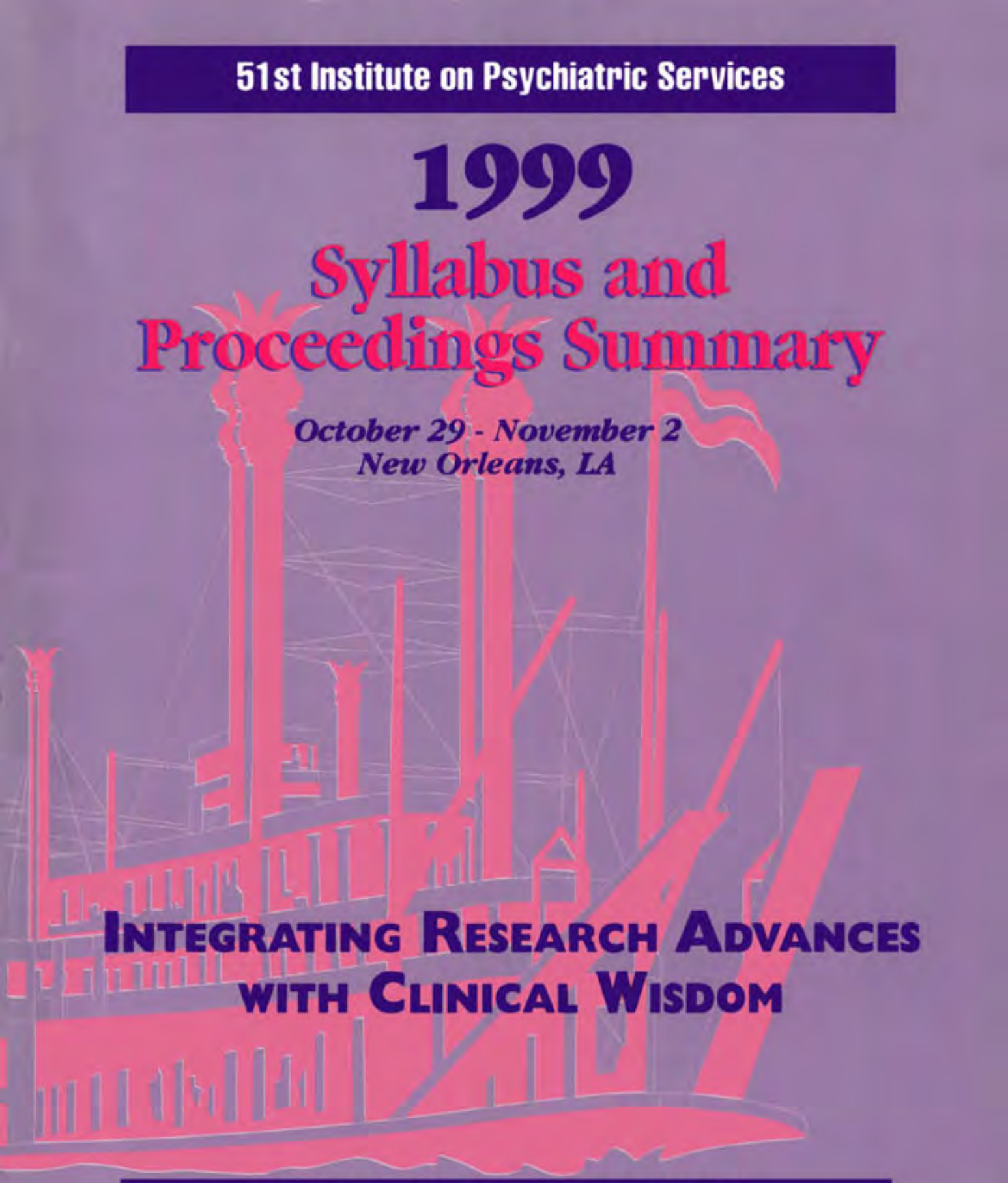
51st Institute on Psychiatric Services

1999

Syllabus and Proceedings Summary

October 29 - November 2
New Orleans, LA



Integrating Research Advances with Clinical Wisdom

American Psychiatric Association

CERTIFICATE OF ATTENDANCE

This certificate provides verification of your completion of educational activities at the 1999 Institute on Psychiatric Services.

This is to certify that

_____

Attended the 1999 Institute on Psychiatric Services of the
American Psychiatric Association
October 29-November 2, 1999
New Orleans, LA

and participated in _____ hours of CME activities that have met the criteria for category 1 credit.

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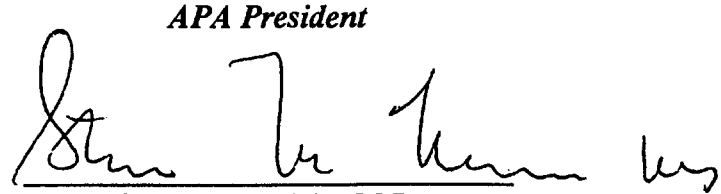
APA President



Steven M. Mirin, M.D.
Medical Director

The American Psychiatric Association (APA) is accredited by the Accreditation Council for Continuing Medical Education to sponsor continuing medical education for physicians.

The APA designates this educational activity for up to 48 hours in category 1 credit towards the AMA Physician's Recognition Award and for the CME requirement of the APA. Each physician should claim only those hours of credit that the/she actually spent in the educational activity.

DAILY LOG FOR ATTENDANCE AT CME FUNCTIONS AT THE 51ST INSTITUTE ON PSYCHIATRIC SERVICES OCTOBER 29-NOVEMBER 2, 1999 • NEW ORLEANS, LA

NOTE: Members are responsible for maintaining their own CME records. A copy of this Certificate may be forwarded to other organizations requiring CME verification. Reporting is on an honor basis.

DAY	TITLE OF SESSION	NUMBER OF HOURS/CME CATEGORY
	TOTAL	

HOW TO OBTAIN CME CREDIT FOR THE 1999 INSTITUTE ON PSYCHIATRIC SERVICES

The American Psychiatric Association is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to sponsor continuing medical education (CME) for physicians. The APA certifies that the continuing medical education activities designated as category 1 for the 1999 Institute sessions meet the criteria for category 1 of the Physician's Recognition Award of the American Medical Association and for the CME requirements of the APA.

The scientific program at the Institute offers a broad range of sessions designated for CME credit. The sessions that meet the criteria for category 1 credit include CME Courses, Full-Day Sessions, Industry-Supported Symposia, Innovative Programs, Lectures, Medical Updates, Multimedia Sessions, Symposia and Workshops. Other sessions, designated for category 2 credit, include Clinical Consultations, the Debate, Discussion Groups, Forums and Posters.

NOTE: **APA members must maintain their own record of CME hours for the meeting. To calculate credit, registrants should claim one hour of credit for each hour of participation in category 1 scientific sessions.** To document that credit, participants should record the session(s) attended on the back page of the **Certificate of Attendance found on page ii, in the front of this book.** This Certificate is for your personal records and may be forwarded to other organizations requiring verification. Documentation of all CME credit is based on the honor system.

CME REQUIREMENTS FOR APA MEMBERS

By referendum in 1974, the membership of the American Psychiatric Association (APA) voted that participation in continuing medical education (CME) activities be a condition of membership. The CME requirement aims at promoting the highest quality of psychiatric care through encouraging continuing professional growth of the individual psychiatrist.

Each member must participate in 150 hours of continuing medical education activities per three-year reporting period. Of the 150 hours required, a minimum of 60 hours must be in category 1 activities. Category 1 activities are sponsored or jointly sponsored by organizations accredited to provide CME and meet specific standards of needs assessment, planning, professional participation and leadership, and evaluation of learning.

In December 1983 the Board of Trustees ratified the current method of reporting CME activities. Although the basic requirement of 150 hours every three years (with at least 60 hours in category 1) remains the same, members no longer need to report these specific activities, but need only sign a compliance statement to the effect that the requirement has been met.

Individual members are responsible for maintaining their own CME records and submitting a statement of their compliance with the requirement after completing the necessary 150 hours of participation. **APA certificates are issued only upon receipt of a complete report of CME activities.** To receive an APA certificate, you can submit a completed APA report form or use one of the alternate methods detailed below.

HOW TO EARN A CERTIFICATE FOR CME COMPLIANCE

As an APA member, you can obtain an APA CME certificate by using one of the following methods:

If you are licensed in California, Delaware, Florida, Georgia, Hawaii, Iowa, Kansas, Maine, Maryland, Massachusetts, Michigan, Minnesota, Missouri, Nevada, New Hampshire, New Mexico, Ohio, Rhode Island or Utah, **you may demonstrate that you have fulfilled your APA CME requirements by sending the APA a copy of your re-registration of medical license.** These states have CME requirements for licensure comparable to those of the APA. Your APA Certificate will be valid for the same length of time as the re-registration.

(Continued)

HOW TO FULFILL THE CME REQUIREMENTS OF THE APA

If you hold a current CME certificate from a state medical society having CME requirements comparable with those of the APA, **you may receive an APA CME certificate by sending the APA a copy of your state medical society CME certificate.** The APA will issue a CME certificate valid for the same period of time. The state medical societies currently having CME requirements comparable to those of the APA are Kansas, New Jersey, Pennsylvania and Vermont.

If you have a current AMA Physician's Recognition Award (PRA), **forward a copy of your PRA to the APA** and you will receive an APA CME certificate with the same expiration date.

You may also **report your CME activities directly to the APA,** using the official APA report form. This form may be obtained from the APA Office of Education, 1400 K Street, N.W., Washington, DC 20005, or call (202) 682-6179 or filed electronically via the APA Home Page at http:/www@psych.org.

APA REPORT FORM

CME credits are reported to the APA Office of Education by category as described below.

CATEGORY 1:

Continuing Medical Education Activities with Accredited Sponsorship (60 hours minimum, no maximum). Category 1 activities are sponsored by organizations accredited for CME and meet specific criteria of program planning and evaluation. Fifty hours of category 1 credit may be claimed for each full year of internship, residency or fellowship training taken in a program approved by the Accreditation Council for Graduate Medical Education (ACGME). Fifty hours of category credit (25 hours each for Parts I and II) may be claimed for the successful completion of the certification examinations of the American Board of Psychiatry and Neurology or the Royal College of Physicians and Surgeons of Canada. In addition, 25 hours of category 1 credit may be claimed for the successful completion of each of the following certifying examinations: in Addiction Psychiatry, Child Psychiatry, Administrative Psychiatry, Forensic Psychiatry and Geriatric Psychiatry. The other 90 credits may be taken in additional category 1 activities or spread throughout activities in category 2.

CATEGORY 2:

Category 2 activities are those that have no accredited sponsor certifying them for Category 1 CME credit. Some programs are presented by accredited sponsors, but do not meet the criteria for category 1 and therefore, are designated as category 2. Other activities included in category 2 are medical teaching, reading of professional literature, preparation and presentation of papers, individual study programs, consultation and supervision, and preparation for board examinations. You may claim credit for activities in category 2 on an hour-for-hour basis.

EXEMPTIONS

All APA Life Fellows and Life Members who were elevated to that membership category on or before May 1976 are exempt from the CME requirement, but are urged to participate in CME activities. Members who became Life Members or Fellows after that date are not exempt.

Any member who is inactive, retired, ill or disabled may request an exemption from the CME requirement by applying to his or her District Branch Membership Committee. After determination that partial or total exemption from CME activities is warranted, the District Branch Membership Committee will forward its recommendation to the APA Office of Education.

APA members residing outside of the United States are required to participate in 150 hours of CME activities during the three-year reporting period, but are exempt from the categorical requirements.

CONTINUING MEDICAL EDUCATION

SYLLABUS AND PROCEEDINGS SUMMARY

FOR THE

51ST
INSTITUTE ON PSYCHIATRIC SERVICES

October 29–November 2, 1999

New Orleans, LA

The American Psychiatric Association
Institute on Psychiatric Services
1400 K Street, N.W.
Washington, DC 20005
1-888-357-7924

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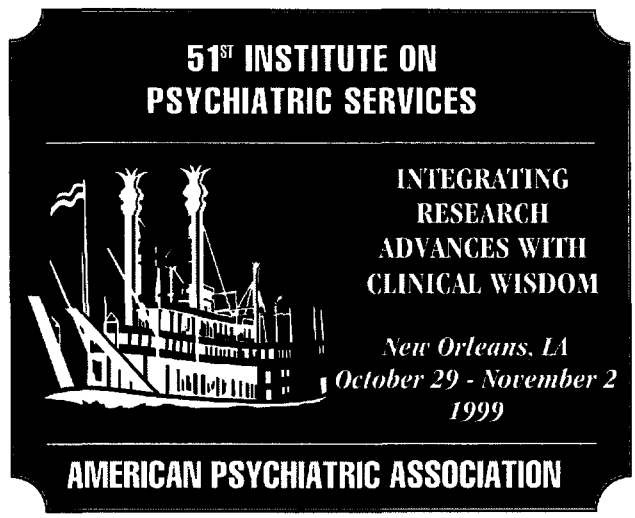
TABLE OF CONTENTS



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Course 1 **Friday, October 29**
8:00 a.m.-12 noon

PSYCHIATRY AND PRIMARY CARE: SHARING CARE

Nick S. Kates, M.B., *Associate Professor, Department of Psychiatry, McMaster University, 43 Charleton Avenue East, Hamilton, ON Canada L8N 1Y3;* Marilyn Craven, M.D., Jonathan S. Davine, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this course, the participant should be able to: 1) understand the role of the family physician in delivering community mental health care and the principles underlying shared care and 2) work collaboratively and effectively with primary care physicians.

SUMMARY:

The increasingly prominent role of the primary care physician in delivering mental health care can be enhanced if supportive, collaborative partnerships can be established with psychiatrists and mental health services. This course presents a number of strategies for collaborative or shared mental health care between family physicians and psychiatrists to help psychiatrists and other mental health professionals develop the skills necessary to work effectively with primary care providers. It reviews the prevalence, presentation and management of mental health problems in primary care and problems in the relationship between psychiatry and primary care. It outlines principles to guide shared mental health care and presents three different sets of implementation strategies aimed to: 1) improve communication; 2) strengthen liaison linkages; and 3) bring mental health services to primary care. Examples of each will be provided. The implications of shared mental health care for residency training, research, academic departments of psychiatry and serving isolated or underserved populations are discussed. Finally, this course offers practical guidelines on how to work productively with primary care physicians, how to establish collaborative relationships, and ways in which models of shared care can be adapted to different communities.

TARGET AUDIENCE:

Mental health providers, especially psychiatrists.

REFERENCES:

1. Craven M, Cohen M, Campbell D, Williams J, Kates N: Mental health practices of Ontario physicians: a study using qualitative methodology. *Canadian Journal of Psychiatry.* 1997.
2. Goldberg D, Gater R: Implications of the world health organization study of mental illness in general health care for training primary care staff. *British Journal of General Practice.* 46:483-485, 1996.

Course 2 **Friday, October 29**
9:00 a.m.-4:00 p.m.

HOMEOPATHIC TREATMENT OF PSYCHIATRIC DISORDERS

Edward B. Gogek, M.D., *P.O. Box 3967, Prescott, AZ 86302-3967;* Arlin E. Brown, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this course, the participant should be able to: 1) begin using homeopathy in their psychiatric practices; 2) learn nine homeopathic medicines, their psychiatric indications and guidelines for safe treatment; and 3) understand the principles of homeopathy, the basic science explaining its likely mechanism of action and the important clinical research validating its efficacy.

SUMMARY:

Recent surveys in *The New England Journal of Medicine* and *JAMA* report that 30 to 40 percent of Americans have tried "alternative medicine." The type of alternative medicine that best fits psychiatry is homeopathy. Like psychotherapists, homeopaths must understand their patients' personalities and deepest concerns, and at times even use dreams to find the right remedy. The homeopath is always asking, "What are this patient's essential issues?" Psychiatrists bored with a pure medication practice or frustrated at being squeezed out of psychotherapy find homeopathy both satisfying and rewarding. Research shows that homeopathy may be effective for a wide range of disorders, including mental illness. Individual reports show cures of disorders, such as OCD, that are refractory to conventional psychiatric treatment. The main principles of homeopathy will be covered along with practical information needed to prescribe homeopathic medicine safely either along with or as an alternative to conventional pharmacological treatments.

TARGET AUDIENCE:

All clinicians interested in learning about homeopathic medicine.

REFERENCES:

1. Coulter CR: *Portraits of Homeopathic Medicines: Psychophysical Analyses of Selected Constitutional Types.* North Atlantic Books, Berkeley, CA, 1986.
2. Hahnemann S: *Organon of the Medical Art.* Edited by Wenda O'Reilly, Birdcage Books, Redmond, WA, 1996.

Course 3 **Friday, October 29**
1:00 p.m.-5:00 p.m.

DEALING WITH RESISTANCE IN ADDICTION PATIENTS

David Mee-Lee, M.D., *David Mee-Lee Training and Consulting, 4228 Boxelder Place, Davis, CA 95616*

EDUCATIONAL OBJECTIVES:

At the conclusion of this course, the participant should be able to: 1) understand how clinicians can improve their method of dealing with resistance in addiction patients; 2) learn new skills in the assessment and treatment of resistance; and 3) identify ways to transform programs and policies to improve treatment effectiveness and efficiency.

SUMMARY:

Denial and resistance are expected features of many addiction patients' presentations. Yet the strategies to deal with resistance have traditionally been education, confrontation and intensive, inpatient services. As the number of individuals under managed care grows, reimbursement and funding increasingly emphasize outpatient treatment. This compels the field to rethink how to deal with patient resistance and engage a person into treatment and recovery in an environment of shrinking resources, greater security and more accountability. This course is designed to help clinicians and care managers improve assessment and treatment of resistance in addiction patients and become better acquainted with models of change. It will teach skills that can help retain patients in treatment and encourage honesty, not game playing; accountability, not arguing and confrontation. Besides improving clinical approaches, this course will also discuss the changes needed to reconfigure treatment services to better match patients' readiness to change. This course will review the staff and program changes needed to better develop specific matching of treatment site and plan.

TARGET AUDIENCE:

Clinicians, care managers, clinical supervisors and medical directors.

REFERENCES:

1. Mee-Lee D: Matching in addictions treatment: how do we get there from here? *Alcoholism Treatment Quarterly Special Issue: Treatment of the Addictions: Applications of Outcome Research for Clinical Management.* New York, Haworth Press, Inc., 12(2), 1995.
2. Miller WR, Tonigan JS: Assessing drinkers' motivation for change: the stages of change readiness and treatment eagerness scale (SOCRATES). *Psychology of Addictive Behaviors. 10(2):*81-89, 1996.

Course 4 **WITHDRAWN**

Course 5 **Saturday, October 30**
8:00 a.m.-12 noon

INTEGRATED MODELS FOR TREATMENT OF DUAL DIAGNOSIS

Kenneth Minkoff, M.D., *Medical Director, Choate Health Management, and Medical Director, Arbour-Fuller Hospital, 200 May Street, South Attleboro, MA 02703-5515*

EDUCATIONAL OBJECTIVES:

At the conclusion of this course, the participant should be able to: 1) identify five philosophical/clinical barriers to integrated treatment and describe how to resolve them; 2) describe the four phases of treatment/recovery in an integrated disease and recovery model for mental illness and addiction; 3) describe and implement a protocol for diagnosing psychiatric illness in the presence of substance disorder, and vice versa; 4) describe and implement a rational strategy for prescribing psychotropic medication to dual-diagnosis patients; 5) become familiar with clinical techniques to engage mentally ill patients to address substance disorder; and 6) describe integrated program models for treatment of dual diagnosis and the specific populations addressed by each model.

SUMMARY:

This course provides a brief overview of the problem of dual diagnosis, with specific emphasis on substance abuse and dependence among the seriously mentally ill. Barriers to the development of integrated treatment are described, which are followed by the presentation of an integrated disease and recovery model for both disorders that address those barriers. This model is then used to organize a structured approach to assessment, diagnosis and treatment. In this model, clinical interventions for this population can be individualized based on phase of recovery, diagnosis and level of acuity, severity, disability and motivation for treatment for each comprehensive dual-diagnosis system of care. Individual strategies of psychotherapeutic intervention, and integrated program models are described for each phase of recovery. Specific attention will be paid to the issue of psychopharmacologic management strategies for psychiatrically symptomatic patients who are also using substances. Participants will be encouraged to discuss clinical and programmatic case problems to illustrate application of those principles.

REFERENCES:

1. Drake RE, Mueser KT: Dual diagnosis of major mental illness and substance abuse. *Recent Research and*

Clinical Implications. New Directions for Mental Health Services. 2(70), San Francisco, CA, Jossey-Bass, 1996.
2. Minkoff K: Dual diagnosis in seriously and persistently mentally ill individuals: an integrated approach. *Practicing Psychiatry in the Community.* 221-253, Edited by Vaccaro J, Clark G, Washington, DC, American Psychiatric Press, Inc., 1996.

Course 6 **Saturday, October 30**
9:00 a.m.-4:00 p.m.

ASSESSMENT AND TREATMENT OF PATIENTS WITH MENTAL RETARDATION

Ruth M. Ryan, M.D., *1556 Williams Street, Denver, CO 80218*

EDUCATIONAL OBJECTIVES:

At the conclusion of this course, the participant should be able to: 1) arrive at accurate and comprehensive psychiatric diagnosis (or diagnoses) for persons with developmental disabilities and 2) devise successful comprehensive treatment plans that use a wide variety of treatment modalities.

SUMMARY:

Persons with developmental disabilities (mental retardation, autism and others) present a complex, fascinating and potentially rewarding challenge for psychiatrists, mental health professionals and the system. This course will illustrate methods of accurate psychiatric diagnosis, comprehensive medical and behavioral assessment and updated information on pharmacologic and nonpharmacologic treatments. Principles of successful rehabilitation require a team-oriented multi-dimensional approach, which will be emphasized. Material discussed will be relevant to any setting. Participant examples, questions and discussion are strongly encouraged.

REFERENCES:

1. Reiss S, et al: Emotional disturbance and mental retardation: diagnostic overshadowing. *American Journal of Mental Deficiency* 86:567-574, 1982.
2. Ryan R: Posttraumatic stress disorder in persons with developmental disabilities. *Community Mental Health Journal.* 1994.

Course 7 **Saturday, October 30**
1:00 p.m.-5:00 p.m.

THE CAPE COD MODEL OF PSYCHOTHERAPY

Andreas Laddis, M.D., *Medical Director, Cape Cod & ISL CMHC, 830 County Road, Pocasset, MA 02559-0000;* Ann Dextraze, L.C.S.W., Richard Fellman, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this course, the participant should be able to: 1) recognize these disorders as disorders of current purposes; 2) discern the natural modularity of life goals; 3) conceive the psychotherapeutic relationship as tangent of the client's life purposes; and 4) feel confident to make basic treatment plans.

SUMMARY:

The Cape Cod Model of Psychotherapy is for the treatment of severe, compounded personality disorders and post-traumatic stress syndromes. Structured in autonomous modules, each unit accomplishes at once relief of symptoms, measurable self-change and reconstruction of the client's life. The premise of the Model is that symptoms can be understood as manifestations of disorder in the completion of purposeful action. The problem is that self-improvement is impossible at the speed of the task at hand. The aim of intervention is to guide the client for self-change in the very course of his/her life goals; to "coach" him/her from the right distance. It is applicable from the very first contact and essential during crisis. No client is "unready" for this treatment; everyone is amenable to motivation toward their particular life purposes. The results are dramatic and they accumulate, despite breaks in treatment. The faculty will present a brief outline of the theory and then present, in detail, the clinical principles, techniques and risks. There will be time for learning exercises using clinical vignettes.

TARGET AUDIENCE:

Clinicians in teams with capacity for crisis intervention and coaching of homework.

REFERENCES:

1. Benjaman LS: Personality disorders: models for treatment and strategies for treatment development. *Journal of Personality Disorders.* 11:307-324, 1997.
2. Budman SH, Gurman AS: *Theory and Practice of Brief Psychotherapy.* New York, Guilford Press, 1988.

Course 8 **Sunday, October 31**
8:00 a.m.-12 noon

CURRENT CODING AND DOCUMENTATION REQUIREMENTS

APA Committee on Codes and Reimbursements

Chester W. Schmidt, Jr., M.D., *Chairman and Professor, Department of Psychiatry, Johns Hopkins Bayview Medical Center, 4940 Eastern Avenue, A4C, Baltimore, MD 21224-2735;* Monica A. Basco, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this course, the participant should be able to: 1) understand evaluation and management codes and psychiatric evaluation and therapeutic procedure codes and 2) understand the background and basics of the developing documentation guidelines for evaluation and management codes and psychiatric evaluation and procedure codes.

SUMMARY:

The *Physician's Current Procedural Terminology* (CPT), published by the American Medical Association (AMA), is a listing of descriptive terms and identifying codes for reporting medical services and procedures performed by physicians. Many clinicians are not sufficiently familiar with the principles and details of coding, thereby risking loss of income and opening themselves to increased audit liability. Documentation guidelines for the Evaluation and Management codes have been developed by the AMA and the Health Care Financing Administration (HCFA) which are now being revised. Additionally, documentation guidelines for the psychiatric evaluation and service codes are being developed by medical directors of third-party carriers and the APA. This course provides instruction about coding systems and the basics of CPT. A detailed review of all codes used by psychiatrists will include instruction about the concepts of levels of service, places of service, use of modifiers, as applied to office and hospital concepts of levels of service, places of service, use of modifiers, as applied to office and hospital visits, consultations and specific psychiatric service codes. Documentation guidelines already in place and in development will be described and discussed in relationship to psychiatric practice.

REFERENCES:

1. Albaum-Feinstein A: A health information manager's perspective: meeting the challenge of coding and documentation. *Journal of Practical Psychiatry and Behavioral Health.* 2:146-150, 1996.
2. American Medical Association, *Current Procedural Terminology.* Chicago, IL, American Medical Association, 1999.

Course 9 **Sunday, October 31**
8:00 a.m.-12 noon

COMPUTER APPLICATIONS FOR THE MILLENNIUM

Robert S. Kennedy, M.A., *Director of Computer Operations, Department of Psychiatry, Albert Einstein College of Medicine, 1300 Morris Park Avenue, Room 402, Bronx, NY 10461;* Thomas A.M. Kramer, M.D., *Arkansas Mental Health Research and Training Institute, 4301 West Markham, Slot 766, Little Rock, AR 72205-7101*

EDUCATIONAL OBJECTIVES:

At the conclusion of this course, the participant should: 1) be familiar with the latest hardware and software as they meet the needs of the contemporary psychiatrist and 2) have an understanding of the current technologies that are important for obtaining and utilizing clinical and educational information.

SUMMARY:

The computer applications presented will prepare you for the Millennium. The faculty will demonstrate the important computer applications (some hardware, some software) that the psychiatrist of today will need to see and know about to prepare for the year 2000. Each application will give the attendee a demonstration of the technology, presentation of why each application is important, discussion of useful applications in clinical and academic psychiatry and opportunities for interactive discussions and an hour of hands-on demonstrations. The topics to be presented include: World Wide Web technology (web searching, web site creation, information access (Medline, libraries, books and journals), scanning (graphics, ocr), word processing for clinicians, speech technology, hand held computers, and interactive table top demos.

REFERENCES:

1. Using computers in psychiatry. *Psychiatric Annals.* 24:1, 1994.
2. Computer applications in psychiatry and psychology. *Clinical and Experimental Psychiatry Monograph No. 2.* Edited by David Baskin, Ph.D., Brunner/Mazel, New York, 1990.

Course 10 **WITHDRAWN**

Course 11 **Sunday, October 31**
1:00 p.m.-5:00 p.m.

COGNITIVE THERAPY FOR SEVERE MENTAL DISORDERS

Jesse H. Wright, M.D., *Professor of Psychiatry, Department of Psychiatry, University of Louisville, Norton Psychiatric Clinic, P.O. Box 35070, Louisville, KY 40232-5070*

EDUCATIONAL OBJECTIVES:

At the conclusion of this course, the participant should be able to: 1) utilize cognitive therapy (CT) interventions for inpatients; 2) apply cognitive therapy techniques to

symptoms of psychosis and bipolar disorder; and 3) address treatment adherence problems using a cognitive therapy approach.

SUMMARY:

In recent years, cognitive therapy methods have been developed to meet the special needs of patients with chronic and severe psychiatric symptomatology. This course presents these newer cognitive therapy applications for the treatment of inpatients, individuals with bipolar disorder and those experiencing psychotic symptoms. Cognitive-behavioral conceptualizations and specific treatment procedures will be described for these patient groups. Several modifications of standard cognitive therapy techniques will be suggested for the treatment of severe or persistent mental disorders. Participants in this course will learn how to adapt cognitive therapy for patients with problems such as psychomotor retardation, paranoia, hypomania and nonadherence to pharmacotherapy recommendations. Cognitive therapy procedures will be illustrated through case discussion, role plays, demonstrations and videotaped examples. Worksheets that can facilitate application of cognitive therapy techniques will be provided. Participants will also have the opportunity to discuss the application of cognitive therapy for their own patients.

REFERENCES:

1. Basco MR, Rush AJ: *Cognitive Behavioral Therapy for Bipolar Disorder.* New York, Guilford Press, 1996.
2. Basco MR, Rush AJ: Compliance with pharmacotherapy in mood disorders. *Psychiatric Annals,* 25:269-279, 1995.

Course 12 **Sunday, October 31**
1:00 p.m.-5:00 p.m.

ASSESSING THREATS AND VIOLENCE AT HOME AND WORK

James R. Missett, M.D., *Department of Psychiatry, Stanford University, 1187 University Drive, Menlo Park, CA 94025*

EDUCATIONAL OBJECTIVES:

At the conclusion of this course, the participant should be able to: 1) identify elements of a threat; 2) distinguish among obligations to the threatener, harasser or domestic abuser to the victim and employer in the case of workplace threats; 3) understand the legal ramifications of any actions taken by the psychiatrist; and 4) competently assess, treat and consult in domestic and workplace violence situations.

SUMMARY:

Psychiatrists are seeing increasing numbers of patients who report being the victims of threats or violence at home and work. Alternatively, psychiatrists may be asked to evaluate, treat or consult about the person accused of threatening and/or violent behavior. Each of these assessments, treatments and consulting situations present special professional, ethical and legal considerations. This course will focus on practical strategies for the individual psychiatrist to use in approaching such evaluation, treatment or consulting situations. A psychologist will review, through a slide presentation, various ways to approach assessing, treating or consulting about individuals who are the victims of threats and violence at home or at work. A forensic psychiatrist will discuss the legal ramifications of evaluation in, and consulting about, threats and violence. A detailed review of the various elements involved in an assessment of verbal threats and actual dangerousness will be given. The course will conclude with a class analysis of various case studies to put the points previously covered into practice. Handouts will accompany each presentation and be keyed to each topic.

REFERENCES:

1. Ammerman R, Hersen M: *Assessment of Family Violence.* New York, John Wiley & Sons, 1992.
2. Brown S: *Counseling Victims of Violence.* Alexandria, VA, American Association for Counseling and Development, 1991.

