); **Retired** (members who have fully retired from active practice); and

R. Sanford Kiser, MD

Associate (members in good standing with the Texas Society of Psychiatric Physicians who apply for membership). To apply for membership, psychiatrists must complete an Academy Membership Application form and submit their annual dues. Members enrolled prior to January 1, 2005 will be recognized as **Founding Members** and their 2004 dues will be waived.

HOW TO APPLY

For further information about the Academy or to obtain a Membership Application, please contact the Academy's office (401 West 15th Street, Suite 675, Austin, TX 78701; telephone: 512/478-0605; email: TxPsychiatry@aol.com).

Texas wants you and needs you. Let us hear from you. ■

MEMBERSHIP CHANGES

TSPP NEW MEMBERS

The following membership applications have been approved by the TSPP Executive Committee and have been transmitted to the APA.

General Member
Bruhn, Marjorie, MD (reinstatement)
Mayor, Ajay, MD
Mateus, Beatriz, MD
Shahidi, Lori, DO
Wu, Beverly, MD
Melton, Bengi, MD
Siddiqui, Shakil, MD (reinstatement)

Member in Training
Bartley, Scott R., MD
Burman, Malika, MD
Johnson, Neysa, MD
Lawhon, Janet , MD

Change in Status from MIT to General Member
Hegybeli, Eric, DO
Mukhara, Hemalatha, MD
Kang, Jane, MD
McLaren, Kimberly, MD

Transfer from Other District Branches
Cavanaugh, Regina, MD
Keith, Dona, MD
Pieper, Andrew, MD
Satpathy, Satyajit, MD

ACADEMY NEW MEMBERS

General Member
Stuart D. Crane, MD
Kirk S. Dutton, MD
Willard S. Gold, MD
Thomas A. Grugle, MD
Michael D. Jenkins, MD
Wayne F. Keller, MD
Matthew E. Levine, MD
Thomas A. Martin, III, MD
William Streusand, MD
Daniel T. Villarreal, MD

Fellow
Theodore Dake, Jr., MD
R. Sanford Kiser, MD

Associate Member
A. David Axelrad, MD

In Memoriam...

James Chester Gayle Cochran, Jr., MD
Houston

Mona E. Mernin
Bulverde

Donald L. Thomasson, MD
Houston

FDA Weighing Revision of Antidepressant Labels for Children

On September 14, a scientific advisory committee voted 15-8 to recommend to the Food and Drug Administration (FDA) that it put a "black box" warning on the labels of antidepressants about the suicide risk for the youths who take them. The FDA had requested that the scientific advisory committee interpret the results of its new analysis which showed evidence of a link between the antidepressants and suicidal tendencies in young people.

According to Steven Pliszka, MD, UTHSC San Antonio, "the FDA analysis indicated that there is a 2-4% rate of suicidal ideation in the antidepressant group versus a 1-2% rate in the placebo group. Only Prozac has proven efficacy, but the negative results in other studies are probably related to flaws in the study." Regarding the "black box" warning, Dr. Pliszka said, "Psychiatrists should be certain the patient meets criteria for major depressive disorder and inform the patient's family about the issue. In most cases of moderate to severe MDD, the benefit still outweighs the risk."

AACAP Supports Stronger Warnings But Not Black Box for Antidepressants

On September 28, Richard Sarles, MD, President of the American Academy of Child and Adolescent Psychiatry (AACAP) released the following statement:

The American Academy of Child and Adolescent Psychiatry (AACAP) urges the FDA not to issue a black box warning against the use of all antidepressants for the treatment of depression in children and adolescents. Efficacy and safety data on pediatric antidepressant use has been the subject of ongoing review. The research and its reviews show efficacy, while the signal for the risks of increased suicidal thinking and self-harm events is not strong and can be monitored.

A black box warning has not been justified by the latest reclassification — by nine experts in pediatric suicide — of 4,400 cases in controlled clinical trials on all antidepressants. Reviewing the new classification, the FDA concluded that only 78 out of 4,400 children and adolescents randomized to active drugs suffered increases in suicidal ideation and/or self-harm behavior. Analysis of risk difference — estimating the absolute increase in the risk of suicidal thinking or behavior due to treatment — revealed that it ranged between 2 and 3 percent. This means that out of 100 patients treated, 2 to 3 patients might have shown increases in suicidality during the early stages of treatment that extended beyond the risk from the disease being treated. Depression carries a substantially higher rate of illness, impairment, and shortened life span than does the 2 percent attributable to pharmaceutical treatment.

These data do not support actions that would remove or weaken treatment options for children and adolescents who respond to antidepressant medications. These analyses do not help child and adolescent psychiatrists and other physicians make rational treatment decisions.

With so few cases of increased suicidal thinking or behavior in the 4,400 children being studied, science cannot guide prescribers in identifying which patients are at risk from antidepressant treatment. For this reason alone, a black box warning only confuses, not enlightens, the decision- making about the treatments. The small number of children and adolescents who had increased suicidal thinking or harmed themselves with the intent to die make it impossible to determine with any certainty what early signs might warn the physician or family that their child is at particular risk. In FDA-reviewed studies, none of the patients' characteristics that were present before the antidepressant treatment, such as a previous history of suicidal thinking or behavior, identified those who would be most apt to experience these side effects.

The data do not support a warning that may be misinterpreted by some practitioners or families to mean that antidepressant medications cause children and adolescents to commit suicide. In all of the 4,400 patients taking an SSRI who had increased suicidal thinking or behavior, none of them went on to commit suicide. There were no deaths reported in these studies. This is yet another reason to resist issuing a black box warning.

Instead of issuing a black box, we urge that the new data serve to enhance the warning section now in the label of these medications.

New instances of suicidal thinking and self-harm with intent to die may appear early in the course of therapy, or at a time of dose changes, whether the dose is increased or decreased. Accordingly, frequent telephone or in-person monitoring is recommended until the patient has completed one month of treatment.

Patients and families should receive a written list of symptoms, such as increased suicidal ideas or ruminations or the impulse to hurt oneself. During the monitoring contacts, the physician should ask the patient and the family about any new or increased suicidal ideation and the occurrence of self-harm events, particularly with any intent to die.

In addition, the physician, patient, and family should be alert to the new appearance of or increasing severity of the following symptoms: anxiety, agitation, panic attacks, insomnia, irritability, hostility (aggressiveness), impulsivity, akathisia (psychomotor restlessness), hypomania, and mania. A causal link between the emergence of such symptoms and either the emergence of suicidal ideas and impulses or new self-harm behavior has not been established. In child or adolescent patients for whom such new symptoms are severe, abrupt in onset, or were not part of their presenting symptoms, consideration should be given to changing the therapeutic regimen, including possibly gradually discontinuing the antidepressant medication.

