California Psychiatrist

The Newsletter of the California Psychiatric Association

Volume 27, Number 1 Spring 2012

The President's Message

In Closing...

Barbara Yates, M.D.

By Barbara Yates, M.D.
CPA President

It's hard to believe my two-year presidency is coming to an end. It has been full of wonderful experiences, and I will have many memories to take with me as I transition to Past President. For example, in the last two weeks, I have been involved in meetings at the national, state and local levels.

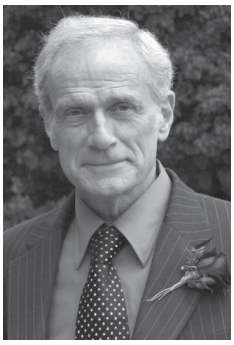
At the national level, I was delighted to attend Advocacy Day for the APA. The day of training was valuable for the updates on legislative issues, the viewpoints of the invited speakers, and the interactions with colleagues from across the country. Unfortunately, I was ill the day that we went to talk to our legislators, but our California team did an excellent job. The top issues highlighted by the APA were to discuss the negative impact of legislation that is being proposed to define psychologists as "physicians" in the Medicare program, and to continue to urge that Medicare's Sustainable Growth Rate (SGR) formula, which would cut payments to physicians by more than 27% if enacted, be fixed. There was also discussion regarding essential health benefits packages, and pleas made to preserve GME funding in an era where there is a projected physician shortfall. Finally, the mental health needs of veterans and returning military with regards to suicide prevention, PTSD research, and Women's Health were discussed.

At the state level, our California Psychiatric Association had its spring council meeting. We continue to work on many different

(Continued on page 10)

From the President-Elect

Sunshine for Laura



Ronald Thurston, M.D.

By Ronald C Thurston, M.D.
CPA President Elect

Laura Wilcox was among three people killed at a Nevada County mental health clinic in 2001, all shot dead by a chronically mentally ill man who refused to resume treatment–despite past benefits and the best efforts of family, physicians and staff.

Laura's death spurred the California Legislature to pass an Assisted Outpatient Treatment (AOT) plan that would likely have averted her death. The bill was signed into law a year after her death. The bill's initial "sunset" provision was later extended until 2013. Now, a bill sponsored by CPA–AB 1569 (Allen)–would keep the sunshine on until 2017.

Laura's Law defines criteria for court-ordered outpatient treatment for seriously ill individuals. The treatment must be likely effective for the illness and the "least restrictive" option for the individual who–despite grave disability, hazard to self or others, repeated hospitalizations or incarcerations–fails to access or maintain offered services.

The failure to access and maintain treatment–despite proven advantages–is often because of impaired judgment due to the illness itself. About half of all seriously and persistently mentally ill individuals lack the capacity to realistically assess and respond to their circumstances–something obvious to even the most casual observer.

Laura's Law is fully implemented

(Continued on page 10)

Inside This Issue

From the Editor ...

Yvonne B. Ferguson, M.D., MPH

Dear Members,

State budget shortfalls, revamping of the Department of Mental Health, insurers waiting in the wings for the Supreme Court ruling on Healthcare reform, and information technology advances are but a few reasons to be involved with your professional organization. Don't just remain "in the loop" but become proactive and interactive with CPA. We like to hear from you and we listen to your feedback. Welcome your new officers at this year's annual meeting in Dana Pointe and stay connected with us.

--Yvonne B. Ferguson, M.D., MPH, Newsletter Editor

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APA WebSite: www.psych.org

Table of Contents

Spring 2012

Capitol Insight Special Insert

REMINDER!!!

The California Psychiatrist will eventually be converting to an electronic newsletter. Please send your confidential email address to Lila-schmall@calpsych.org If you do not send an email address you will still get your newsletter by regular mail.

Legal Update

A Cautionary Tale About Off Label Prescribing

Daniel H. Willick, Esq.

By Dan Willick, J.D., Ph.D.

A. Introduction.

In 2006 the federal government indicted a psychiatrist, Dr. Peter Gleason, for conspiracy to illegally market the prescription medication Xyrem for unapproved medical uses. The conspiracy was alleged to be one involving the manufacturer of the drug and Dr. Gleason, who was paid fees to present speeches and seminars advising physicians that Xyrem could be prescribed for off label uses, including to treat depression and pain relief. (Xyrem had been approved by FDA for the treatment of narcolepsy.) Media accounts indicate that Dr. Gleason was prescribing the drug for off label uses by his patients as well.