Course 13 **Monday, November 1**
8:00 a.m.-12 noon

SPIRITUALITY/RELIGION IN PSYCHIATRIC PATIENTS

APA Committee on Religion and Psychiatry

Susan R. Downs, M.D., *Assistant Clinical Professor, Department of Psychiatry, University of California at San Francisco, 1537 Bonita Avenue, Berkeley, CA 94709;* David B. Larson, M.D., Elizabeth S. Bowman, M.D., Nalini V. Juthani, M.D., Susan L. Deppe, M.D., Khushro B. Unwalla, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this course, the participant should be able to: 1) cite the research on faith, spiritual commitment and mental health; 2) elicit and evaluate a patient's spiritual/religious beliefs; 3) ascertain the level of spiritual development within a psychodynamic formulation; and 4) make appropriate therapeutic interventions.

SUMMARY:

This course will present an overview of religious/spiritual faith in America and its role in mental health. The stages of faith and spiritual development as defined by Fowler and Wilbur will be described. The course will then discuss methods for obtaining a religious history and a description of the patient's spiritual belief system, as well as how that belief system affects the patient's life. The psychodynamic meaning and clinical use of God images and spiritual beliefs will be emphasized. Emphasis will also be placed on countertransference issues and integrating the spiritual belief system into the overall treatment. By utilizing a holistic biopsychosocial spiritual approach, the power of the patient's beliefs can augment other therapeutic interventions.

REFERENCES:

1. Bowman ES: understanding and responding to religious material in the therapy of multiple personality disorder. *Dissociation.* 1989, 2:231-238.
2. Fowler JW: *Stages of Faith: The Psychology of Human Development and the Quest for Meaning.* San Francisco, Harper & Row, 1981.

Course 14 **Monday, November 1**
8:00 a.m.-12 noon

WRITING ABOUT CLINICAL EXPERIENCES

John S. Strauss, M.D., *Yale Medical School, 50 Burton Street, New Haven, CT 06515*

EDUCATIONAL OBJECTIVES:

At the conclusion of this course, the participant should be able to: 1) appreciate more fully the details, depth and richness of clinical experience and 2) describe these experiences in writing.

SUMMARY:

In this course, participants will write about their clinical experiences and then read from their writings. In the current professional climate, the values of clinical experiences threaten to become lost. The goal of this course is to help participants feel freer to explore the richness and importance of these experiences by using writing as a medium. For some, such an endeavor might sound more frightening or impossible than it actually is. In this course, the point will not be perfection, absolute beauty, total certainty, or even good paragraph structure or grammatical correctness, but will describe experiences, to share them with others, and then to receive feedback about what is the most telling, memorable and life-like about what one has heard. There will be no attention to what is wrong or inadequate about the accounts. The only requirement of participants is that they be willing to try.

REFERENCES:

1. Chessick R: *What Constitutes the Patient in Psychotherapy?* Northvale, NJ, Jason Aronson, 1992.
2. Mishara AL: Narrative and psychotherapy: the phenomenology of healing. *American Journal of Psychotherapy.* 49:180-195, 1995.

Course 15 **Monday, November 1**
9:00 a.m.-4:00 p.m.

LEARN TO BUILD ELECTRONIC MEDICAL RECORDS

Daniel A. Deutschman, M.D., *Medical Director of Behavioral Health, SW General Health Center, Cleveland, OH & Associate Clinical Professor, Case Western University School of Medicine, 7255 Old Oak Boulevard, Suite 303, Middleburg Heights, OH 44130*

EDUCATIONAL OBJECTIVES:

At the conclusion of this course, the participant should be able to understand: 1) how electronic medical records can enhance quality of care and office efficiency; 2) how they are designed and built; 3) what elements should be present; 4) where to get assistance in building such systems; and 5) how building your own personal electronic medical records allows continuous iteration and improvement.

SUMMARY:

This course will teach psychiatrists having no computer sophistication how to begin to build electronic medical records (EMR) or use them with their patients. The instructor, a practicing psychiatrist, developed such a system in 1995. The database has since grown to include more than 10,000 records from clinical visits with patients. The EMR facilitates assessment, diagnosis, treatment and research. It improves practice management and the quality of clinical records. Participants will learn the fundamentals of designing and building EMR. They will learn to build tables, queries, data entry forms and look-up tables. Developing prescriptions, lab test requests and medication trial reports will also be discussed. The format will be interactive, with ample time for questions and answers. A mature electronic medical record system will be demonstrated. Costs for software, hardware and time to program the EMR will also be discussed. Instructional resources will be described which will allow participants to develop electronic medical record systems on their own.

TARGET AUDIENCE:

Practicing physicians with minimal computer experience.

REFERENCES:

1. Modai I, Rabinowitz J: Why and how to establish a computerized system for psychiatric case records. *Hosp Community Psychiatry.* 44:1091-1095, 1993.
2. Allen SI, Johannes RS, et al: Prescription-writing with a pc. *Computer Methods and Programs in Biomedicine.* 22:127-135, 1986.

Course 16 **Monday, November 1**
1:00 p.m.-5:00 p.m.

DEVELOPMENT OF CONDITIONAL RELEASE PROGRAMS AND PLANS

John D. Justice, M.D., *Drawer 1127, Weston, WV 26452; Theodore A. Glance, M.A., Sharon Phares, M.S.W.*

EDUCATIONAL OBJECTIVES:

At the conclusion of this course, the participant should be able to: 1) develop forensic programs that will address clinical, legislative, judicial, community, security and financial concerns; 2) assess the risk of violence; 3) develop a conditional release program which addresses identified areas of risk; and 4) appreciate the need to establish relationships with various groups.

SUMMARY:

One of the primary areas requiring attention is the forensic patient's ability to maintain his or her daily living arrangements. This is the area of expertise of the forensic social worker. Finances, housing, mental health and medical appointments, and family interaction are critical events that need to be addressed in the conditional release. Through case presentations, the course participant will be required to focus on these critical events and address them in the conditional release. Practical suggestions from a veteran social worker and the details required for successful communication with the agencies involved in the financial and community resource arena will be discussed. At the conclusion of this course, the participant will have gained an appreciation of the detailed work necessary to increase the likelihood of a successful conditional release.

TARGET AUDIENCE:

Inpatient forensic practitioners and treatment teams.

REFERENCES:

1. Heilbrun K, et al: Community placement for insanity acquittees: a preliminary study of residential programs and person-situation fit. *The Bulletin of the American Academy of Psychiatry and the Law.* 22:551-560, 1994.
2. Harris V, Koepsell T: Rearrest among mentally ill offenders. *The Bulletin of the American Academy of Psychiatry and the Law.* 26:393-402, 1998.

Course 17 **Tuesday, November 2**
8:00 a.m.-12 noon

HOW TO MEASURE OUTCOMES WITHOUT BREAKING THE BANK

Gabriel Kaplan, M.D., *Chairman, Department of Psychiatry, Franciscan Health, 25 McWilliams Place, Suite 606, Jersey City, NJ 07302-0000;* James R. Westphal, M.D., *Chair, Department of Psychiatry, Louisiana State University Medical Center at Shreveport, 1606 Regatta Drive, Shreveport, LA 71119*

EDUCATIONAL OBJECTIVES:

At the conclusion of this course, the participant should be able to: 1) enumerate available rating scales utilized for outcome measurements; 2) select appropriate outcome measures for specific populations; and 3) summarize the costs involved in setting up outcome systems.

SUMMARY:

This course is for mental health professionals wishing to learn about cost-effective outcome tools. Clinicians in both the public and private sectors are increasingly asked to demonstrate effectiveness of treatment. Measuring outcomes not only serves the purpose of demonstrating value to managed care and public agencies, but also allows clinicians to improve quality of care. Outcomes systems costing thousands of dollars are now available; however, they are financially prohibitive for most clinicians. The faculty will discuss valid tools found in the public domain or those available at a reasonable price that can be combined to create an outcome system. This course is divided into four sections: 1) *Basic Concepts* will outline quality improvement notions such as cycle of quality, efficacy, effectiveness, dimensions, motivation, methodology and outcome theory; 2) *Adult Outcome Tools* will review scales used to measure health/function status (HSQ-12, GAS), symptoms (SCL-90, BPRS, Beck) and satisfaction (CSQ); 3) *Child Outcome Tools* will describe scales utilized with youngsters to determine general functioning (CBCL) and specific symptomatology (Conners, CDI); and 4) *Practicum* will provide participants an opportunity to apply principles obtained from this course.

TARGET AUDIENCE:

Clinicians in solo and group settings practicing in private and public systems.

REFERENCES:

1. Hunkeler EM, Westphal JR, Williams M: Computer assisted patient evaluation systems: advice from the trenches. *Behavior Health Tomorrow,* 5(3):73-75, 1996.
2. Hunkeler EM, Westphal JR, Williams M: Developing a system for automated monitoring of psychiatric outpatients: a first step to improve quality. *HMO Pract.* 9(4):162-164, 1995.

Discussion Group 1 **Friday, October 29**
8:00 a.m.-9:30 a.m.

CURRENT ISSUES IN COMMUNITY PSYCHIATRY

American Association of Community Psychiatrists

Charles W. Huffine, Jr., M.D., *President, American Association of Community Psychiatrists, and Assistant Medical Director for Children and Adolescents Program, King County Mental Health Division, 3123 Fairview Avenue, East, Seattle, WA 98102-3051*

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to demonstrate a working knowledge of current trends in community psychiatry and apply concepts to their home situations, through interactive discussion with peers and leaders in the field.

SUMMARY:

Dr. Huffine will offer a brief overview of the current issues and topics in community psychiatry and solicit questions and discussion regarding these or other issues brought by attendees. He will solicit comments from individuals working in different practice settings and from as diverse a group as possible. The goal will be to seek common themes and concerns emerging in the field and to gain some perspective on such themes and methods for addressing them.

Dr. Huffine will provide consultative input to the discussion based on his role as president of the American Association of Community Psychiatrists and his experiences in community practice with severely mentally ill adults, older adults, and child and adolescent programs.

TARGET AUDIENCE:

Persons with an active interest in community psychiatric practice.

REFERENCES:

1. Stein LI, Test MA: Alternative to mental hospital treatment. I conceptual model, treatment program and clinical evaluation, Archives of General Psychiatry, 1980; 37(4):392–400.
2. Stroul BA, Friedmen RM: A System of Care for Children and Youth with Severe Emotional Disturbance (Revised 1998) National Technical Assistance Center for Children's Mrt. Georgetown Univ Child Development Center Wn.

Discussion Group 2 **Friday, October 29**
10:00 a.m.-11:30 a.m.

MEDICAL LEADERSHIP IN MENTAL HEALTH SYSTEMS

American Association of Psychiatric Administrators

Christopher G. Fichtner, M.D., *Medical Coordinator, Department of Human Services, State of Illinois, 100 West Randolph Street, Suite 6-400, Chicago, IL 60601*; Paula G. Panzer, M.D., *Member, Institute Scientific Program Committee, Associate Chief Psychiatrist for Domestic Violence Trauma Services, Jewish Board of Family and Children Services, and Assistant Clinical Professor of Psychiatry, Columbia University College of Physicians and Surgeons, 500 West End Avenue, Suite GR-J, New York, NY 10024*

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to (1) identify and define current major leadership issues for psychiatrists in public and private mental health systems; (2) compare and contrast experiences in different settings in terms of (a) problems and opportunities prompting psychiatric leadership, (b) the needs and expectations that come to the attention of psychiatrists in leadership roles.

SUMMARY:

Leadership roles for psychiatrists in organized systems of care are evolving. Medical directors and other psychiatrist administrators are challenged to uphold standards of clinical excellence, as well as to think with creativity and vision about the health care systems within which they work. Recent research suggests that psychiatrist medical directors in public sector systems find greater satisfaction when their positions include substantial administrative roles that provide opportunities for impact on the system of care. Psychiatrists in leadership roles may also experience isolation. In a number of state systems, psychiatrist administrators have been involved in the development of programs at the interface of public and private sectors. Some psychiatrists have transitioned from program and agency medical directorship roles to roles involving quality and contractual monitoring of increasingly privatized services. Administrative psychiatrists also find themselves at a strategic nexus in a resurgence of academic public psychiatry affiliations. This discussion group will provide a forum for discussion among psychiatrists holding leadership and management positions within public and private sectors. Program, agency, state, county, and managed care medical directorships involve common and divergent tasks, processes, and themes. The discussion group will promote exploration of various dimensions of psychiatrist leader-

ship in organized mental health systems and provide an opportunity for exchange of information and sharing of experiences with other psychiatrists working in a variety of public and private sector leadership roles.

REFERENCES:

1. Ranz JM, Eilenberg J, Rosenheck S: The psychiatrist's role as medical director: task distributions and job satisfaction. Psychiatric Services 1997; 48:915–920.
2. Ranz J, Stueve A: The role of the psychiatrist as program medical director. Psychiatric Services 1998; 49:1203–1207.

Discussion Group 3 **Saturday, October 30**
8:00 a.m.-9:30 a.m.

ANATOMY OF A MALPRACTICE CASE

Mark R. Nathanson, M.D., *Associate Professor of Psychiatry, Department of Psychiatry, Columbia University Program for Geriatric/Gerontology Rehabilitation, 85 Fifth Avenue, Suite 932, New York, NY 10003-3019*

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to understand the components of a malpractice case including examination before trial, deposition, discovery, voir dire, settlement, jury selection, and other trial terms. I will emphasize ways to protect and avoid malpractice suits, particularly with notes and record keeping.

SUMMARY:

The discussion group will use a real-life malpractice case, which the director was involved in, to go through all elements of a jury trial. The case involved a medically ill 69-year-old woman who required ECT and subsequently had medical complications. Although the suit was won, it is important for the participants of the discussion to understand the basics elements of a malpractice case, including the process a defendant must go through. This process includes the examination before trial, meeting with one's attorney before trial, discovery phase, voir dire, the details of jury selection, the plaintiff's attorney and how he/she functions, understanding a jury, the use of expert testimony and expert witnesses, the role of the judge and the court system, and evidence and preclusion of evidence. There will be ample discussion focusing on the emotional impact of participating in the process of a malpractice trial. We will cover the many stresses imposed by this process and suggestions will be offered in coping effectively during and after the malpractice case. There will be emphasis on strategies to avoid malpractice cases including detailed review of note writing, record keeping physician-patient relationships, implied contracts, and duties and responsibilities of the physician and of the patient. The discussion group will be based on audience participation throughout, and one hour will be reserved at the conclusion for more general discussion with the participants.

TARGET AUDIENCE:

Clinical practitioners delivering direct patient care in any discipline.

REFERENCES:

1. American Psychiatric Association: American Psychiatric Association Task Force Report 14: Electroconvulsive Therapy. Washington, DC, American Psychiatric Association, 1978.
2. Hallek SL: Law in the Practice of Psychiatry. New York, Plenum, 1980.

Discussion Group 4 **Saturday, October 30**
1:30 p.m.-3:00 p.m.

CULTS: PSYCHIATRIC PERSPECTIVES

David A. Halperin, M.D., *Associate Clinical Professor, Department of Psychiatry, Mt. Sinai School of Medicine, 20 West 86th Street, New York, NY 10024-3604*

EDUCATIONAL OBJECTIVES:

To heighten the awareness of psychiatrists and other mental health professionals about cults and other cult-like organizations, which promise to become particularly active within the next year as the millenium approaches; to suggest psychotherapeutic and forensic approaches to this phenomenon.

SUMMARY:

As the millenium approaches, there will be a heightened sense of the "End of Days" and an increasing interest in chiliastic, millenarian, and survivalistic groups. Even within people of non-Christian orientation, the Y2K computer glitches are beginning to produce widespread anxiety that familiar sources of power will collapse and there will be chaos and anarchy. These anxieties and fears are heightened by aegis of the Internet, which often transmits rumors in the coating of fact and whose immediacy intensifies the anxiety of the vulnerable. The mental health issues posed by the stressor of the millenium may well become a significant mental health problem for all professionals in the next two years. This discussion group will deal with the distinctive criteria of cult organizations, discuss the characteristic personality traits of those vulnerable to cult affiliation, and characteristic family structure of cult members and those considering affiliation in cult-like groups. During the discussion, emphasis will be placed on the role of the mental health professional in helping vulnerable

individuals deal with these stressors and the role of the mental health professional in working with the families of the prospective cult member. Forensic issues presented by cult affiliation will also be considered in this context. Discussion will be fostered in dealing with the complex topic by encouraging members of the audience to share their experiences in working with this newly emergent target population.

TARGET AUDIENCE:

Psychiatrists and psychologists.

REFERENCES:

1. Psychodynamic Perspectives on Religion, Sect and Cult. Edited by Halperin, DJ. Wight-PSG, Boston, 1983.
2. Halperin D: Psychiatric perspectives on cult affiliation. Psychiatric Annals 4, April 1990.

Discussion Group 5 **Saturday, October 30**
3:30 p.m.-5:00 p.m.

CAPITATION VERSUS FEE-FOR-SERVICE: CLINICAL RISKS AND BENEFITS

Bruce J. Schwartz, M.D., *Vice Chairman, Department of Psychiatry, Montefiore Medical Center, 111 East 210th Street, Bronx, NY 10467*; Scott Wetzler, Ph.D., *Chief, Division of Psychology, Department of Psychiatry, Montefiore Medical Center, 111 East 210th Street, Bronx, NY 10467*

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to appreciate the advantages and disadvantages of risk-based contracting.

SUMMARY:

The concept of capitation conjures up the image of terrible risks and few benefits. Under a capitated agreement, psychiatrists are clinically and financially responsible for providing mental health and substance abuse services to a defined population, usually measured in terms of thousands of lives rather than the dozens of patients to which we are used to. Clinicians may imagine that many will become patients and will require intensive psychiatric treatment. In contrast, psychiatrists are comfortable working on a fee-for-services basis, where we are certain to be paid a specified amount according to the amount of service we provide. In a capitated environment, although we may fear that we have less control over our finances and time, in fact, we have more control over them. Incomes can be much more predictable in a capitated arrangement than in a fee-for-service one since providers are paid on a set per-member per-month basis, and utilization rates are much more stable than we might imagine. In addition, capitation frees the psychiatrist from the time-consuming and demeaning utilization management process imposed by managed care organizations.

In this discussion group, we will describe the experience over the last four years of developing a behavioral care IPA and assuming full-risk capitated agreements for inpatient and outpatient care for nearly 100,000 lives in a broad geographic region. We will describe the operation, finances, governance, and utilization patterns, and present a model of clinical care that emphasizes cost-effective treatment. Providers and provider groups that are willing to assume capitated contracts are in a position to benefit from the efficiencies that they achieve. We will also discuss some of the ethical concerns that providers might have about a capitated arrangement. Most especially, we welcome interested participants to describe the opportunities and obstacles to capitation in their particular clinical setting.

TARGET AUDIENCE:

General psychiatrists in individual or group practices.

REFERENCES:

1. Wetzler S, Schwartz B, Sanderson W, Karasu T: Academic psychiatry and managed care: a case study, Psychiatric Services, 1997; 48:1019–1026.
2. Schwartz B, Wetzler S: A new approach to managed care: the provider-run organization. Psychiatric Quarterly, 1998; 69:345–353.

Discussion Group 6 **Sunday, October 31**
8:00 a.m.-9:30 a.m.

RACISM AND PSYCHIATRY

David E. Schultz, M.D., *Director, Residency Training Program, Department of Psychiatry, Loma Linda University School of Medicine, 1601 Barton Road, Apt. 1116, Redlands, CA 92373*; Khushro B. Unwalla, M.D., *Resident, Department of Psychiatry, Loma Linda University School of Medicine, 7411 Windrose Drive, Highland, CA 92346*

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to appreciate the current state of racism and psychiatry as a patient of a different race from the examining psychiatrist is diagnosed and treated.

SUMMARY:

This presentation will be the third annual discussion on the issues of racism and psychiatry. We have fostered an extremely interesting and mutually informative discussion at each of our prior two presentations. Interest in this topic has been no less than dramatic and eye-

opening. We would like to continue our exploration of the topic at the request of the participants in our last discussion in Los Angeles and because of our continued interest in the topic. We believe that annual revisitation of the topic is extremely important to keep the issues of transcultural and racial psychiatry in the foreground, especially in the community institutions that are represented at this yearly forum.

REFERENCES:

1. Racism and Psychiatry. Edited by Thomas A, Sillen S. Brunner/Mazel, Inc. New York, 1972.
2. APA: DSM-IV, Washington, DC, 1995.

Discussion Group 7 **Sunday, October 31**
10:00 a.m.-11:30 a.m.

DOWN SYNDROME DEMENTIA OF THE ALZHEIMER TYPE

Mark H. Fleisher, M.D., *Assistant Professor of Psychiatry, University of Nebraska Medical College, 985575 Nebraska Medical Center, Omaha, NE 68198-5575*

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation the participants should be able to demonstrate an understanding of the classification, etiology, diagnostic, treatment, and outcome issues for persons with dementia associated with Down syndrome.

SUMMARY:

This discussion will examine some of the issues associated with the dementia of Down syndrome. Important similarities and differences exist that create opportunities for discussion of Down syndrome dementia. Issues of classification, cause, clinical course, treatment, and outcomes will be discussed in an open, interactive process that will allow for a valuable exchange of ideas. Down syndrome is a common yet complicated condition that has historically been integral to our understanding of Alzheimer disease. Nevertheless, as interest has increased dramatically in senile dementia, interest in Down syndrome dementia seems to have faded. For many clinicians mental retardation and dementia are a challenge they were not trained to treat. Most psychiatry training programs offer inadequate opportunities to acquire expertise in these areas. Therefore, the need for up-to-date clinical information is tremendous. A discussion format based around case presentations will allow the participants to develop their knowledge and interest in this important area and how to apply it clinically. Clinicians will be able to develop a greater understanding of the differences and similarities of this Alzheimer-like condition.

REFERENCES:

1. Rogers SL, Farlow MR, Doody RS, et al: Donepezil Study Group: a 24-week double blind, placebo-controlled trial of donepezil in patients with Alzheimer's disease. Neurology 1998; 50(1):136–45.
2. Tyrrell J, Cosgrave M, Hawi Z, McPherson J, et al: A protective effect of apolipoprotein E e2 allele on dementia in Down's syndrome. Biol Psychiatry 1998; 43(6):397–400.

Discussion Group 8 **Sunday, October 31**
1:30 p.m.-3:00 p.m.

PROBLEMS AND PITFALLS OF WORKING WITH BOSNIAN REFUGEES

Abdul Basit, Ph.D., *Research Associate, Department of Psychiatry, University of Chicago, 7230 Arbor Drive, Tinley Park, IL 60477*; John J. Tuskan, Jr., R.N., M.S.N, Captain, *U.S. Public Health Service, and Senior Public Health Advisor, Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, Refugee Mental Health Program, 5600 Fishers Lane, Room 18C07, Rockville, MD 20857*

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to recognize special problems encountered in working with Bosnian refugees and learn what treatment strategies were effective and why.

SUMMARY:

Historically the United States has been the final destination for most refugees. The past two decades have seen a particularly great number of Bosnian Muslim refugees fleeing war and persecution. These refugees have posed unique challenges to the service providers, partly because they had a significant history of torture and partly because their cultural and religious backgrounds were quite different. Consequently, clinicians encountered special problems when they tried to intervene therapeutically because they were not aware of the importance of incorporating Islamic values into mental health services. This session will focus on clinical and cultural problems encountered by clinicians in the resettlement of Bosnian refugees. The presentation will further explain: (1) what strategies were helpful to build bridges, span barriers, and strengthen human ties, and (2) how integrated complementary techniques proved effective in enhancing spiritual development of group members.

TARGET AUDIENCE:

Psychologists, psychiatrists, and social workers working with refugees.

REFERENCES:

1. Holtzman WH, Bornemann TH, (eds): Mental Health of Immigrants & Refugees Hog Foundation for Mental Health, The University of Texas, 1990.
2. Clinical Guidelines in Cross-cultural Mental Health. Edited by Comas-Diaz L, Griffith EEH. New York, Wiley, 1988.

Discussion Group 9 **Monday, November 1**
8:00 a.m.-9:30 a.m.

ETHNOGRAPHIC RESEARCH WITHIN CLINICAL PRACTICE

Susan L. O'Dell, Ph.D., *Psychotherapist in Private Practice, 1422 West Thome Avenue, Chicago, IL 60660*

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to understand more fully the process of the ethnographic approach to qualitative research and be able to apply this understanding to research possibilities within clinical practice.

SUMMARY:

This facilitated discussion group will explore some of the issues, benefits, limitations, and ethical considerations of conducting ethnographic research within a psychotherapeutic practice. The development of the research question, qualitative methodology, compilation of the data, and the use of the clinical results of this research process as a way to deepen understanding of clinical issues will be presented and discussed with the participants. Examples from the ethnographic studies conducted by the facilitator will illustrate various aspects of this qualitative research process and its impact on clinical practice.

REFERENCES:

1. Strauss A, Corbin J: Basics of Qualitative Research: Grounded Theory Procedures and Techniques. Newbury Park, Ca, Sage Publications, 1990.
2. Marshall C, Rossman G: Designing Qualitative Research. Newbury Park, Ca, Sage Publications, 1989.

Discussion Group 10 **Monday, November 1**
1:30 p.m.-3:00 p.m.

PSYCHIATRISTS IN REHABILITATIVE SETTINGS

Mark Ragins, M.D., *Medical Director, Village Integrated Services Agency, 456 Elm Avenue, Long Beach, CA 90802-2426*

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to understand some of the differences between the rehabilitation model and the medical model and the adaptations possible for psychiatrists to be successfully integrated into rehabilitation settings.

SUMMARY:

Traditionally, clinical and psychiatric services have been separated from rehabilitation services in both settings and value systems, often with people being referred for rehabilitation services after they were stabilized clinically and therefore ready for rehabilitation. As rehabilitation services have broadened to include the entire range of people with serious psychiatric illnesses, there is an increased need to integrate the two services over long periods. Dr. Ragins was the co-winner of APA's 1995 Van Ameringen Award for psychiatric rehabilitation for his work adopting psychiatric practice into the Village ISA, a model rehabilitation-based, integrated service agency. He is also actively training residents in this area. Discussion will be promoted among the participants focusing primarily on the personal aspects of their experiences including boundary issues, empowerment, collaboration, reduction of professional distance, risk taking, and attaining comfort with atypical settings like clubhouses and home visits.

REFERENCES:

1. The Journal of CAMI, Vol. 4, No. 2.
2. Hargreaves WA: A capitation model for providing mental health services in California. H&CP 1992; 43:3.

Discussion Group 11 **Tuesday, November 2**
10:00 a.m.-11:30 a.m.

PSYCHOTHERAPY OF PSYCHOSIS

Jon E. Gudeman, M.D., *Medical Director, Milwaukee County Mental Health Division, and Professor of Psychiatry, Medical College of Wisconsin, 9455 Watertown Plank Road, Milwaukee, WI 53226*

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to conduct a diagnostic interview, make a phenomenologic cross-sectional diagnosis, and determine biologic treatment.

SUMMARY:

Although not in vogue today, the psychotherapy of psychosis remains an important tool and technique for treatment. This session will review an approach to psychotherapy from the vantage point of the precipitant to

illness and the subsequent decompensation. The presenter fully recognizes the importance of the biologic underpinnings of psychosis and the crucial role of psychopharmacologic intervention.

Psychosis is seen as a defense against painful affect. Whether biologically or psychologically induced it manifests itself not only as biologic decompensation but also with psychologic defenses of denial, distortion, avoidance, and projection. These defenses keep the person with illness at a distance. The job of the therapist is to help the patient acknowledge the pain in his or her life, and then begin to put this in perspective so that simultaneous with medical intervention, the therapist helps the person by techniques that include triangulation, grieving the loss, experiencing the pain of the current situation, gaining contact with his/her own body, establishing the beginning of an alliance, and the neurasthemic phase of illness.

How the therapist approaches the psychotic patient not only as an educator of illness, but also as an empathic listener and guide, will be emphasized. This approach draws heavily on the work of psychotherapists of psychosis such as Reich, Sullivan, Will, and Semrad.

REFERENCES:

1. Semrad, Van Buskirk, Buie, Silberger, Maltsberger: Teaching Psychotherapy of Psychotic Patients. Grune and Stratton, New York, 1969.
2. Havens L: Participant Observation. Jason Aronson, New York, 1976.

Full-Day Session 1 **Friday, October 29**
8:30 a.m.-5:00 p.m.

INTERDISCIPLINARY CARE IN THE NEW AGE OF AIDS

APA AIDS Education Project, Columbia University HIV Mental Health Training Project, American Psychological Association, and National Association of Social Workers

Marxhall Forstein, M.D., *Medical Director, HIV/Mental Health and Addiction Services, Department of Psychiatry, Fenway Community Health Center, 24 Olmstead Street, Jamaica Plain, MA 02130;* Francine Cournos, M.D.; Richard Herman, M.A.; Meg Kaplan, Ph.D.; John Anderson, Ph.D.; Evelyn Tomaszewski, M.S.W.; J. Stephen McDaniel, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, participants should be able to recognize the clinical and psychiatric aspects of HIV disease and identify components of an interdisciplinary team approach to patient care.

SUMMARY:

Psychiatrists and mental health professionals must be prepared for the challenges of providing HIV care. Treatment of neuropsychiatric and psychiatric problems is becoming increasingly more sophisticated as the body of knowledge on pharmacologic interventions, drug-drug interactions, prevention strategies, successful coping approaches, techniques for enhancing adherence, and a host of other new advances expands. New technologies and therapies have generated a wave of optimism and hope. These advances, however, have also introduced great clinical challenges for those working in the mental health arena.

This conference will bring practitioners up to date with the latest thinking on mental health care for patients infected or affected by HIV. Providing this care requires an interdisciplinary team approach. Psychiatrists, psychologists, and social workers all play vital roles, including evaluation, diagnosis and treatment, education, psychotherapy, and care management. We will review the unique contributions each discipline has made to AIDS mental health care.

During this training an interdisciplinary faculty will provide an overview of the clinical and psychiatric dimensions of HIV disease. Both didactic and case presentations will provide an open forum for discussion of integrated clinical care.

REFERENCES:

1. Kwasnik B, et al: HIV mental health services integrated with medical care, in HIV Mental Health for the 21st Century, New York University Press, 1997.
2. Feingold A, Slammon W: A model integrating mental health and primary care services for families with HIV. Gen Hosp Psychiatry 1993; 15:290-300.
3. Meredith K, Larson T, et al: Building comprehensive HIV/AIDS care services. AIDS Patient Care 1998; 12:5.
4. Wright ER, Shuff M: Specifying the integration of mental health and primary care services for persons with HIV/AIDS. Soc Networks 1995; 17:319-340.

Industry-Supported Symposium 1 **Friday, October 29 12 noon-1:30 p.m.**

ENHANCING COMPLIANCE WITH ANTIDEPRESSANTS

Supported by Glaxo Wellcome Inc.

Adam K. Ashton, M.D., *Department of Psychiatry, Buffalo Medical Group, 295 Essjay Road, Williamsville, NY 14221*

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, participants should be able to understand the importance of noncompliance in treatment of depression and how to choose antidepressants with a more favorable side-effect profile.

