



the central coast PSYCHOLOGIST

Newsletter of the Central Coast Psychological Association
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PRESIDENT'S MESSAGE



By Fred Cutter, Ph.D.

September 10, 2004 is World Suicide Prevention Day! On this day numerous events, conferences, campaigns, and local activities will call public attention to one of the world's largest causes of premature and unnecessary deaths – Suicide. The International Association of Suicide Prevention (IASP) in collaboration with the World Health Organization (WHO) sponsored this day last year and will do so again this year. They encourage community activities, and participation by clinicians, and volunteers.

Each year approximately one million people die from suicide around the world representing one death every 40 seconds. In addition 20 to 50 million nonfatal attempts occur. There are also the many family members and friends whose lives are profoundly affected emotionally, socially, and economically for each suicidal death.

In San Luis Obispo (SLO) County, the actual number of suicidal deaths for 2002 (latest year for complete data) was 37 (29* males and 7 females). *(This includes 2 male suicides at CMC). Using 2000 census data, the population of males was 126,704 and the number of females was 119,947. This yields a suicide rate of 22.8 per 100,000 live males and 5.8 per 100,000 live females. The total suicide rate is 15.0 which is higher than the national suicide rate of 12.0.

All of us would agree that even one suicidal death per year is bad. However, there is such a thing as a base rate

even for suicidal death. I wrote a computer program that estimates the expected number of suicidal deaths in any catchment area. This software uses the known suicide rates for age, gender, divorce, mental illness, depression, and number of prior suicide attempts. I used very conservative guesses for each of these parameters. The number for SLO County was 144.4. The difference reflects the prevention values of providing support, treatment, and problem solving aid to potential victims in the county. We can reduce the number of suicidal deaths even further by practicing our profession. We are not alone in this, but together we do make a difference.

What can we do to facilitate this public and collective effort to raise awareness? We can reach out to other professional and volunteer helpers to engage in any awareness raising activity. I presented these ideas on the July 24th KVEC broadcast of "Partners in Health" broadcast led by Dr. Paul Klosterman. I invite all of you to try to offer something in your areas of expertise. Contact me to join an ad hoc committee ASAP. Our next meeting scheduled for September 10th will be too late for action. We can coordinate our efforts with the announcement of our new web page: WWW.CentralCoastPsych.Org.

Other web pages which are relevant to this topic are:

- WWW.IASP.INFO,
- WWW.Suicideology.Org
- WWW.HHPub.Com/Journals/Crisis
- WWW.SuicidePreventTriangle.Org

IN THIS ISSUE

Request to Help Returning California National Guard Members	2
CCPA Disaster Response Committee	2
CCPA Welcomes New Members & Member Announces Retirement	3
CCPA Member Profile: Emily Rosten, MSW, Ph.D.	3
Local Mental Health Services and The County Budget	4
New Book By Dr. Steve Brody	4
Medication Insights	5-7
Progress Notes of the California Psychological Association.	8-9
Summer 2004 Calendar of Events.	10
2005 California Psychological Association Annual Convention Call for Papers	10
Traveling Psychologists.	10
NEW CCPA WEB SITE	10
Announcements / Advertisements	11

REQUEST TO HELP RETURNING CALIFORNIA NATIONAL GUARD MEMBERS

Dear California Psychologists:

I received the following request via post. Please circulate it among your chapter and division members as soon as possible.

Dear Dr. Hildebrandt:

I am writing on behalf of the thousands of California National Guardsmen who are currently deployed. As you know we are experiencing the largest deployment of Guard and Reserve soldiers since World War II.

As these soldiers return home, often after a year away in a combat zone, there is much that can be done to help ease their return into civilian life.

The California National Guard has an active program, along with the Veteran's Administration, to provide needed services to our Guardsmen. However, California is a big state and our Citizen-Soldiers live everywhere.

I ask that you solicit your members to see who would be willing to see a Guard Soldier and/or family one time pro bono. The psychologist would only do an evaluation and reassure the person about the normalcy of the behavior, or if needed, refer them on for treatment at a Veteran's Administration facility. Your volunteers would ensure that every California Guard Soldier would have a local source to turn to initially. This is not a political issue or statement for your members, but an opportunity to help individual California Citizen Soldiers and the community.