When the dust ultimately settled, Dr. Gleason pleaded guilty to one misdemeanor count of engaging in interstate commerce of a misbranded drug for which he was placed on probation for one year and paid a nominal fine. Additionally, his license to practice medicine in Pennsylvania was suspended on the grounds that he failed to disclose his arrest and federal conviction in his licensing application. The licensing agency in Maryland reprimanded him for improper patient record keeping. Because of the suspension in Pennsylvania, his California license was suspended for a year by the Medical Board of California. Dr. Gleason committed suicide in early 2011. However, the Florida licensing board filed a complaint against his license in July of that year, apparently not knowing of his death. These sad events raise the question of the extent to which physicians may be prosecuted for promoting off label use of medications. They also raise issues of whether physicians, particularly psychiatrists, face inordinate risks of malpractice claims when they engage in off label prescribing.

It is significant to note that the recent decision by the United States Supreme Court in the case of *Sorrell v. IMS Health Inc.*, 131 S.Ct. 2653, 180 L.Ed. 2nd 544 (2011), may greatly undercut the ability of the federal government to sue pharmaceutical manufacturers for alleged illegal marketing promoting off label use of drugs. The *Sorrell* decision overturned a Vermont statute which prohibited the sale of prescriber-identifying information to drug companies for use in marketing. The U.S. Supreme Court ruled that the law was a violation of the First Amendment right to free speech. There is much discussion about whether the ruling in *Sorrell* will be expanded to bar FDA prosecution of manufacturers for advertising off label uses of medications. FDA regulations and federal law prohibit promotion of a drug for uses which are not FDA approved – so called off label uses. Nevertheless, the story of what happened to Dr. Gleason is a cautionary tale which urges care in off label marketing or prescribing and his case suggests physicians not promote off label use of medication in return for payment by the medication manufacturer.

Prudence suggests that physicians who prescribe off label use of medications should take the points described below seriously.

B. General Guidelines.

The general rule is that physicians may be permitted to prescribe a drug cleared by FDA for sale for one purpose for an off label purpose, if the use of the drug is safe and effective in the professional judgment of the prescribing physician and is properly documented. Precautions a physician should take when prescribing off label include:

- Review any arrangements the physician may have with the drug's manufacturer to make sure there is no violation of the federal anti-kickback law (42 U.S.C. §1320a-7(b).)
- Examine whether any claim may be made that prescribing off label is a conspiracy with the drug manufacturer to violate the law. Dr. Peter Gleason was paid to present seminars to promote off label use of Xyrem and was charged with conspiracy and alleged to have made misleading statements about the drug.

(Continued on page 4)

- Under AMA guidelines, a physician may prescribe off label use of an FDA approved drug "based on sound scientific evidence and sound medical opinion…". A physician prescribing off label should have peer reviewed scientific evidence to support the prescribing.
- There may be payer resistance to paying for off label use of drugs on the grounds the use is "investigational" and not covered by insurance. Obtain and comply with the health insurer or health plan guidelines for off label prescribing.
- If the off label use is at a medical institution, does the institution require IRB approval? IRB approval is necessary for investigational use.
- The prescribing physician should maintain scrupulous records of the off label use of medications, including records of patient informed consent after truthful disclosure of risks and benefits.
- Since professional liability for adverse outcomes of off label prescribing is a risk, the physician should seek input from his or her malpractice insurer on best practices before prescribing off label.

C. APA Position Statement.

The American Psychiatric Association issued a position statement on the matter ("Patient Access to Treatments Prescribed by Their Physician"), which states in part: "**Prescribing and Reimbursement for FDA-Approved Drugs and Devices for Unlabeled Uses**

(1) APA reaffirms the following policies: (a) A physician may lawfully use an FDA-approved drug product or medical device for an unlabeled indication when such use is based upon sound scientific evidence and sound medical opinion; (b) When the prescription of the drug or use of a device represents safe and effective therapy, third party payers, including Medicare, should consider the intervention as reasonable and necessary medical care, irrespective of labeling, and should fulfill their obligation to their beneficiaries by covering such therapy; and (c) APA encourages the use of three compendia (AMA's Drug Evaluations*; United States Pharmacopeia-Drug Information, Volume I*; and American Hospital Formulary Service-Drug Information) in conjunction with the peer-reviewed literature for determining the medical acceptability of unlabeled uses. (These two compendia currently are being merged as the results of an alliance between the American Medical Association and the United States Pharmacopeia.)" [A more detailed exposition of the APA position statement is available online at the APA website (www.psych.org).]