SUMMARY:

A patient's ability to comply with antidepressant treatment directly affects outcome. Limiting non-compliance is a strategy that enhances potential remission of depressive symptomatology. This symposium is intended to provide clinicians with practical tools in promoting compliance and avoiding medication side effects, which may contribute to discontinuation of treatment. Andrew A. Nierenberg, M.D., a past apa presenter, will discuss issues in noncompliance in the treatment of depressive disorders. Bonnie Saks, M.D., will discuss mechanisms for antidepressant-induced side effects and how to limit adverse reactions by choice of antidepressant. Adam Keller Ashion, M.D., a past apa chairperson, will discuss the issue of antidepressant-induced sexual dysfunction, along with current strategies to limit sexual dysfunction. Antidote strategies to reverse serotonin reuptake inhibitor-induced sexual dysfunction will be reviewed.

No. 1A
COMPLIANCE TO ANTIDEPRESSANT TREATMENT

Andrew A. Nierenberg, M.D., *Associate Director, Depression Clinic, Department of Psychiatry, Massachusetts General Hospital, 15 Parkman Street, WACC 812, Boston, MA 02114-3117*

SUMMARY:

Antidepressants have superior efficacy compared with placebo (Depression Guideline Panel, 1993) but only if patients actually take them. It has been long recognized that compliance or adherence to antidepressant regimens is sub-optimal. Patients frequently miss doses and stop taking antidepressants before the recommended duration of adequate acute and continuation treatment. Naturalistic follow-up studies have shown that those patients who do manage to adhere to treatment guidelines have better outcomes (Melfi et al., 1998). Patients deviate from optimal treatment schedules and duration because of inconvenience, cost, the meaning of medications, and side-effect burden. For patients to take antidepressants, they must perceive that benefits outweigh discomfort and side-effect burden, be educated about the expected timing of response relative to the appearance of side effects, and the need for continued treatment after acute response. This presentation will review the challenge of patient compliance/adherence in the treatment of depression and possible therapeutic interventions.

No. 1B
IDENTIFYING SEXUAL DYSFUNCTION AND SEX RECEPTORS

Bonnie R. Saks, M.D., *Clinical Associate Professor, Department of Psychiatry, University of South Florida, 3333 Kennedy Boulevard, Suite 106, Tampa, FL 33609*

SUMMARY:

Sexual function and intimacy are highly important to people yet may not be discussed between doctor and patient. Sexual dysfunction can be created and exacerbated by many illnesses and medications, particularly antidepressants. Some antidepressants, however, can alleviate sexual side effects and enhance sexual function. Psychiatrists should include sexual histories in their evaluations, be able to make a differential diagnosis of cause, and apprise patients of treatment options. Such interview techniques will be presented in this presentation.

Understanding biochemical mechanisms of action of antidepressants and receptor binding is useful in determining cause and treatment of sexual side effects of antidepressant medications. 5HT2 agonism and antagonism will be explored as well as dopamine stimulation and reuptake inhibition as regards sexual function. Nitric oxide and hormonal interaction with antidepressants, serotonin, and sexuality will also be discussed.

No. 1C
MANAGEMENT OF SRI-INDUCED SEXUAL DYSFUNCTION

Adam K. Ashton, M.D., *Department of Psychiatry, Buffalo Medical Group, 295 Essjay Road, Williamsville, NY 14221*

SUMMARY:

Serotonin reuptake inhibiting antidepressants (SRIs) have revolutionized the treatment of depressive and anxi-

ety disorders since their release in the United States in the late 1980s. Unfortunately, sexual dysfunctions have been reported to be common side effects of this class of drugs. According to the DSM-IV, sexual dysfunctions are defined as any clinically significant alteration in desire, arousal, or orgasm resulting in marked distress or interpersonal difficulty.

Several strategies for management of SRI-induced sexual dysfunction have been forwarded. These include waiting for spontaneous remission, dose reduction, change in antidepressant, drug holiday, and augmentation with another pharmacologic agent. Augmentation strategies have included yohimbine, amantadine, cyproheptadine, bupropion, stimulants, buspirone, bethanechol, nefazodone, and ginkgo biloba. This presentation will delineate clinically relevant techniques for determining the optimal intervention for subsets of patients. Suggestions will be based upon the largest published study of SRI-induced sexual dysfunction as well as a recently completed study of bupropion as an augmenting agent. Yohimbine, effective in 80% of patients, was a superior augmenting agent when compared with amantadine and cyproheptadine. In addition, bupropion was effective in reversing SRI-induced sexual dysfunction in 66% of patients. Efficacy, advantages, and disadvantages of all proposed treatment strategies will be reviewed.

REFERENCES:

1. Depression Guideline Panel. Clinical Practice Guideline. Number 5. Depression in Primary Care: Volume 2. Treatment of Major Depression. Rockville, MD: US Dept. of Health and Human Services, Public Health Service, Agency for Health Care Policy and Research. AHCPR Publication No. 93-0551, 1993.
2. Melfi CA, Chawla AJ, Crogham TW, Hanna MP, Kennedy S, Sredt K: The effects of adherence to antidepressant treatment guidelines on relapse and recurrence in depression. Arch Gen Psych 1998; 56:1128-1132.
3. Saks BR: Sexual Dysfunction (Sex, Drugs, and Women's Issues. Psychiatry Update March/April 1999; Volume 6: Number 2.
4. Saks BR: Identifying and Discussing Sexual Dysfunction. J Clin Psychiatry Monograph March 1999; 17:1.
5. Ashton AK, Rosen RC: Bupropion as an antidote for serotonin reuptake inhibitor-induced sexual dysfunction Journal of Clinical Psychiatry 1998; 59(3):112-115.
6. Ashton AK, Hamer R, Rosen RC: Serotonin reuptake inhibitor-induced sexual dysfunction and its treatment: A large-scale retrospective study of 596 psychiatric outpatients. Journal of Sex and Marital Therapy 1997; 23(3):165-175.

Industry-Supported Symposium 2 — **Friday, October 29 12 noon-1:30 p.m.**

CLINICAL PERSPECTIVES ON TREATING PSYCHOSIS AND AGITATION IN ELDERLY PATIENTS WITH DEMENTIA

Supported by Janssen Pharmaceutica and Research Foundation

Alan P. Siegal, M.D., *Associate Clinical Professor, Department of Psychiatry, Yale University, 60 Washington Avenue, #203, Hamden, CT 06518-3272*

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, participants should be able to identify the signs and symptoms of behavioral disorders in geriatric patients; discuss the differential diagnosis of agitated derly patients; differentiate among different classes of psychotropic agents based efficacy and safety; select appropriate medication for optimal treatment.

SUMMARY:

In an aging society, the mental health profession is being called upon more often to apply its talent and skill in managing demented patients. These patients often exhibit agitation, aggression, and psychosis. In Alzheimer's disease alone, 20% to 50% of all patients will exhibit alteration in perception, including hallucinations, delusions, and paranoia. Agitation has been estimated to affect up to 90% of all demented individuals at some time during the course of their illness.

It is important to view behavioral dyscontrol in demented individuals within a medical rather than just a psychiatric paradigm. Careful assessment of comorbid medical illness, physiological alterations in bodily functions, and differential diagnosis of psychiatric disorders is necessary to appropriately manage behavioral problems. Data from emerging research on newer medications, including atypical antipsychotics, will be presented along with a number of paradigms to evaluate behavioral dyscontrol in the elderly demented patient.

No. 2A
ASSESSMENT OF THE GERIATRIC PATIENT: BEHAVIORS THAT GET OUR ATTENTION IN THE ELDERLY

Jeanne M. Jackson, M.D., *Assistant Professor, Department of Psychiatry, Oregon Medical School and University, 143 NE 102nd Avenue, Portland, OR 97220;* Alan P. Siegal, M.D.; Robert B. Portney, M.D.

SUMMARY:

Behavioral problems in elderly patients frequently result from the interplay of multiple factors. Thorough assessment requires evaluation of the medical, psychiatric, and social issues pertinent to the individual. Medical problems such as dementia, delirium, pain, constipation, sleep deprivation, sensory limitations, and medical illnesses should be considered early in the differential diagnosis. Additionally, possible psychiatric etiologies such as psychosis, depression, and anxiety disorders as primary or exacerbating factors should be considered. Furthermore, social issues such as losses, isolation, and environmental stressors require assessment to determine how to best support the elderly person.

In this portion of the symposium, thorough assessment of behavioral problems will be highlighted through a case study of a "typical" nursing home patient. Emphasis will be on the interaction of multiple problems in various medical, psychiatric, and social arenas and how these various problems contribute to the development and maintenance of a behavioral disturbance.

No. 2B
MEDICAL INTERVENTIONS FOR THE PSYCHIATRIST: WHAT ELSE YOU NEED TO KNOW TO MANAGE THE AGITATED GERIATRIC PATIENT

Robert B. Portney, M.D., *Department of Psychiatry, Harvard Medical School and Geriatric Neuropsychiatrist, McLean Hospital, 6 Hearthstone Place, Andover, MA 01810-5421*

SUMMARY:

Elderly patients are often recipients of aggresive psychiatric treatment for behavioral disturbances before an evaluation of any potential contributing medical causes is completed. A medical evaluation of a patient's psychiatric symptoms is essential to diagnosis. This presentation will include medical causes, as well as medications and substances causing psychiatric symptoms most frequently seen in practice. Diagnostic testing, individualized by patient, will also be reviewed. Recognizing the medical perspective in evaluating elderly patients with dementia will improve their care.

No. 2C
PSYCHOSIS AND AGGRESSION IN DEMENTIA

Alan P. Siegal, M.D., *Associate Clinical Professor, Department of Psychiatry, Yale University, 60 Washington Avenue, #203, Hamden, CT 06518-3272*

SUMMARY:

The noncognitive psychiatric and behavioral symptoms of late-life dementias, such as delusions, hallucinations, agitation, and aggression, are observed in up to 90% of patients with dementia. The most effective treatment of these behavioral disturbances are antipsychotic medications. The efficacy of the conventional antipsychotic agents in these disturbances, however, has been modest and associated with a high incidence of adverse events.

Newer antipsychotic drugs, combining serotonin and dopamine antagonists, have been developed. They may relieve behavioral disturbances with less sedation, fewer anticholinergic side effects, and at lower doses, and pose less risk of extrapyramidal symptoms. The advantages and disadvantages of the newer antipsychotics will be evaluated and their optimal use discussed.

Emerging data from clinical trials of risperidone, olanzapine, quetiapine, and clozapine will be presented.

REFERENCES:

1. Small GW, Rabins PV, Barry PP, et al. Diagnosis and treatment of Alzheimer disease and related disorders: consensus statement of the American Association for Geriatric Psychiatry, the Alzheimer's Association, and the American Geriatrics Society. JAMA. 1997. Oct 22-29; 278(16):1363-1371.
2. Practice guide for the treatment of patients with alzheimer's diseease and other dementias of late life. Am J Psychiatry. 1997. 154:5(suppl).
3. Jeste DV, Krull AJ: Behavioral problems associated with dementia: Diagnosis and treatment. Geriatrics. 1991;46:28-34.
4. Tariot PN, Treatment strategies for agitation and psychosis in dementia. J Clin Psychiatry. 1996;57(suppl 14):21-29.
5. Katz IR, Jeste DV, Mintzer JE, et al: Comparison of risperidone and placebo for psychosis and behavioral disturbances associated with dementia: a randomized, double-blind trial. J Clin Psychiatry. 1999;60:107-115.
6. Jeste DV, Eastham JH, Lacro JP, et al: Management of late-life psychosis. J Clin Psychiatry. 1996;57(Suppl 3):39-45.

Industry-Supported Symposium 3 — **Friday, October 29 7:00 p.m.-10:00 p.m.**

THE CHALLENGE OF MANAGING MOOD DISORDERS

Supported by Janssen Pharmaceutica Research and Foundation

Gary S. Sachs, M.D., *Department of Psychiatry, Harvard Medical School and Massachusetts General Hospital, 15 Parkman Street, WAC-812, Boston, MA 02114*

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, participants should be able to better differentially diagnose mood disorders, understand cognitive-behavioral techniques, in bipolar disorder, and be able to wrote new pharmacotherapies for mood disorders.

SUMMARY:

The four presentations in this symposium are designed to provide up-to-date insights into new advances in the diagnosis and psychopharmacologic and psychotherapeutic treatment of mood disorders. Participants in this symposium will learn to recognize signs and symptoms of bipolar versus unipolar mood disorders, to understand new treatment approaches for these conditions, to be familiar with cognitive-behavioral psychotherapy interventions, and to become acquainted with systematic algorithms of treatment based on menus of reasonable choices. Recent research on these topics will be presented as well as case studies.

No. 3A
COGNITIVE-BEHAVIORAL THERAPY FOR BIPOLAR DISORDER

Michael W. Otto, Ph.D., *Associate Professor of Psychology, Harvard Medical School, Director, Cognitive Behavior Therapy Program, Massachusetts General Hospital, 15 Parkman Street, WACC 812, Boston, MA 02114*

SUMMARY:

Historically, bipolar disorder has been conceptualized as a biologically driven form of mental illness. Therefore, the majority of research on bipolar disorder has explored genetic and biochemical diatheses and pharmacological treatments. However, limitations to pharmacotherapy alone are suggested by a five-year relapse rate of 73%, even in patients with favorable acute responses to medication and adequate maintenance treatment. Furthermore, a growing number of studies suggest that life stressors and psychological variables such as negative cognitive styles, contribute vulnerability to bipolar mood episodes. Cognitive-behavioral therapy (CBT) is a structured, active, and present-oriented psychotherapy that has the potential to augment pharmacotherapy, improve quality of life, and lower rates of relapse. This presentation will focus on adjunctive cognitive-behavioral techniques for the control and management of treatment-refractory hypomania and depression. Specialized strategies for modifying dysfunctional thinking and behavior, identifying and coping with triggers for relapse, and improving medication compliance will be discussed. Suggestions for regulating activities, minimizing circadian rhythm disruptions, charting mood fluctuations, and recognizing early warning signs of episodes will also be presented. The importance of psychoeducation and family involvement will be addressed, and recent data supporting the application of adjunctive CBT will be reviewed.

No. 3B
PROMISING NEW TREATMENTS FOR MOOD DISORDERS

Nassir Ghaemi, M.D., *Assistant Director, Harvard Bipolar Research Center, 15 Parkman Street, WACC-812, Boston, MA 02114*

SUMMARY:

Objective: To identify new treatments and novel therapeutic approaches for mood disorders

Methods: I will discuss recent research on new treatments for mood disorders, especially bipolar disorder, schizoaffective disorder, and psychotic depression. I will review recent studies of novel anticonvulsants, atypical neuroleptic agents, and new antidepressants as used in those conditions.

Results: Novel anticonvulsants and atypical neuroleptic agents are particularly promising new treatments for mood disorders, particularly bipolar disorders. Clinical experience and naturalistic studies are now being augmented by double-blind data to provide greater guidance to clinicians in using these agents for mood disorders. Relevant clinical features include being aware of when these agents might be used alone and when they are best used as adjunctive treatments with standard mood-stabilizing agents such as lithium and valproate. Side effect data will be reviewed and the clinical decision-making process of when to use these agents and when not to use them will be discussed.

Conclusion: Exciting new treatment approaches are being developed for patients with mood disorders. Novel anticonvulsants and atypical neuroleptic agents are among the most promising new classes of agents for these conditions.

No. 3C
BIPOLAR DISORDERS: DIAGNOSTIC PUZZLES AND SOLUTIONS

K.N. Roy Chengappa, M.D., *Associate Professor, Department of Psychiatry, Western Psychiatric Institute and Clinic, 3811 O'Hara Street, Pittsburgh, PA 15071*

SUMMARY:

Prior to the widespread use of lithium, subjects with manic depressive illness (especially what we now term as bipolar I disorder) were often misdiagnosed as suffering from schizophrenia. Subsequently, especially in centers

that had a special interest in bipolar disorders and used lithium extensively, the opposite may trend have occurred to a degree. To an extent, psychoses in the presence of bipolar disorders may still be misdiagnosed as schizophrenia or schizoaffective disorder: The increasing acceptance of the softer spectrum of bipolar disorders (bipolar II, etc.) has now resulted in could what be an overdiagnosis of bipolar disorders.

Diagnosis remains a critical issue in this condition for several reasons, including but not limited to the need for long-term (even life-long) treatments. In some situations, coming to an accurate diagnosis is easier said than done. Also, the use of pharmacologic agents requires special consideration; for instance, a woman on thymoleptic agents who wants to become pregnant, children and adolescents, the elderly, the medically infirm, polyphamacy, the rapid cycling patient, treating a bipolar II subject with antidepressants in the absence of mood stabilizers, etc. While all the issues cannot be addressed in this discussion, certain issues such as bipolar I vs. schizoaffective bipolar type disorder, bipolar II vs. borderline personality, mixed manic states vs. agitated or atypical depression, mixed states vs. rapid cycling, and ADHD vs. bipolar disorder in children will be considered as possible puzzles and potential solutions to such clinical dilemmas will be offered.

No. 3D
EFFECTIVE TREATMENT OF MOOD DISORDERS: CASE STUDIES

Gary S. Sachs, M.D., *Department of Psychiatry, Harvard Medical School and Massachusetts General Hospital, 15 Parkman Street, WAC-812, Boston, MA 02114*

SUMMARY:

Objective: To gain an understanding of practical strategies of treating affective disorders by case examples.

Methods: I will review a number of difficult cases of patients with mood disorders, utilizing a systematic algorithm of treatment based on a menu of reasonable choices. We are presently developing a systematic treatment enhancement program (STEP) in a longitudinal NIMH-sponsored study of outcomes of treatment for bipolar disorder. We utilize standardized clinical monitoring forms (CMF) and self-report mood charting methods to maximize diagnostic accuracy and reliable assessment of therapeutic outcome.

Results: Affectively ill patients can be treated effectively by using systematic treatment approaches based on rational combinations of mood stabilizers, adjunctive mood stabilizers, and/or antidepressant agents. In patients with bipolar disorder, antidepressant agents are best used acutely and intermittently, and avoided in rapid-cycling conditions. In bipolar patients, with nonresponse to one or two mood-stabilizing agents, the addition of novel anticonvulsants or atypical neuroleptic agents is often helpful.

Conclusion: Systematic treatment utilizing algorithms of reasonable choices is an effective technique in managing patients with affective disorders.

REFERENCES:

1. Alloy LB, Reilly-Harrington NA, Fresco D, Whitehouse WG, Zechmeister JS: Cognitive styles and life events in subsyndromal unipolar and bipolar disorders: stability and prospective prediction of depressive and hypomanic mood swings. Journal of Cognitive Psychotherapy: An International Quarterly in press.
2. Scott J: Cognitive therapy for clients with bipolar disorder. Cognitive and Behavioral Practice 1996; 3:29-51.
3. Goodwin FK, Ghaemi SN: Understanding manic-depressive illness. Archives of General Psychiatry 1998; 55:23-25.
4. Ghaemi SN, Sachs GS, Baldassaus CF: Treatment resistant bipolar disorder: Clinical aspects & management, Challenges in Psychiatric Treatment, Edited by Pollack M. Rosenbaum, Jr. Guilford Press, New York, pp. 53-88.
5. Goodwin FK, Jamison KR: Manics Depressive Illness. Chapter 5 Diagnosis. Oxford University Press, New York, 1990, pp. 85-123.
6. Schatzberg AF: Bipolar disorder: recent issues in diagnosis and classification. Journal of Clinical Psychiatry 1998; 59 (supplement 6):5-10.
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Industry-Supported Symposium 4 — **Saturday, October 30 6:30 a.m.-8:00 a.m.**

ASPECTS OF EFFECTIVENESS IN SCHIZOPHRENIA: HOW DO ATYPICALS COMPARE?

Supported by Janssen Pharmaceutica and Research Foundation

Robert R. Conley, M.D., *Associate Professor, Department of Psychiatry, University of Maryland, and Maryland Psychiatric Research Center, Tulip Drive, PO Box 21247, Baltimore, MD 21228*

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, participants should be able to (1) Analyze and interpret new and existing clinical data concerning the efficacy and safety of the new atypical antipsychotics, (2) describe various

approaches to the effective management of treatment-resistant schizophrenia, (3) consider the implications of various treatment issues to the concept of overall effectiveness through the use of case studies.

SUMMARY:

This very timely program has been developed to help physicians understand the importance of the concept of effectiveness vs efficacy. The three presentations will focus on the most current clinical data available in an effort to properly compare the efficacy and side effect issues of the atypical antipsychotic medications through didactic as well as case study modes of learning. In addition, new insights will be discussed concerning the challenging aspect of effectively managing treatment-resistant schizophrenia. A review of case studies will illustrate the relationship between efficacy, side effects, and dosing in schizophrenia in order to show what constitutes appropriate management including utilizing optimal therapeutic approaches. The state-of-the-art clinical comparisons combined with the practical therapeutic approach examined via case studies should benefit the practicing psychiatrist as well as other mental health professionals in reviewing how to effectively manage the psychotic patient.

No. 4A
EFFICACY VERSUS EFFECTIVENESS: COMPARATIVE TRIALS OF ATYPICAL ANTIPSYCHOTICS

Robert R. Conley, M.D., *Associate Professor, Department of Psychiatry, University of Maryland, and Maryland Psychiatric Research Center, Tulip Drive, PO Box 21247, Baltimore, MD 21228*

SUMMARY:

New data contine to emerge concerning the efficacy and safety of the new atypical antipsychotic medications. Published and unpublished studies with various study designs have been employed, which have achieved differing results. This presentation will enable participants to practically analyze existing data and thus compare these new agents in "real world" settings. The treatment of this topic will ensure that the audience is familiar with the pharmacology of the atypical antipsychotics. Similarities and differences will be identified concerning side-effect profiles. In addition, new data will be presented that offer insights into the pharmacoeconomics of treating schizophrenia with these newer agents. Finally, the concept of effectiveness, considering all of the above issues and their interrelationships, will be discussed.

No. 4B
THE CHALLENGE OF TREATMENT-RESISTANT SCHIZOPHRENIA

Zafar A. Sharif, M.D., *Assistant Professor, Clinical Psychiatry, Columbia University and Creedmoor Psychiatric Center, 80-45 Winchester Boulevard, Building 40, Queens Village, NY 11427;* Ahmad Raza, M.D., Ph.D.; Christine Miller, B.A.

SUMMARY:

Up to 30% of patients with schizophrenia have a significant degree of treatment resistance to adequate trials of conventional antipsychotic agents. The only treatment of proven efficacy in this group of patients is clozapine. With the introduction of several novel antipsychotic agents the obvious question of their efficacy in refractory patients arises. Data from the Maryland Psychiatric Center, and an open study being conducted at Creedmoor, are not supportive of superiority of olanzapine over conventional agents in refractory patients. In our study, 18 treatment-refractory patients have been treated with doses of olanzapine up to 30 mg and treatment periods of 12 to 16 weeks in an open prospective trial. Based on a minimum 25% decrease in the total PANSS score to define clinically significant response, only one patient could be classified as a responder after 12 weeks of treatment. A retrospective study at Creedmoor comparing risperidone with clozapine demonstrated the efficacy of risperidone (proportion of patients classified as responders) to be about half that of clozapine (25% versus 58%, respectively). Other studies in the literature will be reviewed that address the issue of efficacy of risperidone and olanzapine in refractory patients. An additional important clinical question is what should we do for patients who have failed an adequate clozapine trial? Augmentation of clozapine with electroconvulsive therapy (ECT), or with risperidone are strategies that are being evaluated at Creedmoor. Data will be presented that suggest that between 30% and 50% of patients who have failed clozapine will respond to these augmentation strategies.

No. 4C
ALGORITHMS FOR EFFECTIVENESS: A REVIEW OF CASE STUDIES

Lili C. Kopala, M.D., *Department of Psychiatry, Dalhousie University, 5909 Jubilee Road, Halifax, NS, Canada B3H 2E2*

SUMMARY:

The overall effectiveness of antipsychotic medications goes beyond efficacy (comparing a compound to a gold standard drug) to encompass issues related to safety

with longer-term use, acceptability to patients, and cost effectiveness. In the past, the extrapyramidal side effects (EPSE) of first-generation antipsychotics such as haloperidol dominated the scene. The risk of tardive dyskinesia was ever present. As well, drug-induced dysphoria was likely under recognized. More recently developed, second-generation antipsychotics such as risperidone, olanzapine, and quetiapine, have diminished EPSE and are generally more acceptable to patients. They have their own unique side-effect profiles, including what appears to be differential effects on cognition and subsequent functional adaptation, weight gain, and health care costs.

The effective and continuous treatment of psychosis is challenging but offers the hope of superior quality of life for affected individuals. These issues will be reviewed and illustrated with video case examples.

REFERENCES:

1. Conley RR, Tamminga CA, Bartko JJ, et al: Olanzapine compared with chlorpromaine in treatment-resistent schizophrenia. Am J Psychiatry 1998; 155(7):914-920.
2. Brecher, M. Risperidone versus olanzapine in the treatment of schizophrenia or schizoaffective disorder. Eur Neuropsychopharmacol 1998; 8(suppl2):S238.
3. Kopai LC, Good KP, Fredrikson D, Whitehorn D, Lazier L, Honer WG: Risperidone in schizophrenia: improvement in symptoms and pre-existing extrapyramidal signs. International Journalist Psychiatry in Clinical Practice 1998; Volume 2, pp. S19-S25.
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Industry-Supported Symposium 5 **Saturday, October 30 12 noon-1:30 p.m.**

ANTIDEPRESSANT COMBINATIONS FOR DRUG-RESISTANT AND INTOLERANT CASES

Supported by Wyeth-Ayerst Laboratories

Richard C. Shelton, M.D., *Department of Psychiatry, Vanderbilt University, 1500 21st Avenue South, Suite 2200, Nashville, TN 37212*

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, participants should be able to understand the scope and nature of refractory depression; better understand the physiological basis for the treatment of refractory depression, particularly augmentation strategies; and broaden their knowledge about treatment approaches for refractory patients in psychiatric practice.

SUMMARY:

The number of persons being treated for depression has skyrocketed in the last decade. However, the fact that more patients with depression are being treated in primary care means that the management of depression by psychiatrists is become more oriented to refractory patients. Therefore, it is incumbent on psychiatrists to be proficient in the treatment of these patients. This symposium is intended to broaden the understanding of participants in not only the available management strategies, but also the basic neurobiological basis of depression and its treatment. In particular, we will present an "intracellular" view of depression and treatment (including management of depression) that will go "beyond the receptor" to post-receptor processes that are involved in response to antidepressants; signal transduction mechanisms (g-proteins, second messenger systems, kinases, DNA binding proteins), promoters, and genes and gene products. This will serve as the basis for a more extensive discussion of established and novel strategies for the management of difficult-to-treat patients.

No. 5A
MOLECULAR MECHANISMS OF RESISTANCE AND TREATMENT

Richard C. Shelton, M.D., *Department of Psychiatry, Vanderbilt University, 1500 21st Avenue South, Suite 2200, Nashville, TN 37212*

SUMMARY:

Psychiatrists are faced with the problem of refractory depression on a regular basis. How, then, do we choose a rational path to deal with these clinical problems? This presentation will present a cellular framework for understanding the mechanisms involved in the pathophysiology of depression, as well as targets of drug action. Specifically, we will trace the actions of antidepressant drugs, from call surface receptors, through transductional linking mechanisms (e.g., adenine cyclase, phosphorylation enzymes, etc.), to the synthesis of specific gene products. We will show how drugs of apparently divergent mechanisms of action (e.g., serotonin vs. norepinephrine uptake blockade) may yield common therapeutic effects. Further, we will show how the activation of these cascades by combinations of treatments may explain the mechanisms for augmentation. By expanding our understanding of these mechanisms we may become more effective at making rational therapeutic decisions.

No. 5B
RATIONAL CHOICES FOR REFRACTORY PATIENTS

Andrew A. Nierenberg, M.D., *Associate Director, Depression Clinic, Department of Psychiatry, Massachusetts General Hospital, 15 Parkman Street, WACC 812, Boston, MA 02114-3117*

SUMMARY:

Up to half of depressed patients require treatment beyond a firstline antidepressant to manage partial or nonresponse. Once an antidepressant trial has been optimized, clinicians must decide whether or not to augment the falling antidepressant or, alternatively, stop the antidepressant and switch to another one. Understanding actions of both augmentation strategies and antidepressants can help make the therapeutic choice more rational, but the ultimate proof of efficacy resides in carefully designed clinical trials and proof of effectiveness is in the clinic. This presentation will critically review available data for augmentation (e.g. lithium, thyroid, buspirone, pindoiol, inositol, and atypical antipsychotics) and combination strategies (e.g. SSRIs plus bupropion, stimulants, dopaminergic agents, TCAs) as well as the efficacy of switching antidepressants (SSRI to SSRI, veniataxine, bupropion, mirtazapine, TCAs). The results of a survey of psychiatrists will also be presented to assess clinicians' perceptions of these strategies.

REFERENCES:

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4. Nierenberg AA, Dougherty D, Rosenbaum JF: Dopaminergic agents and stimulants as antidepressant augmentation strategies. J Clin Psychiatry 1998; 59(Suppl 5):60-63;(discussion 64).

Industry-Supported Symposium 6 — **Saturday, October 30 12 noon-1:30 p.m.**

COGNITIVE DYSFUNCTION AND OUTCOME IN SCHIZOPHRENIA

Supported by U.S. Pharmaceuticals, Pfizer Inc.

Herbert Y. Meltzer, M.D., *Professor, Department of Psychiatry and Director, Division of Psychopharmacology, Psychiatric Hospital at Vanderbilt University, 1601 23rd Avenue South, Suite 306, Nashville, TN 37212*

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, participants should be able to understand the dimensions of cognitive dysfunction in schizophrenia, its development and significance for outcome for work function and skills acquisition. The effect of antipsychotic drugs on cognition will be understood.

SUMMARY:

The central role of cognitive dysfunction in the etiology, course, and outcome of schizophrenia has been established by numerous studies over the last 50 years. Evidence will be presented that diverse and extensive cognitive dysfunction is present in schizophrenia, including deficits in working memory, semantic memory, recall memory, learning, executive function, and attention. The incidence, time course, and severity of cognitive impairment and its relation to outcome in patients with schizophrenia will be described and compared with mood disorders (Harvey). Published studies and new data on the role of cognition in community placement, social skills, acquisition, and social problem solving in schizophrenia will be reviewed (Green). Published studies and new data on the effect of typical and atypical antipsychotic drugs and cognitive rehabilitation to improve or worsen cognition in schizophrenia will be reported (Meltzer).

No. 6A
COGNITIVE FUNCTIONING IN SCHIZOPHRENIA: IMPLICATIONS FOR OUTCOME OF THE ILLNESS

Philip D. Harvey, Ph.D., *Associate Professor of Psychiatry, Mt. Sinai School of Medicine, 100th Street and Madison Avenue, New York, NY 10029*

SUMMARY:

Cognitive impairment in schizophrenia is present before, during, and after active psychotic episodes. Many different domains of cognitive functioning are impaired in schizophrenia, with the most severe deficits in areas of memory, including memory span, serial learning, and delayed recall. At the same time, there is a gradient of impairment across cognitive functions, with aspects of long-term memory often essentially unimpaired. The average impairment level is one to two standard deviations below normal. Individuals who will go on to develop schizophrenia perform considerably more poorly in childhood than their siblings and peers who do not develop the illness. Patients in their first episode of illness have impairments that are only slightly less severe

than patients with chronic illness. Patients with a poorer overall outcome are consistently more impaired in their cognitive function. The severity of negative symptoms but not positive symptoms is consistently found to be related to the overall severity of cognitive impairment. Analyses of the profile of memory impairment have suggested that it resembles that seen in dementias subcortical. Some poor outcome patients have deficits in cognitive function that are as severe as those seen in progressive dementias such as Alzheimer's disease. Good outcome in schizophrenia requires improving cognitive impairment.