Thank you for your help. Please forward the names and contact information to me at Military Department, 9800 Goethe Road, Box 9, Sacramento, CA 95826-3561. We will compile a list. Again, for all the Guard Soldiers, thank you!"

Sincerely,

Stephen M. Wyman, M.D.

Brigadier General (R)

Special Assistant To the Adjutant General
California National Guard

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CCPA DISASTER RESPONSE COMMITTEE— NOW IS THE TIME TO JOIN THE EFFORT!!!

By Sharon Rippner, Ph.D., Chair, CCPA-DRC

Over a decade ago the APA and the American Red Cross entered into a Memorandum of Understanding that provided a nation-wide network of psychologists, working through their State and Local professional organizations, to respond to crises. The goal was to have a force of well organized and trained psychologists ready to render crisis intervention assistance in the event of natural or man-made disasters. Today that APA/ARC coalition is still intact and there are numerous psychologist disaster response committees/teams throughout the United States that make up the APA Disaster Response Network.

Within California we are organized under the Disaster Response Committee of the California State Psychological Association. The Central Coast Psychological Association has been part of that Committee response from early on. Initially our CCPA Disaster Response Committee was co-chaired by Dr. Terri Quinn and myself. For the last few years Dr. Robert Alberti has been leading the effort, not only in chairing our CCPA DRC but also in coordinating a county wide response with other mental health disciplines. At the first of this year Dr. Alberti retired and I agreed to once again chair the CCPA DRC.

On August 21 and 22 there will be an ARC Disaster Mental Health training in Buellton. This will be a convenient opportunity to get this necessary training if you would like to be an effective part of our local disaster response effort. With the inevitable natural disasters of storms and fires, and now the additional threat of terrorism, it is important that we build a strong local disaster response. A team of psychologists, well trained in disaster response and willing to serve the community, makes a tremendous difference when disaster strikes.

If you are currently a member (active or inactive) of the CCPA DRC, or would like to join this committee, please get in touch with me as soon as possible and no later than August 1. You can reach me via email at sarphd@msn.com or by telephone at 959-9628.

P.S. If you are attending the APA Convention you might want to find your way to the DRN gathering on Wednesday, July 28 from 6:30 to 8:00 PM, poolside (near Paddles Bar) at the Renaissance Ilikai Hotel, Waikiki. But, remember to come back for the August training!!!

CCPA MEMBER PROFILE: EMILY ROSTEN, MSW, PH.D.



I was born and raised in Ithaca, New York, and were it not for Ithaca's winters, might be living there today. When I decided to move to the Central Coast several years ago I told friends that San Luis was like Ithaca on the West Coast—a small college town in a beautiful area with a great farmers' market, some urban culture and a liberal heart.

I left Ithaca to go to college in Michigan, and I have a degree in Special Education for emotionally disturbed children from Michigan State (1981) and a Master's degree in Social Work from the University of Michigan (1983). While an undergraduate I met several deaf children and became interested in learning Sign Language and understanding issues about deafness. After I completed my Master's degree I went to New York City to work as a social worker at a Community Mental Health Center for deaf people located at Lexington School for the Deaf.

I spent a year in New York City and then, for a big change of pace, moved to Little Rock, Arkansas to work at a Rehabilitation Research and Training Center on Deafness. (I remember Bill Clinton as governor, and being astonished that he wanted to run for president.) In between camping, white water canoeing, long visits with a boyfriend in San Diego (that's when I developed my desire to live in California), and some work too, I decided to pursue my Ph.D. in Psychology.

In 1986 I left Arkansas for the State University of New York at Albany. I completed my Ph.D. in 1990, after an internship at the University of Utah Counseling Center in Salt Lake City. I stayed in Salt

Lake for thirteen years, working first at the University Women's Resource Center and later had a full time private practice, where I worked with deaf and hearing, gay and straight, Mormon and non-Mormon clients. Utah was a wonderful place to indulge my interests in hiking, camping, and spending time out of doors as well as the arts— there were great concerts, lots of theater and I always made it to the Sundance Film Festival. Unfortunately, despite its natural beauty and wonderful charm, as a political liberal I found Utah's hyper religiosity and conservative politics a bit taxing.