D. California Law.

California law is also instructive regarding off label prescribing in that it requires health care service plans and insurers to cover off label prescriptions where presented with proof which meets the following requirements (Health & Safe Code section 1367.21, Insurance Code section 10123.195.) The requirements as stated in the California Health & Safety Code are:

"(1) The drug is approved by the FDA.

(2) (A) The drug is prescribed by a participating licensed health care professional for the treatment of a life-threatening condition; or

(B) The drug is prescribed by a participating licensed health care professional for the treatment of a chronic and seriously debilitating condition, the drug is medically necessary to treat that condition, and the drug is on the plan formulary. If the drug is not on the plan formulary, the participating subscriber's request shall be considered pursuant to the process required by [Health & Safety Code] Section 1367.24.

(3) The drug has been recognized for treatment of that condition by any of the following:

(A) The American Hospital Formulary Service's Drug Information.

(B) One of the following compendia, if recognized by the federal Centers for Medicare and Medicaid Services as part of an anticancer chemotherapeutic regimen:

(i) The Elsevier Gold Standard's Clinical Pharmacology.

(ii) The National Comprehensive Cancer Network Drug and Biologics Compendium.

(iii) The Thomson Micromedex DrugDex.

(C) Two articles from major peer reviewed medical journals that present data supporting the proposed off-label use or uses as generally safe and effective unless there is clear and convincing contradictory evidence presented in a major peer reviewed medical journal."

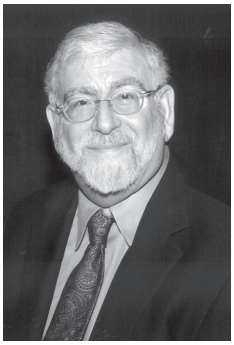
(Continued on page 11)

March, 2012 Board of Trustee's Report

Marc D. Graff, M.D.
Area 6 Trustee

The Board of Trustees met on March 10-11, 2012 in Arlington, Virginia. Items of interest to many included discussion of DSM 5 (proceeding apace with publication expected for May, 2013), Maintenance of Certification and Licensure discussions (many concerns, few reassurances), and budget discussions (so far, so good). The DSM 5 discussions were lengthy and thorough. The review process for DSM 5 is quite complex and now includes input from three separate committees, the Assembly and the Board. Concern was expressed about the greatly increasing number of articles about DSM 5, many of which have a distinctly negative tone. There will be a final public posting of the DSM 5 on the web from May 1 to July 1 of this year, at www.dsm5.org.

Membership continues to be a matter of great concern. Membership continues to slowly decline, (as is true in many other medical organizations) in spite of a number of efforts being made to reverse this. There will be further efforts made to increase membership, including a push to expand the category of international members.


Marc Graff, M.D.

A number of awards, formerly funded by pharmaceutical corporations will now be funded by APA directly.

A proposal from the Assembly about reinstituting the APA State Legislative Institutes was received favorably by the Board, and efforts will be made to make this happen, while taking into account the realities of current finances.

There was discussion about the political winds in Washington and the behavior of various insurance companies in dealing with parity issues and mental health coverage issues. As usual, events are marching rapidly. The Board will meet again during the Annual Meeting in Philadelphia this May.

Area 6 APA Assembly Representative Report

Barton J. Blinder, M.D., Ph.D.
Area 6 APA Representative

As we approach the Annual Meeting in May, I'm pleased to report that the Assembly and its Work Groups have made considerable progress addressing many of our major issues involving membership, access to care, maintenance of licensure and certification, and state legislative initiatives and contacts to advance the interest of patients in our profession.

A number of important Action Papers will be presented to address the difficulty in passing referenda including initiatives involving APA Bylaw changes, extending benefits to seriously ill patients by eliminating co-payments and restrictions on medication and follow-up therapeutic sessions with their psychiatrists, promoting greater participation by members in sub-specialties through more active links with sub-specialty societies, and further extending continuing education benefits by making available during the year to DBs and individual's recordings of the wide array of Courses given at our Annual Meeting.

We expect to hear shortly the result of the Supreme Court's decision regarding the Affordable Care Act and its mandate for individual coverage as well as other critical components. Whether we go forward or significant portions are struck down, the challenges for all of us in providing access to care to our patients will remain.


Barton J. Blinder, M.D.

There are a number of very important concerns on the horizon, including the completion of DSM-5 to be published in 2013 which will involve our further comment as the drafts are finalized for each diagnosis and the results of the clinical trials are fully analyzed. There continues to be concerns with Personality Disorders and especially the ease of diagnosis and the inclusion of dimensions of behavior and severity.