APA Expresses Concern

APAs Medical Director James Scully, Jr., MD submitted the following letter to the FDA on September 28:

On behalf of the more than 35,000 physician members of the American Psychiatric Association (APA) and on behalf of the child and adolescent patients that many of us serve, I am writing to comment on proposed labeling of antidepressant medications for use by youth. We wish, first, to commend the FDA's professionalism in convening and administering the September 13-14 public meeting of the Psychopharmacologic Drugs and Pediatric Advisory Committees. We also appreciate the agency's testimony before the House Energy and Commerce Oversight and Investigations Subcommittee that accurately represented the state of the science of child psychopharmacology in the treatment of major depressive disorder. Now, as the process of developing new cautionary language proceeds, we wish to state the following points for your consideration and for the record:

Minimize Risk of Restricting Access to Appropriate Medical Care for Pediatric Major Depression: Major depression affects an estimated 23 percent of children and 8.3 percent of US adolescents, or approximately 2.6 million youth ages 6-17. With a national shortage of child psychiatrists — about 6,000, for nearly 50 million American youth in this age range — primary care providers, and particularly, pediatricians and family practitioners carry a substantial portion of the caseload of children and adolescents with major depression who are receiving any medical care for their illnesses — less than one-third of children with the disorder. Until very recently, pharmaceutical industry data has suggested consistently that there had been no response to the FDA's earlier warnings of the need to closely monitor patients on these medications. Only days after the FDA advisory committees met, however, Medco reported that there has been a dramatic drop in the prescription of these medications for adolescents in the past six months — an indication that the physician, parent, and patient communities are using caution as they wait for more definitive data on this issue. It is essential that any new labeling language — particularly if a "black box" warning is introduced — provide a balanced view of risks ***and benefits*** of appropriate medical treatment of child and adolescent depression, lest the effect be to further frighten parents and caregivers whose children are receiving the medications, influencing many to have their children stop taking them, and to deter many primary care physicians and other non-psychiatrist physicians from prescribing them. We believe such outcomes of a new policy will place many more young people at risk of self-injurious behavior due to clinical depression than appropriate treatment ever will.

Correct Misperceptions Regarding the Effectiveness of Appropriate Treatment of Pediatric Major Depression As Demonstrated in the TADS: We are concerned that on the basis of one hasty exchange between the senior TADS research investigator and members of the Advisory Committees meeting regarding the design and analysis of the NIMH-supported TAD study, that the effectiveness of treatment for child and adolescent depression is being underestimated. This issue warrants revisiting. Unlike the other 23 industry- and NIMH — supported clinical trials that the FDA analysis reviewed, which used a single clinical rating of the severity of depression at the conclusion of a trial, the 52-week TADS timeframe had influenced the investigators to use random regression analysis as its primary outcome measure in order to better understand the trajectory of change over the course of extended treatment. Although this analysis was the primary outcome measure for the TADS, the investigators also had used other statistical analyses to evaluate improvement at 12 weeks, including the CDRS more typically used in FDA efficacy trials and Clinical Global Impression-Improvement scale ratings. At 12-weeks, these secondary ratings provided robust evidence that fluoxetine, with or without concomitant psychotherapy, was approximately twice as effective in treating depression in the adolescent patients as either psychotherapy alone or placebo. However, these available data were over-shadowed when an Advisory Group panelist asked the TADS investigator if, on the basis of the random regression analysis results, the TADS would be considered a failed FDA trial. This investigator neglected to note that random regression slope analyses are minimally effective with only three observations and are not comparable to analytic techniques used for FDA efficacy studies. In fact, the usual end-point analyses presented in the paper were highly positive at a level that FDA would approve an indication. This inadvertent remark to the advisory committee, that TADS could be perceived as failing to separate fluoxetine and placebo, fundamentally changed perceptions of the TADS findings on the part of PDPAC members and at the subsequent congressional hearing. Yet as Dr. Temple noted in his remarks to the Oversight Subcommittee, it is premature to conclude on the basis of short-term efficacy trials that antidepressant medications have no benefit in the treatment of pediatric MDD. To this point, it is critical to note that TADS is a far more ambitious study than the typical industry-sponsored study to obtain FDA review of the safety and efficacy of a medication. For one, it was designed to investigate the effectiveness of these treatments in the broad range of patients who typically are seen in routine clinical practice — including children with ADHD and exposure to substance abuse, children who clearly represent the heterogeneity of diagnosis referred to by Dr. Temple. The TADS also followed study participants for more than one-year, rather than the usual 3 months. Findings reported in JAMA in August and cited at the September meeting provided unambiguous evidence that we have effective treatments for adolescent depression.

Educate Physicians Regarding the Importance of Rigorous Monitoring: As the national medical specialty society with lead responsibility for the treatment of mental disorders across the lifespan, the APA is eager to work with the federal government and with the larger medical community to accelerate our efforts to educate physicians as to the critical importance of rigorous monitoring of young patients prescribed antidepressant medications. Any warnings without a clear method for monitoring suicidal ideation risks will be a disservice to physicians, parents and patients. Likewise, the effectiveness of medication and evidence-based psychotherapy for treating this devastating mental disorder should be clear in future communications. In summary, any such educational outreach from the FDA and from the professional community must attend equally to the risks and to the benefits of the best care that, today, we can offer.

We appreciate your consideration of these concerns. The APA looks forward to continuing to work with the FDA to help assure medically appropriate access to life-saving medications for Major Depressive Disorder. ■

Congratulations....

According to the APA, twenty TSPP members will achieve Life Status as of January 1, 2005. **Distinguished Life Fellow: Frederick W. Brown, III, MD** (San Antonio), **Lida Lacy Edmundson, MD** (Dallas), **Joel S. Feiner, MD** (Dallas), **Robert MA Hirschfeld, MD** (Galveston), **Adib R. Mikhail, MD** (The Woodlands), **Theodore Pearlman, MD** (Houston), **Franklin C. Redmond, MD** (San Antonio), **Margo K. Restrepo, MD** (Houston), **Mary L. Scharold, MD** (Houston), **John R. Stafford, MD** (Houston), and **Stuart W. Twemlow, MD** (Houston); **Life Fellow: Timothy L. Sharma, MD** (Houston); and, **Life Member: Jason D. Baron, MD** (Houston), **Claudio Cepeda, MD** (San Antonio), **Estrella de Forster, MD** (San Antonio), **Louis F. Fabre, MD** (Houston), **Paul A. Grandy, MD** (Kingwood), **Irving L. Humphrey, III, MD** (Dallas), and **Ramon M. Rubio, MD** (San Antonio).