In 2002, I decided to indulge my inner California girl and moved to the Central Coast. I enjoy my work with severely mentally ill, "mentally disordered offenders" at Atascadero State Hospital. After years of private practice it is wonderful to have paid health insurance and vacations. Nonetheless, both for the variety and the extra income, I am beginning to develop a small private practice evaluating juvenile offenders and conducting child custody evaluations. In my free time (and there is never enough of it) I am having fun exploring the Central Coast. I also enjoy the arts, good books, traveling and spending time with friends.

You may contact Emily at 466-0004, 468-2302, or emily@tcsn.net

CCPA WELCOMES NEW MEMBERS

CCPA welcomes two new members. Dr. Joseph Holifield graduated from Loyola University in 1999 and works with the Templeton Unified School District. He would like to know more about our Information and Referral Service.

Dr. Leslie Bolin is a neuropsychologist employed both at Atascadero State Hospital and in private practice with Dr. Jane Fong at the Pact Clinic in Paso Robles. Les is interested in becoming involved in the CCPA newsletter, Continuing Education, and Information and Referral. Welcome aboard, Les and Joe!

CCPA MEMBER ANNOUNCES RETIREMENT

Margaret O'Neill, Ph.D. has announced her retirement from the practice of psychology. She has been an active and loved member of CCPA for many years and has provided leadership as co-president, treasurer, and continuing education chair. We will miss her as she will be leaving the area by August 30. Dr. O'Neill would be happy to hear from friends and colleagues. You can contact her at (805) 995-2651.

LOCAL MENTAL HEALTH SERVICES AND THE COUNTY BUDGET

By Dale Wolff, Ph.D., Director, San Luis Obispo County Behavioral Health

Well, there's bad news and there's good news. The bad news is there will be a million dollars less County mental health service capacity in 2004-05. The good news is that the cut isn't three million or more. When negotiations began, it was over the bigger numbers, as both State and local projections were grim. Then the County Administrator came up with about \$800,000; the Governor's Revised Budget promised \$200,000 back from expected cuts; the Sheriff helped out by funding a couple of therapist positions; and the Board of Supervisors voted to fund Transitions' Growing Grounds and socialization programs with \$371,000.

Of course, none of the restorations were as easy as all that. It took a lot of analyzing, balancing, calculating, explaining, promising, horse-trading, staff-soothing, outcome-projecting, pleading, and political advocating to get to the result we achieved. An important piece of the advocacy came from a community task force including our own Dr. Fred Cutter, who addressed the Board of Supervisors with data and persuasive logic.

It is, of course, a great relief that the disaster was avoided that would have eliminated two outpatient clinics, a youth treatment facility, part of the school site youth program, and virtually all of the contracted rehabilitation services.

Nevertheless, the cuts remaining are significant, for the third year in a row. There will be four fewer therapists to provide outpatient services, a reduction in family advocacy and elimination of the parent advocate program, a cut of \$100,000 in vocational assistance, less case management, and a loss of administrative positions, even as regulations and compliance demands keep proliferating. The impacts in the community will include longer waits for anything but emergency-type service, fewer visits for shorter durations, and less help getting beyond immediate symptom relief and back into full functioning and meaningful recovery.

We look toward Sacramento for some major revision of flawed funding formulas in respect to mental health allocations, or to California voters to decide it's time to help by passing a major mental health initiative on the November ballot.

As of November 1, I'll be rooting from the sidelines as I retire from the County, taking my record of 27 years as a local mental health director and daring anyone to beat it without taking steroids or blood pressure medicine. The support of the local psychology community has been appreciated!

NEW BOOK BY DR. STEVE BRODY

Dr. Steve Brody has written a new book, soon to be published, entitled *The New Commandments*. He provides us with the following synopsis of this inspirational story.

SYNOPSIS

Dr. Peter Hart is hearing voices—not usually a good thing for a psychologist. His wife of twenty-five years has died, and the world is on the brink of nuclear Armageddon.

Can Peter find peace—for himself, and the world—before Islamic extremists blow up New York, London, and Tel Aviv? They have already destroyed Washington, D.C.

Haunted by Einstein's warning that, "The unleashed power of the atom has changed everything save our modes of thinking, and we thus drift toward unparalleled catastrophes," Peter's mission, inspired by the voices, becomes clear: to change these "modes of thinking" with ten new commandments.