The following areas will require our attention and input:

1. A national movement to decriminalize the use of certain substances in an effort to provide alternatives to

(Continued on page 11)

An Opportunity: Provide State Leadership in Mental Health and Substance Use Services


William Arroyo, M.D.

By William Arroyo, M.D.

There is a current critical gap in California leadership as it pertains to mental health services and substance use treatment. This is largely due to the plan by the current administration to consolidate state agencies and functions, in part, to address the fiscal problems of the state. The administration's proposal is to eliminate the State Department of Mental Health and relocate its functions in other state agencies. In this effort, the position of Deputy Director of Mental Health and Substance Use Disorder Services has now been established within the State Department of Healthcare Services (DHCS). The responsibility of this post is to provide state leadership for mental health and substance use services which is particularly critical as the state moves to implement the various components of healthcare reform. It would be especially advantageous for the residents of California to have a leader who has a depth of knowledge in both mental health and substance use services. The CPA strongly urges any psychiatrist who is interested in this position to contact the State Department of Healthcare Services administration to further inquire about this position.

For more information go to: http://www.dhcs.ca.gov/Documents/Deputy%20Duty%20Statement.pdf

Support for a Mental Health Champion

By Lila Schmall, CPPAC Coordinator

The California Psychiatric Political Action Committee (CPPAC) has lined up a commitment from two CPA psychiatrists to hold fundraisers in their homes for Assemblyman Jim Beall (D- Santa Clara), the winner of the American Psychiatric Association's Jacob Javits award for his legislation requiring that all DSM disorders be covered at parity with other health conditions. He is running for a California Senate seat against a former Chair of the Assembly Insurance Committee, Joe Coto, and insurance companies, many from outside of California, are pouring large sums of money into Mr. Coto's campaign. CPPAC is helping to ensure that Jim Beall has sufficient assets to be competitive in this race for a Senate seat.

Congratulations!

Newly Elected Officers and Deputy Representatives:

CPA President Elect
Timothy Murphy, M.D.

CPA Treasurer
William Arroyo, M.D.

MIT Deputy Representative
David Safani, M.D.

ECP Deputy Representative
Steven Koh, M.D.

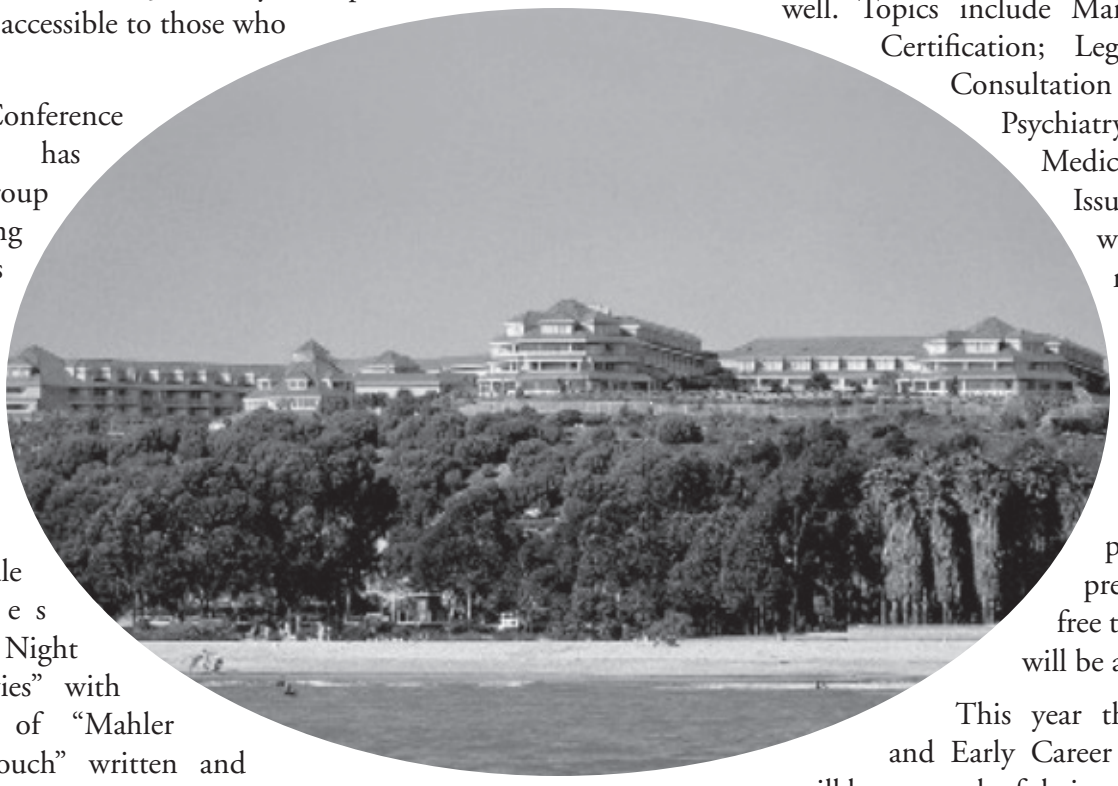
If you are willing to be a Key Contact please email Lila Schmall at Lila-schmall@calpsych.org or call 800-772-4271 for a key contact form.