Leslie Secrest, MD will become President of the Dallas County Medical Society in January, 2005.

Foster Care: Effective Advocacy in Action

On a hot day in late July, sitting at the back of the legislative hearing room, Federation lobbyist Steve Bresnen was monitoring a public hearing of the Select Interim Committee on Child Welfare and Foster Care. It had been a long day filled with testimony mostly unrelated to issues being tracked by the Federation. A casual comment during the testimony of an employee of the Department of Family and Protective Services went almost unnoticed, except for Steve Bresnen. Steve did a double-take when he heard it. When the agency employee concluded his testimony, Steve sought him out and asked if he had heard him correctly. The employee confirmed to Steve that he testified that the agency had included in its contract with providers an outcome measure that encouraged the maintenance of behavior of children without the use of psychotropic medications, restraint and seclusion. Steve obtained a copy of the contract the following day and located the contract provision:

> 18.E.6. The child maintains behavior without use of psychotropic medications, restraints, or seclusions. This outcome is measured by determining the percentage of children for whom behavior is managed without the use of psychotropic medications, restraints, or seclusions.

The Federation had decided to monitor the hearing because of a comprehensive report issued by Comptroller Carole Keeton Strayhorn in April, 2004 entitled "Forgotten Children," which called for sweeping reforms in the foster care system. In addition, recent news reports about the foster care system singled out psychiatric treatment as a problem, alleging inappropriate psychiatric treatment of children in the foster care system. The reporting of abuse of children using psychotropic medications raised a red flag that Scientology's Citizens Commission on Human Rights had targeted foster care to launch another opportunistic attack against psychiatry and psychiatric treatment.

In the Comptroller's report, there was a recommendation that the Health and Human Services Commission establish a Foster Care Medical Review Team to review diagnostic services, medication, treatment and therapy delivered to Texas children in foster care. Federation Executive Director John Bush immediately contacted Charles Bell, MD, Deputy Executive Commissioner of HHSC to inquire about the status of the Foster Care Medical Review Team and was informed that it existed as the Advisory Committee on Psychotropic Medications, and that two TSPP members had been appointed to serve on the Review Team, Alex Kudisch, MD and Joseph Burkett, MD.

During the TSPP Leadership Conference in early August, Steve briefed members and advocates about the outcome measure contained in the agency contract with providers. Shortly thereafter, Steve attended a meeting of the Advisory Committee on Psychotropic Medications and along with TSPP member Joseph Burkett, MD advised the committee of the contract provision and concerns it raised about the potential for denying appropriate medical care to children in foster care. There was general consensus that the contract provision be removed but agency personnel persuaded the committee that their recommendation should not be included in a report they were preparing for the Legislature outlining recommendations for the foster care system. Committee member Joseph Burkett, MD, however, submitted a written objection for the Committee's report which stated: "Outcomes established through contracts or other means must carefully guard against wording that creates incentives to deny care to those who need it, but rather focus on improvements in child functioning. The contracts with providers of residential childcare need to be revised to ensure that the contract does not conflict with current scientific, evidenced-based treatment trends."

John Bush put together a group of child and adolescent psychiatrists to advise the lobby team about issues involving the foster care system. The work group included: Emilie Becker, MD, Joseph Burkett, MD, Claire Friedman, MD, Saundra Gilfillan, DO, James Hageman, MD, Alex Kudisch, MD, William Patrick Moore, MD, Steven Pliszka, MD, Sonja Randle, MD, Harry Rauch, MD, Linda Rhodes, MD, Jane Ripperger-Suhler, MD, Valerie Robinson, MD, Fernando Torres, MD, and Mitch Young, MD. The workgroup reviewed the Comptroller's report, the agency contract, a white paper on the issue drafted by Steve Bresnen and other materials, exchanged emails and participated on a conference call. Their guidance provided the Federation lobby team useful information to be used in developing a strategy to address various issues.

Steve Bresnen then directed communications with key policymakers in State government about psychiatry's concerns and proceeded with the development of a coalition team to implement the strategy. The coalition included: the Federation of Texas Psychiatry, Texas Medical Association, Texas Pediatric Society, Texas Alliance of Child and Family Services, National Alliance for the Mentally Ill of Texas, Texas Academy of Family Physicians, Texas Society of Child and Adolescent Psychiatry, Texas Foster Parents Association and the Texas Association of Child Placing Agencies. The coalition members refined plans for advocating for changing the agency's contract provision. Steve directed the implementation of the plan.

Following several meetings between Steve, acting on behalf of the coalition, with key leaders in the Department of Family and Protective Services, the agency on September 30 issued a letter to residential child care contractors that said that the agency would issue a contract amendment in the very near future to delete the contract outcome regarding psychotropic medications, restraints and seclusion.

The Federation is scheduled to provide testimony on October 4 to the Interim Select Committee on Child Welfare and Foster Care during which the Federation will commend the agency for their decision to delete from the provider contract the outcome measure relating to psychotropic medications, restraints and seclusion and to express support for the final report of the Advisory Committee on Psychotropic Medications.

The Advisory Committee's Report, issued in early September, defined psychotropic medications as "any medication that acts primarily on the central nervous system and that is used primarily or adjunctively in the

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Foster Care: Call for Reform

In a comprehensive report issued by Comptroller Carole Keeton Strayhorn in April, 2004 entitled "Forgotten Children," the Comptroller identified 87 recommendations for improving foster care in Texas. In July, Comptroller Strayhorn expressed concern that the recommendations were not being implemented by the Texas Department of Family and Protective Services (DFPS) and announced that the report's recommendations would constitute sweeping new legislation to reform the foster care system in Texas during the Legislative Session in 2005.

Recommendations for reforming the foster care system include:

I. RAISE THE BAR ON QUALITY

The Dual System

1. Eliminate the inefficient dual foster care system, shift all daily care and case management activities to contracted providers and direct savings to DPRS for greater system oversight.

Quality Contracting

2. HHSC should create a foster care performance team to develop criteria for outcome-based contracts and measurable outcomes for residential care.
3. The performance team's outcome measures should be used instead of the existing DPRS outcome measures.
4. DPRS should use outcome-based contracts for all foster care services beginning in fiscal 2005.
5. HHSC and DPRS should revise payment methods to create financial incentives for reducing the length of stay and institutionalization of children in foster care.