No. 6B
DEFINING THE STEPS BETWEEN NEUROCOGNITIVE DEFICITS AND FUNCTIONAL OUTCOME IN SCHIZOPHRENIA

Michael F. Green, Ph.D., *Department of Psychiatry, UCLA Neuropsychiatric Institute, 760 Westwood Plaza, C9-420, Los Angeles, CA 90024-1759;* Robert Kern, Ph.D.

SUMMARY:

In a previous review of the literature (mainly from 1990-1995) we found that, across studies, certain neurocognitive abilities were consistently linked to functional outcome. In this review, the outcome domains included psychosocial skill acquisition, social problem solving, and community outcome. Looking across these domains of outcome, secondary verbal memory was a strong predictor/correlate of outcome, regardless of the measure of functional outcome used. Immediate verbal memory (a component of working memory) was reliably associated with skill acquisition. Vigilancee (the ability to discriminate signal from noise in a briefly-presented array of stimuli) was reliably related to social skill acquisition and social problem solving. Card sorting (a measure of executive functioning) was consistently related to community outcome.

The literature in this area has doubled in the three years since the review. The newer findings are generally consistent with those from the initial review, with some caveats. In general, secondary verbal memory, immediate verbal memory, card sorting, and vigilance are related to the three areas of functional outcome. This literature will be reviewed in three ways: by looking at the number of replicated findings, but tallying box scores, and through formal meta-analysis. Attention will be paid to the limitations of this literature and future directions.

No. 6C
EFFECT OF ANTIPSYCHOTIC DRUGS ON COGNITION IN SCHIZOPHRENIA

Herbert Y. Meltzer, M.D., *Professor, Department of Psychiatry, and Director, Division of Psychopharmacology, Psychiatric Hospital at Vanderbilt University, 1601 23rd Avenue South, Suite 306, Nashville, TN 37212*

SUMMARY:

Varying degrees of cognitive impairment are present in 85% of patients with schizophrenia from the first episode of schizophrenia on; lesser impairment may be present during the premorbid period. Typical neuroleptic drugs have been found to have minimal effects in improving cognition. Those agents with strong anticholinergic properties may worsen some types of memory. There is a growing literature that indicates that some atypical antipsychotic drugs have the ability to improve some domains of cognition. In particular, clozapine has been found to improve attention, semantic memory, and recall memory in a number of studies. It does not improve executive function as assessed by the Wisconsin Card Sorting Test or working memory. Risperidone has recently been found to improve spatial working memory and other types of cognition. Olanzapine improves semantic memory and recall memory, and ziprasidone, another new atypical antipsychotic, also improves recall memory, executive function, and motor performance. These effects on cognition are largely independent of effects on psychopathology. These preliminary findings suggest that the choice of which antipsychotic drug for specific patients, in part, should be determined on their individual efficacy with regard to cognition and the specific impairments in individual patients.

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Industry-Supported Symposium 7 **Saturday, October 30 6:00 p.m.-9:00 p.m.**

GENDER, AGE AND DEPRESSION: WHERE ARE WE GOING?

Supported by Eli Lilly and Company

Alan F. Schatzberg, M.D., *Kenneth T. Norris, Jr. Professor and Chairperson, Department of Psychiatry and*

Behavioral Sciences, Stanford University School of Medicine, 401 Quarry Road, #300, Stanford, CA 94305-5490

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, participants should be able to discuss acute management and treatment of childhood and adolescent depressions during the acute phase and after the young patient has responded; understand the roles of estrogen and progesterone in the treatment of premenstrual dysphoric disorder and the potential use of SSRIs in treating it; comprehend the role of estrogen replacement in the promotion of antidepressant response in perimenopausal and postmenopausal depression; discuss treatment strategies for both vascular and nonvascular depression; and understand methods to optimize compliance with treatment in patients of all age groups.

SUMMARY:

In recent years a great deal of data have emerged on the management of depression in special populations. These findings point to the need for clinicians to be sensitive to age- and gender-based factors. Graham Emslle will present data on acute treatment and follow-up studies on depression in childhood and adolescence, emphasizing not only the acute management and treatment, but what to do once the young patient has responded. Meir Steiner will review treatment of premenstrual dysphoric disorder, the roles of estrogen and progesterone, and the potential use and dosing strategies of SSRIs. Vivian Burt will present on optimizing treatment in perimenopausal and postmenopausal depression, and discuss the role of estrogen replacement to promote antidepressant response. The efficacy of antidepressants in both subtypes will be reviewed. Charles Nemeroff will discuss depression in geriatric patients, reviewing data on both vascular and nonvascular depression. Lastly, John Zajecka will present on optimizing compliance in depressed patients of all age groups. Clinical implications will be emphasized.

No. 7A
DEPRESSION IN YOUNG POPULATIONS: ACUTE TO POST RESPONSE FOLLOW UP

Graham J. Emslie, M.D., *Department of Psychiatry, University of Texas Southwestern Medical Center, 5323 Harry Hines Boulevard, Dallas, TX 75235-8589*

SUMMARY:

Increasing evidence shows that depressive disorders are prevalent and serious disorders in children and adolescents. Recent and ongoing pharmacologic studies have shown the effectiveness of acute treatment with SSRIs. However, although acute efficacy trials have demonstrated positive results, little is known about continuation and maintenance treatment. We will present naturalistic one-year follow-up information of 96 children and adolescents with major depressive disorder who had been randomized in an eight-week, double-blind, placebo-controlled trial of fluoxetine.

Eighty-seven of the 96 subjects were followed for one year. Of these, 74 (85%) recovered from the depressive episode during that time. Twenty-nine subjects (39%) had a recurrence of depression during follow-up, with 55% of these occurring within six months.

Results of this study are similar to adult studies, with respect to recovery of depressive episodes. Most patients (85%) recover from the episode within one year, but approximately 40% have a recurrence within 12 months, which is a higher recurrence rate than in adults. Recovery was associated with younger age, lower severity of depressive symptoms, higher family functioning, and fewer comorbid diagnoses. Recurrence, which occurs both on and off medication, was difficult to predict, as there was little clinical data associated with recurrence in this population.

No. 7B
HORMONES, SEROTONIN, AND FEMALE-SPECIFIC MOOD DISORDERS

Meir Steiner, M.D., Ph.D., *Department of Psychiatry, McMaster University, St. Joseph's Hospital, 50 Charlton Avenue East, Hamilton, ON, Canada L8N 4A6*

SUMMARY:

The role of the gonadal hormones in PMS and PMDD has been considered of central importance. To date, however, studies attempting to attribute premenstrual symptoms to changes in hormonal levels have produced mixed and mostly nonreplicable results. Nevertheless data on the potential roles of estrogen withdrawal and the gabaergic-like properties of progesterone are intriguing. What is known is that normal ovarian function is the cyclical trigger for menstrually related biochemical events (in particular along the serotonergic cascade) and these in turn may induce premenstrual syndromes in predisposed women. Thus older treatment options included interventions aimed at the elimination of ovulation (abolish the trigger). More recently, the serotonin reuptake inhibitors, including clomipramine, fluoxetine, sertraline, paroxetine, and citalopram have gained in popularity as they continue to be proven efficacious in treating women with premenstrual dysphoria. Continuous, as well as intermittent (late luteal phase only), dosing seems to be effective for both psychological as well as physical symptoms and also diminish the burden of illness and improve quality of life.

No. 7C
LATE-LIFE DEPRESSION: A CEREBROVASCULAR DISORDER?

Sumer Verma, M.D., *One Mason Street, Lexington, MA 02173-6314*

SUMMARY:

Geriatric depression has attracted increased interest in recent years as our population ages. This talk will review the diagnosis, biology, and treatment of geriatric depression. Geriatric depression can present as a symptom of an underlying medical or neurological disorder—particularly those involving the cardiovascular and endocrine systems. Some depressed patients—often with pronounced agitation and overall severity—demonstrate vascular-related changes in brain tissue as evidenced on magnetic resonance imaging. The possible biological significance of these will be discussed as will be the difficulties in treating these patients.

Data on recent controlled trials on antidepressants in geriatric depression will be reviewed. The newer antidepressants, e.g., selective serotonin reuptake inhibitors (SSRIs) are much better tolerated than are the older tricyclic antidepressants (TCAs) but some investigators argue the latter are more potent, particularly in geriatric patients. Data regarding this debate are reviewed. To date the studies indicate the SSRIs generally enjoy broadly comparable efficacy to the TCAs with a markedly better sideeffect profile, although there are some studies suggesting norepinephrine reuptake blockade may result in a more robust response in some patients. Currently, risk-benefit analysis still favors the newer drugs over the TCAs as first-line treatments in geriatric depression. Finally, long-term treatment of geriatric depression will be reviewed.

No. 7D
OPTIMIZING COMPLIANCE ACROSS AGE GROUPS

Charles DeBattista, M.D., *Department of Psychiatry, Stanford University, 401 Quarry Road, Stanford, CA 94305-5723*

SUMMARY:

Compliance with medications for psychiatric disorders, including depression, lags behind compliance with medication prescriptions for nonpsychiatric physical conditions. Geriatric patients may be at greater risk for noncompliance with psychiatric medication than patients of other age groups. Medication factors that have been identified with noncompliance include divided dosing, greater side effects, delayed response, cost, and prophylaxis vs. acute treatment. Patient-related variables in non-compliance include lack of education about diagnosis and treatment expectations, lack of patient involvement with medication decisions, and deficits in patient-physician communication. In this review, factors influencing compliance with antidepressants and other psychiatric medications are discussed with an emphasis on strategies for enhancing compliance.

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Industry-Supported Symposium 8 — **Sunday, October 31 6:30 a.m.-8:00 a.m.**

THE SPECTRUM OF EFFECTIVE USE OF SSRIS IN MULTIPLE PSYCHIATRIC ILLNESSES

Supported by Forest Laboratories, Inc. and Parke-Davis

James G. Barbee IV, M.D., *Vice Chairperson, Department of Psychiatry and Associate Professor of Psychiatry and Pharmacology, Louisiana State University Medical Center, 1542 Tulane Avenue, Box T4-6, New Orleans, LA 70112-2825*

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to describe how serotonergic pathways in the CNS influence psychiatric disease progression; summarize pharmacologic profiles of the SSRIs; and review the differential diagnosis of psychiatric disorders

based on DSM-IV criteria and medical management including appropriate selection of SSRIs.

SUMMARY:

The serotonin (5-HT) neurotransmitter has been implicated in a variety of psychiatric disorders including schizophrenia, depression, generalized anxiety disorder (GAD), panic disorder, and obsessive compulsive disorder (OCD). These findings have stimulated research and development of drugs that will target serotonergic pathways selectively. Selective serotonin reuptake inhibitors (SSRIs) powerfully inhibit reuptake of serotonin and thereby potentiate serotonergic neurotransmission. They are being extensively tested in clinical trials and novel indications continue to emerge. Their unique safety and efficacy profiles have helped to place these agents as drugs of first choice for the management of a number of psychiatric disorders in recent years.

Although SSRIs share the same mechanism of action and have common properties, there are pharmacokinetic and pharmacodynamic differences among these agents. These differences will influence their use in the various psychiatric disorders as well as patient populations. Issues include drug interaction potential, frequency and severity of adverse effects, and efficacy for the specific diagnosis. A complete understanding of the profile of each member in the class will help guide effective management.

No. 8A
SSRIS AND ANXIETY DISORDERS

James G. Barbee IV, M.D., *Vice Chairperson, Department of Psychiatry and Associate Professor of Psychiatry and Pharmacology, Louisiana State University Medical Center, 1542 Tulane Avenue, Box T4-6, New Orleans, LA 70112-2825*

SUMMARY:

Anxiety disorders are a heterogeneous group of disorders in which the prevalent symptom is the feeling of impending threat or doom that is not well defined or realistically based. According to the National Institute of Mental Health Epidemiological Catchment Area (NIMH-ECA) study, 8.3% of all Americans meet the diagnostic criteria for anxiety, making it the most prevalent of the psychiatric disorders. The clinical conditions that are included under the catch-all of anxiety include panic disorder w/wo agoraphobia, agoraphobia, social phobias, specific phobias, and obsessive-compulsive disorder. While the mainstay of pharmacologic therapy has been benzodiazepines and tricyclic antidepressants, recently the selective serotonin reuptake inhibitors (SSRIs) have emerged as the new first-line agent of choice. SSRIs have now been shown to be effective in a variety of anxiety disorders, including panic, obsessive-compulsive disorder, and social phobia. The International Consensus Group on Depression and Anxiety recommends a treatment period of 12 to 24 months with SSRIs. Pharmacotherapy should be discontinued slowly over a period of four to six months. SSRIs are well tolerated and effective with a favorable adverse effects profile, although they must be used skillfully to obtain the optimum result in anxious patients. Interestingly, SSRIs have potential benefits in treating difficult disorders such as OCD and phobias.

No. 8B
SSRI USE IN DEMENTIA AND AGITATION

George S. Alexopoulos, M.D., *Professor, Department of Psychiatry, New York Hospital, Cornell Division, 21 Bloomingdale Road, White Plains, NY 10605-1504*

SUMMARY:

Symptoms of agitation, such as restlessness, physical aggression, and other behavioral complications, afflict as much as 90% of patients suffering from some form of dementia, including Alzheimer's disease. Additionally, depression is a common psychiatric disorder, affecting a large percentage of the older population. Comorbid medical conditions and drugs used for their treatment complicate the care of these psychiatric diseases in the elderly. Drug selection may be influenced by such factors as metabolism, polypharmacy, adverse events, safety in overdose, long-term tolerability, and patient compliance. Elderly demented patients are particularly sensitive to the extrapyramidal and cognitive side effects of antipsychotics. Similarly, benzodiazepines offer few benefits and may cause memory impairment, dependency, sedation, and falls. Serotonergic drugs have recently emerged as encouraging alternatives to neuroleptics and benzodiazepines for the treatment of the behavioral disturbances of dementia. These agents have already established efficacy as antidepressants. Selective serotonin reuptake inhibitors (SSRIs) are well tolerated and safe in overdose and can be given once a day so that compliance problems are minimized. For these reasons, SSRIs are an important part of the armamentarium against geriatric depression and agitation syndromes.

No. 8C
SSRIS IN THE TREATMENT OF PERSONALITY DISORDERS

Paul H. Soloff, M.D., *Professor, Department of Psychiatry, University of Pittsburgh Medical School, 3811 O'Hara Street, Pittsburgh, PA 15213*

SUMMARY:

A pharmacologic approach to treating patients with personality disorders (PD) is based on evidence that some dimensions of personality are mediated by variations in neurotransmitter physiology and are responsive to medication effects. Affective instability and impulsive-aggression, personality dimensions frequently associated with self-destructive and suicidal behaviors, have been related to diminished central serotonergic regulation of mood and impulse. SSRI antidepressants have demonstrated therapeutic efficacy against impulsive-aggression, anger, and affective instability, independent of effects on depression. These therapeutic efforts are especially important in reducing the incidence of self-mutilation and risk of suicidal behavior. Comorbidity with major depression increases the urgency and utility of this recommendation. Efficacy, safety in overdose, and a favorable side-effect profile make the SSRI antidepressants the treatment of first choice for the affective dysregulation and impulsive-aggression of the patient with PD.

No. 8D
SSRIS IN THE PATIENT WITH MOOD DISORDERS

Mark H. Rapaport, M.D., *Department of Psychiatry, University of California at San Diego, 8950 Villa La Jolla Drive, #2243, La Jolla, CA 92037-2315*

SUMMARY:

Depression is a common, life-disrupting, potentially lethal illness that can affect both sexes and all ages. Suicide occurs in as many as 15% of patients with depression. Studies show that fewer than one in 20 patients are correctly diagnosed and adequately treated. The cornerstone for effective treatment of depression is pharmacotherapy. Since their introduction, selective serotonin reuptake inhibitors (SSRIs) have become one of the most widely used classes of medication in psychiatry. Generally, in double-blind comparative trials, all SSRIs demonstrated antidepressant efficacy similar to that of the "standard" tricyclic antidepressants (TCAs). SSRIs have a more favorable tolerability profile than TCAs and, unlike the tricyclics, are not associated with anticholinergic adverse effects and cardiotoxicity. They are associated with other side effects, which appear to diminish with continued treatment. There is now a wealth of information demonstrating that SSRIs may differ in their efficacy profiles in certain depressive symptoms and in certain subtypes, such as anxious depression, dysthymia, and atypical depression. Some of these differences are attributable to structural characteristics, which affect half-lives, drug-interactions, and pharmacokinetics. The ever-increasing database of information on the various SSRIs will make it possible to differentiate subtle differences in clinical effects.

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Industry-Supported Symposium 9 — **Sunday, October 31 6:30 a.m.-8:00 a.m.**

THE ROLE OF ANTIPSYCHOTICS IN LONG-TERM MOOD STABILIZATION

Supported by Eli Lilly and Company

Paul E. Keck, Jr., M.D., *Associate Professor and Vice Chairman, Department of Psychiatry, University of Cincinnati, PO Box 610559; 231 Bethesda Avenue, Cincinnati, OH 45267*

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, participants should be able to (1) understand the role of antipsychotics (typical and atypical) in the treatment of patient with bipolar disorder, (2) understand the proposed mechanisms underlying mood effects and side effects.

SUMMARY:

Psychosis occurs commonly during the course of bipolar disorder. Neuroleptics have traditionally been used in the management of acute affective psychosis. However, recent surveys indicate that these agents are also commonly used in maintenance treatment as well. Neuroleptics carry significant limitations, however, in both acute and maintenance treatment.

Unlike neuroleptics, which appear to have antimanic effects but no appreciable antidepressant activity, atypical antipsychotics appear to exert antidepressant effects and, with some agents, mood-stabilizing activity. New findings regarding the acute and long-term efficacy and safety of atypical antipsychotics in the treatment of patients with bipolar disorder will be presented. In addition, proposed pharmacologic mechanisms associated with thymoleptic activity of these agents will be discussed in detail.

No. 9A
ANTIPSYCHOTICS IN ACUTE AND MAINTENANCE TREATMENT

Paul E. Keck, Jr., M.D., *Associate Professor and Vice Chairperson, Department of Psychiatry, University of Cincinnati, PO Box 610559; 231 Bethesda Ave., Cincinnati, OH 45267*

SUMMARY:

The advent of neuroleptic drugs was one of the great breakthroughs in the pharmacotherapeutics by biomedical science in the 20th century. Antipsychotic drugs have proven efficacy in alleviating psychotic symptoms and preventing their recurrence in idiopathic and drug-induced psychotic drugs. However, more than 40 years of experience with these compounds have clearly revealed limitations. These include the fact that: (1) neuroleptics are not effective in all patients with psychosis, (2) they do not exert therapeutic effects against all domains of morbidity, (3) they have an extensive side effect profile. The thrust of new drug development has been to identify new compounds that have enhanced antipsychotic efficacy and reduced side effects as compared with standard neuroleptic compounds.

In addition to more favorable side-effects profiles, atypical antipsychotic drugs offer the promise of superior efficacy that may be reflected in various measures of disease morbidity as well as provides new insights into the pathophysiological basis of psychosis. Emerging data suggest that these new agents may not only exert antipsychotic effects, but may also possess thymoleptic activity. Data regarding the potential pharmacologic mechanisms underlying putative thymoleptic properties of these agents will be reviewed. These data also suggest that the thymoleptic properties of the new antipsychotics may also differ among agents. The challenge for investigators, clinicians, and patients is to determine the full extent of the therapeutic benefits, risks, and cost effectiveness of these compounds and develop a rational policy for their optimal utilization.

No. 9B
ATYPICAL ANTIPSYCHOTICS: MECHANISMS OF MOOD ACTIVITY

Diana O. Perkins, M.D., *Associate Professor, Department of Psychiatry, University of North Carolina at Chapel Hill, CB#7600, Neurosciences Hospital, Chapel Hill, NC 27599-7160*

SUMMARY:

Most guidelines regarding the treatment of bipolar disorder suggest that neuroleptics are usually indicated as adjunctive treatment for acute mania or acute psychotic depression. However, a number of recent surveys indicate that neuroleptics are also commonly used in the maintenance phase of treatment of this illness. Neuroleptics, however, are associated with significant side effects and have not been demonstrated to prevent depressive episodes.

Atypical antipsychotics have a number of advantages over atypical agents, including better efficacy in the treatment of negative symptoms of psychosis and they suppress neurological side effects. In addition, atypical antipsychotics appear to exert thymoleptic effects. New controlled studies of clozapine, risparidone, and olanzapine in the treatment of acute mania will be presented. Available studies examining the long-term efficacy and safety of these agents in maintenance treatment will also be discussed.

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cal and limbic GABA A receptors. Eur J Pharmacol 1998; 349:R7-R8.

Industry-Supported Symposium 10 **Sunday, October 31 12 noon-1:30 p.m.**

NOVEL ANTIDEPRESSANT STRATEGIES TO OPTIMIZE OUTCOME

Supported by Pharmacia & Upjohn, Inc.

J. Craig Nelson, M.D., *Professor, Department of Psychiatry, Yale University, 20 York Street, New Haven, CT 06404*

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, participants should be able to review the mechanisms involved in antidepressant therapy, the importance of norepinephrine, and the role norepinephrine reuptake inhibitors play in the treatment of depression.

SUMMARY:

For the past decade, the role of serotonin has been the focus of attention in antidepressant research. Five selective serotonin reuptake inhibitors (SSRIs) have been marketed in the United States and three other, recently introduced antidepressants employ other serotonergic mechanisms. Yet the role of norepinephrine has a long history in the study of depression. The action of tricyclic drugs and observations of effects of reserpine led to the early theory of catecholaminergic depletion in depression. Other theories of antidepressant action have evolved since then such as the down regulation of beta-adrenergic receptors. Recent studies using alpha-methyl-paratyrosine (AMPT) to deplete norepinephrine levels have produced relapse in patients successfully treated with noradrenergic compounds. The findings suggest that the actions of noradrenergic compounds are mediated by norephinephrine. The introduction of reboxetine, a selective norepinephrine reuptake inhibitor (SNRI), has renewed interest in this mechanism of action. The faculty for this symposium will review mechanisms of antidepressant action and relative efficacy of SSRIs and SNRIs, discuss the use of antidepressants in the treatment of melancholia, review the European experience with the new antidepressants, and provide a broader framework for evaluating outcome associated with antidepressant therapy.

No. 10A
EUROPEAN PERSPECTIVE ON ANTIDEPRESSANT THERAPY

Stuart A. Montgomery, M.D., *Professor, Department of Psychiatry, Imperial College, PO Box 8751, London, United Kingdom W13 8WH*

SUMMARY:

Depression is believed to result from a dysfunction in the noradrenergic or serotonergic systems, with the noradrenergic system affecting drive and the serotonergic system affecting changes in mood. Therefore, it is reasonable that different symptoms of depression may benefit from drugs acting mainly on one or the other neurotransmitter systems. A series of studies using depletion techniques have shown that interruption of serotonin synthesis compromises the efficacy of selective serotonin reuptake inhibitors (SSRIs) but not norepinephrine reuptake inhibitors (NRIs). Reboxetine, a selective NRI, represents a new class of drugs. It acts specifically at noradrenergic sites unlike the nonselective tricyclic antidepressants (TCAs). To examine differences between serotonergic and noradrenergic compounds in a clinical setting, this presentation will review the European clinical data on reboxetine used either alone or as adjunctive therapy. The focus of the review will be on reboxetine's efficacy for subsets of depressive symptoms, in particular those affecting drive and mood.

No. 10B
TREATMENT OF SEVERE MELANCHOLIA AND DEPRESSION

Steven P. Roose, M.D., *Professor of Clinical Psychiatry, New York State Psychiatric Institute, 1051 Riverside Drive, New York, NY 10032-2603*

SUMMARY:

The favorable side-effect profile and broad efficacy of the selective serotonin reuptake inhibitors (SSRIs) have made them the first-line treatment for depression. But depression is not a homogenous illness, and there are distinct subtypes (e.g., unipolar and bipolar). Even in the unipolar group, there are subtypes such as atypical and delusional. One implication of subtypes is that they respond to some antidepressants and not others. Therefore, one would not have the expectation that every antidepressant will treat every subtype of depression. Consistent with this hypothesis are reports from studies that suggest the SSRIs may not be as effective as the tricyclic antidepressants (TCAs) in the treatment of melancholia. Data supporting this premise come from: 1) two randomized, controlled trials comparing citalopram and paroxetine with chlorimipramine; 2) meta-analysis of clinical trials; and 3) historical comparisons of fluoxetine and nortriptyline. If patients are classified according to severity of illness, then outcome differences between SSRIs and TCAs are not consistently reported. However, severity is a poorly defined concept with arbitrary criteria; patients' depressive symptoms are designated as severe for a multitude of reasons.

This presentation will review data relevant to the controversy over the pharmacological treatment of melancholia, including a discussion of the methodological problems common to the studies. The research design and preliminary results for a study in progress will also be presented.

No. 10C
OUTCOME ASSESSMENT IN DEPRESSIVE ILLNESS

A. John Rush, M.D., *Betty Jo Hay Distinguished Chairperson in Mental Health, Rosewood Corporate Chairperson in Biomedical Science, Department of Psychiatry, University of Texas Southwestern Medical Center, 5323 Harry Hines Boulevard, MC 9086, Dallas, TX 75235-9086*

SUMMARY:

Increasingly, investigators in clinical trials of antidepressants report measures of both symptom reduction and functional improvements as evidence for positive outcomes. This presentation will review the clinical value of such measures based on data gathered from a number of antidepressant trials. Specific, readily available assessment tools, which are designed to measure symptoms and functions in day-to-day clinical settings, will also be discussed. Data from randomized, controlled trials of antidepressants will be presented in support of their use. The question of whether features of pretreatment symptoms have predictive value in the selection of antidepressants will also be explored using evidence gathered from the acute-phase antidepressant trials. Further, the question of whether measures of symptoms may help clinicians and patients determine when a trial with an antidepressant has failed and it is time to switch to another antidepressant or to augment the current agent will also be discussed. Results from a number of antidepressant clinical trials will be presented to illustrate the clinical utility of symptom assessments at critical decision points in the care of depressed. The impact that symptom assessments have on physician staffing, length of patient visits, and reimbursement determinations will also be reviewed.

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Industry-Supported Symposium 11 — **Sunday, October 31 12 noon-1:30 p.m.**

IMPROVING THE COURSE OF SCHIZOPHRENIA

Supported by U.S. Pharmaceuticals, Pfizer Inc.

Daniel E. Casey, M.D., *Professor, Department of Mental Health, Veterans Affairs Medical Center, 3710 SW US Veterans Hospital Road, Portland, OR 97201*

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, participants should be able to understand the factors that are critical to successfully managing psychotic episodes, relapse prevention and adverse effects in schizophrenia.

SUMMARY:

Schizophrenia is a serious and potentially life-long disabling illness with a complex course of multiple phases. To best manage this debilitating disorder it is essential to understand how the characteristics of the illness will influence the clinical goals, strategies and outcomes. A series of presentations will focus on specific aspects of schizophrenia to update the audience on issues related to management of acute psychotic episodes, the chronic phases of illness, the importance of positive and negative symptoms, and the role of adverse medication side effects. Dr. Alan Mendelowitz will present algorithms for selecting treatment strategies for both first-episode patients and those in an acute exacerbation of the chronic forms of psychosis. He will review issues related to the importance of rapidly controlling acute psychotic symptoms utilizing the different i.m. drugs when indicated. He will then discuss the critical concepts in managing psychosis in the first few weeks of treatment to maximize the efficacy of new atypical agents. Dr. Daniel Casey will discuss the importance of optimizing relapse prevention by understanding the impact of drug discontinuation, dosing parameters, negative symptoms, and atypical antipsychotic medicines. Finally, Dr. Peter Weiden will summarize the adverse side effects of both traditional and novel antipsychotic drugs and discuss their changing role in treatment. He will review how EPS were, but are no longer the primary side effects and why this advancement requires a recalibration of

the importance of other side effects, such as weight gain, sexual difficulties, and sedation.

No. 11A
EARLY INTERVENTION AND ACUTE TREATMENT OF SCHIZOPHRENIA

Alan J. Mendelowitz, M.D., *Department of Psychiatry, Hillside Hospital, 75-59 263rd Street, Glen Oaks, NY 11004*

SUMMARY:

Early intervention in patients with schizophrenia and the initial pharmacological treatment of a patient's acute episode are two vitally important clinical decisions in the treatment of patients with schizophrenia. There is evidence that the earlier one intervenes with antipsychotic treatment in patients with psychosis, the better the response to treatment. The choice of antipsychotic agent to be used in first-episode patients and in the acute management of acutely decompensated patients may impact compliance. These clinical decisions and treatment algorithms for these populations will be reviewed with an emphasis on finding treatment strategies that help to control acute symptoms while minimizing patients' experience of short-term and long-term side effects. Examination of clinical trials utilizing both typical and atypical antipsychotics will be reviewed. Potential treatment algorithms will be presented.

No. 11B
ENHANCING THE LONG-TERM OUTCOME OF SCHIZOPHRENIA

Daniel E. Casey, M.D., *Professor, Department of Mental Health, Veterans Affairs Medical Center, 3710 SW US Veterans Hospital Road, Portland, OR 97201*

SUMMARY:

Schizophrenia is a chronic, progressive illness characterized by periods of remission and relapse for most patients. Therefore, a long-term management plan is required to obtain the maximum benefit of treatment. Neuroleptic drugs have been the mainstay of treatment, but the limitations of partial efficacy and high rates of troublesome side effects have led to noncompliance and frequent relapses. To fully understand the potential benefits of the novel, atypical antipsychotics, it is necessary to first review the data regarding relapse rates with the typical neuroleptics when drugs were discontinued or doses were reduced to target therapy to symptom suppression. Additionally, the limited efficacy of the old drugs in positive and negative symptoms as well as in depression associated with psychosis will be reviewed. The role of adverse effects, such as extrapyramidal syndromes, tardive dyskinesia and subjective experiences of dysphoria in treatment will also be reviewed.

The new atypical antipsychotics appear to offer wider efficacy across the symptoms of schizophrenia, particularly in negative symptoms and depression, and better tolerability with far fewer adverse effects. These favorable features of the new agents offers the hope for improved efficacy, better compliance, lower relapse rates, and the opportunity for an improved quality of life.

No. 11C
ACCEPTABILITY OF SIDE EFFECTS AS MOVING TARGETS

Peter J. Weiden, M.D., *Director, Neurobiological Disorders Service, St. Lukes-Roosevelt Hospital Center, 411 West 114th Street, Suite 3B, New York, NY 10025*

SUMMARY:

Acceptability of a side effect changes over time. The history of cigarette smoking is a vivid demonstration of this phenomenon. "Not one single ease of throat irritation due to smoking Camels. These were the findings of 2,400 weekly throat examinations done by noted ENT specialists"[44]

The premise is that "acceptability" is a moving target. Acceptability is based as much on expectations as the actual side effects. In other words, a side effect that was acceptable yesterday may not be acceptable today. Likewise, an acceptable side effect today may become unacceptable tomorrow.