Save the Date!
Annual Meeting Coming Up – Great Program, Lovely Location

By Lila Schmall, CPA Associate Executive Director

The CPA Annual Conference for 2012 will be held September 28-30, 2012 at the beautiful Laguna Cliffs Marriott Resort and Spa perched atop the cliffs overlooking the Pacific Ocean located in Dana Point, CA.

The Dana Point marina, the Ocean Institute and the sparkling Pacific shoreline are just steps away, and the location is convenient to John Wayne Airport as well as easily accessible to those who are driving.



Your Conference Committee has gathered a group of outstanding speakers to cover a broad range of topics of interest to all psychiatrists.

The schedule includes "Friday Night at the Movies" with a showing of "Mahler On The Couch" written and produced by Percy and Felix Adlon, with Maria Lymberis, MD as discussant.

Plenary sessions will include, John Oldham, MD presenting on "Personality Disorders" and "Organization of Personality Disorders in the DSM 5" We are fortunate to have Dr. Oldham for the full 3 hour session on Saturday.

For Sunday do not miss the session on "Bullying" which is so timely in today's environment. Jerry Weichman, PhD, who sits on the Board of Directors for the *Bullying Prevention Initiative of California* will be presenting. Also we were lucky to get Tim Page, Professor at both the Thornton School of Music and the Annenberg School for Communication and Journalism at the University of Southern California, to discuss his experience growing up with Asperger's Syndrome.

Workshops will be interesting and educational as well. Topics include Maintenance of Certification; Legal Updates; Consultation Liaison Psychiatry and Medically Relevant Issues. There will be 2 or 3 more CME credits offered on Saturday afternoon for those who prefer the presentations to free time. Courses will be announced.

This year the Residents and Early Career Psychiatrists will have a track of their own scheduled for Saturday afternoon. Please look for more information on the CPA website as it becomes available.

As always both the Legislative Luncheon and the PAC Major Donor Dinner will be invigorating and informative.

Please look for the Annual Conference brochure in early summer!

APA Advocacy Day March 13th, 2012

Steve Koh, M.D.

By Steve Koh, M.D.
and Larry Malak, M.D.

The American Psychiatric Association (APA) held its annual Advocacy Day in Washington DC this year from March 12th to 14th. The focus was to have APA members visit Capital Hill and speak with various Representatives, Senators and their staff about issues facing the field of psychiatry and healthcare.

Advocacy Day started with daylong updates on current federal legislative issues and political climate by APA's staff. The staff were crucial and instrumental in helping us understand complex issues. This preparatory day enabled us to be prepared for the visits on the Hill.

Meetings were held with the staff of a number of Representatives and of Senator Diane Feinstein. Some of the issues discussed pertained to all of healthcare and medicine, including the permanent fix to Medicare reimbursements along with the repeal of Sustainable Growth Rate and the maintenance of federal funding for Graduate Medical Education. These two subjects were very well received and although the repeal of SGR is difficult, all members of the hill agreed the temporary fixes led to great uncertanty for doctors continued participation and potential poor access for patients.

More specific to the field of psychiatry, concerns were raised regarding the mental health and treatment of our veterans. With many VA's not able to provide comprehensive women's services and the staggering number of suicides in our veteran population, a strong push was made for increasing services and for the continued funding of research of traumatic brain injury and post traumatic stress disorder. Looking at the influx of returning veterans from Iraq and Afghanistan, all our local representatives voiced their strong support and willingness to help support these issues.

Larry Malak, M.D.