Overwhelmed with grief and loneliness, Peter digs deeper into what he calls the silence, or Presence, or God, and learns to fill the emptiness with "faith, not fear"; Spirit, rather than ego. From New York to the Middle East, a world movement emerges—spearheaded by his commandments—as Peter delivers his final message on the eve of the terrorists' deadline.

Spouting Biblical prophecy about the Anti-Christ, Pastor Vern stalks Peter from the Blue Mountains of Oregon to the thrilling conclusion in Jerusalem. Islamic extremist Enrique also shadows Peter, threatening to kill him and his daughter, Terra. CIA Director Ted Sizemore must choose between his duty as an American and his faith as an evangelical Christian.

As Islam and the West hurtle toward disaster, author and psychologist Dr. Steve Brody draws from the wisdom of the world's many voices of faith—as well as proven principles of conflict resolution—to reveal ten principles for achieving universal (and personal) peace.

Siddhartha and the *Celestine Prophecy* meet Tom Clancy in this suspense-filled, inspirational journey. From the mystic teachings of Sufi poet Rumi, to the stirring parables of Jesus and the Jewish prophets, this uplifting spiritual thriller will fill your soul while leaving you on the edge of your seat.

Although *The New Commandments* is fiction, the world's political and religious realities are not. Muslims grow increasingly hostile toward the United States. America becomes more militant in its response. And weapons of mass destruction proliferate. Can we change these "modes of thinking" as Einstein called them? Or must we inexorably "drift toward unparalleled catastrophes?"

The New Commandments says that we *can* change how we think about and resolve our differences—both internationally and within ourselves—and with page-turning suspense, shows the way.

MEDICATION INSIGHTS

By Fred Raleigh, Pharm.D., BCPP

Polypharmacy: Wicked, Good or Simply Misunderstood?

Before we begin our discussion about the management of bipolar and other mood disorders I have been asked by your editor to discuss the issue of polypharmacy. Why don't we begin by trying to define the term polypharmacy? Let us look at both the long standing classical definition and what seems to be emerging, based on the pharmacological profile of the newer chemical moieties that are available today for the management of various psychiatric conditions.

In a classical pharmacological sense, the term polypharmacy refers to the practice of using more than one agent from the same therapeutic class, order, or group of medications to treat the presenting symptoms or condition. For example, using two members from the thiazide diuretic family to manage blood pressure or using two antidepressants from the tricyclic class to manage depression. For years this definition swayed many prescribers and dictated what patients received to manage their symptoms. Many consumer advocacy groups also lobbied for a reduction in the practice of polypharmacy. There were even some legislative mandates as a result of this lobbying. One example of these mandates can be found in California's Department of Mental Health, where there has been a long standing practice to not allow the use of "polypharmacy" unless there was a second opinion and other evidence that non-polypharmacy practices had been documented to be a failure or unsuccessful in managing the patient's presenting symptoms.

Yet, over the last several decades, since this classical definition became accepted, there have been some significant advances in our technology that might give us pause to change our thoughts on the matter of polypharmacy in the classical sense. First, we can now more accurately measure a chemical compound's receptor affinity. Second, many newer chemical moieties have multiple receptor affinities whose degree of affinity varies from agent to agent in the same class or family. Third, our knowledge of

brain circuitry and where the psychiatric agents appear to be exerting their influence has improved significantly with the advent of non-invasive technologies (i.e. MRI, PET, ligands, tagged isotopes, etc.) that allow us to peer into the human mind to see what neurocircuitry might be responsible for the actual cluster of presenting behavioral symptoms. This last item appears to have significant importance on how we are now using and will use psychiatric medications in the future. Finally, it is not the similarity of these newer products' receptor affinities that make these agents unique, it is the disparate receptor affinities that these products possess that account for their diverse activity against various psychiatric symptom clusters.

What do we mean when we say disparate receptor affinities? Let's look at the now widely used atypical agents to expand on this thought. The majority of the newer atypicals, with the exception of aripiprazole (Abilify), are collectively and colloquially known as the "S₂D₂ Me Too" agents. What this means is that the agents risperidone (Risperdal), olanzapine (Zyprexa), quetiapine (Seroquel) and ziprasidone (Geodon) all share the same ability to block dopamine-2 and serotonin-2 type receptors in certain areas of the brain. This receptor blocking activity occurs with varying degrees of affinity at both the dopamine and serotonin receptors impacted. In addition, these same agents have different receptor binding affinity not only for the dopamine and serotonin receptors but also for numerous other brain receptors and neurotransmitters including, but not limited to, histamine receptors, muscarinic receptors, noradrenergic receptors and in some cases even NMDA or glutamatergic receptors. It is these agents' ability to bind with different degrees of affinity, from full to partial blocking, that makes the newer atypical agents unique despite the fact that they fall into the same class of psychiatric agents. A similar phenomenon is seen with the newer mood

Medication Insights continued on page 6...

modulators or anticonvulsants. We will continue this line of thought for these newer anticonvulsants when we begin our discussion on the management of mood disorders.