II. DIRECT MORE DOLLARS INTO CARE

Medicaid for Rehabilitative Services

6. HHSC and DPRS should pursue an amendment to the Medicaid State Plan specifically for foster care children served in Residential Treatment Centers (RTCs).

Title IV-E Funding

7. DPRS should increase the amount it claims from Title IV-E for preplacement services.

Medicaid Services

8. HHSC and DPRS should expedite the delivery of foster children's Medicaid information to caregivers.
9. HHSC and DPRS should work together to obtain more timely medical and dental examination of children.

Medicaid Reimbursement

10. HHSC and DPRS should provide foster care contractors with assistance and training to help them claim Medicaid reimbursement for foster care services.

Funding Flexibility

11. HHSC should combine federal, state and local funding to create "wraparound" managed care programs for foster children.
12. HHSC and DPRS should work with other state agencies and local communities to pool funding and provide preventive services designed to keep children out of foster care and in their own homes.

RTC Charter Schools

13. Residential Treatment Center contracts with charter schools should include mandatory participation in the School Health and Related Services program.

III. MAKE THE FOSTER CARE SYSTEMS MORE ACCOUNTABLE

Caseworkers

14. DPRS should establish formal guidelines and documentation standards for caseworker-child visitation.
15. DPRS should use caseworker-child visitation as one of its performance measures.

Licensing

16. Residential Child Care Licensing (RCCL) should apply current licensing standards for "Permanent Therapeutic Camps" to all therapeutic camps and their associated campsites and should immediately move children from camps that do not meet the standards. All areas of therapeutic camps, including associated campsites, should have a thorough health inspection by local health inspectors.
17. DPRS should upgrade the standards applied to therapeutic camps for personnel responsible for the overall treatment program and admissions assessments to make them comparable to those for residential treatment centers.
18. TDH and its local affiliates should assume responsibility for complete health inspections of all foster care residential facilities.
19. DPRS should develop rules and standards such that facilities with repeated violations would trigger full inspections and lead to license revocation.
20. DPRS should revoke the licenses of facilities

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Foster Care: Call for Reform continued from page 4

that have ongoing problems affecting the health, safety and well-being of children.

21. DPRS should permanently bar any board members, officers and lead administrators of a facility that has lost its license, or that voluntarily closes after an adverse action, from holding a license or operating a foster care facility in Texas.
22. RCCL should complete at least one thorough inspection of each residential facility annually and make more frequent inspections, as required, according to its monitoring plans.
23. DPRS should promote quality care in foster care facilities by maintaining a best practices database for foster care facilities and caregivers.
24. DPRS should provide training on licensing standards to all staff who visit facilities.

Data Integrity

25. DPRS should require the facilities it licenses to immediately report all serious incidents involving runaways, missing children, arrests of children and all potential licensing violations to the agency's intake phone center.
26. DPRS should require its contract managers and other staff to immediately report any findings or information concerning licensing violations to the intake phone center.
27. DPRS should develop a quality assurance system that performs sample audits of reports, investigations and inspections to ensure their completeness and validity.
28. DPRS should develop criteria and questions for licensing investigations and should require workers to fully document their inspections, investigations and administrative closures in the Child Care Licensing (CCL) database; the reasoning behind their decisions; and any follow-up actions taken thereafter.

Contracts

29. HHSC should immediately amend the DPRS care provider contracts to add a conflict-of-interest disclosure provision and strengthen financial accountability provisions.
30. HHSC should require DPRS to discontinue its practice of allowing providers to dictate contract terms.
31. HHSC should amend DPRS foster care provider contracts to eliminate clauses allowing providers to reject or eject foster children by fiscal 2008.
32. The executive director of DPRS should revoke signatory approval previously delegated to Child Protective Services (CPS) district directors for contracts with an anticipated value over $25,000 in one year.
33. HHSC should direct DPRS to establish risk assessment procedures.
34. DPRS should direct its contract monitors to make periodic unannounced visits to contractor facilities.
35. DPRS should ensure that all contractor files are complete and accurately reflect their performance on an ongoing basis.
36. HHSC and DPRS should fully use charitable no-pay caregivers to aid Texas foster children.
37. SAO should conduct a management review of HHSC and DPRS to improve contract administration and management systems.
38. HHSC, in coordination with the State Auditor's Office (SAO), should perform complete, on-site financial audits of selected providers.
39. SAO in coordination with the Comptroller of Public Accounts should review DPRS payments to contractors in a timely manner.
40. DPRS should consider enabling providers to go online to view their reimbursement accounts or provide detailed data so that providers can reconcile their accounts.
41. GGSC's Rate Analysis Department should assume responsibility for the rate-setting process for residential foster care.
42. HHSC should ensure that the agencies and programs under its oversight use coordinated and consistent cost report audit policies.

IV. ENSURE THE HEALTH AND SAFETY OF ALL FOSTER CHILDREN

Abuse and Neglect

43. DPRS should prohibit the placement of sex offenders, sexual predators and children with violent criminal histories with other children.
44. DPRS should track and report the number of reports it receives concerning child-on-child physical and sexual abuse by facility.
45. DPRS should thoroughly investigate all complaints, allegations or reports and should list the dates and outcomes on its public Web site on facilities. These should be randomly reviewed by HHSC to ensure that investigations are timely and thorough.
46. DPRS should arrange advanced training for residential licensing investigators on investigative protocols and techniques.
47. DPRS should require an FBI check of criminal records in other states for all prospective facility staff, foster parents and others who come into frequent or regular contact with children, and as part of an investigation into allegations of abuse.
48. DPRS should work with other states to develop agreements to check central registries of abuse and neglect in states where applicants have lived previously.
49. DPRS should require complete background checks before staff or others have access to children.
50. DPRS should provide information to prospective foster care employers of all criminal convictions of individuals submitted for a background check.
51. DPRS should perform a risk assessment on anyone who has been convicted of a crime before they are allowed access to children.
52. DPRS should assure the places of prior foster care employment are available in its database to facilities as part of the background check for prospective foster caregivers.
53. DPRS should require that foster care providers test for drugs as a condition of employment and that facilities randomly test their employees for drugs.
54. DPRS should consider requiring psychological testing of facility staff and prospective foster parents to identify individuals who are mentally unsuitable to care for children.
55. **HHSC should create a Foster Care Medical Review Team to review the diagnostic services, medication, treatment and therapy delivered to Texas children in foster care. The HHSC Deputy Commissioner for Health Services should coordinate the team.**
56. **Foster care caseworkers, foster parents and parents (if they have not lost or surrendered their parental rights) should be required to sign authorizations for psychotropic medications to be given to foster children.**
57. DPRS should develop "Medical Passports" for foster children.