Additionally, the maintenance and application of mental health parity was discussed. Parity legislation has been passed, but the continued enforcement of this law is increasingly important as the Essential Health Benefit package is defined and the Affordable Care Act is implemented. Our representatives were supportive on this topic as well and agreed progress must not be undone as we move forward with healthcare reform.

Overall, the trip to Washington DC was an informative experience. Much was learned about the legislative process and how it can benefit our field and our patients. It was clear that physicians' experience, voice and perspectives are well respected by our elected officials. Even though we are all in different career stages, together we represent the profession of psychiatry and experiences like this underscore the importance of advocacy. Ultimately, we work for our patients' wellbeing. Advocacy has an important role in our effort. It was an honor to represent our colleagues and peers in DC.

Letter to the Editor

Dr. Thurston's article in the recent newsletter concerning Marijuana touches on important points to consider. In turn, several come to mind. While it is clear that chronic use of Marijuana can be detrimental to those with Anxiety, Mood, and Psychotic Disorders, there seems to be a constant confounding of the perils of chronic use of Marijuana with the potential legality of its obtainment. The two issues seem different. We already know that Marijuana is detrimental to such persons with the drug precisely in its current illegal, *not* legal, state. Those who are bound to abuse Marijuana already do so, illegality be damned. Clearly, there isn't that much difficulty in obtaining it. Whether legalizing it makes it that much more detrimental is thereby unclear. We don't know what percentage of people who might have a predisposition towards the aforementioned disorders would necessarily have them uncapped by initiating use of Marijuana. Issues of potency and frequency of use are necessarily pertinent in this discussion. While it is plausible that increased ubiquity of the drug does make more likely it's use amongst some persons, it's also not clear what percentage of people who heretofore hadn't tried it would thereafter persist in its use. The analogy is along the lines of alcohol. The legality of alcohol allows some to drink to get drunk, but not all people who decide to get drunk necessarily persist in doing so beyond a point. For that matter, not all people who try alcohol in one form or another necessarily persist with it, drunkenness notwithstanding.

Alternately, what we do know is that Alcohol is hugely deleterious and on any number of medical fronts, costing an exorbitant sum in health care dollars each year. The CDC notes that the cost of excessive alcohol consumption in the United States in 2006 reached $223.5 billion or about $1.90 per drink. It has also indicated that excessive alcohol consumption is the third leading preventable cause of death in the United States and is associated with multiple adverse health consequences, including liver cirrhosis, various cancers, unintentional injuries, and violence. And yet, not only has alcohol been legal for decades, certainly to remain so indefinitely, but moreover it is hugely lauded and promoted. It is as much a part of our social fabric as are clothing, cars, and politics. Yes, there can be a different social consciousness about it because it isn't expressly used by all by which to become grossly inebriated but it would be an outright lie to say that it was initially banned, and thereby predictably gained enormous popularity, because of it's taste. It was, and is, the active ingredient itself, alcohol, a necessarily mind altering one even if but slightly, that is the cornerstone of its popularity. Casual drinkers might be appalled at that notion, but I would defy any of them to have so vested an interest in their drink of choice if none of it any longer contained alcohol. And even after all the decades' worth of data that more than proves it's deleterious effects, no one is even remotely proposing making Alcohol illegal again. But if public health cum welfare is such a concern in this whole debate, why not? Somehow, Marijuana remains vilified. Funny, but I smell something here more than a bit hypocritical, infinitely more acrid than pot smoke itself.

The War On Drugs has also been a colossal failure. By no means has it decreased drug use. In fact, it has increased drug use. In a recent, June 16, 2011 Op-Ed contribution, former President Jimmy Carter notes that the Global Commission on Drug Policy found the global consumption of opiates to have increased 34.5 percent, cocaine 27 percent and cannabis 8.5 percent from 1998 to 2008. It has also hugely increased the number incarcerated in America, escalating from 500,000 people in 1980 to nearly 2.3 million at the end of 2009, the single greatest being those incarcerated for nonviolent drug offenses, increasing more than twelvefold since 1980. The gross misappropriation of money in all of this is staggering. Former California Gov. Arnold Schwarzenegger pointed out that, in 1980, 10 percent of his state's budget went to higher education and 3 percent to prisons; in 2010, almost 11 percent went to prisons and only 7.5 percent to higher education.

So, to what end do we continue to demonize hedonistic pursuit by some by deeming them criminal, as well? We end up smearing the valence of would-be criminality across all people, about as anti-humanistic a consideration as you can get. So, one might not approve of hedonism, true, but to deem it necessarily criminal is criminal itself. As psychiatrists, I'd really like to think that we can voice much more humanism and reason into this increasingly tired debate of whither the legality of Marijuana.