The ability of the newer psychiatric medications to have different degrees of measurable receptor binding affinity is what makes the use of more than one of these agents at the same time in the same patient a valuable alternative to monotherapy depending, of course, on the current state of the symptoms being managed.

If we consider the classical definition of polypharmacy a clinician would not need to prescribe two members of the atypical family together for they would both be doing the same thing. Or would they? If a compound has a different receptor binding affinity profile, even though it is in the same grouping, is it indeed exerting the same influence as the other members in the same group? My purpose here is to not debate semantics but to pose questions for the reader to consider. I would like to elaborate on this point a bit further with the example given below.

Suppose a clinician institutes therapy with olanzapine (Zyprexa) at a beginning dose of 10 mg. At this dose the clinician notices some minor but discernible improvement in presenting symptoms. Though there is some minor improvement the patient is still bothered by the symptoms and agrees to an increase in the dose to see if increasing the dose will help to ameliorate the symptoms. Sure enough, each successive dose increase brings a reduction in the symptoms until such a time as the patient reports satisfaction with the relief provided by the prescribed agent. And by satisfaction, I mean that the patient and/or family and, if relevant, supportive staff are also comfortable with the results of this line of therapy. Unfortunately, there is just one small problem and that is the final dose that brings about resolution of the patient's presenting problems; in our case it takes 250mg of Zyprexa to bring the patient's symptoms under control. The cost for 250mg of this product is prohibitive for this patient and the patient cannot afford to purchase the medication after discharge. Insurance refuses to pay

for doses over accepted FDA dosing guidelines. What is the clinician to do?

In one sense the clinician has used a practical prescribing scenario using just one agent from the group of atypicals and has slowly increased the dose until symptoms resolve or abated without intervening side effects that might have required stopping the agent or reducing the dose to a less effective level. Yet, is it possible that the reason the dose of our sample product had to be increased to the effective dose mentioned was because of this agent's receptor affinity? Though I cannot answer this question with certainty I can volunteer some information that may shed some light.

In the original clinical trials that led to FDA approval for the respective atypical agents, it was found that each atypical had a differing ability to deal with the cluster of behaviors known as positive or negative symptoms associated with schizophrenia. For example, of all atypicals approved, only risperidone showed statistically significant improved efficacy against the reference product, haloperidol (Haldol), for relieving both positive and negative symptom clusters. Olanzapine, during its clinical trials, showed superior efficacy to the reference product for management of negative symptoms but not positive symptoms. Similar results were also seen with both quetiapine and ziprasidone. Does this mean that these agents are not as valuable as risperidone? No, it just means that the dose employed in clinical trials before receiving FDA approval did not equally address both positive and negative symptoms. Thus, clinicians might find that simple increases in the dose of these agents is all that is required to adequately address the positive and negative symptoms usually seen in schizophrenic patients. In large part the need for a dose increase is due to the agent's receptor binding affinity potential.

Going back to our example of the patient who is stabilized on olanzapine 250 mg per day at significant cost, would it be farfetched to suggest that using two agents from this class, but at lower doses, might provide the same benefit as using one agent, but at higher doses? Would the difference in



MEDICATION INSIGHTS *continued from page 6*

these two agents' receptor binding affinities account for greater neurotransmitter coverage and thus better behavioral circuitry protection?

As previously mentioned, I cannot answer this question just pose it. I can ask at this point that if the total cost for the two atypicals is less than the total cost for the use of one agent and the patient's symptoms are managed equally as well, then is there not a clinically demonstrable case for polypharmacy? Cost-wise and even clinically it might be prudent to use a small amount of a second atypical with more potent dopamine (D-2) blockade along with the primary agent initially prescribed. It might be clinically effective to combine the disparate binding affinity of these two agents from the same therapeutic group to boost the chances for the desired outcome. By definition we are now employing polypharmacy, but with our newer knowledge gained through the use of MRI and similar technologies. Are we harming or helping the patient? Are we costing the patient or the "payer" more or less to treat the condition?