Medically Fragile Children

58. HHSC should implement a Medicaid catastrophic case management program for medically fragile foster children in DPRS care.
59. **The Foster Care Medical Review Team should review the cases of medically fragile foster children and establish best practices guidelines for their evaluation, placement and care.**

Foster Children with Mental Retardation

60. HHSC should design an assessment system that ensures that children with developmental disabilities are identified properly.
61. HHSC should maximize federal reimbursements for the care of foster children with mental retardation.
62. HHSC should appoint a task force on foster care children with developmental disabilities to obtain input from expert advocates on the development of a more comprhensive and "seamless" service system for such children.

Foster Child Facilities

63. **DPRS should identify behavior management systems that incorporate safe personal restraints appropriate for use with children and require that contractors use only approved systems.**
64. DPRS should thoroughly investigate each foster child death, refer every foster child death case to the state risk director and internal and external child-death review committees, and should place the results of the reviews in the child's death investigation file.
65. DPRS should standardize the forms, information and documentation required in child death files.

Missing Foster Children

66. DPRS should capture accurate, timely information in the agency's foster child database.
67. DPRS should upgrade licensing standards to include a requirement that foster care providers notify the agency and law enforcement immediately of missing children.
68. DPRS should develop a missing child database.
69. DPRS should develop a page on its Web site providing the names and photographs of missing foster children.
70. DPRS should include a field in its statewide, computerized intake system that clearly identifies calls involving foster children.

V. PROVIDE A BRIGHTER FUTURE FOR TEXAS FOSTER CHILDREN

Longterm Outcomes

71. HHSC and DPRS should seek non-traditional independent living funds from multiple federal sources.
72. DPRS should form partnerships with the state's local work force development boards to expand transitional services for Texas foster teens and create one-stop centers for foster care youth, using existing workforce funds.

Academic Needs

73. TEA should include information on the education of Texas children in foster care in its state dropout plan and annual reports to the Legislature; TEA also should provide this information to DPRS.
74. DPRS caseworkers should consider foster children's educational needs, and the education services available from each foster care facility, when making placement decisions.
75. TEA and the Texas Higher Education Coordinating Board should develop outreach programs for foster children to ensure that they are aware of the availability of state funding for their college expenses.

Academic Data

76. TEA should include "foster care" as a separate data element in the state's Public Education Information Management System (PEIMS).
77. TEA should include educational services provided by all the state's foster care facilities in district and campus report cards.

Foster Grandmas and Grandpas

78. DPRS should partner with volunteer and advocacy organizations to develop a Texas Foster Grandmas and Grandpas Program.
79. DPRS should work with nonprofit organizations to solicit contributions for the Texas Foster Grandmas and Grandpas Program.
80. DPRS should work with the Texas Education Agency to seek funding for the Texas Foster Grandmas and Grandpas Program.
81. TexasOnline and all Texas state agencies that serve children, youth and families should publicize the Texas Foster Grandmas and Grandpas Program on their Web sites.
82. DPRS should work with nonprofit organizations to recognize Texas Foster Grandmas and Grandpas program participants through annual volunteer service awards.

VI. TECHNICAL RECOMMENDATIONS CONCERNING RATE SETTING

83. DPRS should calculate separate rate components for direct care and for other cost centers such as administration, facility and other operating costs, as do other long-term care methodologies.
84. DPRS should use either medians or means, weighted by days of service, to calculate the direct care rate components by level of care.
85. DPRS should incorporate more provider cost report data in the rate calculation process.
86. DPRS should use an objective means to adjust its rates to appropriation limits.
87. DPRS should cap funds for administration and require recovery of funds expended above the cap. ■

Foster Care: Effective Advocacy in Action continued from page 4

treatment of mental or neurological disorders." The Committee addressed the issue of prescribing medications to children that have not been approved by the Food and Drug Administration (FDA) as follows: "While the majority of medications employed in child psychiatry have not been studied extensively by the pharmaceutical industry, their use can be beneficial. Physicians use information regarding research and clinical trials when making decisions regarding these medications. Medication used without FDA approval is not necessarily dangerous to a child; it means only that the drug has not been studied for use in children or the drug in question has not received FDA approval." The Committee determined that the list of psychotropic medications approved for use by children and youth in foster care should be the same as those medications available to other Medicaid eligible children on a nondiscriminatory basis. The list of psychotropic medications approved for use by foster children is based upon the Medicaid Preferred Drug List developed by HHSC.

The Advisory Committee outlined recommendations for protocols and monitoring systems, as follows:

A. Establish an effective consultation and monitoring system for the use of psychotropic medications by foster children to ensure that children in foster care receive consistent medical treatment, in keeping with currently accepted medical practice and to provide easy access to expert clinical consultation services for DFPS staff, individual clinicians, and providers of residential and foster care.
B. Improve the training system to be competency-based with expanded training topics and participants to improve the scope of training and education regarding the use of psychotropic medications and verify competencies in these areas.
C. Develop clear provisions regarding informed consent required for the administration of psychotropic medications to foster children.

The Committee added three additional recommendations:

1. DFPS should seek funding to conduct or commission a study to examine the current trends in prescribing psychotropic medications to children and youth placed in residential and foster care by DFPS.
2. Consider the use of a Medical Passport for children in the foster care system in order to improve continuity of medical care.
3. DPFS initiate a public/private work group to design and implement an improved and expanded competency-based training program that is correlated with the clinical monitoring and consultation system recommended by the Committee.

The positive outcome achieved in this advocacy experience is attributed to psychiatrists' participation on governmental committees and with the Federation's lobbying activities. The success of this effort can also be attributed to the outstanding work of Steve Bresnen who developed strategy and tactics, built a broad coalition of advocates, and effectively communicated with state policymakers. ■

TSPP Elections 2004

Nominations for TSPP elective offices will be finalized at the Annual Business Meeting on November 13, 2004 in San Antonio at the Omni Hotel during the Annual Convention and Scientific Program. The Nominating Committee, composed of Priscilla Ray, MD, Chairman, Charles Bowden, MD, and A. David Axelrad, MD, submit the following slate of candidates for consideration:

President-Elect 2004-2005:
Gary L. Etter, MD (Fort Worth; to replace Karen D. Wagner, MD, PhD who resigned due to conflicts in her schedule)

Secretary-Treasurer 2004-2005:
George D. Santos, MD (Houston; to replace Gary Etter, MD who has been nominated to serve as President-Elect 2004-2005)

President-Elect 2005-2006:
Leslie H. Secrest, MD (Dallas)

Secretary-Treasurer 2005-2006:
George D. Santos, MD (Houston)

APA Representative 2005-2008:
J. Clay Sawyer, MD (Waco)

Councilor-at-Large 2005-2008:
Lynda Parker, MD (Amarillo)

Following the finalization of the slate of candidates during the TSPP Annual Business Meeting on November 13, 2004, elections will be governed by the TSPP Bylaws, Chapter Nine, as follows:

Section II. At the annual business meeting, the nominees for office recommended by the Nominating Committee, the nominees for office submitted by the Chapters, and the nominees submitted by written petition signed by at least 20 voting members, shall be presented to the entire voting membership present. Additional nominations may be made from the floor by any voting members.