Lloyd Benjamin, MD
Clinical Professor of Psychiatry
UCDMC, Department of Psychiatry

President's Message *(Continued from page 1)*

fronts, and it would be impossible to summarize the more than six-hour meeting here. We addressed items at the national level including a preview of many of the May APA Assembly action papers and updates from our representatives, and heard from committees such as the Access to Care Task Force, which is trying to address mental health care at a national level. At the state level, we received information on state legislation, state departmental reorganization, and budget issues, and we heard updates from our many active committees including reports from the MITs and ECPs, our Annual Meeting Committee, the State Facilities Task Force, Public Psychiatry, and our Judicial Action Committee. OPIC (Organized Psychiatry in California) also gave a report on their review of statements regarding marijuana and suggested CPA establish a task force with expertise to study this issue further.

Finally, at a local level, I greatly enjoyed attending the Northern California Psychiatric Society's recent annual meeting in Monterey. The speakers varied from the more biological to the more psychological, and covered a diverse array of topics from women's issues to ECT treatment. Two of my favorite talks were on "Tiger Mom", which involved a discussion of a driven style of Asian parenting, and an interactive lecture on dreams where I got to exchange a dream with a colleague.

As I look to the future, I think there are a couple of areas that CPA will continue to need to address as an organization. One area is that of how technology can affect our communication. Last summer, we had our first council meeting that was conducted entirely by conference call. Although we did not vote to repeat this experience next summer, meeting in this manner is becoming more and more possible as technology evolves, and having people attend a meeting from a distance could be helpful in getting more people involved. Technology also brings with it new issues to address – such as texting during meetings, or how much can be communicated by email (a recent audio digest speaker talked of email as being as confidential as putting a postcard into the US mail). The other structural area that may need addressing is the change made two years ago to have our APA Area 6 Assembly Representatives be persons other than the CPA President and President-Elect. Although this has allowed much more activity at the national level, I wonder if there is a way to keep this separation but still have our President attend the APA Assembly so that he or she is able to stay better connected on a national level.

In closing, I 'd like to say thank you to the CPA staff, committees, and council, who all work hard to make our organization as great as it is. Thanks to all of you for allowing me to serve as President these past two years. I look forward to continuing in the coming years as Immediate Past President of CPA and as an APA Assembly Representative from the Northern California Psychiatric Society. And as always, I continue to welcome any thoughts or ideas you may have about how we can make the California Psychiatric Association even better.

Sunshine for Laura *(Continued from page 1)*

only in Laura's home county. In 2010, the California State Association of Counties gave Nevada County its Challenge Award, citing overall savings due to reduced hospitalization and incarceration. In 2011, Nevada County received a National Association of Counties Achievement Award in Health. (Los Angeles County has a very limited version of AOT.)

Laura's Law is modeled after Kendra's Law in New York. New York data, and a study of AOT from Duke University, show that these programs improve lives and save money. AOT programs now operate in Iowa, North Carolina, Hawaii, and Arizona.

AOT saves money overall, but the mental health department pays while other departments save. The compartmentalization of county budgets makes overall savings decisions extremely difficult. Unless counties take a full budget view, AOT looks like an added expense for somebody rather than an offset saving for everybody. Moreover, any new mental health program threatens funding security for every other mental health program, arousing vigorous opposition from their constituencies.

Although Laura's death spurred the creation of the California AOT, it did not spur the money to pay for it–such were the politics and resources at the time. AOT was made a county option, and a county funding decision. Despite overall savings, it's still a hard sell.

There are of course genuine civil rights concerns, and the persistent belief that a combination of persuasion and adequate services will reach and recover everyone and–oddly, as one AOT opponent has said, it's ultimately the impaired individual's "own choice to live a more limited life." Other opponents assert–inaccurately–that coercion doesn't work.

I have provided coercive treatment in hospital to thousands of seriously mentally ill individuals–many of them on many occasions–and I can say that it works. Few left angry. Many were grateful. But–despite their own personal experience with treatment success, and the best efforts of family–they often dropped out of treatment; the illness relapsing and they resuming their "more limited–and now more hazardous–life." The current LPS system of short, involuntary holds is too expensive, too crisis-oriented and too hospital-bound to maintain a successful recovery. AOT fills the gap.

Fifty percent of individuals–some say more–who have experienced coercive treatment are forever distrustful of treatment. I read that statistic as good news: 50% of individuals experiencing coercive treatment are not distrustful! The pre-treatment number was, after all, 100%. If they had trusted the system, they would not have ended up in coercive treatment the first time.