In reality, using a combination of two atypicals at lower doses to accomplish the same thing we would do by pushing the dose of one atypical agent is both pharmacologically sound and economically prudent. Yet, there are many psychiatric and cultural stereotypes that must be overcome to make the practice of simultaneously using two members of the atypical group acceptable to patients and their families, consumer advocacy groups, health insurance plans and payers, and finally the professions involved in the management of the patient with mental illness.

We will close by providing a bit more grist for the mill. Years ago clinicians assigned the responsibility of managing psychiatric patients began to use numerous agents from different pharmacological classes to manage the myriad of symptoms that psychiatric patients present, primarily because it seemed that, in most cases, no one approach was the answer. Consequently, by definition, prescribers were not prescribing polypharmacy because they were not using two agents from the same therapeutic group. Yet, in reality they are treating a disorder of the brain with multiple agents, whose primary pharmacological action is that of a central nervous

system depressant. So even though by a narrow definition, polypharmacy was or is not being practiced, in a broader sense, the primary function of all these disparate agents being employed is to directly impact and depress neurotransmitter activity.

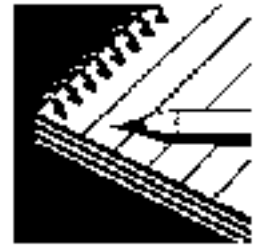
It would appear that some of what we hear and read today might be hype from the industry that brings us these products and clinicians should always be wary of promotional claims. This said, it is also clear that there appear to be distinct and subtle differences between the many psychiatric agents that fall in the same group. Is this uniqueness directly related to the differences in these agents' receptor binding affinity? Or is the difference due to the difference in the individual's number of various types of receptors in the brain? Or is it still beyond our grasp to fully comprehend these observed phenomena?

The purpose of this article is to pose some different ideas about the practice of polypharmacy. The advent of newer psychiatric agents that have a direct impact on multiple neurotransmitters and neurocircuitry due to their multiple receptor affinities should be causing us to rethink just what polypharmacy is today when viewed in a historical perspective. Polypharmacy may not be the same pejorative term it was years ago. Perhaps by now the reader may have a different idea about polypharmacy and realize that the answer is not that polypharmacy is either simple or wicked or good but that the use of polypharmacy is simply misunderstood and more research is needed in the area of polypharmacy to shed some light on this controversial issue.

Questions and comments about this column are welcome. Readers should feel free to contact the author directly by sending your thoughts or comments to
fraleigh@thegrid.net

PROGRESS NOTES OF THE CALIFORNIA PSYCHOLOGICAL ASSOCIATION

EDITOR: Charles Faltz, Ph.D.
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IMPORTANT MANDATORY CONTINUING EDUCATION (MCEP) NOTICE: CHANGES IN VALID CONTINUING EDUCATION (CE) PROVIDERS

Due to changes in the California Board of Psychology's regulations, CE providers of programs for psychologists now have to meet a new requirement to be approved as a recognized CE provider in the State of California. MCEP, APA and California Medical Association have all met this requirement and have been recognized as approved providers, however, the Accrediting Council for Continuing Medical Education (ACCME) has not yet been approved. MCEP and CPA have attempted, on many occasions, to persuade ACCME to request recognition and remain a valid California CE provider. Each attempt, unfortunately, has been unsuccessful. As a result of ACCME's lack of action in this matter, psychologists who are seeking CE credits through ACCME will, for the time being, not receive MCEP credit. For more detailed information on this topic please read "MCEP Acts to Educate and Facilitate Changes Created by BOP Regulation Changes", an article in your July/August issue of the California Psychologist or visit CPA's website at:

<http://www.calpsychlink.org/articles/accme.htm>

THE CPA CENTRAL OFFICE HAS MOVED

The CPA Central Office has a new location as of June 1, 2004. CPA's new contact information is listed below.

New Address:

3835 North Freeway Blvd, Suite 240
Sacramento CA 95834

New Phone Numbers:

CPA: (916) 286-7979
CPA Fax: (916) 286-7971

MCEP: (916) 286-7980

MCEP Fax: (916) 286-7985

Email Addresses:

All email addresses will remain the same.