Applying the "moving target" model to antipsychotics, the extrapyramidal side effects (EPS) were initially considered "minor". Later, during the 1980s, there was increasing recognition of the terrible burden of EPS. Unfortunately, lack of options then forced clinicians and patients to accept EPS as routine and expected. Beginning with clozapine in the early 1990s, it became possible to treat schizophrenia without causing EPS. Now, with first-line atypical antipsychotics available, it is no longer acceptable for patients to have to endure clinically significant EPS.

As the EPS problem recedes, however, patients will become more distressed by non-EPS side effects, including sedation, weight gain, amennorities, anticholinergic effects, and sexual difficulties. The moving target model suggests that much more attention needs to be paid to these non-EPS side effects. This presentation will conclude by reviewing the differential side-effect profiles of current and future atypical antipsychotics.

[44]From the text of a Camel magazine advertisement, circa 1960.

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Industry-Supported Symposium 12 — **Sunday, October 31 6:00 p.m.-9:00 p.m.**

FROM COMPLIANCE TO ALLIANCE IN SCHIZOPHRENIA

Supported by Eli Lilly and Company

Peter J. Weiden, M.D., *Director, Neurobiological Disorders Service, St. Lukes-Roosevelt Hospital Center, 411 West 114th Street, Suite 3B, New York, NY 10025*

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, participants should be able to develop new strategies to involve patients and motivate them towards self-care; recognize how factors such as coercion, family involvement, and patients education can affect the recovery process; understand the psychopharmacology of newer agents and how they can facilitate reintegration into the community.

SUMMARY:

A major barrier in achieving better outcomes in the treatment of schizophrenia is medication noncompliance. As the newer, "atypical" antipsychotics replace the older "conventional" antipsychotics, compliance will remain a vexing problem as the magnitude of outcome differences between compliant and noncompliant becomes wider. In 1978, Barofsky hypothesized that most patients are noncompliant as they begin treatment, and compliance is initially obtained through clinician's use of coercion or pressure. This relationship evolves, with time, from coercion to alliance, and compliance changes to adherence motivated by self-care.

This symposium's structure will parallel the Barofsky model as it addresses coercion leading to alliance and self-care. It will begin with Ronald Diamond, M.D., presenting the use of power and coercion in treating noncompliant patients in denial, followed by Peter Weiden, M.D., discussing the role of family influence in promoting medication compliance. Next will be Ruth Dickson, M.D., discussing how the side-effect profiles of newer medications helps the alliance, and Patricia Scheifler, M.S.W., showing how to use patient education as a way to develop partnerships with patients in the recovery process. The final speaker will be Ralph Aquila, M.D., explaining how psychopharmacology can be used to facilitate psychiatric rehabilitation and community reintegration.

No. 12A
USING POWER AND COERCION IN COMPLIANCE

Ronald J. Diamond, M.D., *Professor of Psychiatry, Department of Psychiatry, Mental Health Center of Dane County, 625 West Washington Avenue, Madison, WI 53703*

SUMMARY:

Many different strategies are used to encourage medication compliance. Clinicians often use rational arguments to convince patients that taking medication will help them improve their quality of life. Patients, on the other hand, may not see medication as helping to meet their own goals and often weigh the pros and cons of medication very differently than do clinicians. Coercion is thought of as an alternative when rationality fails. Coercion is actually much more complicated than just legal control. Coercion exists on a continuum from persuasion to pressure to control of resources to use of force. Underlying all coercion is the differential in power between patient and clinician. Power is the ability to change the behavior of others. Power comes from various sources including force of one's personality, from specialized knowledge, from status, from control of resources, and from laws permitting involuntary treatment.

While the clinician's power can help influence a patient's behavior, it can also interfere with a direct exchange of views. Differentials in power tend to keep a relationship paternalistic and interfere with the development of a patient's sense of autonomy. The goal for long-term treatment must be to help patients take more control over their own lives. Unfortunately, patients often connect taking medication with losing control. Even when medication is initially court ordered, the long-term goal must be to move to a more collaborative relationship. Even decanoate injections can be used within a more collaborative, power-sharing context. A number of specific strategies will be discussed to facilitate power sharing, including joint decisions about target

symptoms, sharing information in the clinical notes, and joint decisions about how medication is to be prescribed.

No. 12B
PSYCHOSOCIAL MANAGEMENT OF NONCOMPLIANCE

Peter J. Weiden, M.D., Director, *Neurobiological Disorders Service, St. Lukes-Roosevelt Hospital Center, 411 West 114th Street, Suite 3B, New York, NY 10025*

SUMMARY:

Social support and influence are well-known predictors of compliance among patients with chronic medical conditions; for example, married people are more likely to remain on antihypertensive regimens than single people. Unfortunately, most patients with schizophrenia have poor or nonexistent social supports, placing most of the social influencing on the family of origin. Accordingly, this presentation focuses on the family of origin and its potential to influence compliance.

First, I will review literature on the effectiveness of family interventions in schizophrenia and discuss possible ways that families might be able to influence their relative's compliance with antipsychotic medications. I will also cover compliance pitfalls that families should avoid, such as "overselling" medications or relying too heavily on a brain disorder model that is perceived as humiliating. I will then discuss other dangers when families try to influence compliance, including eventual burnout from being "pill police," or even physical harm should a family member get into a medication argument with their acutely ill relative. I intend to show how the goal is to support families in using their relationship more effectively in promoting compliance, while at the same time lessening the frustrations and hardships that occur for the families of noncompliant patients.

No. 12C
PSYCHOPHARMACOLOGY OF NONCOMPLIANCE

Ruth A. Dickson, M.D., *Associate Professor, Department of Psychiatry, University of Calgary, 3500 26th Avenue, Calgary, AB, Canada T17 6J4*

SUMMARY:

The majority of patients prescribed neuroleptics become noncompliant. The new antipsychotics potentially promote medication adherence by 1) more effectively treating schizophrenia symptoms, 2) decreasing side effects, 3) reducing hospital days, 4) simplifying drug regimes, and 5) engendering hope that recovery is possible. Ironically, the need for a more collaborative patient-physician relationship may have been fostered by the lack of "atypical" depot preparations and by the mandatory hematological monitoring of clozapine patients, both generally viewed as major shortcomings of these novel drugs. An alliance must develop that facilitates the person with schizophrenia assuming more control of his or her own recovery process. More, not less, psychosocial rehabilitation may be both possible and necessary for successful outcomes of patients with the new antipsychotic medications.

The reduction in symptoms and neurological syndromes secondary to "atypical" antipsychotic treatment decreases the social stigmatization that neuroleptic-treated persons have historically endured. Some of the new medications also cause fewer sexual and reproductive side effects. This is positive but requires a better understanding and respect for the patient's beliefs and values about sexuality, fertility, and desire to bear children. This lecture will discuss the complex relationship of the novel antipsychotics to medication adherence with an emphasis on schizophrenia and sexuality.

No. 12D
FROM COMPLIANCE TO COLLABORATION

Patricia L. Scheifler, M.S.W., *Consultant, Western Mental Health Center, PO Box 55053, Birmingham, AL 35255*

SUMMARY:

To be most effective, patient education should be delivered in a way that truly facilitates learning, yet patients often spend years passively receiving information about their illness and learning very little. It is as if their negative symptoms are matched by educational inertia within our systems of care. Neither patients nor their professional caregivers are held to minimal educational standards that, for example, are required of high school students and teachers. This presentation will review methods and case examples that can be used with symptomatic patients to make psychoeducation truly effective. Once patients are educated, then the treatment relationship can move from passive compliance to active collaboration (Corrigan).

The newer antipsychotic medications make it more important than ever to develop a collaborative partnership for the recovery process. Cognitive improvements from newer antipsychotics help patients better grasp and master material regarding their symptoms and treatments. In turn, their improved learning abilities make it more important to provide accurate and up-to-date medication information. Also, as negative symptoms improve with the newer medications, many patients will

not be as passive and will expect more in the way of a collaborative relationship with their clinicians.

No. 12E
REHABILITATION ALLIANCE: COMPLIANCE IN THE COMMUNITY

Ralph Aquila, M.D., *Director, Residential Community Services, Project Renewal and Department of Psychiatry, St. Luke's-Roosevelt Hospital Center, 448 West 48th Street, New York, NY 10036;* Dennis McCrory, M.D.; George D. Santos, M.D.

SUMMARY:

To recover, a patient with schizophrenia must exchange his or her self-image of permanent patienthood with that of being a "civilian" with an illness. In doing so, another exchange takes place. Medication compliance for "controlling symptoms" is replaced with taking medications to "get a life." The traditional doctor-patient relationship focuses on symptoms, falling far short of rehabilitation. Along with Fountain House, a clubhouse (rehabilitation) program, we have found the alliance in which a doctor works side-by-side with patient/members preferable. This way, psychopharmacology focuses more on rehabilitation than symptom suppression.

The expectations of antipsychotic medications also shift from symptom suppression to meaningful rehabilitation for the member/patient. Fortunately, newer atypical antipsychotics are much better at promoting "real" rehabilitation. One-year employment outcomes in a double-blind trial of olanzapine vs. haloperidol found employment rates doubled from 10% to 20% for the olanzapine-treated group, but were essentially unchanged in the haloperidol group. Similarly, our qualitative experience with Fountain House members switched to atypical antipsychotics is that they become better at handling and remaining in community job placements. It appears that there are synergistic effects between the clubhouse model and atypical antipsychotics. Our impression is consistent with the beneficial interactions between clozapine and rehabilitation reported by Rosenheck and colleagues.

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Industry-Supported Symposium 13 — **Monday, November 1 6:30 a.m.-8:00 a.m.**

ALZHEIMER'S DISEASE: CLINICAL IMPLICATIONS OF NEW DEMENTIA RESEARCH

Supported by Novartis Pharmaceuticals Corporation

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, participants should be able to: (1) describe the currently available tools to make a diagnosis of dementia, (2) demonstrate an understanding of how treatment research may aid psychiatrists in diagnosis and management of dementia, and (3) recognize imaging techniques that monitor the progression of dementia and response to treatment.

SUMMARY:

To recognize and manage the rising number of elderly people with dementia, clinicians need to apply recent findings in dementia research to their everyday practice. Making a diagnosis of a specific type of dementia requires not only a sound cognitive and thorough psychiatric examination, but also the implementation of numerous neuroscientific techniques, including CSF testing, neuroimaging, and genotyping. These techniques, in par-

ticular neuroimaging that looks at brain volume, blood flow, and metabolism, may become increasingly useful tools to monitor the progression of dementia and also to gauge treatment response.

Difficulties psychiatrists may come across in trying to effectively and safely manage dementia patients are the frequent comorbid medical and psychiatric illnesses of these elderly patients, as well as the high rate of polypharmacy. Useful information may be gained from experience in recent clinical trials that used a dementia patient population that closely approximated a real world clinic population. Such trials have very relevant results for effective, safe management of dementia patients.

The high rate of behavioral disturbances in patients with dementia and the need for tolerable treatments presents another challenge to psychiatrists. However, recent research in the area provides the clinician with evidence to support effective treatment options, including cholinesterase inhibitors, for the problem behavioral signs and symptoms that these patients often exhibit.

No. 13A
EARLY DETECTION AND PREVENTION DEMENTIA

Gary W. Small, M.D., *Professor of Psychiatry and Biobehavioral Sciences and Director, Center for Aging, University of California at Los Angeles, Neuropsychiatric Institute, 760 Westwood Plaza, Los Angeles, CA 90024-8300.*

SUMMARY:

Several recent observations suggest that the common form of late-onset Alzheimer disease (AD), beginning after age 65 years, may actually show subtle manifestations years earlier. Measures of brain function using positron emission tomography (PET) and genetic risk (apolipoprotein E-4 [APOE-4]) in middle-aged persons with mild memory complaints show significantly lower function in brain regions known to be affected by AD. Moreover, such metabolic patterns appear to predict future cognitive decline in people with age-related memory complaints. Structural images of medial temporal regions also show early atrophy as a predictor of future cognitive decline. Evidence of preclinical neuritic plaques and neurofibrillary tangles, the neuropathological hallmarks of AD, is consistent with very early and subtle preclinical changes. Also, a study of the early autobiographies (mean age = 22 years) and the later (age 75-95) cognitive performances of 93 nuns found that low idea density and grammatical complexity in early life were associated with low cognitive test scores in late life. Thus this age-related, genetically determined, gradually progressive disease may subtly begin decades before the patient manifests obvious symptoms. Discovering genetic causes and susceptibilities is likely to lead to clarification of underlying disease mechanisms and discovery of interventions that will alter pathogenesis. Early intervention may then delay AD onset and eventually prevent the disease in some people. This presentation will review new findings on predicting cognitive decline and current and future studies aimed at prevention.

No. 13B
TRANSLATING TREATMENT DATA TO THE REAL WORLD

Lon S. Schneider, M.D., *Associate Professor, Department of Psychiatry, University of Southern California School of Medicine, 1975 Zonal Avenue, KPM-400, Los Angeles, CA 90033-1071*

SUMMARY:

Potential treatment approaches in dementia include symptomatic treatment of cognitive impairment, behavioral symptoms, slowing the rate of cognitive decline, and delaying the age of onset. Several pharmacological approaches toward improvement of cognitive symptoms will be discussed, with an emphasis on cholinergic approaches since they appear most promising at the moment, and two cholinesterase inhibitors are currently available clinically. The indications, contraindications, methods of administration, management of side effects, and expected therapeutic responses of cholinergic medications will be discussed. These drugs seem to provide modest, but clinically significant improvement in cognition and functional activities in some patients. Potential approaches to slowing the rate of cognitive decline or time to placement include the use of antioxidants and cholinergic drugs. The therapeutic options for physicians continue to expand. Considerations in pharmacological intervention, including the use of combination drug therapy, will be reviewed.

No. 13C
ACTIVITIES OF DAILY LIVING: A KEY PARAMETER IN ALZHEIMER'S DISEASE

Linda Teri, Ph.D., *Department of Psychosocial and Community Health, University of Washington, Box 357263, Seattle, WA 98195-7263*

SUMMARY:

Activities of daily living (ADLs) are critically impaired in patients with Alzheimer's disease, affecting and being affected by both cognitive and affective status.

The very term, activities of daily living, encompasses basic physical care needs, such as toileting, dressing, and eating as well as more complex care needs, such as shopping, meal preparation, and finances. Thus, ADLs necessitate an identifiable level of cognitive function and skill. Understanding the role of cognition and affect in ADL function may well facilitate accurate assessment and management. This presentation will provide state-of-the-art information about the nature of ADL impairment in patients with Alzheimer's disease and the association of such impairment to cognitive decline and affective health. It will begin by providing some basic definitions of ADL impairment common in patients with AD. It will discuss the importance of understanding the association of ADL impairment in day-to-day function and management. Data will then be presented from a large sample of patients with AD to demonstrate the relationship of cognitive, affective, and behavioral impairment and reduced ADLs. Recent studies emphasizing the association of ADL function, patient depression, cognitive decline, and collateral assessment will be discussed.

No. 13D
MANAGEMENT OF COMORBID CONDITIONS

George T. Grossberg, M.D., *Samual W. Fordyce Professor and Chairman, Department of Psychiatry and Human Behavior, St. Louis University Medical School, 1221 South Grand Boulevard, Suite 202, St. Louis, MO 63104-1016*

SUMMARY:

Behavioral or psychiatric symptoms in AD are quite common, with a recent study showing that nearly 80% of AD patients exhibit psychiatric symptoms sometime during the course of the illness. Psychiatric symptoms in AD are also the leading reason for nursing home admission in the U.S. Agitation is the most common behavioral symptom seen in AD, affecting up to 80% of patients. Overtly aggressive behaviors may affect up to 40% of patients. Psychotic symptoms are found in about 33 1/3% of patients, with delusions and visual hallucinations predominating. Depression affects 20% to 40% of patients with AD, can occur at any stage of the illness, and may be an early symptom as well as a potential marker. Wandering, day/night confusion, socially inappropriate behaviors, apathy/indifference are also frequent. Less commonly, sexual impulse control problems may be found.

Treatment of behavioral/psychiatric symptoms in AD starts with identifying potential triggers such as delirium, pain, or other syndromes. Psychosocial, environmental, as well as pharmacologic therapies all play a role. Particularly important is the behavioral diary, especially in the long-term care settings.

Over the past few decades, a large number of effective pharmacological and nonpharmacological treatments for unipolar depressive disorders have become available. In particular, the use of antidepressants has markedly increased with improved recognition and diagnosis of depression. However, a significant proportion of patients fail either to comply with or tolerate antidepressant treatment. Dr. Delgado will review some of the most common strategies developed for the enhancement of patient compliance, including the choice of agents with relatively good tolerability, and conduct a comprehensive discussion of possible adverse events before starting patients on a new agent in order to anticipate and proactively manage them. He will also discuss the use of medications with counteracting effects when dose adjustments fail. Even when patients receive adequate (with respect to both dose and duration) antidepressant treatment and adhere to it, as many as 30% of them will not respond fully. Dr. Fava will provide an overview of the studies that support the use of switching antidepressants as a strategy in the management of partial and non-responders, while Dr. Nelson will discuss the advantages and disadvantages of the combination and augmentation strategies in refractory depression. Once depressed patients respond to antidepressant treatment, clinicians must make decisions about intensity and duration of treatment in order to minimize the risk of side effects while maintaining a prophylactic effect. Dr. Zajecka will review the most relevant clinical issues that arise in the long-term treatment of depression, such as the emergence of side effects (i.e., sexual dysfunction, weight gain) that may adversely impact patients' quality of life and/or compliance. Finally, Dr. Frank will review the empirical evidence for the further optimization of treatment outcome by combining psychotherapy with antidepressant medication both in the short and long term.

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Industry-Supported Symposium 14 **Monday, November 1 6:30 a.m.-8:00 a.m.**

OPTIMIZING TREATMENT OUTCOME IN DEPRESSION

Supported by Organon Inc.

Maurizio Fava, M.D., *Director, Depression Clinic and Research Programs, Massachusetts General Hospital, 15 Parkman Street, WACC 812, Boston, MA 02114*

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should become familiar with commonly used clinical strategies aimed at improving both compliance and response in the treatment of depression; learn the relative risks and benefits of therapeutic approaches to treatment resistance and how to deal with the issues that emerge in the context of maintenance treatment with antidepressants.

SUMMARY:

Over the past few decades, a large number of effective pharmacological and nonpharmacological treatments for unipolar depressive disorders have become available. In particular, the use of antidepressants has markedly increased with improved recognition and diagnosis of depression. However, a significant proportion of patients fail either to comply with or tolerate antidepressant treatment. Dr. Delgado will review some of the most common strategies developed for the enhancement of patient compliance, including the choice of agents with relatively good tolerability, and conduct a comprehensive discussion of possible adverse events before starting patients on a new agent in order to anticipate and proactively manage them. He will also discuss the use of medications with counteracting effects when dose adjustments fail. Even when patients receive adequate (with respect to both dose and duration) antidepressant treatment and adhere to it, as many as 30% of them will not respond fully. Dr. Fava will provide an overview of the studies that support the use of switching antidepressants as a strategy in the management of partial and nonresponders, while Dr. Nelson will discuss the advantages and disadvantages of the combination and augmentation strategies in refractory depression. Once depressed patients respond to antidepressant treatment, clinicians must make decisions about intensity and duration of treatment in order to minimize the risk of side effects while maintaining a prophylactic effect. Dr. Zajecka will review the most relevant clinical issues that arise in the long-term treatment of depression, such as the emergence of side effects (i.e., sexual dysfunction, weight gain) that may adversely impact patients' quality of life and/or compliance. Finally, Dr. Frank will review the empirical evidence for the further optimization of treatment outcome by combining psychotherapy with antidepressant medication both in the short and long term.

No. 14A
APPROACHES TO THE ENHANCEMENT OF PATIENT COMPLIANCE

Pedro L. Delgado, M.D., *Department of Psychiatry, University of Arizona School of Medicine, 1501 North Campbell Avenue, Tucson, AZ 85724-0001*

SUMMARY:

The number of safe and effective medication treatments for depression has increased significantly over the past 10 years. Relative to the older tricyclic antidepressants and monoamine oxidase inhibitors, the newer medications offer comparable efficacy with fewer side effects and a markedly reduced risk for serious adverse effects. In spite of these benefits and in spite of the extensive and successful efforts that have been made to inform the general population about the diagnosis and treatment of depression, many patients do not comply with treatment recommendations. While specific factors such as side effects lead to high rates of noncompliance with medication treatment, noncompliance is a multifactorial phenomenon. The reasons for noncompliance can include rational and intentional decisions based on beliefs about the illness, concerns over side effects, ineffectiveness of treatment, complexity of the regimen, costs of the medication, decisions influenced by the symptoms of the disorder, the presence of substance abuse, lack of confidence in the provider, and many other cultural and attitudinal factors.

This presentation will review the patient- and provider-related factors that influence compliance with psychotropic drug treatment of depression and discuss strategies for enhancing compliance. In particular, the decision-making process for selecting an antidepressant agent and management of the treatment course will be a focus of discussion. Short- and long-term side effects of antidepressant agents will be contrasted, and strategies for reducing side effects without losing the antidepressant response will be presented.

No. 14B
MANAGEMENT OF NONRESPONSE AND INTOLERANCE: SWITCHING STRATEGIES

Maurizio Fava, M.D., *Director, Depression Clinic and Research Programs, Massachusetts General Hospital, 15 Parkman Street, WACC 812, Boston, MA 02114*

SUMMARY:

Switching antidepressants is one of the most common strategies in the management of depressed patients who do not tolerate or respond to drug treatment. In particular, the emergence of acute side effects such as agitation and insomnia or of long-term side effects such as weight gain and sexual dysfunction, frequently leads clinicians to switch antidepressant agents. This approach has been supported by a number of studies that have found that many depressed patients who are unable to tolerate a specific antidepressant treatment benefit from being switched to another antidepressant agent. Similarly, studies on non- and partial responders to antidepressant treatment have shown relatively good response to being switched to other antidepressants. The strategy of switching is often more acceptable to patients and less costly than polypharmacy, and the risk of significant drug-drug interactions is markedly reduced and limited to the initial phases of treatment. However, switching from relatively short-acting selective serotonin reuptake inhibitors to antidepressants of other classes may be associated with a risk for discontinuation-emergent adverse events. In summary, switching strategies appears to be a safe and effective approach to the treatment of depressed patients who are intolerant of or nonresponsive to antidepressant treatment. Further studies are needed to establish whether switching patients from one antidepressant class to another is more effective than switching to drugs of the same class.

No. 14C
COMBINED DRUG TREATMENTS: PROS AND CONS

J. Craig Nelson, M.D., *Professor, Department of Psychiatry, Yale University, 20 York Street, New Haven, CT 06404*

SUMMARY:

Combined pharmacologic treatment strategies have been used in depression for a variety of purposes. They are widely used in refractory depression to enhance response. They have been used to speed up response, especially in inpatients. They may be helpful in patients who develop tachyphylaxis. Combined drug treatments have also been used to enhance effects on specific target symptoms. For example, benzodiazepines have been used with antidepressants to reduce anxiety. Trazodone has been used with antidepressants to enhance sleep. Antipsychotic treatments have been used with antidepressants in psychotic depression. This presentation will review the various uses of combined strategies in depression, the evidence supporting their efficacy, and their methods of administration. Their advantages and disadvantages will be considered. Treatments that have been reported to enhance initial efficacy will receive special emphasis.

No. 14D
CLINICAL ISSUES IN LONG-TERM TREATMENT WITH ANTIDEPRESSANTS

John M. Zajecka, M.D., *Assistant Professor of Psychiatry and Medical Director, Ambulatory Psychiatric Service, Rush Presbyterian-St. Luke's Medical Center, 1725 West Harrison Street, Suite 955, Chicago, IL 60612*

SUMMARY:

Optimal recovery from depression requires adherence to treatment throughout the acute, continuation, and maintenance phases of treatment. There is an increasing recognition of the importance of long-term antidepressant treatment, particularly for depressive subtypes such as chronic and recurrent depression. Practical clinical issues in the identification and management of continuation and maintenance antidepressant treatment will be discussed including the educational strategies to ensure compliance and the management of potentially late-onset side effects that may impair compliance and/or optimal recovery, such as sexual dysfunction, weight gain, and asthenia.

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Industry-Supported Symposium 15 **Monday, November 1 12 noon-1:30 p.m.**

EFFECTS OF EXTRAPYRAMIDAL SYMPTOMS IN PSYCHOTIC ILLNESSES: BEYOND MOVEMENT DISORDERS

Supported by Zeneca Pharmaceuticals

S. Charles Schulz, M.D., *Professor and Chairperson, Department of Psychiatry, University of Minnesota Medical School, F282-2A West, 2450 Riverside Avenue, Minneapolis, MN 55454*

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, participants should be able to recognize and identify EPS and tardive dyskinesia and engender sensitivity to stigma patients associate with these symptoms.

SUMMARY:

Extrapyramidal motor and cognitive dysfunctions have long been regarded as unavoidable companions of antipsychotic efficacy. The introduction of the atypical antipsychotics, which cause far fewer of these adverse effects, have brought about changes in the conception of treatment outcomes. However, despite increased interest in side effects in general and heightened expectations for treatment outcomes, many physicians, nurses, and other health care professionals fail to recognize the appearance or importance of EPS in the patients they treat. Even symptoms of tardive dyskinesia may go undetected or may be mistakenly considered part of the underlying disorder. When asked about motor and cognitive drug-related effects, patients frequently express the discomfort and stigma they feel. The presenters will identify the cardinal signs and symptoms of EPS and TD; discuss the relationship between EPS and cognitive parameters; and compare profiles of conventional and atypical antipsychotics. Collectively, the faculty will discuss the best strategies for avoiding EPS and treating them when they do occur.

No. 15A
EXTRAPYRAMIDAL SYMPTOMS OFTEN HAVE FAR-REACHING EFFECTS

S. Charles Schulz, M.D., *Professor and Chairperson, Department of Psychiatry, University of Minnesota Medical School, F282-2A West, 2450 Riverside Avenue, Minneapolis, MN 55454*

SUMMARY:

It is widely reported that antipsychotic-induced extrapyramidal symptoms (EPS) occur in 50%-75% of patients who take conventional antipsychotics and at even higher rates in elderly and adolescent patients. These side effects may lead to poor compliance in addition to discomfort. Unfortunately, EPS often go unrecognized or are misdiagnosed in routine clinical practice. EPS may cause dysphoria to such an extent that patients are unable to articulate, and symptoms like akathisia, which have a behavioral component, may be misinterpreted as underlying psychopathology. No matter what the reason, better identification of EPS, including tardive dyskinesia (TD), and the use of averting strategies will help clinicians improve overall patient outcomes. The atypical antipsychotics by virtue of their cleaner side-effect profile have made the use of antipsychotics safer and better tolerated. They are now widely used and are rapidly becoming the de facto standard pharmacologic treatment for schizophrenia because of their lower propensity to induce EPS and TD. This presentation will review the identification of signs and symptoms of EPS and TD, delineate risk factors for developing symptoms, and present strategies for avoiding these disabling and at times disfiguring adverse effects. Patient and caregiver perceptions of EPS will also be discussed along with the effect symptoms have on medication compliance.

No. 15B
EXTRAPYRAMIDAL SIDE EFFECTS AND COGNITION

Dawn I. Velligan, Ph.D., *Assistant Professor, Department of Psychiatry, University of Texas Health Science Center, 7703 Floyd Curt Drive, San Antonio, TX 78284*

SUMMARY:

Individuals with psychotic illnesses and dementias often experience impairment in multiple neurocognitive abilities including attention, memory, and executive functions. The extrapyramidal side effects (EPS) of traditional antipsychotic medications used to treat these disorders are also known to significantly impair cognitive functioning, particularly on tests requiring motor output, speed, and readiness to respond. Furthermore, the anticholinergic medications used to treat EPS impair

cognition, most notably memory function. Cognitive deficits are important in that they predict role performance and memory outcomes in patients with psychotic illnesses. Novel or atypical antipsychotic medications are much less likely to cause EPS at doses that are effective in treating psychotic symptoms. Recent evidence suggests that patients taking novel antipsychotics perform better on tests of neurocognitive ability than those treated with conventional antipsychotics. The cognitive advantages of atypicals may be largely due to their decreased tendency to produce EPS. Paying attention to the presence of EPS in patients treated with antipsychotics and utilizing medications that cause the lowest levels of EPS may improve both cognitive and functional outcomes for patients with psychotic illnesses.

No. 15C
ATYPICAL ANTIPSYCHOTICS AND MOTOR SIDE-EFFECTS

Rajiv Tandon, M.D., *Director, Schizophrenia Program, Department of Psychiatry, University of Michigan Medical Center, 1500 East Medical Center Drive, Ann Arbor, MI 48109-0210*

SUMMARY:

While conventional antipsychotic medications are effective in reducing psychopathology in various psychotic disorders, they are only minimally effective in treating cognitive and negative symptoms of schizophrenia. Their use is also associated with a whole range of adverse effects that compromise quality of life and hinder patient acceptance of and compliance with treatment. Atypical antipsychotics are significantly better than conventional antipsychotics with regard to these side effects. The EPS advantage of atypical antipsychotics translates into several "secondary" benefits, including better negative symptom efficacy, lesser dysphoria, less impaired cognition, and the possibility of a lower risk of TD. By definition, all atypical antipsychotics are associated with a lower risk of EPS than are conventional antipsychotics; there are, however, important differences between the various atypical antipsychotics with regard to this EPS advantage. Pharmacologically, different atypical antipsychotics differ in the degree of separation between the dose response curves for their antipsychotic and EPS effects. Clinically, this pharmacological difference translates into different degrees of EPS risk with increasing doses of the atypical antipsychotic. Since the EPS advantage of the atypical agents is the basis of their advantages over conventional neuroleptics, it is critical that they be used in such a manner that EPS are avoided. Implications for the use of atypical antipsychotics will be discussed.

REFERENCES:

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Industry-Supported Symposium 16 **Monday, November 1 12 noon-1:30 p.m.**

CHRONIC DEPRESSION: PSYCHOTHERAPY AND PHARMACOTHERAPY: ADDITIVE OR SYNERGISTIC? FOCUS ON EFFICACY AND ISSUES IMPACTING TREATMENT ADHERENCE

Supported by Bristol-Myers Squibb

Martin B. Keller, M.D., *Chairman, Department of Psychiatry and Human Behavior, Brown University and Butler Hospital, 345 Blackstone Boulevard, Providence, RI 02906*

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposia participants will have a greater capacity to evaluate the effectiveness of pharmacotherapy, psychotherapy and combination treatment options to maximize treatment outcome in patients with chronic depression.

SUMMARY:

Chronic depression accounts for approximately one-third of all depressive episodes and is associated with a high rate of comorbidity and psychosocial impairment. It has been associated with a poor response to treatment and is often misconstrued as a treatment-refractory disorder. The public health significance of depression has been increasingly recognized, and depression is considered one of the four most disabling illness in the world, yet little research has been directed toward determining the best modality of treatment for this chronic, disabling disorder.

This symposium will explore the most recent advances in the treatment of chronic forms of depression. The effectiveness of pharmacotherapy and psychotherapy monotherapies as well as combination pharmacotherapy/psychotherapy regimens will be presented. The efficacy of the different treatment modalities will focus on key

symptoms of depression and issues impacting treatment adherence. The exciting results of the largest combined treatment study ever undertaken and the first of its kind with chronically depressed outpatients will be presented.