Section III. The election of officers shall be conducted by mail ballot whenever more than one slate of officers is nominated. The ballot shall list in alphabetical order, as candidates for office all members nominated in accordance with the Constitution and Bylaws. The ballot shall not in any way indicate the particular process by which the candidate was nominated. If no nominations are made by the Chapters, by petition, or from the floor, the slate submitted by the Nominating Committee will be considered to be elected by acclamation by those members at the annual business meeting.

Section IV. In contested elections, the ballots shall be mailed to all voting members within seven (7) days after the Annual Business Meeting. The ballots must be returned within thirty (30) days following the Annual Business Meeting....

As stipulated in Section V-VIII, the ballots will be tallied and reported at a regularly scheduled meeting of the Executive Council and the certified election results announced by mail to the entire membership following the Executive Council meeting.

Elective positions are currently held by the following members:

Officers 2004-2005:

President
J. Clay Sawyer, MD (Waco)

President-Elect
Karen Dineen Wagner, MD, PhD (Galveston)

Vice President
John Casada, MD (San Antonio)

Secretary-Treasurer
Gary L. Etter, MD (Fort Worth)

Immediate Past President
Priscilla Ray, MD (Houston)

APA Representatives:

A. David Axelrad, MD, Houston
(2004-2007, second term)

Priscilla Ray, MD, Houston
(2003-2006, fourth term)

J. Clay Sawyer, MD, Waco
(2002-2005, first term)

Councilors-at-Large:

Leslie H. Secrest, MD, Dallas
(2004-2007, first term)

Lynda Parker, MD, Lubbock
(2002-2005, first term)

Franklin D. Redmond, MD, San Antonio
(2003-2006, first term)

Representative to the APA Division of Government Relations:

Leslie H. Secrest, MD, Dallas
(2003-2006, third term)

Representative to the APA Division of Public Affairs:

Timothy K. Wolff, MD, Dallas
(2003-2006, third term)

Candidates for Foundation Board Announced

Elections to be Conducted at Annual Meeting

The Nominating Committee of the Texas Foundation for Psychiatric Education and Research, composed of Charles Bowden, MD, Conway McDanald, MD and Clay Sawyer, MD, submit the following slate of candidates for positions on the Foundation's Board of Directors:

Six Three Year Terms (May 2005-May 2008)

- **David Briones, MD**, El Paso, to be re-appointed to another 3 year term.
- **Jacquie Collier, Georgetown**, to be re-appointed to another 3 year term.
- **Arthur Farley, MD, Austin/Houston**, to be re-appointed to another 3 year term.
- **Miriam Feaster, Friendswood**, to be re-appointed to another 3 year term.
- **Charles Gaitz, MD, Houston**, to be appointed to an initial 3 year term replacing Tracy Gordy, MD
- **Edward Reilly, MD, Houston**, to be re-appointed to another 3 year term.

Elections for these positions will be conducted at the Foundation Annual Membership Meeting at the Omni Hotel in San Antonio on November 13, 2004 during the TSPP/Foundation Annual Business Meeting. Foundation members, which include all TSPP members in good standing, may submit names of candidates for the position of Foundation Director by submitting a petition signed by at least 20 members. Nominations may also be entertained from the floor during the Annual Membership Meeting. If there is a contested election, the election will be conducted by mail ballot in accordance with the Bylaws of the Foundation. Otherwise, the election will be conducted at the Annual Membership Meeting.

The Foundation's Board of Directors are charged with supervising, managing and controlling all of the policies, activities and affairs of the Foundation. There may be as many as 25 individuals holding a position of Director. There are two classes of Directors. Designated Directors are persons serving on the Board by virtue of positions they may hold in organized medicine or among mental health advocacy organizations (ie President-Elect of TSPP, Secretary-Treasurer of TSPP, Immediate Past President of TSPP, President of the NAMI Texas, Chairman of the Mental Health Association in Texas, and President of the Texas Depression and Bipolar Support Alliance. There are currently 5 Designated Directors.

In addition to Designated Directors, the Board may be composed of not less than 12 Elected Directors. Elected Directors are elected by the membership of the Foundation to serve three year terms on the Board. At least 3 Elected Directors must be Past Presidents of TSPP.

Current Elected Directors include Diane Batchelder, Charles Bowden, MD, David Briones, MD, Jacque Collier, Arthur Farley, MD, Miriam Feaster, Hal Haralson, Grace Jameson, MD, Shirley F. Marks, MD, Conway L. McDanald, MD, Mohsen Mirabi, MD, Stella Mullins, Edward Reilly, MD, Linda Rhodes, MD, Larry Tripp, MD, and Paul Wick, MD. Designated Directors currently are: Gary L. Etter, MD, Jerry Grammer, PhD, Linda Groom, Priscilla Ray, MD, and Karen D. Wagner, MD, PhD.

The Board has elected Alex K. Munson, MD, Georgetown, as an Honorary Director..

TSPP President's Message

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So much has changed in that decade with regard to the practice of medicine in general and the practice of psychiatry in particular. Psychiatry is likely now the lowest-paid specialty in the U.S. Before this past decade, we appear to have been the third lowest-paid specialty (with only pediatricians and family practitioners earning less). Solutions to problems must, of necessity, change as well, as Henry Ford so eloquently observed. The APA's suggested solutions to District Branch problems, no matter how well-intentioned, are not working. New and innovative solutions must be found and must be tried. If this approach is not taken, then our organizations will continue to dwindle in membership and in resources until they become ineffective in function and relevant to no one. That result cannot be allowed to happen, and it certainly does not deserve to happen. **An innovative solution is now in place in Texas, a solution which addresses a large and untapped market: unrepresented psychiatrists who have let it be known that they want to be involved in organized medicine in a new and more effective way.** This solution was previously promised to us as acceptable to the APA. To dissociate the fourth-largest District Branch in the APA (and a loyal District Branch since 1956) would, in the long run, hurt only the APA itself, and would serve no one's best interests. Regardless of any action taken by the Board, our membership support assures that TSPP will continue to be the preeminent organization representing the interests of psychiatrists in Texas. I am proud to serve as President of a professional medical organization which is truly membership-oriented, membership-driven, and membership-run.