SERZONE WITHDRAWN FROM MARKET

Bristol-Myers Squibb announced it would no longer make or sell its antidepressant Serzone, which has been linked to life-threatening liver problems. A company spokesperson said the drug, already withdrawn in major markets such as Europe and Canada, was being discontinued worldwide, including in the United States, due to poor sales. The company does not admit that the drug is unsafe. Patients taking Serzone should consult with their prescribers for additional information.

UNDERSTANDING AND TREATING SOCIAL PHOBIA

Social phobia is not only common; it can be chronic and severely debilitating for many people. Recent articles provide information about understanding and treating social phobia and can be found online at:

http://www.counseling.org/publications/jcd/jcd_winter04.pdf

http://www.medscape.com/viewarticle/405792_print

http://www.cnsspectrums.com/pdf/art_337.pdf

ANTIDEPRESSANT DISCONTINUATION SYMPTOMS

The U.S. Food and Drug Administration (FDA) has advised that people who are discontinuing SSRI antidepressants may experience significant symptoms. The symptoms can include severe restlessness, anxiety, insomnia, suicidal thoughts and hostility. Practitioners need to monitor these patients closely when initiating, changing dosages or discontinuing this treatment.

The longer a drug's half-life—the time it takes for half the amount of drug in the body to be eliminated—the less likely it is to cause withdrawal problems. Eli Lilly's Prozac, for example, has a long half-life, remaining in the body for days or even weeks after someone stops taking it. As a result, people who take it are less likely to experience withdrawal effects. GlaxoSmithKline's Paxil, on the other hand, generally leaves the body in a day or two. Effexor, made by Wyeth, disappears faster still. Prescribers advise patients taking antidepressants to avoid skipping doses. People who take Paxil or Effexor sometimes experience withdrawal symptoms when they forget to take their pill for a day or two.

**AVOID MALPRACTICE:
DOCUMENTING SUICIDE RISK ASSESSMENT**

Suicide is one of the most common causes of legal action against mental health professionals. Proper documentation of suicide assessments is a psychologist's best defense in any lawsuit that might occur as a result of a patient's suicide. Proper documentation also serves the higher purpose of providing quality care. Here is a link to an article in Law and Psychiatry written by two attorneys, which discusses the documentation of a suicide risk assessment. For legal advice, a psychologist should always consult an attorney. When a patient suicides, a psychologist should always notify the malpractice carrier. The URL to the article is:

<http://www.reidpsychiatry.com/columns/Stacy%2005-04.pdf>

**MANDATED REPORTING
AND DOMESTIC VIOLENCE**

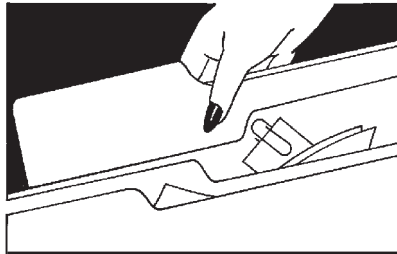
A frequent practice question submitted by CPA members is whether evidence of domestic violence is a mandated report. In general, there is no mandate for psychologists and others who provide mental health treatment to report domestic violence. Accordingly, there is no exception to privilege for psychologists' reporting evidence of domestic violence. A number of years ago an opinion was provided by Legislative Counsel, which found that LCSWs are not included in the domestic violence reporting requirement. The reasoning in the opinion would similarly apply to psychologists. The opinion can be found at:

<http://naswca.org/domviol.pdf>

**UPDATED MEDICARE MENTAL HEALTH
BILLING GUIDE**

The Medicare Mental Health Services billing guide has been updated. It is highly recommended for psychologists who are Medicare providers. It can be found online at:

http://www.medicarenhic.com/providers/billing/menthlth_jun04.pdf



**Bill to Allow Psychological Assistants to Treat
Substance Abuse Signed Into Law**

AB 2182 (Chapter 59, Statutes of 2004), authored by Assemblymember Paul Koretz (D-Los Angeles), adds psychological assistants, marriage and family therapist registered interns and associate clinical social workers to the list of professional persons who can treat a minor who is 12 years old or older for a drug or alcohol related problem. These individuals must be working toward clinical licensure under the supervision of licensed professionals.