No. 16A
THE EFFICACY OF PSYCHOTHERAPY AND PHARMACOTHERAPY IN THE TREATMENT OF CHRONIC DEPRESSION

Martin B. Keller, M.D., *Chairperson, Department of Psychiatry and Human Behavior, Brown University and Butler Hospital, 345 Blackstone Boulevard, Providence, RI 02906*

SUMMARY:

Despite major advances in the treatment of depressive disorders, depression continues to be associated with a high rate of relapse and recurrence. Recurrent and chronic depressions are often thought to be treatment refractory, and misconception regarding chronic depression has resulted in under recognition, inadequate treatment and an ensuing continuum of mental, physical and psychosocial disability.

Recent findings from a large well controlled clinical trial show promise for those suffering from chronic depression and provide the clinician with important insight for the management of this disabling disorder. This presentation will focus on the recently released results of the world's largest combination treatment trial of pharmacotherapy and psychotherapy for chronic depression. This 12 site, 681 patient landmark study attempts to resolve the dilemma of which treatment is the most effective for chronic depression: monotherapy pharmacotherapy or psychotherapy versus combination pharmacotherapy and psychotherapy. The advantages of each treatment will be explored and alternative strategies discussed.

No. 16B
MANAGING THE KEY SYMPTOMS OF CHRONIC DEPRESSION WITH PSYCHOTHERAPY AND PHARMACOTHERAPY

A. John Rush, M.D., *Betty Jo Hay Distinguished Chairperson in Mental Health, Rosewood Corporate Chairperson in Biomedical Science, Department of Psychiatry, University of Texas Southwestern Medical Center, 5323 Harry Hines Boulevard, MC 9086, Dallas, TX 75235-9086*

SUMMARY:

Sleep disturbances are among the most prevalent symptoms of depressive disorders, occurring in greater than 80% of patients and often present as the initial symptom of depression. Sleep disturbances are highly correlative with anxiety symptoms in patients with depressive disorders. Both sleep disturbances and anxiety symptoms have been identified as significant predictors of suicide. Persistent sleep disturbances exacerbate negative mood and result in poor daytime performance. Thus, the rapid and sustained relief of insomnia and anxiety are critical components of any depressive treatment. The management of sleep and anxiety are particularly important in the treatment of patients with chronic forms of depression, where early adherence to treatment is essential in order to achieve long-term compliance to prevent recurrence.

This presentation will explore the impact of pharmacotherapy, psychotherapy, and the combination pharmacotherapy/psychotherapy in the management of these problematic symptoms in chronic depression.

No. 16C
PSYCHOTHERAPY AND PHARMACOTHERAPY: ISSUES IMPACTING TREATMENT ADHERENCE IN CHRONIC DEPRESSION

John M. Zajecka, M.D., *Assistant Professor of Psychiatry and Medical Director, Ambulatory Psychiatric Service, Rush Presbyterian-St. Luke's Medical Center, 1725 West Harrison Street, Suite 955, Chicago, IL 60612*

SUMMARY:

The results of scientifically rigorous studies support the recommendation that many patients with depressive disorders require long-term and possibly, lifetime treatment. Both pharmacotherapy and psychotherapy have proven to be effective for acute major depression, and intuitively it is surmised, but not proven, that combination treatment with pharmacotherapy and psychotherapy may be optimum. However, less is known about the treatment of chronic depressions. Are pharmacotherapy and psychotherapy equally effective in chronic depression, and are there advantages to combining treatment?

It is commonly recognized that the primary cause of treatment failure is lack of patient adherence to the prescribed treatment. This presentation will examine the impact of pharmacotherapy, psychotherapy, and combination pharmacotherapy/psychotherapy on treatment adherence in chronic depression. This presentation will focus on the recently released results of the world's largest combination treatment trial of pharmacotherapy and psychotherapy for chronic depression. Although patients in this study experienced a similar discontinuation

rate in each treatment cell, the reasons for discontinuation in each cell varied widely. Issues impacting adherence to treatment such as efficacy, side effects, and patient preference will be addressed.

REFERENCES:

1. Kupfer DJ, et al: Efficacy of interpersonal psychotherapy as a maintenance treatment of recurrent depression. Arch Gen Psychiatry. 1991; 48:1053-1059.
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Industry-Supported Symposium 17 **Monday, November 1 5:00 p.m.-8:00 p.m.**

QUALITY OF LIFE: DOES TREATMENT MAKE LIFE BETTER?

Supported by U.S. Pharmaceuticals, Pfizer Inc.

R. Bruce Lydiard, M.D., Ph.D., *Director, Psychopharmacology and Clinical Psychopharmacology Research, Medical University of South Carolina, 67 President Street, PO Box 250861, Charleston, SC 29425-0001*

EDUCATIONAL OBECTIVES:

At the conclusion of this symposium, participants should be able to the attendee will have an increased ability to assess the degree to which psychiatric disorders interfere with individual functioning in several domains using various quality of life assessments and will gain a better understanding of the importance of assessment of illness-related functional impairment and treatment effects on this impairment through the use of quality of life instruments.

SUMMARY:

There has been tremendous progress in our understanding of and ability to treat mental illness. The efficacy of treatments has traditionally been assessed via standardized rating instruments specific to a particular disorder as well as global rating of response. Of course, patients never request treatment for high rating scale scores; they seek help because of interference with their daily functioning because of symptoms. Recently, attention has been paid to whether these treatments improve occupational, family, and social functioning, satisfaction, sense of well-being, and other relevant domains. Substantial evidence indicates significant improvement in quality of life (QOL) after treatment of depression. However, other important psychiatric disorders or patient subgroups have been less well explored with respect to QOL. This symposium will present an overview of quality-of-life measures in each of four areas: panic disorder, post-traumatic stress disorder, the geriatric population, and premenstrual disorders. QOL measures before and after successful treatment will also be presented. Finally, some remaining questions and directions for future research will be discussed.

No. 17A
QUALITY OF LIFE IN PTSD

Jonathan R.T. Davidson, M.D., *Professor, Department of Psychiatry, Duke University Medical Center, Box 3812, Durham, NC 27710*

SUMMARY:

Post-traumatic stress disorder (PTSD) is a common trauma-induced psychiatric disorder that may affect up to 8%-10% of the population. Studies consistently demonstrate that individuals with PTSD have a significantly reduced quality of life. Several domains of functioning, including social, financial, and physical functioning, as well as psychological well-being are impaired in individuals with PTSD and may contribute to a reduced quality of life. Despite this, many individuals with PTSD are not receiving treatment for their condition. Data from recent long-term studies indicate that selective serotonin reuptake inhibitors (SSRIs) improve the symptomatology, overall daily functioning and quality of life of patients with PTSD and will be reviewed.

No. 17B
PANIC DISORDER AND QUALITY OF LIFE

Mark H. Rapaport, M.D., *Department of Psychiatry, University of California at San Diego, 8950 Villa La Jolla Drive, #2243, La Jolla, CA 92037-2315;* Mark H. Pollack, M.D.; Cathryn M. Clary, M.D.

SUMMARY:

Recent studies clearly demonstrate that panic disorder is associated with significant diminution of quality of life. Epidemiological analyses suggest that patients with undiagnosed and untreated panic disorder are seven times more likely to utilize primary care medical services, are much more likely to be unemployed or under-

employed, have more marital problems, and both perceive themselves as having and objectively have diminished quality of life. Clinical studies suggest that patients with panic disorder are frequently subject to unnecessary cardiology, pulmonary, and otolaryngology evaluations. Data also demonstrate that there is a direct relationship between decrements in quality of life and life satisfaction measures and specific clinical symptoms of panic disorder. Treatment studies clearly demonstrate that appropriate pharmacotherapy is associated with significant improvement in quality of life. Improvement in quality of life is a consistent finding with effective pharmacotherapy across a wide range of different definitions of positive response. Very recent analyses suggest that a truly comprehensive definition of effective treatment response in panic disorder might benefit from the inclusion of quality-of-life and life-satisfaction measures. Addition of these measures not only make treatment study results more relevant to clinicians but may enhance the differentiation of true treatment responders from placebo responders.

No. 17C
PREMENSTRUAL DYSPHORIC DISORDER AND QUALITY OF LIFE

Ellen W. Freeman, Ph.D., *Research Professor, Department of OBGYN and Psychiatry, University of Pennsylvania Medical Center, 3400 Spruce Street, OBGYN 2 Dulles, Philadelphia, PA 19104*

SUMMARY:

Premenstrual dysphoric disorder (PMDD) is a common and chronic disorder whose hallmark is the cyclic pattern of symptoms that occur premenstrually and remit following menses. The affective and behavioral symptoms of the disorder adversely impact functioning and quality of life to a disabling degree. Moreover, the long-term chronicity of PMDD (over 60% of patients who discontinued treatment experienced recurrence of symptoms within two months) indicates the importance of treatment efficacy not only for symptom reduction but also for its impact on quality of life, particularly as perceived by the patient rather than the physician. Data showing the impact of PMDD on quality of life will be reviewed. Results of treatment trials that demonstrate symptom reduction and improvement in quality of life for serotonergic but not noradrenergic antidepressants will be discussed. Other issues that affect quality of life including the side effects of medications and the preliminary evidence for efficacy of intermittent dosing with serotonergic antidepressants will be addressed. Understanding the impact of PMDD on interpersonal and/or work performance and the efficacy of antidepressant therapies for this disorder is important for treatment of women within the spectrum of mood disorders.

No. 17D
QUALITY OF LIFE IN ELDERLY PATIENTS WITH MAJOR DEPRESSIVE ILLNESS

Sanford I. Finkel, M.D., *Professor and Director, Department of Geriatric Psychiatry, Northwestern University, 303 East Ohio, Suite 550, Chicago, IL 60611*

SUMMARY:

Although the prevalence of major depression may decline with age, minor depression and depressive signs, symptoms, and equivalents appear to increase significantly and are common problems among elderly patients. The diagnosis and treatment of depression in the elderly is often complicated by comorbid medical conditions, cognitive disturbances, polypharmacy, and significant adverse life events. Current and previous physical illness may contribute to depressive symptoms and a lower quality of life in the elderly. A variety of pharmacologic and nonpharmacologic interventions, either alone or in combination, reduce depression and improve quality of life among elderly patients. Data from recent geriatric clinical trials will be reviewed.

REFERENCES:

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2. MH Rapaport, RM Walkow, CM Clary: Methodologies and outcomes from the sertraline multicenter flexible-Dose trials Psychopharmacology Bulletin 1995; 34:183-189.
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6. Small GW, Birkett M, Meyers BS, et al: Impact of physical illness on quality of life and antidepressant response in geriatric major depression. Fluoxetime

Collaborative Study Group. J Am Geriatr Soc 1996; 44:1220-1225.

Industry-Supported Symposium 18 **Tuesday, November 2 6:30 a.m.-8:00 a.m.**

THINGS YOU NEED TO KNOW ABOUT GENERICS BUT WERE AFRAID TO ASK

Supported by Zenith Goldline Pharmaceuticals

Michael A. Silver, M.D., *Medical Director, The Providence Center, 530 North Main Street, Providence, RI 02904*

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participants should be able to: understand the definition and practical implications of the measures of drug bioavailability and interchangeability, become familiar with the FDA bioavailability ratings of generic drugs and understand the significance of each, and understand the pricing terminology of brand and generic companies in order to assess the pharmacoeconomics of a particular drug.

SUMMARY:

Market research reports that more than half of the prescriptions filled in the U.S. are dispensed using generic alternatives to the brand products. Yet consumers and physicians are frequently confused by conflicting stories regarding the degree to which generics do, or do not, serve as equivalent substitutes to branded medications.

Brand companies have recently begun strong campaigns to reverse the trend towards generic prescribing, based upon challenges to the "bioequivalence" and/or interchangeability of the generic for the brand. Physicians have increasingly been lobbied by competing interests to exercise, or not exercise, the "Dispense As Written" option based on conflicting information as to the bioequivalence and interchangeability of generic products for the corresponding brand.

This talk, presented by a former deputy director of the FDA Office Of Generic Drugs, will compare the FDA approval requirements for new compounds with those for generic alternatives. A full explanation of the FDA bioequivalence ratings system and its terms will be offered. Areas of confusion surrounding information presented to physicians concerning the "80% to 125%" bioequivalence statistical analysis factor, and other areas of consumer/prescriber ambiguities referenced in data for FDA approved generic drugs, will be explained. Ample time will be provided for questions from the audience.

No. 18A
FDA PERSPECTIVES ON UNDERSTANDING BIOEQUIVALENCE FOR PHYSICIANS

Robert W. Pollock, M.S., *Lachman Consulting Services Inc., 1600 Stewart Avenue, Westbury, NY 11590*

SUMMARY:

Generic drugs are regularly prescribed by all physicians, yet very few have any understanding of the criteria that the Food and Drug Administration uses to classify and approve generics. Most clinicians simply choose to ignore the topic and assume that FDA approval obviates the need to think about any issues regarding generics, and on most occasions this is a successful strategy. However, if controversy arises about the efficacy or interchangeability of a specific generic drug with the brand-name compound, physicians may be in the difficult position of being unable to make reasonable judgments about the subject, because of a lack of knowledge of the underlying issues. This symposium will attempt to broaden the physician's knowledge about the basic pharmacological concepts involved in producing and rating generic drugs. It will explore the issues of bioavailability, interchangeability, drug ratings, and the requirements for FDA approval. Presenters will also describe and define the multiple and sometimes confusing pricing terminology used by brand and generic companies in order to better understand the pharmacoeconomics of a particular drug. Examples of drugs with different bioavailability ratings will be presented, with specific attention given to clozapine, a drug with special issues.

No. 18B
PHARMACOECONOMICS IN AN ENVIRONMENT OF CONFUSING TERMINOLOGY: WHERE PRICE AND COST ARE DIFFERENT NUMBERS

Terrance Bellnier, M.P.A., *Pharmacy Department, State University of New York at Buffalo, 1111 Elmwood Avenue, Rochester, NY 14620*

SUMMARY:

Because of brand versus generic competition, physicians are increasingly subjected to conflicting information about drug pricing. To make an appropriate assessment of medication costs, clinicians must understand the myriad of pricing terms used in the pharmaceutical industry.

The purpose of this presentation is to educate the physician about pricing used to calculate medication cost and to explore models for analyzing the contribution of medication costs to overall treatment expenditures.

Any discussion of treatment costs must begin with an overview of the esoteric pricing terminology used by industry, such as AWP (average wholesale price). MAC (maximum allowable charge), and WAC (wholesale acquisition cost). Demystifying these terms will make rational pricing comparisons easier for attendees to understand.

Medication for schizophrenia will then be used as an example of how drug costs change over time. The treatment cost of schizophrenia has been estimated at $65 billion per year. With the advent of the second-generation antipsychotics, there has been an increase in medication expenses for this population. Yet changes in health care financing have increasingly underscored the need for cost efficiency wherever possible. The impact of generic clozapine, the first such atypical, will be used as an example of the way lower-cost alternatives can reduce total per-patient treatment costs.

No. 18C
OBTAINING FDA APPROVAL AND PROVIDING EQUIVALENCE WHEN THE ISSUE (RATHER THAN IT) ISN'T ABOUT BIOEQUIVALENCE

Neha Sheth, Pharm.D., *Director, Medical Affairs, Zenith Goldline Pharmaceuticals, 4400 Biscayne Boulevard, Miami, FL 33137*

SUMMARY:

The bioequivalence of generic drugs and interchangeability with the corresponding brand is the subject of ongoing debate. The requirements for drug bioequivalence and approval are well defined in the case of the physical compounds themselves. The FDA approval of generic clozapine intensified the debate because the product labeling includes requirements for the manufacturer to provide an equivalent degree on non-drug elements. Measurement and approval of the non-drug elements of clozapine represented new ground for both the FDA and generic pharmaceutical manufacturing.

In this presentation, I will detail the process taken with the FDA in the approval of two different compounds. The first will be acyclovir, which represents the classical process. For the second, clozapine, we will detail the process and address the unique challenges this compound presented to the ANDA applicant. In addition to the usual requirements for demonstration of bioequivalence, FDA approval for this compound required the implementation of a patient registry for monitoring white blood cell counts for early detection and prevention of leukopenia and agranulocytosis as well as a seamless interface with the National Non-Rechallenge Masterfile to prevent re-challenge of high-risk patients. Approval also required a "closed" distribution system to limit use of the drug to clinicians familiar with the labeling.

I will review the interface between the FDA and the manufacturer that led to FDA approval of each drug and provide prescribing physicians with greater information to help them answer the critical question: "How can I know how to evaluate whether a specific generic drug is equivalent to those of the "branded" manufacturer?

REFERENCES:

1. Drug reimbursement information. In *Drug Topics Red Book.* edited by Cardinale V, Chi JC, Montvale, NJ: Medical Economics Company, Inc; 1999: pp. 79-145
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5. Approved Drug Products with Therapeutic Equivalence Evaluations, 19th Edition, U.S. Department of Health and Human Services, Public Health Service, Food and Drug Administration, Center for Drug Evaluation and Research, Washington, DC, 1999, pp. v-xvii.
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INNOVATIVE PROGRAMS: SESSION 1 SERVICES ACROSS CULTURES AND COUNTRIES

Innovative Program 1 **Friday, October 29 1:30 p.m.-3:00 p.m.**

CULTURE-BOUND SYNDROMES IN DSM-V?

Albert C. Gaw, M.D., *Medical Director, Medfield State Hospital, and Department of Psychiatry, University of Massachusetts Medical Center, 45 Hospital Road, Medfield, MA 02052*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize the best-known culture-bound syndromes, differentiate CBSs from current diagnostic categories in the DSM-IV, and classify them in DSM-V

SUMMARY:

Culture-bound syndromes (CBSs) are "recurrent, locality-specific patterns of aberrant behavior and troubling experience. . .indigenously considered to be 'illnesses' or at least afflictions. . .generally limited to specific societies or culture areas and are localized, folk, diagnostic categories that frame coherent meanings for certain repetitive, patterned, and troubling sets of experiences and observations (1)". Syndromes with names like Koro, Amok, Latah, Pibloktoq, Brain Fag, Falling Out, Possession have been studied and reported in the psychiatric literatures. However, these categories of illness appear to fall outside conventional Western psychiatric nosologic systems and their classification remains elusive. Currently, CBSs are generally assigned to the Appendix I section of the DSM-IV.

This presentation will 1) discuss the evolution of the concept of CBS and describe some of the best-known CBSs, 2) clarify the issues surrounding current debate on the definition and classification of CBSs, 3) suggest a decision tree on how to diagnose CBSs in clinical practice, and 4) propose a classification of CBSs for DSM-V.

REFERENCES:

1. Diagnostic and Statistical Manual of Mental Disorders, 4th ed., Washington, DC, American Psychiatric Association, 1994.
2. Simons RC, Hughes CC: Culture-bound syndromes, GAWAC (ed.), Culture Ethnicity and Mental Illness, Washington, DC, Amer. Psychiatric Press, 1993.

Innovative Program 2 **Friday, October 29 1:30 p.m.-3:00 p.m.**

PSYCHOSOCIAL REHABILITATION OF CIVILIANS IN A WAR ZONE

Daniel L. Creson, M.D., Ph.D., *Professor, Department of Psychiatry, University of Texas at Houston Mental Science Institute, 1300 Moursund Street, Room 277, Houston, TX 77030-3406*; Patricia Blakeney, Ph.D., *Psychologist, Department of Psychiatry, University of Texas at Galveston, 815 Market Street, Galveston, 815 Market Street, Galveston, TX 77550*; Cheryl Robertson, R.N., M.P.H.

EDUCATIONAL OBJECTIVES:

At the conclusion of this innovative program, the participation should be able to describe common obstacles to psychosocial rehabilitation of civilian populations in a war zone; to demonstrate effective evaluation paradigms that can be used in a psychosocial population in a war zone.

SUMMARY:

This session will provide a broad-based overview of issues involved in designing and supporting psychosocial rehabilitation projects for civilian populations caught in war zones. All of the presenters have worked extensively in such settings.

Psychiatrists and mental health professionals have responded in recent years to the increasingly urgent call of humanitarian aid organizations to help meet the psychological needs of traumatized civilians. Efforts to meet the needs of these psychologically traumatized individuals have raised many questions, and as yet there is no consensus on how to answer these questions.

The session will review both theoretical and practical issues and will discuss questions about the importance of cultural and ethical variables. The many problems associated with project evaluation in such settings will be discussed and examples taken from real situations will be provided.

Advantages and disadvantages of direct service to, as opposed to support of, an indigenous mental health delivery system will be discussed as will issues related to continuing trauma vs. finite trauma. Social, psychological, and financial issues related to the diagnosis of post-traumatic stress disorder (PTSD) in militarily active settings will be covered as will treatment and rehabilitation issues. Audience participation will be encouraged.

TARGET AUDIENCE:

Physicians, psychiatrists, and other mental health providers interested in humanitarian aid projects.

REFERENCES:

1. Dahl S., Mutapcic A, Schei B: Traumatic events and predictive factors for posttraumatic stress disorder in displaced Bosnian women in a war zone. Journal of Traumatic Stress, 1998; 2:137–145.
2. DeMartino R, Von Buchwald U: Forced displacement: non-governmental, efforts in the psychosocial care of traumatized peoples. International Responses to Traumatic Stress. Amityville, NY. pp. 193–217.

Innovative Program 3 **Friday, October 29**
1:30 p.m.-3:00 p.m.

MENTAL HEALTH SERVICES ACCESSIBLE TO IMMIGRANTS

Tedla W. Giorgis, Ph.D., *Director, Multicultural Services Division, District of Columbia Community Mental Health Services, 1536 U Street, N.W., Washington, DC 20009*; Lidia R. Carnota-Cohen, M.D., *Acute Care, District of Columbia Community Mental Health Services, St. Elizabeth's Hospital, 2700 Martin L. King Jr., Avenue S.E., Washington, DC 20032*; David M. Band, M.D.; Estela González, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this program the audience should be familiar with the Multicultural Services Division's innovative approach to making a full range of services available to large multiethnic populations

SUMMARY:

Washington, D.C., has a large population of recent immigrants, mainly from Central America, Southeast Asia, and Africa. The provision of adequate health services, especially mental health care, to these populations has been problematic given the cultural and language barriers.

The Multicultural Services Division (MSD) is an innovative program that started in 1987 and bases its success on being rooted in the community. It serves as a bridge between the public mental health system and the community-based multiethnic organizations representing the immigrant and refugee populations, since bilingual and bicultural providers are drawn from these communities. The MSD coordinates services and serves as a referral source for public and private organizations providing health and social services.

This program will provide details on the development and current functioning of this program, which has made mental health services accessible to these underserved populations as a model to communities with large multiethnic populations throughout the country.

TARGET AUDIENCE:

Mental health clinicians, administrators and policy makers working with multiethnic populations in need of mental health services.

REFERENCES:

1. Gaunlett N, Ford R, Johnson N, Navarro T: Meeting mental health needs of ethnic minority groups. Nursing Times 1995; 91:36–37.
2. Ruiz P: Assessing, diagnosing and treating culturally diverse individuals: a Hispanic perspective. Psychiatric Quarterly 1995; 66:329–340.

INNOVATIVE PROGRAMS: SESSION 2 MEDICINE AND PSYCHIATRY

Innovative Program 4 **Friday, October 29**
3:30 p.m.-5:00 p.m.

HOMEBOUND AIDS PATIENTS WITH DEMENTIA

Lawrence B. Jacobsberg, M.D., Ph.D., *Team Psychiatrist, Community Mental Health Services, Visiting Nurse Service, 2170 McDonald Avenue, Brooklyn, NY 12229; Chuck Nuttall, L.C.S.W., Program Coordinator, Community Mental Health Services, Visiting Nurse Service, 2170 McDonald Avenue, Brooklyn, NY 12229*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize symptoms of dementia in AIDS/HIV patients and plan effective treatment strategies for the home care setting.

SUMMARY:

Patients with HIV/AIDS are often homebound as a result of their illness. The Visiting Nurse Service of New York supports HIV–mental health consultation teams, to provide consultation and liaison to the medical home care services of these patients. Dementia has been prominent in problems referred, because its associated high level of disability places greater demand on health care resources in the home care setting.

Quantitative assessment of more than 850 patents over the program's eight-year span has revealed an increase in HIV-associated dementia rates, as would have been expected given the overall longer survival time of AIDS patients.

Symptom presentation varies, but has included language comprehension, memory, and computational processing deficits, each of which necessitates different modifications to the patient's treatment plan. Managing the physical environment (e.g., laying out medication for complex regimens into pill boxes) can address concrete

issues, while manipulating the psychosocial environment with supportive individual or family psychotherapy is useful to address such psychological issues as secondary depression. Psychotropic medications are sometimes prescribed, but in the bulk of cases, the focus is on psychosocial interventions.

TARGET AUDIENCE:

Psychiatrists, psychiatric nurses and clinical social workers.

REFERENCES:

1. Harrison MJ: Guidelines for the management of HIV-associated dementia, myelopathy neuropathy and myopathy. Int J STD AIDS 1998; 9:390–393.
2. Starace F, et al: HIV-associated dementia: clinical, epidemiological and resource utilization issues. AIDS Care 1998; 10:s113–121.

Innovative Program 5 **Friday, October 29**
3:30 p.m.-5:00 p.m.

EFFECTIVENESS OF A PSYCHIATRY MEDICINE CLINIC

William B. Lawson, M.D., Ph.D., *Chief of Psychiatry, Roudebush VA Medical Center, 1481 West 10th Street, Indianapolis, IN 46202*; Carole Gartner, R.N., N.P., *Nurse Practitioner, Psychiatry Medical Clinic, Department of Psychiatry, Roudebush Veterans Affairs Medical Center, 1481 West 10th Street, Indianapolis, IN 46202*; Chris Suelzer, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to learn about the effectiveness of a psychiatry medicine clinic in maintaining patient involvement and develop strategies for implementing a primary care clinic in a psychiatry service.

SUMMARY:

Medical comorbidity is high in the severely mentally ill and is often untreated or unrecognized. An intervention is described that may help to address this problem. This psychiatry service provides inpatient and outpatient mental health and substance abuse services in a tertiary care medical-surgical Veterans Administrations (VA) hospital. However, concerns about access to services led to the development of a primary care medicine clinic physically within the psychiatry service. Examination rooms appropriate for primary care were arranged. A nurse practitioner and a general internist were assigned to psychiatry service simultaneously with the development of VA-initiated psychiatry primary care resident positions. Thus far, of 248 psychiatric patients, primarily with psychotic disorders referred to primary care, 132 have been referred to the clinic. Eighty percent of psychiatric patients referred to primary care kept their appointment after initiation of the program vs. 27% before the program. There was a drop in the rate of medical inpatient admissions and an increase in patient satisfaction ratings. A number of serious previously unrecognized and untreated general medical conditions were identified. A primary care clinic dedicated to psychiatric patients and proximal to psychiatry services provided a significant health benefit to the severely mentally ill.

REFERENCES:

1. Paulsen RH: Psychiatry and primary care as neighbors: from the Promethean primary care physician to multidisciplinary clinic. Int J Psychiatry Med. 1996; 26:113–125.
2. Lambert D. Hartley D: Linking primary care and rural psychiatry: Where have we been and where are we going? Psychiatric Serv 1998; 49:965–967.

Innovative Program 6 **Friday, October 29**
3:30 p.m.-5:00 p.m.

COLLABORATIVE CARE: THE DYNAMIC INTERACTION OF PRIMARY CARE AND PSYCHIATRY

Stuart H. Levine, M.D., *Chief Executive Officer, Topaz Health, and former APA/Bristol-Myers Squibb Fellow, 423 South Pacific Coast Highway 101, Redondo Beach, CA 90277*; Daniel D. Anderson, M.D., *PsychCare Alliance, Department of Psychiatry, Topaz Health, 423 South Pacific Coast Highway 101, Redondo Beach, CA 90277*; Peter B. Hirsch, M.D.; Morris Gelbart, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to demonstrate how to design a program in which psychiatrists work directly with primary care physicians and their patients.

SUMMARY:

Psychiatric disorders account for significant functional impairments in patients treated by primary care physicians and are very common among patients seen in the primary care setting. Since primary care providers, not psychiatrists or mental health professionals, render the majority of mental health care in the U.S., common psychiatric disorders are not being accurately diagnosed or appropriately treated by many primary care physicians.

There are higher costs associated with many of these patients, both directly because of health care costs and indirectly due to patient disability. For example, in 1990, the cost associated with a single psychiatric disorder,

depression, was estimated at $43.7 billion. Of this total, 28% ($12.4 billion) was in direct costs, 17% ($7.5 billion) arose from mortality costs from suicide, and 55% ($23.8 billion) was derived from the two morbidity cost categories of excess absenteeism and reduction in productivity while at work.

Efforts to improve the diagnosis of psychiatric illnesses and to implement effective treatment plans have led to new strategies for integrating mental health into primary care delivery. Investigations have explored consultation models and improved training of primary care physicians through standardized treatment guidelines. It has been suggested that a hybrid approach called collaborative care, where mental health professionals work together with primary care physicians, offers the best optimization of better outcomes, lower treatment costs, and better value of care.

REFERENCES:

1. Katon W, Von Korff M, Lin E, et al: Collaborative management to achieve treatment guidelines. Impact on depression in primary care. JAMA 1995; 273:1026–1031.
2. Sturm R, Well KB: How can care for depression become most cost-effective? JAMA 1995; 273:51–58.
3. Katzelnich DJ, Kobah KA, Greist JH, et al: Effect of primary care treatment of depression on service use by patients with high medical expenditures. Psychiatr Serv. 1997; 48:59–64.
4. Stumm R, Wells K: Improving primary care for depression: are physician knowledge and financial incentives equivalent? October 1996. Revised version in Journal of Mental Health Policy and Economics, 1998.

INNOVATIVE PROGRAMS: SESSION 3 INTEGRATION: COMMUNITY AND RESIDENTIAL SERVICES

Innovative Program 7 Saturday, October 30 8:00 a.m.-9:30 a.m.

THE WASHTENAW COUNTY INTEGRATED HEALTH PROJECT

Karen K. Milner, M.D., *Clinical Assistant Professor, Department of Psychiatry, University of Michigan, 1500 East Medical Center Drive, Ann Arbor, MI 48109*; Thomas Carli, M.D., *Clinical Associate Professor, Department of Psychiatry, University of Michigan, 1500 East Medical Center Drive, Ann Arbor, MI 48109*; Kathleen M. Reynolds, M.S.W.; David Neal, M.S.W.

EDUCATIONAL OBJECTIVES:

At the conclusion of this innovative program, the participant should be able to discuss a model for the collaboration of a public agency and an academic medical center in establishing a viable managed care system in the public sector.