TEXAS SOCIETY OF PSYCHIATRIC PHYSICIANS

2004 TSPP Annual Convention & Scientific Program
TSPP Committee Meetings

Omni Hotel • San Antonio, Texas

DAILY SCHEDULE

FRIDAY, NOVEMBER 12

7:00 am - 8:00 pm	Registration/Information
7:30 am - 4:15 pm	TSPP Committee Meetings
7:30 am - 9:30 am	Forensic Psychiatry Committee
9:00 am - 10:30 am	Socioeconomics Committee Fellowship Committee Budget Committee
10:30 am - 12:00 pm	Membership Committee Professional Practices Committee Continuing Medical Education Committee
12:00 pm - 1:15 pm	Member Luncheon and Program: Comptroller Carole Keeton Strayhorn, invited
1:15 pm - 2:45 pm	Strategic Planning and Coordinating Committee Public Mental Health Services Committee Children and Adolescents Committee Ethics Committee
2:45 pm - 4:15 pm	MIT and Early Career Psychiatrists Program: "Setting Up a Practice" Government Affairs Committee
4:30 pm - 6:00 pm	Executive Council Meeting
6:00 pm - 7:00 pm	Exhibits Opening/Welcome Reception
7:15 pm	TSPP Annual Awards Banquet

SATURDAY, NOVEMBER 13

7:00 am - 4:00 pm	Exhibits
7:00 am - 7:00 am	Registration/Information
7:00 am - 8:30 am	Foundation Board of Directors Meeting
7:30 am - 8:30 am	Continental Breakfast for Program Registrants with Exhibitors
8:45 am - 12:00 pm	Scientific Program Morning Session: "Treating Borderline Personality Disorder in Public Services" Presenter: Elizabeth E. Weinberg, MD Co-Presenters: A. John Sargent, III, MD and Avrim B. Fishkind, MD "New Patient Oriented Research Findings in Bipolar Disorders:" Maintenance Treatment: Illness Course and Specific Drug Efficacy Presenter: Charles L. Bowden, MD Imaging the Hippocampus, Amygdala and Prefrontal Cortex in Bipolar Disorder in Adolescents and Adults Co-Presenter: Jair C. Soares, MD Mixed States in Bipolar Disorders: How to Classify and Treat Co-Presenter: Vivek Singh, MD
12:30 pm - 2:00 pm	Annual Business Meeting Luncheon
2:00 pm - 5:30 pm	Scientific Program Afternoon Session: "Case Presentations: Treatment of Severe Mood Lability and Aggression in Adolescents in the Juvenile Justice System" Presenter: Brigitte Y. Bailey, MD Co-Presenters: Anne T. Lopez, PhD and Steven R. Pliszka, MD "Stereotactic Functional Neurosurgery for Severely Disabling, Medically Intractable Psychiatric Disorders" Presenter: Terrence S. Early, MD Co-Presenter: Haring J.W. Nauta, MD, PhD
6:00 pm	Board Buses for Riverwalk Reception

SUNDAY, NOVEMBER 14

7:30 am - 1:00 pm	Registration/Information
8:00 am - 12:30 pm	Scientific Program Session Resident Paper Competition Winner Presentation "Ethical Considerations in Privacy for Couples, Families and Groups: Split Alliances, Dual Duties and Trust" J. Ray Hays, PhD, JD "Fibromyalgia Syndrome: Diagnosis, Pathogenesis and Management" I. Jon Russell, MD, PhD

Special Thanks

Texas Society of Psychiatric Physicians recognizes the following organizations for their generous support of the 2004 TSPP Annual Convention & Scientific Program

The TSPP exhibit hall provides an educational experience for meeting registrants by presenting the latest information on products and services related to the psychiatric profession.

Please allow adequate time in your schedule to visit the exhibits and express your appreciation for their participation and support of TSPP's Annual Convention.

EXHIBIT DATES AND HOURS

Friday, 11/12 6:00 pm - 7:00 pm
Saturday, 11/13 7:00 am - 4:00 pm

PLATINUM

Abbott Laboratories
AstraZeneca Pharmaceuticals
Eli Lilly and Company
Forest Laboratories, Inc.
GlaxoSmithKline
Janssen
Texas Foundation for Psychiatric Education and Research
Wyeth Pharmaceuticals

GOLD

TSPP Bexar County Chapter

SILVER

Autoflex Leasing - Dallas, Inc.
Medorizon
The Psychiatrists' Program

BRONZE

Cephalon, Inc.
Cyberonics, Inc. (No Exhibit)
Elsevier Science Medical Publishing
Eppointments Plus
Reckitt Benckiser Pharmaceuticals
Texas Depression & Bipolar Support Alliance
United States Air Force
UTMB Correctional Managed Care

MARK YOUR CALENDARS - 2005 TSPP ANNUAL CONVENTION

NOVEMBER 4-6
Hyatt Town Lake Hotel, Austin

TEXAS SOCIETY OF PSYCHIATRIC PHYSICIANS

2004 ANNUAL CONVENTION & SCIENTIFIC PROGRAM

November 12-14, 2004 • Omni Hotel, San Antonio, Texas

Please complete this 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 24** to receive the discounted registration fee. Registration forms and payments by credit card may be FAXED to TSPP at 512/478-5223.

NAME _____ E-MAIL _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____ PHONE _____

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

REGISTRATION FEES

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.

NUMBER ATTENDING EVENT	DISCOUNTED REGISTRATION (If postmarked before 10/24)	AFTER 10/24
WELCOME RECEPTION - Friday Evening		
#☐ NOT Registered for Scientific Program	$40	$50
#☐ Registered for Scientific Program TSPP Members/Texas Academy of Psychiatry Members/Non-Members/Spouse/Guest	No Chg	No Chg
MEMBERS IN TRAINING/EARLY CAREER PSYCHIATRISTS PROGRAM: "Establishing Your Own Successful Psychiatry Practice – One Doctor's Story" - Friday Afternoon		
#☐ Attending @ No Charge		
SCIENTIFIC PROGRAM - Saturday and Sunday		
#☐ TSPP/Texas Academy of Psychiatry Member	$190	$235
#☐ TSPP/Texas Academy of Psychiatry MIT/ Medical Student	$ 25	$ 35
#☐ Non-Member	$235	$290
#☐ Non-Member MIT/Medical Student	$35	$50
#☐ Allied Health Professional	$ 105	$130
#☐ Spouse	$ 95	$120
#☐ Advocacy Organization Leadership	$ 35	$50