This CPA-supported bill is a victory for psychological assistants. CPA was able to negotiate amendments with the sponsors of the bill to include psychological assistants to the list of professional persons, which initially included only MFT interns.

This law will become effective on January 1, 2005.

Resolving Disputes with a Health Plan

The California Department of Managed Health Care has a program that psychologists can use for resolving disputes with health plans regulated by the Agency. Information about the program can be found at:

<http://www.hmohelp.ca.gov/hpp/pr/>

**Free Materials from
SAMHSA Health Education Project**

The Substance Abuse and Mental Health Services Administration (SAMHSA) has launched a multimedia public education effort aimed at increasing public awareness of the stigma and discrimination associated with mental illness. The campaign, "Mental Health: It's Part of All Our Lives," includes broadcast and print public service advertisements that seek to educate the public that mental illnesses are common, affecting almost every family in America, and that recovery can be expected.

The educational materials direct people who would like more information about mental health to SAMHSA's National Mental Health Information Center (1-800-789-2647) — as well as to Web sites in English and Spanish.

www.allmentalhealth.samhsa.gov

www.nuestrasaludmental.samhsa.gov



CALENDAR OF CCPA MEETINGS AND EVENTS

September 10, 2004, 12 p.m.

General Membership Meeting
Place to be announced

September 30, 2004

Newsletter Deadline

November 12, 2004, 12 p.m.

General Membership Meeting
Place to be announced

December 31, 2004

Newsletter Deadline

For further information on all CCPA events, contact Evelyn Alicia, Psy.D.
805-458-2020

CONTINUING EDUCATION OPPORTUNITIES

August 27, 2004

Update on Conducting Risk Assessments of Sex Offenders
Amy Phenix, Ph.D.
Fresno
Contact: 559-456-2777, ext. 2212

October 2, 2004

Rule of Court 5.225 Child Custody Evaluation Mandatory Update 2004
Phil Stahl, Ph.D.
Rebekah Frye, J.D.
Los Gatos
Contact: Alice Handley-Isaksen, Ph.D. jewelbait@earthlink.net

TRAVELING PSYCHOLOGISTS

Dr. Mary Ann West attended the American Psychological Association Convention in Hawaii. She and Dr. Jane Fong are attending the Congress of the International Association for Cross-Cultural Psychology in Xi'an, China and the International Congress of Psychology in Beijing, China in August.

NEW CCPA WEB SITE

By Dana Putnam, Ph.D.

A working version of the new CCPA Web site is now online. Many functions are in place, but the site is not yet completed. Features of the site include separate areas for the public and for psychologists, local and online resources, a member directory and a private member area. Upon completion the site will also include a chat room for member meetings, bulletin boards for member communication, and an email list serve. Please visit the site at: <http://centralcoastpsych.org>.

Dr. Putnam can be contacted at surfdoc@charter.net.

2005 CALIFORNIA PSYCHOLOGICAL ASSOCIATION ANNUAL CONVENTION CALL FOR PAPERS

The 2005 CPA Annual Convention will take place from April 7 to 10 in Pasadena. Presentations are requested in the areas of multiculturalism, quality of life/healthy living, behavioral medicine, medical psychology, preventive health practices, human development, psychopharmacology, forensic psychology, and medical-legal issues.

To submit a presentation proposal, go to www.calpsychlink.org where you will find program types and formats, submission instructions, and other information. You may also contact Annie DeMaria-Norris at 916-286-7979, ex. 121 or adnorris@calpsychlink.org.

INSTRUCTIONS TO CONTRIBUTORS

Contributors should use APA style. Articles may be submitted by e-mail or as hard copy and 3.5" (DD/HD) PC disk. Disk file format should be IBM compatible. Deadlines are June 30, September 30, December 31, and March 31. Contributions should be mailed or e-mailed to the editor.

WHAT'S YOUR EMAIL ADDRESS?

If you did not list your email address on your current membership renewal or if your email address has changed, please forward the current address to Bill at bsafarjan@tcsn.net.

TOOT YOUR HORN!

Won any award lately? Been asked to speak at a prestigious event? Published a book or an article? We want to know about it. Send your submissions to the editor.

If you have a professional website, please send a brief paragraph describing its content and audience and a short biographical statement to the editor.

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