SUMMARY:

The Integrated Health Care Project is a joint project involving Washtenaw County Community Mental Health, Washtenaw County Public Health, Livingston/Washtenaw Substance Abuse Coordinating Agency, and the University of Michigan Health System. The project seeks to integrate behavioral health services, substance abuse treatment, and primary and specialty physical health care for the 12,000 Medicaid and 12,000 indigent clients living within Washtenaw County in accord with the Michigan Department of Community Health's directive to transition to a managed system of care. Its goals include: provision of a person-centered managed care delivery system that provides for integrated care by coordinating the strengths of each agency and meets national quality standards; alignment of financial incentives of each agency to include risk sharing; provision of educational opportunities for health professionals/students in the health professions; and development of a system that promotes health care research with emphasis on evaluation of effective models for integrating health care, development of quality outcome standards and clinical pathways, and evolution of an outreach/educational program. This innovative program will focus on the impetus, barriers, and accomplishments of this project to date, outline the steps necessary for its completion, and discuss its viability in the era of public managed care.

TARGET AUDIENCE:

Mental health care providers.

REFERENCES:

1. Public Mental Health: A Changing System in an Era of Managed Care. American Psychiatric Association Office of Economic Affairs and Practice Management. American Psychiatric Press, Inc., Washington, D.C., 1977.
2. Managed Mental Health Care in the Public Sector: A Survival Manual, edited by Minkoff D, Pollack D. Harwood Academic Publishing, Amsterdam, 1977.

Innovative Program 8 Saturday, October 30 8:00 a.m.-9:30 a.m.

OCOTILLO: A COMMUNITY-BASED TRANSITIONAL RESIDENTIAL PROGRAM

Dean W. McKenzie, M.D., *Clinical Instructor, Department of Psychiatry, University of Arizona, 1501 North*

Campbell Avenue, Box 245002, Tucson, AZ 85724; Mario Cruz, M.D., *Clinical Assistant Professor, Department of Psychiatry, University of Arizona, 1501 North Campbell Avenue, Tucson, AZ 85724*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize effective functions of a transitional residential program within the context of a capitated mental health care system.

SUMMARY:

The purpose of this presentation is to describe a unique transitional residential program within the context of a capitated mental health care system at COPE Behavioral Health Services, Inc. in Tucson, Arizona. The program is a 16-bed residential facility with 24-hour staffing. Its functions include: 1) hospital diversions from emergency rooms, 2) step-down facility from psychiatric inpatient units, 3) a 24-hour crisis phone line, 4) stabilization of subacute outpatients, 5) transitional housing when other treatment needs are present, respite care from psychosocial stressors, and 6) assessment for appropriate level of case management or assisted living services. A psychiatrist on site three to four hours/day covers the facility five days a week with rotating on-call coverage. The presentation will also present utilization data and describe how this program functions within the continuum of available services at COPE Behavioral Services Inc.

REFERENCES:

1. Schneider SE: Ultra-short hospitalization for severely mentally ill patients. Psychiatric Services 1996; 47:137–138.
2. Canton CL: A review of issues surrounding length of psychiatric hospitalization. Hospital and Community Psychiatry 1987; 38:858–863.

Innovative Program 9 **Saturday, October 30**
8:00 a.m.-9:30 a.m.

HOW TO OPERATE A COMPREHENSIVE CRISIS PROGRAM

Erik J. Roskes, M.D., *Assistant Professor, Department of Psychiatry, University of Maryland, 22 South Greene Street, Box 291, Baltimore, MD 21201*; Edgar K. Wiggins, M.H.S., *Executive Director, Baltimore Crisis Response Incorporated, 1105 Light Street, Second Floor, Baltimore, MD 21230*; Sharon Lipford, L.C.S.W.

EDUCATIONAL OBJECTIVES:

At the conclusion of this innovative program, the participant should be able to demonstrate an understanding of the practical aspects of developing and running a community-based crisis intervention program.

SUMMARY:

One of the difficulties frequently facing a severely and persistently mentally ill person is the lack of adequate housing. The problem of where to treat the mentally ill, and specifically the homeless mentally ill, has long been at issue, particularly since the deinstitutionalization "movement" beginning in the 1950s and 1960s. Crisis housing alternatives range from models taken almost directly from inpatient treatment models to quite nontraditional approaches. While some hospitalizations cannot be prevented, many crises related to severe psychosocial stressors need not result in hospitalization, provided that competent and comprehensive community-based services are available. This innovative program will focus on a model program that has developed a variety of alternative treatment venues, ranging from individuals' homes to other community settings to a residential crisis treatment setting in the community. Advantages of this model include maintenance of the individual at or close to home, prevention of dependence on the crisis system, and a substantial cost saving to the public mental health system. Audience participation will be welcomed.

TARGET AUDIENCE:

Crisis interventionists, and hospital, clinical and managed care administrators.

REFERENCES:

1. Fields S, Weisman GK: Crisis residential treatment: an alternative to hospitalization, in The Growth and Specialization of Emergency Psychiatry, edited by Allen M. New Directions for Mental Health Services, No. 67, San Francisco, Jossey Bass, 1995.
2. Stroul B: Psychiatric Crisis Response Systems: A Descriptive Study. Rockville, MD, Center for Mental Health Services, 1993.

INNOVATIVE PROGRAMS: SESSION 4 STRETCHING THE BOUNDARIES

Innovative Program 10 **Saturday, October 30**
10:00 a.m.-11:30 a.m.

CREATIVITY, MADNESS AND WELLNESS

Dianne W. Trumbull, M.D., *Associate Professor, Department of Psychiatry, West Virginia University, Chestnut Ridge Hospital, Morgantown, WV 26505*

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to craft an elective on creativity in which students study theories about the creative process, participate in their own encounters with art forms, and consider clinical applications.

SUMMARY:

The purpose of this program is to offer a view into an elective for residents and senior medical students titled Creativity, Madness, and Wellness. This four-week series of seminars, grand rounds, and special events offers an opportunity to study and participate in the process of creating with faculty from all over the university. In effect, it is a time to interrupt the chronic busyness of doing and get back to being.

I will review the content and form of this elective, in which we study the provocative work of many classical and contemporary writers on play, trauma, and creativity. In the spirit of these writers' work (notably Winnicott), we actively participate in encounters with others and otherness in art, literature, and music.

In these encounters, we address Jung's work on archetypal significance, the true offerings of art, which touch the universal in us all, and, in so doing, evoke a sense of connectedness, continuity, and awe. Finally, we address the clinical applications of our discoveries, that is, a realization that the otherness of art may open new ways of being and doing for ourselves and our patients.

REFERENCES:

1. Winnicott DW: Transitional objects and transitional phenomena: a study of the first not-me possession, 1951; in collected papers: Through Pediatrics to Psychoanalysis, pp. 229–242. London: Tavistock, 1958.
2. Jung C: The Spirit in Man, Art, and Literature. Princeton University Press, 1996.

Innovative Program 11 Saturday, October 30 10:00 a.m.-11:30 a.m.

QUALITY REFORMS IN AUSTRALIA'S MENTAL HEALTH SYSTEM

Andrew M. Stripp, *Director of Mental Health and Human Services, 11-555 Collins Street, Melbourne, Victoria, Australia 3000*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to understand the approach to mental health reform in Australia and the strategies being pursued to develop a high-quality, evidence-based, consumer-oriented service system.

SUMMARY:

The past five years have witnessed a comprehensive reform program in the state of Victoria with the rate of change exceeding all other jurisdictions in Australia. During this time large institutional services have been replaced with new local and community-based services integrated and managed by local general health care providers and nongovernment agencies, resulting in the closure of state hospitals. In the context of an increase in resources, more services are provided to more people, with the bulk of resources allocated to non-inpatient services. Improved service quality is being achieved through a range of incentive strategies linking *increased* funding to improved performance, clinical audits, and strong consumer involvement in service development. New technologies including telepsychiatry and a single client record across all services have been implemented. Resources have been redistributed in line with client need, with a new purchasing framework being established to provide a more transparent and accountable funding system.

REFERENCES:

1. Shepherd G: A first-class service: quality in the new NHS; UK. Unpublished, 1998.
2. Andrew G, Peters L, Teeson M: The measurement of consumer outcomes in mental health. Australian Govt. Publishing Service, Canberra, 1994.

Innovative Program 12 Saturday, October 30 10:00 a.m.-11:30 a.m.

MENTAL HEALTH ACCESS POINT: MANAGED CARE IN THE PUBLIC SECTOR

Diana M. McIntosh, R.N., M.S.N., *Director, Mental Health Access Point, Central Psychiatric Clinic, 3259 Elland Avenue, Cincinnati, OH 45229-2810*; Charles W. Collins, M.D., *Director, Child and Family Division, Department of Psychiatry, University of Cincinnati, 3259 Elland Avenue, Cincinnati, OH 45229-2810*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, participants will understand the concept of Mental Health Access Point (MHAP), a managed care endeavor in a public mental health system, and factors involved in its implementation. They will recognize ways that both children and adults with chronic mental illness can benefit clinically from MHAP.

SUMMARY:

A coalition of community mental health agencies in Hamilton County, Ohio, in an effort to manage local mental health services in a more efficient and effective manner, formed a partnership with the county mental health board to create Mental Health Access Point (MHAP), an innovative, managed care endeavor in a public mental health system. MHAP is the front door to community mental health services for the county. It contains a clinical arm administratively under the

umbrella of Central Clinic, Cincinnati, Ohio. Like most managed care systems, it has three functions: 1) assessment/evaluation; 2) authorization of services; 3) utilization review and monitoring. Recognizing recent advancements in private sector managed care, MHAP attempts to combine the best practices of the public sector with some of the successes of the private sector.

This presentation will describe the factors contributing to the building of MHAP. A quick summary of the program will be given. The process of managing these populations, as well as some successful outcomes, will be recounted. Outcomes will include usual variables of decreased hospitalizations and consumer satisfaction. Lastly, we will relate some clinical outcomes and case vignettes of pre and post MHAP, including children and patients with chronic mental illness.

REFERENCES:

1. Minkoff K, Pollack D: Public Sector Managed Care and Community Mental Health Ideology, 1997.
2. Graham M: Standards for Consumer-Centric Managed Mental Health and Substance Abuse Programs, 1990.

INNOVATIVE PROGRAMS: SESSION 5 OUTREACH AND MOBILE CRISIS

Innovative Program 13 Saturday, October 30 1:30 p.m.-3:00 p.m.

OUTCOME RESULTS OF A SIX-YEAR STUDY OF INTENSIVE OUTREACH TO THE UNSHELTERED HOMELESS MENTALLY ILL IN WASHINGTON, DC

Kenneth Freeman, M.P.H., *Principal Investigator, Research Department, District of Columbia General Hospital, 2213 Luzerne Avenue, Silver Spring, MD 20910*; Sara F. Carroll, Ph.D., C.S., *Nurse Consultant, Research Department, District of Columbia General Hospital, Building 14, Washington, DC 20003*; Robert W. Keisling, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this innovative program, the participant should be able to help the unsheltered mentally ill to take the first steps towards leaving the streets and coming inside.

SUMMARY:

Since 1992, the District of Columbia government has been providing services to mentally ill persons who sleep outside on the streets—the "unsheltered homeless." This was done via intensive outreach, till 2 a.m. nightly for six years by the same team. The primary goal was the protection of the client, especially prevention of hypothermia in the winter and of the public from persons who became dangerous.

All persons sleeping outside were considered "clients" and offered help, but the focus was on the severely mentally ill. The team saw thousands of persons during the study period, of whom 863 were identifiable by name, age, etc. Approximately 80% of this population were homeless, and 20% were emergency cases handled for police or fire departments, and constitute a control group.

Preliminary data indicate that of persons receiving intensive outreach, 40% ended up in housing; an equal number remained homeless. This demonstrates that intensive outreach can help some of the most regressed of the unsheltered mentally ill, if done slowly and in a particular cultural context. The method is compared to the paradigm of "caring for the abandoned child." The issues that lead a person to choose continued homelessness and noncooperation with psychiatric treatment will be discussed. The panel will engage the audience in discussion using and demonstrating the methods of intensive outreach.

REFERENCES:

1. Grob GN: The Mad Among Us, Cambridge, Mass. Harvard Univ. Press, 1994.
2. Rothman DJ: The Discovery of the Asylum: Social Order and Disorder in the New Republic, Boston, Little Brown, 1990.

Innovative Program 14 Saturday, October 30 1:30 p.m.-3:00 p.m.

STREET OUTREACH: A SEAMLESS APPROACH

Diane B. Sonde, M.S.W., *Director, Project Reachout, Goddard-Riverside Community Center, 593 Columbus Avenue, New York, NY 10024*; Carolyn Benson, M.D., *Clinical Director, Project Reachout, Goddard-Riverside Community Center, 593 Columbus Avenue, New York, NY 10024*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to identify the crucial elements needed to make outreach effective as the beginning of a seamless continuum of care designed to stabilize, rehabilitate, and permanently house homeless people with mental illness.

SUMMARY:

Since 1979, Project Reachout has provided outreach, treatment, rehabilitation, and transitional and permanent housing in New York City's Upper West Side. We work with fragile people with long histories of mental illness,

often with repeated hospitalizations, chronic addictions, medical conditions, estrangement from families, and patterns of nonadherence with medication and psychiatric follow up. This presentation will focus on designing outreach for the most severely ill and difficult to treat.

We have found that a linkage model in which clients are referred by outreach workers to other services is less effective than providing a comprehensive array of flexible services through the outreach program itself. Beginning with persistent contacts on the street, close individual attention is provided to move the client smoothly through each treatment stage. This holistic, client-centered approach brings community psychiatry to a new level of accessibility, moving the psychiatric emergency room out into the street to reach people whose mental illness prevents them from negotiating the inflexible and disjointed mental health system. The first half will be a presentation, and the second half will be for Q&A, discussion, and exploration of specific areas of interest.

TARGET AUDIENCE:

Psychiatrists, social workers, clinicians, mental health workers and consumers.

REFERENCES:

1. Diamond R, Factor R: Treatment-resistant patients or a treatment resistant system? Hospital & Community Psychiatry 1994; 45:197.
2. Morse GA, Calysn RJ, Miller J et al: Outreach to homeless mentally ill people: conceptual and clinical considerations. Community Mental Health J, 1996; 32:261–74.

Innovative Program 15 Saturday, October 30 1:30 p.m.-3:00 p.m.

MOBILE CRISIS TEAM: PRACTICAL MEDICATION MANAGEMENT

Lori L. Kondora, Ph.D., *Nurse-Prescriber, Emergency Services, Dane County Community Mental Health Center, 625 West Washington, Madison, WI 53703*; Robert M. Factor, M.D., Ph.D., *Medical Director, Emergency Services, Dane County Community Mental Health Center, 625 West Washington, Madison, WI 53703*; Lori L. Blahnik, R.N., M.A.

EDUCATIONAL OBJECTIVES:

At the conclusion of this innovative program, the participant should be able to recognize essential components of a medication management system for a mobile crisis unit of a CMHC. Participants will also appreciate ethical dilemmas inherent in such a system.

SUMMARY:

This innovative program will be an opportunity to discuss the practical management of medications (meds) in a community mental health center's mobile crisis unit. Panel members represent three different traditions including the following: medical director, nurse-prescriber, and RN. Panel members will present challenges and triumphs in developing a practical med management system for serving our community-based consumers. We will provide a brief overview of our system at MHC of Dane County and then lead a discussion of ideas and suggestions on how we can learn from one another to improve services for consumers in different settings. Topics to be included will be professional composition of our unit, who prescribes, who packages, our relationship with pharmacies, who pays, patient assistance programs, medication samples/gifts from pharmaceutical companies, med education, consumer participation, prescribing choices between expensive and inexpensive meds, who handles meds, emergency access to meds, injection clinics and the impact of managed care. This will be an interactive discussion in which audience members will be encouraged to share their own challenges and triumps regarding their experiences finding a practical med management system that meets the varying needs of consumers and the systems in which we all operate.

TARGET AUDIENCE:

Consumers, nurses, physicians and pharmacists.

REFERENCES:

1. Factor R, Diamond R: Emergency psychiatry & crisis resolution. In J. Vaccaro & G. Clark (Eds.), Practicing Psychiatry in the Community: A Manual. Wash DC, APA, (pp. 51–76).
2. Nehls N, Blahnik L, Nestler K, Richarson D: A collaborative nurse-physician practice. In J. Vaccaro & G. Clark (Eds.), Practicing Psychiatry in the Community: A Manual. Wash DC, APA, pp. 87-96.

INNOVATIVE PROGRAMS: SESSION 6 VISITING NURSE SERVICE INNOVATIVE PROGRAMS

Innovative Program 16 Sunday, October 31 10:00 a.m.-11:30 a.m.

HOMELESS MOBILE OUTREACH TEAM OUTCOMES: LINKAGE

Thomas Laverack, *Program Coordinator, Community Mental Health Service, Visiting Nurse Service, 1601 Bronxdale Avenue, Bronx, NY 10462*; Judith D. Fisher, M.D., *Team Psychiatrist, Community Mental Health*

Service, Visiting Nurse Service, 1601 Bronxdale Avenue, Bronx, NY 10462

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to comprehend the outcomes of a mobile psychiatric outreach about linkages to permanent housing and outpatient treatment.

SUMMARY:

The Visiting Nurse Service of New York (VNS) has operated the Bronx Outreach Team for the Homeless (BOTH) since 1995. BOTH attempts to identify and engage homeless mentally ill individuals on a street outreach basis and then assist them in procuring permanent housing and access to appropriate psychiatric treatment. It is well known that these goals are often difficult to achieve with this population. We will present data from a group of BOTH clients (N=116) examining the association between demographic and clinical characteristics and outcome as measured by successful placement and treatment referral. BOTH data indicate that the severity of a client's Axis I diagnosis, including comorbid substance abuse, is less indicative of a client's inability to achieve stable housing and treatment than the presence of a moderate to severe Axis II diagnosis. Clients with marked personality disorders tend to have greater difficulty following through the necessary steps needed to access permanent housing and treatment. These data will be discussed in further detail and case vignettes presented.

TARGET AUDIENCE:

Psychiatrists, nurses and clinical social workers.

REFERENCES:

1. Morse, GA et al: Outreach to homeless mentally ill people: conceptual and clinical considerations. Community Mental Health J 1996; 32.
2. Tessler RC, Dennis DL: Mental illness among homeless adults: a synthesis of recent NIMH-funded research. Research in Community and Mental Health 1992; 7:5–53.

Innovative Program 17 **Sunday, October 31**
10:00 a.m.-11:30 a.m.

COLLABORATIVE PROGRESS NOTES AS OUTCOME PARAMETER

Katherine Levine, C.S.W., *Program Coordinator, Community Mental Health Services, Visiting Nurse Service, 450 East 149th Street, Bronx, NY 10455*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to use notes to measure stabilization, effectiveness, problem ownership, and satisfaction of those served, and understand the difference in effectiveness and satisfaction between those using the collaborative notes versus the standard notes.

SUMMARY:

The Visiting Nurse Service of New York operates a federally funded Mobile Community Support Team (MCST) serving seriously emotionally distressed children and their families in the South Bronx. MCST works with very distressed clients to prevent hospitalization and to improve the quality of the family system. We are studying the use of the collaborative progress note, a measure of continuous quality improvement. Every progress note is reviewed by the client through the use of a standardized form, and results are discussed between client and treating staff member. We will also present data (N=60) on the impact of the collaborative progress note on the treatment process. Cases using the collaborative note will be compared with cases using the traditional progress note in terms of safety risk reduction, problem intensity, problem ownership, and consumer satisfaction.

TARGET AUDIENCE:

Psychiatrists, nurses, and clinical social workers.

REFERENCES:

1. Holcomb WR, et al: The development and construct validation of a consumer satisfaction questionnaire for psychiatric inpatients. Evaluation and Program Planning 1989; 12:189–194.
2. Levois M, et al: Artifact in client satisfaction assessment, experience in community mental health settings. Evaluation and Program Planning 1989; 12:139–150.

Innovative Program 18 **Sunday, October 31**
10:00 a.m.-11:30 a.m.

TERMINATION AND BOUNDARIES: PUSHING THE LIMIT

Marian Cremin, C.S.W., *Program Coordinator, Community Mental Health Service, Visiting Nurse Service, 2170 McDonald Avenue, Brooklyn, NY 11223*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should gain an understanding of the value of periodic contact of families with worker after the six-week intervention has terminated and discover what parents per-

ceive as the effect of contact during gatherings with previous worker.

SUMMARY:

The Visiting Nurse Service of New York (VNS) operates a Home-Based Crisis Intervention Service (HBCI), a hospital diversion program for seriously emotionally disturbed children. Staff work with children and their families intensively, up to six hours daily, with "24/7" availability. Although powerful attachments develop in this setting, clients know from the outset that the service has a six-week maximum, culminating in appropriate referral or, when indicated, admission. VNS operates four HBCI programs throughout New York City. There are few data available on outcomes for HBCI clients. As one measure of outcome, we collected satisfaction data from parents in our Brooklyn HBCI program. We will present results (N=50) from parent satisfaction surveys following discharge and from four annual "booster shot" events held for families who have participated in the program.

TARGET AUDIENCE:

Child mental health workers, psychiatrists, nurses and clinical social workers.

REFERENCES:

1. Dean C: Impowerment Skills for Family Workers. New York, NYS Division of Community Services, 1996.
2. Garberino J: Raising Children in a Socially Toxic Environment. New York, Jossey Boss, 1995.

INNOVATIVE PROGRAMS: SESSION 7 NATURAL SUPPORTS: CONSUMERS AND FAMILIES

Innovative Program 19 **Sunday, October 31 1:30 p.m.-3:00 p.m.**

INTEGRATING PROFESSIONAL AND CONSUMER TREATMENT

Jeffrey Bedell, Ph.D., *Associate Professor of Psychiatry, Mount Sinai School of Medicine, 79-01 Broadway, Room H3-48, Elmhurst, NY 11373*; Ann Marie T. Sullivan, M.D., *Associate Professor of Psychiatry, Mount Sinai School of Medicine, 79-01 Broadway, Room H3-48, Elmhurst, NY 11373*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to make better use of consumers in treatment.

SUMMARY:

Treating patients with serious mental illnesses (SMI) requires multiple services including pharmacotherapy, psychological treatments, and intensive case management. Integration of consumers of mental health services into the treatment team is also effective for persons with SMI. This presentation describes an innovative treatment program that integrates the unique skills of consumers, social workers, and psychiatrists to manage risk and reduce hospitalization of recidivist patients with SMI. This presentation describes the Community Options (CO) program of the Mount Sinai School of Medicine in New York. It will emphasize the services provided by consumers showing how they were designed to capitalize on their unique indigenous status and the novel services they are able to provide. Also, a highly structured and interdisciplinary risk-management program will be described. All service components include integrated psychiatric, social work, and consumer services. The results of a controlled 18-month follow-up evaluation of 63 patients will be presented. It compared levels of treatment compliance, service use, family burden, quality of life, symptoms, and satisfaction among three methods of community aftercare, each requiring a different type of participation on the part of the psychiatrist, social worker, and the indigenous consumer paraprofessional.

REFERENCES:

1. Bedell JR, Hunter RH, Corrigan PW: Current approaches to assessment and treatment of persons with serious mental illness. Professional Psychology: Research and Practice. 1997; 28:217–228.
2. Mueser KT, Bond GR, Drake RE, Resnick SG: Models of community care for severe mental illness: a review of research on case management. Schizophrenia Bulletin 1998; 24:37–74.

Innovative Program 20 **Sunday, October 31 1:30 p.m.-3:00 p.m.**

SELF-HELP SUPPORT GROUPS: BENEFICIAL FOR ANXIETY DISORDERS

Marilyn Gellis, Ph.D., *Founder and Director, Institute for Phobic Awareness, Phobics Anonymous World Service Headquarters, P.O. Box 1180, Palm Springs, CA 92263*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize the value of self-help support groups as adjunct therapy for anxiety and panic related disorders and learn how to motivate and interest patients in their formation and attendance.

SUMMARY:

This session is intended to introduce the benefit of self-help support groups to professionals who treat the number one worldwide mental health problem, anxiety disorders, affecting roughly 30 million people.

While working with anxiety disorders since 1981, when I myself became agoraphobic, I have found that the most beneficial treatment is a multimodal integrated approach addressing the intellectual, emotional, physical, and spiritual aspects of recovery.

Self-help support groups provide no "quick fix" or "cure"—just a unique compliment to—not a replacement for therapy, medical treatment, medication, etc.

At some point, however, formal therapy ceases due to finances, location, or patient progress. This is when support group meetings are especially effective because of the unique camaraderie, communication, and rapport that occurs, providing emotional companionship in a nonthreatening setting, thus serving as an antidote to loneliness, isolation, helplessness, misunderstanding, and ridicule, through a network of members with common concerns.

New friends, meetings, and telephone contacts provide a safety net vital to someone in a crisis or panic state that cannot be matched by the most highly educated caring professional who has not been affected, and thus having no personal insight into the suffering and devastation of the problem.

REFERENCES:

1. The Twelve Steps of Phobics Anonymous, First Edition. Palm Springs, CA, 1989.
2. From Anxiety Addict To Serenity Seeker, First Edition. Palm Springs, CA, 1991.

Innovative Program 21 **Sunday, October 31**
1:30 p.m.-3:00 p.m.

TRAINING PROFESSIONALS IN FAMILY PSYCHOEDUCATION

Christopher S. Amenson, Ph.D., *Director of Training Institute, Pacific Clinics, 909 South Fair Oaks Avenue, Pasadena, CA 91105*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to understand the knowledge base and teaching skills required to educate families about schizophrenia and plan a comprehensive training program to teach these skills.

SUMMARY:

The PACT report indicated that family psychoeducation was the intervention for schizophrenia with the second strongest research support, after medication. Yet, only 37% of families receive minimal family contacts.

The Los Angeles County Department of Mental Health and NAMI created a staff training program designed to train two experts in family psychoeducation at each clinic. This presentation will describe the process, content, and outcomes of this professional training program.

This presentation will discuss the political, fiscal, and advocacy efforts required to implement this level of system change, including professional and systemic barriers and facilitators. The 60-hour and 22-hour versions of the professional training curricula will be described with emphasis on overcoming professional resistance to unfamiliar roles and building upon existing knowledge and skills. The process and outcomes of classroom and in vivo practice will be discussed.

The published evaluation of the program outcomes will be described: 37 professionals completed the training; these professionals taught 41 family classes in seven languages; families were highly satisfied with the classes; and the program was replicated in San Diego County.

REFERENCES:

1. Amenson CS: Training professionals to provide family psychoeducation, submitted for publication.
2. Amenson CS: Schizophrenia: Family Education Methods, Pasadena, CA, Pacific Clinics, 1998.

INNOVATIVE PROGRAMS: SESSION 8 ELEMENTS OF CARE

Innovative Program 22 **Sunday, October 31**
3:30 p.m.-5:00 p.m.

EMPLOYING FORMERLY HOMELESS PERSONS AS BUDDIES

Deborah Fisk, M.S.W., *Clinical Coordinator, New Haven Access, 566 Whalley Avenue, New Haven, CT 06511*; Dawn Johnson, B.A., *Outreach Worker and Case Manager, Columbus House, 200 Columbus Avenue, New Haven, CT 06511*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, participants should be able to recognize the value of employing consumers of psychiatric services in mental health agencies and clinical projects, and recognize that these consumers bring a unique expertise to clinical care that should be valued.

SUMMARY:

Researchers have documented that consumers of mental health services have made valuable contributions to

rehabilitative projects that serve persons with mental illness and have advocated that mental health agencies employ consumers in their agencies and clinical projects. Building on their experiences employing consumers and as employed consumers on a federally funded homeless outreach team, these presenters developed a consumer-operated project known as the Buddies Project. One current outreach team client and one transferred client were employed to be "buddies" with homeless persons with mental illness who have been only moderately engaged with an assertive homeless outreach team. The "buddy" spends four to six hours each week participating in mainstream social activities with assigned clients. It is hoped that this unique relationship can provide the additional support necessary to help these clients secure permanent housing and agree to receive outpatient clinical treatment services.

TARGET AUDIENCE:

Mental health professionals, consumers and family members.

REFERENCES:

1. Davidson L, Weingarten R, Steiner J, Stayner D, Hoge MA: Integrating prosumers into clinical settings, in Consumers as Providers in Psychiatric Rehabilitation: Models, Applications and First Person Accounts. edited by Mowbray International Association of Psychosocial Rehabilitation Services, 1997.
2. Dixon L, Krauss N, Lehman A: Consumers as service providers: the promise and challenge. Community Mental Health Journal 1994; 30:615–634.

Innovative Program 23 **Sunday, October 31**
3:30 p.m.-5:00 p.m.

A NOVEL ADDITION TO CONTINUITY OF CARE: ONE COMMUNITY'S APPROACH TO CARE FOR THE CHRONIC MENTALLY ILL

Mark E. Hickman, Ph.D., *Director, Residential Services, Center for Behavioral Health, 645 South Rogers Street, Bloomington, IN 47403*; Sylvia J. Dennison, M.D., *Chief, Addiction Section, Department of Psychiatry, University of Illinois at Chicago, 912 South Wood Street, NPI Room 521, MC-913, Chicago, IL 60612*; Linda Groce, R.N., B.S.N.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, participants will understand alternatives to hospitalization and their relative efficacy. In addition, they will be familiar with a novel program to fill the gaps in continuity of care.

SUMMARY:

The authors present results of a program designed to fill a perceived gap in local continuity of services. The program features 24-hour accessibility, around-the-clock nursing and case management services, and daily MD or CNS visits for medication management or detoxification services. Clients may come for a few hours or a few days and are encouraged to use the drop-in center for nonemergency issues in place of the more expensive emergency room. Utilization review reveals (1) general nursing services are utilized more heavily than specialty psychiatric nursing; (2) of 994 visits, 395 provided an alternative to hospitalization; (3) the cost of rendering care for chronically mentally ill clients in the drop-in center showed a 35% decrease compared with hospitalization. Emergency room visits by chronically mentally ill clients who had previously used this resource for social and other nonemergency purposes decreased by nearly one quarter as well. An additional, unforeseen benefit of the drop-in center is that of providing a safe first step for clients being discharged from state psychiatric facilities. The authors discuss program implementation and barriers thereto, funding sources, and give preliminary patient outcome data.

TARGET AUDIENCE:

Psychiatrists, psychologists, nursing staff and mental health technicians

REFERENCES:

1. Creed F, Mbaya P, et al: Cost effectiveness of day and inpatient psychiatric treatment: results of a randomized controlled trial. British Medical Journal 1997; 314:1381–1385.
2. Lehman AF, Dixon LB, et al: A randomized trial of assertive community treatment for homeless persons with severe mental illness. Archives of General Psychiatry 1997; 54:1038–1043.

Innovative Program 24 **Sunday, October 31**
3:30 p.m.-5:00 p.m.

TLC: TOWARD LOCAL CARE

Paul A. Deci, M.D., *Associate Professor, Department of Psychiatry, Medical University of South Carolina, Charleston VA Medical Center 11-C, 109 Bee Street, Charleston, SC 29401*; Mary B. Curlee, M.S.W., *Program Coordinator, South Carolina Department of Mental Health, 7901 Farrow Road, Columbia, SC 29203*; John J. Connery, M.A.; Gail N. Mattix, M.S.W.

EDUCATIONAL OBJECTIVES:

At the conclusion of this innovative program, the participant should be able to determine replication possibilities and resource contacts, outline a planning strategy for program development, describe a homeshare program model, and identify program, client, and cost outcome indicators.