NUMBER ATTENDING EVENT	DISCOUNTED REGISTRATION (If postmarked before 10/24)	AFTER 10/24
TSPP/TEXAS ACADEMY OF PSYCHIATRY MEMBER LUNCHEON		
#☐ TSPP/Texas Academy of Psychiatry Member Luncheon - Friday	$15	$20
AWARDS BANQUET – Friday Evening		
#☐ Awards Presentations/Banquet	$25	$35
ANNUAL BUSINESS MEETING LUNCHEON		
#☐ Annual Business Meeting and Luncheon – Saturday	$15	$20
RIVERWALK RECEPTION – Saturday Evening		
#☐ Riverwalk Reception	$15	$25

TOTAL REGISTRATION FEE ENCLOSED $ _____

#☐ Vegetarian Plate Requested
** No add'l charge if requested prior to 10/24*
*** After 10/24 & On-site add add'l $5.00 for each Luncheon/Banquet Fee*

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

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

Method of Payment

☐ **Check** ☐ **VISA** ☐ **MasterCard** **Credit Card #**_____ **Exp. Date** _____

Name of Cardholder (as it appears on card) _____

Signature _____

Credit Card Billing Address _____
ADDRESS CITY STATE ZIP

CANCELLATION POLICY: In the event of cancellation, a full refund will be made if **written notice is received in the TSPP office by October 24, 2004, less a 25% handling charge. No refunds will be given after October 24, 2004.**

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

An Opportunity to Participate

Foundation Annual Campaign 2004

It's October which means the Texas Foundation for Psychiatric Education and Research is launching its Annual Campaign. Have you given your charitable donation to the Foundation yet?

The Foundation was established as a charitable organization in 1991 to educate the public about psychiatry, psychiatric illnesses and treatments; to increase public awareness of the signs and symptoms of mental illness, the availability and methods of treatment, and the sources of assistance for persons with mental illnesses; to enhance the quality of assistance to the psychiatric patient, particularly by improving access to care, improving conditions in hospitals, mental health centers and other facilities, and changing perceptions of mental illness to increase the understanding of treatment and care; to support research to improve care for the psychiatric patient; to remove any stigma of mental illness which may inhibit or prevent proper care, through educational and public service activities; and, to serve as a clearinghouse for information about all aspects of psychiatry, and as a bridge between psychiatric medicine and the community served by the Foundation.

Since its inception, the Foundation has received 1,136 donations amounting to $250,894. Sources of funding include:

TSPP Members - 57.9%
Individuals - 12.7%
Businesses - 10.8%
Foundations - 14.0%
Organizations - 4.6%.

The Foundation has awarded 79 grants totaling $101,184.59. This year, the Foundation has provided financial support to TSPP for the Annual Scientific Program, to the Depression and Bipolar Support Alliance of Texas for support of educational activities; and to eleven TSPP Chapters to support activities during Mental Illness Awareness Week. Since 1994, the distribution of grants by category has been:

Public Education - 59.7%
Professional Education - 33.4%
Research - 6.9%.

Please give generously to your Foundation.

TEXAS FOUNDATION FOR PSYCHIATRIC EDUCATION AND RESEARCH

ANNUAL FUND 2004

I am pleased to support the Foundation with a contribution of:

☐ $50 ☐ $100 ☐ $250 ☐ $500 ☐ $1000 ☐ $_____

I am pleased to commit a pledge of:

$ _____ payable over the period of _____

DONOR INFORMATION

Name_____

Address _____

_____

Telephone ( ) _____

☐ **Contact me about a PLANNED GIFT.**

Special Instructions/Requests:

_____

_____

_____

Please make your check payable to "Texas Foundation for Psychiatric Education and Research"
401 West 15th Street, Suite 675, Austin, Texas 78701.
Your contribution is tax deductible to the full extent of the law. Thank you for your support!

CALENDAR OF MEETINGS

October 2004

14-16 NAMI Texas Annual Convention
"Delivering on the Promise of Recovery"
Omni San Antonio Hotel
San Antonio, TX
Registration information: 512/693-2000

November 2004

3-6 Learning Disabilities Association Annual Conference
"Yesterday, Today, Tomorrow"
Renaissance Austin Hotel
Austin, TX
Registration information: 512/458-8234

6 Borderline Personality Disorder: Professional, Family and Consumer Perspectives
Cullen Auditorium, 1200 Moursund St., Houston, TX
Sponsored by: The National Education Alliance for Borderline Personality Disorder, The Menninger Clinic and The Menninger Dept. of Psychiatry and Behavioral Sciences at Baylor College of Medicine, and NAMI Metropolitan Houston
Contact: Pam Gierhart, 281/398-2478 or Carolyn Hamilton, CEHamilton@aol.com; www.borderlinepersonalitydisorder.com

12 TSPP Committee and Council Meetings
Omni Hotel
9821 Colonnade Blvd.
San Antonio, TX
Hotel reservations: 210-691-8888
TSPP Office: 512/478-0605

13-14 TSPP Annual Convention and Scientific Program
"Beyond Essentials: Excellence in Texas Psychiatry"
Omni Hotel
9821 Colonnade Blvd.
San Antonio, TX
Hotel reservations: 210-691-8888
TSPP Office: 512/478-0605

FEDERATION OF TEXAS PSYCHIATRY

The Federation was established on July 1, 2004 with the following purposes:

A. to promote the common professional interests of psychiatrists by encouraging their participation as members of state professional psychiatric associations, including the Texas Society of Psychiatric Physicians and the Texas Academy of Psychiatry, and state professional subspecialty psychiatric associations including organizations for Child and Adolescent Psychiatry, Addiction Psychiatry, Geriatric Psychiatry and Forensic Psychiatry;

B. to facilitate the coordination of and work in concert with state professional psychiatric associations and state professional subspecialty psychiatric associations, to unify programs that advance public and professional education and advocacy for psychiatry and persons with psychiatric illnesses;

C. to provide centralized services to state professional psychiatric associations and state professional subspecialty psychiatric associations;

D. to make psychiatric knowledge available to other practitioners of medicine, to scientists, and to the public; and,

E. to promote the best interests of patients and those actually or potentially making use of mental health services.

The *Texas Psychiatrist* is published 5 times a year for its membership in February, April, June, August, and October. ***Members of TSPP and the Academy are encouraged to submit articles for possible publication.*** Deadline for submitting copy to the Federation Office is the first day of the publication month. Copy must be edited, acceptable for publication.

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

Federation of Texas Psychiatry
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