Civil rights are a legitimate concern but should not be framed as "patients' rights." We all have the same rights; they're civil rights. When the public defender wins the release of an individual crippled by untreated, yet treatable mental illness, he is striking a blow for all of our civil liberties–at the expense of the mentally ill person. We are all of us guaranteed the right to live our lives unmolested by well-meaning families and healthcare workers, yet most of us would approve intervention to prevent something like suicide.

The discussion needs to be focused on where and how to draw the line between rights and reasonable intervention, and this discussion needs to take into account the crippling effects of mental illness, the real world outcomes for people with mental illness and–fortunately–the availability of effective treatment.

Despite the complications, obstacles and painfully slow start for Laura's Law, the AOT needs to remain an open option. thurstonrc@gmail.com

Legal Update (Continued from page 4)

Finally, the statute cited above requires that, if requested, the physician prescribing off label must submit to the health plan or the insurer documentation that each of the above requirements is met.

E. **Conclusion.**

The guidelines stated above provide an approach to the documentation in medical records for off label prescribing. Such documentation is important to defend against possible malpractice claims and should be followed even if the patient is not covered by insurance or a health plan.

Finally, it has been suggested to me that insurers and HMOs may have formularies which require off label use of medication for certain conditions. I would be interested in knowing if this is true.

Please contact me at dwillick@sbcglobal.net.

If it is true, do the insurers or HMOs which require such off label use provide their physicians with the documentation described above (e.g., reference to peer reviewed articles supporting the off label use; reference to a recognized publication which states the drug is appropriate for the formulary driven off label use)? Perhaps it is appropriate to request such information from the insurer or HMO that is requiring the off label use.

Area 6 APA (Continued from page 5)

incarceration through linkage to the mental health system and more enlightened court proceedings.

2. Increasing evidence of the efficacy of neurostimulatory procedures (RTMS, DBS, and others in development involving ultrasound) in the approach to treatment resistant depression, OCD, and brain injury and dementia, promoting recovery progress in brain injury and preventing degeneration in dementia.

3. The pipeline of new medications in psychiatry has dried up considerably due to funding, disappointing clinical trials, and the antagonistic atmosphere between our profession and industry—this needs correction and a new and better collaborative approach.

4. The scientific basis of our findings in psychiatry, especially pharmacologic trials, has come under criticism for inadequate design, lack of reliability, and withholding of negative results.

On a positive note, I have completed (with the assistance of Peter Forster and the support of Assembly leadership) a survey of all APA DBs assessing financial stability, membership trends, and ability to carry out APA strategic goals locally. Our hope is that the results of this survey will guide the efforts of a new APA work group on APA/DB alignment leading to APA support that will strengthen our DBs. The results will be presented to the Assembly at the Annual Meeting in Philadelphia.

CPA continues to expand and contribute a leadership role in the Assembly and throughout APA.

University of California
San Francisco
UCSF
School of Medicine
Fresno Medical Education Program

UCSF FRESNO CHILD & ADOLESCENT PSYCHIATRY FACULTY POSITION

The University of California San Francisco-Fresno Medical Education Program (UCSF Fresno) and Central California Faculty Medical Group (CCFMG) are recruiting for a faculty position in conjunction with the development of a Child & Adolescent Psychiatry Fellowship within the UCSF Fresno Department of Psychiatry. The faculty member will serve as a clinical educator assisting in the development of the fellowship program and participating in clinical and didactic teaching once the fellowship begins.

The faculty member will also provide clinical services within the mental health programs offered by the Fresno County Department of Behavioral Health, Children's Mental Health Services, the major clinical teaching site of the fellowship. Children's Mental Health Services houses several innovative programs serving youth and families in the child welfare and juvenile justice systems. Candidates with an interest in these areas are encouraged to apply.

The current General Psychiatry Residency Program at UCSF Fresno trains four residents per year in a four-year program. Medical students from UCSF do core and elective rotations at Community Regional Medical Center, another major educational affiliate. Fresno offers a vibrant multicultural community and a modest cost of living with close proximity to national parks and other recreational activities. Salary and faculty appointment are commensurate with experience, with several options for loan repayment. Must be Board Certified/Board Eligible.

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BUTTE COUNTY

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We are a HPSA/NHSC-designated County. Please contact Geoff Davis at gdavis@buttecounty.net or 530-891-2986. J1/H1 Visa applications welcome.

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