SUMMARY:

The South Carolina Department of Mental Health is developing a mental health care system built around quality community-based services with less reliance on large, centralized institutions. This transition effort is called "Toward Local Care," or TLC. The innovative program will describe the planning, implementation, and results of the transitional movement that made it possible to reduce hospital census, and for severe and persistently mentally ill patients to return to community living. The presenters will highlight a model program, Homeshare, which offers the flexibility to tailor a placement to an individual's desires and needs for a successful community living experience. The participants will receive information on program and client data gathered from seven years of TLC project operation. This innovative program exposes participants to a proven, effective consensus process to achieve reform from a traditional hospital-based system into an individualized rehabilitative community-based system. The ongoing evaluation evidences success in goals of decreasing hospital bed utilization, implementation of cost-effective programs, and positive results on quality of life and consumer satisfaction indicators. The planning methods, projects, and outcomes are potentially replicable in a small or large system of care. There will be planned and spontaneous opportunity throughout the workshop for questions and sharing of experiences and ideas on the information presented.

TARGET AUDIENCE:

Clinicans, program administrators, and program planners.

REFERENCES:

1. Deci PA, Bevilacqua JJ, Morris JA, Dias JK: Community service development for consumers in long-stay psychiatric hospitals in SC. International Journal of Law & Psychiatry, 1996; 19:265–287.
2. Deci PA, Mattix GN: Homeshare: the forgotten alternative, in Innovative Services for Difficult to Treat Populations. Edited by Henngeler SH, Santos AB. Washington, DC, American Psychiatric Press, 1997.

INNOVATIVE PROGRAMS: SESSION 9 ACTIVE INTERVENTIONS: OUTCOMES

Innovative Program 25 Monday, November 1 8:00 a.m.-9:30 a.m.

FROM HOMELESS TO HOUSED: ENCOURAGING RESOCIALIZATION

Michelle May, M.S.W., *Program Director, Calvary Shelter, Inc., 928 5th Street, N.W., Washington, DC 20001*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, participants should be able to identify strategies for developing individual and group programming to encourage re-integration into community living, what to look for in site selection, and how to manage personality conflicts within the program.

SUMMARY:

This seminar will discuss effective methods of encouraging formerly homeless women to re-learn socialization skills in permanent housing settings through program development and location selection.

Calvary Women's Shelter developed a permanent housing program through funding from HUD for Shelter Plus Care housing two years ago. Housing was targetted to women with substance abuse problems and HIV/AIDS (who also had co-occurring depressive and trauma disorders) and was oriented in one- and two-bedroom apartments with no staff on site.

Although women entered the program with minimal time in recovery from substance abuse, most were able to minimize relapse through developing community support systems, which were programmed by the shelter staff to include individual and group activities with and without staff supervision. In addition, women were given assignments to contact other members of their community outside of these regular program activities in order to increase their ability to socialize independently from the program's routine.

The housing site was located in a safe neighborhood, and apartments were scattered within a large complex in order to discourage women from isolating themselves from the rest of the neighborhood and to encourage normalization.

TARGET AUDIENCE:

Program staff and managers, including social workers, counselors, and therapists who provide services or work in residential settings.

REFERENCES:

1. Moneyham L, et al: Perceptions of stigma in women infected with HIV. AIDS Patient Care and STDS, 1996; 10:162–67.
2. O'Connor PG, Samat JH: The substance using human imunodeficiency virus patient: approaches to outpatient management. American Journal of Medicine 1996; 101:435–444.

Innovative Program 26 Monday, November 1 8:00 a.m.-9:30 a.m.

REPORT FROM AN INTENSIVE OUTPATIENT CLINIC: YEAR ONE

Mark H. Townsend, M.D., *Associate Professor of Psychiatry, Louisiana State University School of Medicine, 1542 Tulane Avenue, Box T4-6, New Orleans, LA 70112-2825*; Janet E. Johnson, M.D., *Assistant Professor of Psychiatry, Tulane University Medical Center, 1440 Canal Street, New Orleans, LA 70112*; William W. Malone, M.P.H.; M. Diane Leblanc, M.S.W.; Elaine Spencer-Carver, M.S.W.

EDUCATIONAL OBJECTIVES:

At the conclusion of this innovative program, the participant should be able to discuss benefits of intensive outpatient treatment and to have a tentative understanding about how to start such a clinic at his or her own site.

SUMMARY:

Members of this panel will discuss the lessons they have learned in developing and opening an intensive outpatient behavioral health clinic for the seriously mentally ill. The clinic is affiliated with an urban public hospital with 110 acute-care psychiatry beds and was designed to assure continuity of care between inpatient and outpatient mental health providers. Neither a partial hospital nor an assertive outreach program, the clinic provides intensive but time-limited services to consumers who are not yet able to return to routine community mental health care. The clinic works to avert quick readmission among high-utilization consumers as well as to stabilize consumers who have experienced a serious exacerbation. The panel will take the audience through the various stages in the development of the clinic, from conceptualization to practice to preliminary measures of outcome. This innovative program will be highly interactive, and the opinions and experiences of the audience will be solicited and expected. The panel consists of members of the psychiatry faculties of the two medical schools that participate in the clinic and the administration of the hospital itself.

TARGET AUDIENCE:

Mental health providers and consumers.

REFERENCES:

1. Olfenson M, et al: Linking inpatients with schizophrenia to outpatient care. Psychiatric Services 1998; 49:911–917.
2. Chen A: Noncompliance in community psychiatry: a review of clinical interventions. Hosp Community Psychiatry 1991; 42:282–287.

Innovative Program 27 Monday, November 1 8:00 a.m.-9:30 a.m.

INFIDELITY TO THE ASSERTIVE COMMUNITY TEAM MODEL: CONSEQUENCES FOR LOUISIANA

Leslie M. Snider, M.D., *Assistant Professor, Department of Psychiatry, Tulane University Medical Center, 1440 Canal Street, New Orleans, LA 70112*; Edward Faust, M.S.W., *Program Manager, St. Charles Assertive Community Treatment Team, 1809 West Airline Highway, La Place, LA 70068*; Robert G. Ellis, M.D.; Daisy Gray; Nancy Pherigo, R.N.; Jason Gray, L.P.N.; Joel S. Feiner, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this innovative program, the participants should be able to describe the necessary elements of successful ACT programs and critically examine models of ACT based on the experience of SCAT in rural Louisiana. Participants should be able to demonstrate an understanding of the challenges to maintaining quality, intensive community mental health services in an era of limited resources and demands for expansion to greater numbers. An understanding of the ACT experience in Louisiana, as contrasted with other programs, will assist other community practitioners and program planners in the development and maintenance of the "gold standard" of care for the seriously mentally ill in their own states.

SUMMARY:

The St. Charles Assertive Community Treatment Team (SCAT) is an innovative public mental health program created under the ACT model of care in the bayous of rural Louisiana. Developed in 1994, SCAT is the first ACT model to be implemented in Louisiana and has served as the model of quality, comprehensive, community-based services in the state. SCAT has provided an invaluable service to rural Louisiana residents with serious mental illness who lack public transportation to mental health clinics, adequate housing, and other social service resources. Success has been seen in access

to mental health care for previously untreated persons, improved quality of life, improved general health status, and decreased recidivism to jails and hospitals.

A restructuring of SCAT in the summer of 1998 expanded outreach services by the staff to selected clients from clinics in the surrounding four parishes, in addition to the core SCAT clients. This expansion came without an increase in staff or resources. In this presentation, we will examine the consequences of the dilution of SCAT services, including deviations from the ACT model (client-staff ratios, level and intensity of services), programmatic coping strategies, staff and consumer morale, and outcomes research data.

REFERENCES:

1. McGrew J, Bond G: The associations between program characteristics and service delivery in Assertive Community Treatment. Administration and Policy in Mental Health 1997; 25:176.
2. McDonel E. et al: Implementing Assertive Community Treatment programs in rural settings. Administration and Policy in Mental Health. 1997; 25(2):154.

INNOVATIVE PROGRAMS: SESSION 10 INNOVATIONS FROM NORTHERN CHICAGO

Innovative Program 28 Monday, November 1 10:00 a.m.-11:30 a.m.

THE COOK COUNTY JAIL PROJECT

Carl Alimo, Ph.D., *Cermack Mental Health, 28 South California Boulevard, Chicago, IL 60608*; Joel M. Silberberg, M.D.; Daniel J. Luchins, M.D.; Ronald Simmons, Psy.D.; Thomas A. Simpatico, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this innovative program, the participant should: (1) understand that the Cook County Jail has become a key component in the functional system of mental health care in Chicago; (2) understand some of the key strategies that have allowed three large bureaucracies (city, county, and state) to work together in the interest of good patient care; (3) understand how this collaboration has dramatically improved patient care.

SUMMARY:

This innovative program will describe the effectiveness of a project being piloted in northern Chicago designed to move persons with serious and persistent mental illness who are prisoners at the Cook County Jail back into the community. An analysis of the movement patterns of the chronic mentally ill in northern Chicago will be discussed. Likely ways in which patients are lost to follow-up will be described. The interaction of the Chicago Police Department and the Cook County criminal justice system will be described in detail. A distinction will be proposed between the "conventionally" chronic mentally ill and the chronically mentally ill with significant propensity toward criminality. A discussion of the pilot project will show how city, county, and state bureaucracies are working together to screen approximately 12,000 inmates daily in order to identify those who will be relinked with community agencies. The impact on recidivism and treatment compliance will be described. All aspects of the presentations will be made with exportability in mind. The panel will facilitate a discussion of how elements of the project might be implemented in the communities of audience members.

REFERENCES:

1. Teplin LA: The prevalence of severe mental disorder among male urban jail detainees: comparison with the Epidemiological Catchment Area program. American Journal of Public Health. 1994; 80:663–669.
2. Travis J: The mentally ill offender: viewing crime and justice through a different lens. Presented at a conference of the National Association of State Forensic Mental Health Directors, Sept, 1997. US Office of Justice Web page.

Innovative Program 29 Monday, November 1 10:00 a.m.-11:30 a.m.

EVOLVING A SYSTEM OF CARE FOR THE DEAF MENTALLY ILL

Khen Nickele, M.S.W., *Network Staff, Chicago Read Mental Health Center, 4200 North Oak Park Avenue, Chicago, IL 60634*; Teri Hedding, *Coordinator of Deaf Systems, Chicago Read Mental Health Center, 4200 North Oak Park Avenue, Chicago, IL 60634*; Thomas A. Simpatico, M.D.; Bruce Munroe-Ludders

EDUCATIONAL OBJECTIVES:

At the conclusion of this innovative program, the participant should be able to promote: (1) an understanding of some of the aspects of deafness and deaf culture that challenge the ability to provide effective mental health care; (2) familiarity with some of the strategies Illinois is using to develop its statewide system of care for the chronic mentally ill who are deaf or hard of hearing.

SUMMARY:

This innovative program will describe how a system of care for the deaf and hard-of-hearing mentally ill is rapidly evolving in Illinois. In describing the evolutionary steps of this system, panel members will point out

obstacles that are commonly encountered by mental health providers working with deaf and hard-of-hearing patients. Clinical vignettes will illustrate problem situations that commonly occur, and easy to implement solutions will be suggested. The benefits of creating a system of support for mental health care providers working with the deaf will be described. Several such systems will be discussed, including the statewide system that is rapidly developing in Illinois. The description of these systems will emphasize: (a) key elements any system for working with the deaf mentally ill should have, (b) avoidable obstacles to access of services commonly encountered by the deaf mentally ill, (c) the need to have a working knowledge of deaf culture in order to provide effective mental health care to the deaf. All elements of the presentations will be designed to promote general discussion. Particular attention will be paid to what might be effective strategies for audience members to use in their areas of practice.

REFERENCES:

1. Hindley P: Psychiatric aspects of hearing impairments. Journal of Child Psychology and Psychiatry 1997; 38:101–117.
2. Myklebust HR: The Psychology of Deafness. New York, Grune & Stratton, 1960.

Innovative Program 30 Monday, November 1 10:00 a.m.-11:30 a.m.

OUTPATIENT COMMITMENT PROJECT OF NORTHERN CHICAGO

Mark Heyrman, J.D., *Professor of Law, University of Chicago, 6020 South University Avenue, Chicago, IL 60637*; Thomas A. Simpatico, M.D.; Patricia Hanrahan, Ph.D.; Daniel J. Luchins, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this innovative program, the participant should: (1) appreciate the clinical benefits outpatient commitment offers, (2) understand why OPC programs are often unsuccessful, (3) understand the particular design elements that are helping a pilot project in northern Chicago promote the consistent and systemic use of OPC.

SUMMARY:

A brief survey of the history of outpatient commitment will lead to the description of a pilot project currently underway in northern Chicago. The design elements of the project will be emphasized, particularly those that are felt to be innovative and substantially leading to the success of the project. Specific case vignettes will be used to illustrate the utility of outpatient commitment and to underscore how the success or failure of this instrument is directly linked to the effectiveness with which all components of the functional system of care are communicating. Key elements of what should constitute the functional system of mental health care in a large urban setting will be proposed. A discussion regarding the exportability of this pilot project will invite the audience members to relate their own experiences with outpatient commitment. Clinical, legal, and ethical dilemmas regarding outpatient commitment will be introduced in order to spark general discussion.

REFERENCES:

1. Swartz MS, Burns BJ, Hiday VA, George LK, Swanson J, Wagner HR: New directions in research on involuntary outpatient commitment. Psychiatric Services 1995; 46:381–395.
2. Torrey EF, Kaplan RJ: A national study of the use of outpatient commitment. Psychiatric Services 1995; 46:778–784.

Lecture 1 **WITHDRAWN**

Lecture 2 **Friday, October 29**
8:00 a.m.-9:30 a.m.

A COMPREHENSIVE INTERVENTION PROGRAM FOR MALTREATED INFANTS AND TODDLERS

Charles H. Zeanah, Jr., M.D., *Professor of Psychiatry and Pediatrics, and Director of Child and Adolescent Psychiatry, Tulane University School of Medicine, 1440 Canal Street, TB-52, New Orleans, LA 70112*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to list four systems for which it is necessary to intervene on behalf of young children in foster care; the lcarner will be able to provide two reasons why a relationship approach is necessary when intervening with young children in foster care.

SUMMARY:

This presentation describes preliminary results from a comprehensive intervention program for maltreated infants and toddlers in foster care in New Orleans. The program represents a unique partnership between state government, a community human service agency, and a medical school department of psychiatry. Supported in part by state government as an innovative demonstration program, the program also has supplemental funding from several private foundations. The program is staffed by a multidisciplinary team of faculty and trainees who share expertise in infant mental health. The Infant Team works collaboratively with a variety of systems affecting the lives of high-risk infants and toddlers, including legal, child welfare, health care, educational, and mental health care systems. The goals of the program are to reduce the length of time that children less than 48 months of age spend in foster care and to reduce rates of maltreatment recidivism in this population.

REFERENCES:

1. Larricu JA, Zeanah CH: Intensive intervention for maltreated infants and toddlers in foster care. Child and Adolescent Psychiatric Clinics of North America 1998; 7:357-371.
2. Zeanah CH, Larrieu JA, Vallicre J, Heller SS: Relationship assessment in infant mental health, in Handbook of Infant Mental Health, 2nd edition. Edited by Zeanah CH, New York, Guilford Press, (in press).

Lecture 3 **Friday, October 29**
10:00 a.m.-11:30 a.m.

PSYCHOPHARMACOLOGY AND PSYCHOTHERAPY: COLLABORATIVE TREATMENT

Michelle B. Riba, M.D., *Vice Chair, APA Institute Scientific Program Committee, Secretary, APA Board of Trustees, and Associate Chair for Education and Academic Affairs, Department of Psychiatry, Michigan University Medical Center, 1500 East Medical Center Drive, Ann Arbor, MI 48109-0704*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to review the background and stages of development regarding collaborative treatment, provide specifics regarding the opportunities and problems in providing such treatment, and use clinical examples to explore legal, ethical, and clinical issues in collaborative treatment.

SUMMARY:

Psychiatrists have provided psychotherapy to patients with a wide variety of disorders for most of this century. With the advent of newer, more powerful and more effective medications, psychopharmacology has joined psychotherapy as an integral part of the treatment provided by psychiatrists. Other clinicians have also increasingly provided psychotherapy—social workers, psychologists, nurses, counselors—with varying degrees of relationships with psychiatrists. Some nonphysician clinicians have chosen to collaborate with primary care physicians, for example. Many psychiatrists have chosen to focus on medication management and collaborate with other clinicians who provide patients with psychotherapy treatment. The area of collaborative or split treatment has burgeoned due to many factors—managed care, heightened awareness of the need for both psychotherapy and medication, increased numbers of clinicians who provide treatment changes in reimbursement, etc. This lecture will provide insights into collaborative treatment, the opportunities and perils for clinicians and patients, and underscore some of the needed research.

REFERENCES:

1. Goldman W, McCulloch J, Cuffel B, et al: Outpatient utilization patterns of integrated and split psychotherapy and pharmacotherapy for depression. Psychiatric Services 1998; 49:477-482.
2. Appelbaum PS: General guidelines for psychiatrists who prescribe medication for patients treated by nonmedical psychotherapists. Hospital and Community Psychiatry 1991; 42:281-282.

Lecture 4 **Friday, October 29**
10:00 a.m.-11:30 a.m.

FROM EXCLUSION TO INCLUSION: EVOLUTION OF PSYCHIATRIC CARE OF PERSONS WITH MENTAL RETARDATION

Ludwick S. Szymanski, M.D., *Director of Psychiatry, Institute for Community Inclusion, Children's Hospital of Boston, Massachusetts, and Associate Professor of Clinical Psychiatry, Harvard Medical School, 53 West Boulevard Road, Newton, MA 02159-1218*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session the participants will acquire understanding of the principles of modern services to persons with developmental disabilities and principles of developmental neuropsychiatry.

SUMMARY:

In the past, the individuals who had mental retardation were *excluded* from the mainstream of community life, deemed unable to participate in it, and often lived in large, residential institutions. They were excluded from psychiatric care, deemed unable to benefit from it, or at best received neuroleptics in order to render them docile. In contrast, the goal of the current approach is *inclusion* of all disabled persons in the life of the community. Psychiatrists are expected to provide full range of psychiatric treatment for mental disorders comorbid with mental retardation with the goal of facilitating the inclusion and maximizing the patient's quality of life. It is hoped that in the near future basic competence in psychiatry of developmental disabilities (developmental neuropsychiatry) will become *included* in the fund of knowledge of every psychiatrist, rather than being the domain of a few, subspecialists. This field also offers excellent opportunities for acquiring skills important for every psychiatrist in care of every patient, such as a developmental approach to psychopathology and biopsychosocial integration in diagnosis and treatment.

REFERENCES:

1. Crocker AC: Exceptionality. Developmental and Behavioral Pediatrics 1998; 19:300-305.
2. Szymanski LS, Wilska M: Mental retardation, in Psychiatry. Edited by Tasman A, Lieberman J. Saunders Publishing Co., 1997.

Lecture 5 **Friday, October 29**
1:30 p.m.-3:00 p.m.

CLINICIAN-PATIENT RELATIONSHIP: WHAT IS ESSENTIAL?

Roger Peele, M.D., *Clinical Professor of Psychiatry, George Washington University School of Medicine, 8002 Lions Crest Way, Gaithersburg, MD 20879-5637*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant will be able to state the essential ingredients of effective physician-patient relationships.

SUMMARY:

Many health-care, public-policy positions are designed to preserve the physician-patient relationship. Most of these positions are not explicit, however, as to what should be preserved and what the benefits are of preserving the relationship. Only the need for confidentiality of the relationship has received any attention in public debates.

Beyond confidentiality, there are other essentials: (1) compassion, (2) commitment to the welfare of the patient, (3) a sense of control of the illness, (4) championing the patient's interest, and (5) having the knowledge and skills to provide competent care and treatment. Competence is tied to an ability to develop the hermeneutics and rhetoric that the patient can believe and can feel is fundamental to his or her illness and well-being. The benefits of enriching the relationship are enormous, and anything that diminishes the relationship adds enormously to the costs of health care. The implications of these essentials for public policy will be explored.

REFERENCES:

1. Frank JD, Frank JB: Persuasion and Healing: A Comparative Study of Psychotherapy. Baltimore, Johns Hopkins University Press, 1991.
2. Shapiro AK, Shapiro E: The Powerful Placebo. Baltimore, Johns Hopkins University Press, 1997.

Lecture 6 **Friday, October 29**
1:30 p.m.-3:00 p.m.

COMPLIMENTARY THERAPIES IN THE PRACTICE OF PSYCHIATRY

Nalini V. Juthani, M.D., *Director of Psychiatry Education, Bronx-Lebanon Hospital, and Associate Professor of Psychiatry, Albert Einstein College of Medicine, 1276 Fulton Avenue, Fourth Floor, Bronx, NY 10456*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should have knowledge about commonly used complimentary therapies and learn about some of the postulated theories as to why patients resort to alternatives, develop greater awareness of the nature of and potential efficacy of complications of alternative therapies, and stimulate further dialogue among psychiatric community regarding future research regarding potential value of complimentary therapies.

SUMMARY:

Complimentary therapies are those modalities of treatment used as an adjunct to conventional medical treatments. Complimentary therapies include herbal remedies, homeopathy, spiritual healing, massage therapy, ayurvedic treatment, yoga, meditation, mind-body connection, etc. There is a growing demand in our society for wellness and healing through reconnection of mind-body and spirit. This lecture will discuss commonly used alternative treatments for psychiatric conditions and address theories that have been proposed to explain the increasing use of these therapies. It will provide useful information to conventional health care professionals about the health beliefs, values, attitudes, and motivations underlying their patients' decision to use alternative therapies. These patients apparently seem quite willing to pay out of pocket for such therapies, and the therapies are perceived to be innocuous. However, serious complications are now being reported with some herbal remedies. Our challenge as caregivers is to respond to the growing popularity of complimentary therapies and complex societal factors that nurture their usage.

REFERENCES:

1. Astin JA, Why patients use alternative medicine: results of a national study. JAMA, 1998, Vol 279:19.
2. Fugh-Berman, A: Alternative Medicine—What works. Baltimore, Williams & Wilkins, 1997.

Lecture 7 **Friday, October 29**
3:30 p.m.-5:00 p.m.

FREUD MEETS REALITY: EFFECTIVE CHANGES IN CLINICIANS' ATTITUDES IN AN INNER-CITY MENTAL HEALTH CENTER

Harvey Bluestone, M.D., *Member, APA Institute Scientific Program Committee, and Director of Psychiatry, Bronx-Lebanon Hospital Center, 1285 Fulton Avenue, Bronx, NY 10456-4302*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, participants should understand the depth of feeling therapists have to their calling, which involves core values, and both professional and personal identity; and learn approaches required to alter attitudes and behavior.

SUMMARY:

Clinicians trained in the traditional modes of 20th century psychodynamic psychotherapy are struggling to adapt to a fiscally driven 21st century approach. A major area where this struggle to adapt is occurring is in mental health clinics. For four years Bronx-Lebanon Hospital's department of psychiatry has been attempting to make the changes necessary to save a financially troubled, previously free-standing clinic and make it viable for the 21st century realities of mental health center practice.

The newer model of treatment is a more focused, pragmatic methodology with an emphasis on target symptoms. It uses medication and short-term rather than long-term approaches. Additionally, the clinicians who essentially functioned as individual practitioners were required to accept the responsibility of working collaboratively with other mental health professionals and with administrators in a cohesive organization. Attempts at change met massive resistance. This resistance represented a defense of their core identity as a psychotherapist understanding the basis of this resistance and utilizing various educational and interpersonal techniques we have achieved some success in what remains a work in progress.

REFERENCES:

1. Rosenheck R, Armstrong M, Callahan D, Dea R, et al: Obligation to the least well off in setting mental health service priorities: A consensus statement, Psychiatric Services 1998; 40:1273-1290.
2. Plakun EM: Treatment of personality disorders in an era of limited resources. Psychiatric Services 1996; 47:128-130.

Lecture 8 **Friday, October 29**
3:30 p.m.-5:00 p.m.

SOCIAL DEVELOPMENTAL ISSUES IN ADOLESCENTS

Charles W. Huffine, Jr., M.D., *President, American Association of Community Psychiatrists, and Assistant Medical Director for the Children and Adolescents Program, King County Mental Health Division, 3123 Fairview Avenue, East, Seattle, WA 98102-3051*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize adolescent development as primarily social, understand its functions and the historical forces giving rise to adolescence. They should also understand the implications of the social developmental process on our nosological system and on the evaluation and treatment of psychiatric disorders in adolescence.

SUMMARY:

Adolescence is a social phenomenon born of the social upheavals of the industrial revolution. It serves to provide more time for individuals to prepare to participate in a more complex economy and social order. Central to developmental task of adolescence is the attainment of a personal identity and an ability to exercise personal

choice in determining the course of one's life. This has liberated each individual in society to realize his or her full potential. It has also enhanced economic and intellectual progress as individuals develop flexibility and adaptability. These developmental tasks are essentially social in nature. They determine the individual's relationship with their community. But they are daunting and filled with risk. Most adolescents suffer some anxiety and feelings of anomie. Many youth experience barriers to their social development. In reality they don't have choices due to adverse socioeconomic circumstances or constitutional limitations such as an emotional disorder. Frustrations in the process of adolescent development are expressed behaviorally, since behavior is the vehicle for social expression. The outrageous behavior of some very disturbed youth carries social meaning understood at some level by all adolescents. Through media attention and their iconic quality, certain youth behaviors become incorporated into the styles, affectations, and music of normally developing teens. Clinically we find that some adolescents succumb to the stresses and frustrations of adolescence. The incidence of youth suicide and anorexia nervosa appear to have risen coincident with the emergence of adolescence. Many other adolescents express the symptoms of psychiatric disorders in social developmental language. This tends to obscure their presence.

Most disruptive behavior disorder diagnoses are of doubtful benefit to our nosological system because they are blind to the developmental processes. Their behavioral criteria are in reality the social and developmental expression of other psychiatric illnesses. Psychiatrists must be mindful of the social context of their adolescent patients and evaluate and treat teenagers within their communities. Adolescent therapists cannot remain aloof from a teenager's life. The best treatment occurs at a teen's school, recreational programs, or with family. It is wise to include peers and other significant adults in the treatment. Group modalities are most congruent with an adolescent's social-developmental tasks. Providing care to the most disturbed youth in our community has meaning to all youth. Caring for teens who are failing by mobilizing a community and providing psychiatric leadership gives other teens a sense of safety and ameliorates the alienation so common in adolescents. Interpreting and advocating for disturbed youth helps to prevent societal backlash against all teenagers for their tendency to assault social conventions with their style, music, and provocative parodies of the adult social order. The social developmental nature of adolescence requires the skills and tools of community psychiatric practice.

REFERENCES:

1. Rakoff VM: History in adolescent disorders. Adolescent Psychiatry 1980; 8:85-99.
2. Offer D, Offer J: Three developmental routes through normal adolescence. Adolescent Psychiatry 1976; 4:121-141.
3. Stroul BA, Friedman RM: A System of Care for Children and Youth with Severe Emotional Disturbances, 2nd Ed. Wash. D.C., CASSP Technical Assistance Center, 1994.

Lecture 9 **Saturday, October 30**
8:00 a.m.-9:30 a.m.

CITY OF ONE: A MEMOIR OF GROWING UP ORPHANED

Francine Cournos,, M.D., *Professor of Clinical Psychiatry, Columbia University, 722 West 168th Street, Unit 12, New York, NY 10032*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to acquire knowledge about how children experience the illness and death of a parent and to encourage clinical approaches that best meet the emotional and practical needs of bereaved children.

SUMMARY:

This presentation will offer both a personal and professional perspective on childhood loss and its aftermath. One component of the presentation will involve the presenter reading from her recently published book, *City of One: A Memoir.* The book recounts the author's experiences with the deaths of both her parents when she was a child, her subsequent experiences as an orphan and foster child, and her adult search to make sense of her somewhat eccentric early life.

The talk will also explore the professional issues her story raises: disclosure of illness by a parent to a child; the nature of childhood bereavement; the importance of permanency planning; and the practical and emotional needs of children living with new caretakers. Suggestions for taking care of today's foster children and orphans of the AIDS epidemic will conclude the presentation.

REFERENCES:

1. Cournos F: City of One: A Memoir. New York, W. W. Norton, 1999.
2. Essential Papers on Object Loss. Edited by Frankiel RV. New York, University Press, 1994.

Lecture 10 **Saturday, October 30**
8:00 a.m.-9:30 a.m.

SCHIZOPHRENIA: THE FUNDAMENTAL QUESTIONS

Adolf Meyer Award

Nancy C. Andreasen, M.D., Ph.D., *Andrew H. Woods Chair of Psychiatry, and Director, Mental Health Clinical Research Center, University of Iowa Hospitals and Clinics, 200 Hawkins Drive, 2911 JPP, Iowa City, IA 52242-1057*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be knowledgeable about the historical concept of schizophrenia and be able to discuss the adaptation of Bleuler's unitary model to the next decade and to examine the psychophysiology and ideology of schizophrenia.

SUMMARY:

Because of its diversity of symptoms, defining the phenotype of schizophrenia is a fundamental challenge. Although this problem is often dismissed as reflecting "heterogeneity," early clinicians such as Kraepelin and Bleuler stressed that schizophrenia might in fact be defined by a "unitary process" that affects multiple mental processes, including cognition, emotions, and volition. This presentation will describe a "neo-Bleulerian" unitary model: patients with schizophrenia have a "cognitive dysmetria" that arises when a neurodevelopmental aberation disrupts the cortico-cerebellar-thalamic-cortical circuit (CCTCC), which monitors and coordinates all mental activities. This model may be useful for targeting clinical treatments and for seeking the molecular mechanisms of the illness.

The symptoms of schizophrenia encompass the entire range of psychological functions that characterize human beings. The conceptual challenge of schizophrenia is to postulate a neural mechanism that could explain this diversity of symptoms. A parsimonious contemporary model of the fundamental deficit in schizophrenia should posit an abnormality in a basic cognitive process that could explain the diverse symptoms of schizophrenia and that is mediated by specific neural circuits. Ideally, this process should be so fundamental that it can be precisely measured in humans and even modeled in animals, since animal models facilitate the testing of new medications.

Early attempts to assess cognition in schizophrenia emphasized the use of neuropsychological tests. While this approach has been useful in the study of patients with focal brain lesions, it is less applicable to many mental illnesses, which are inherently less "localizable." Consequently, newer approaches stress the use of well-conceived paradigms developed within the framework of experimental cognitive psychology. This strategy is more heuristic in examining fundamental cognitive processes such as memory or language.

This presentation will illustrate this approach by discussing the application of several experimental paradigms in PET studies of cognition in schizophrenia that use 150 H2O to measure cerebral blood flow. Specifically, this presentation will summarize data from a series of PET studies that explore multiple different cognitive processes in order to determine whether fundamental abnormalities can be observed in components of neural circuits that are task-independent. Tasks examined include recognition memory for faces, recall memory of complex narratives, and divided attention. Convergent evidence from these various studies suggests that patients suffering from schizophrenia have disruptions in the CCTCC when they perform a wide range of mental tasks.

Based on these findings, we have proposed a theory of "cognitive dysmetria" as the fundamental abnormality in schizophrenia. The CCTCC is a crucial feedback loop that modulates both motor coordination and cognitive coordination. A defect in its ability to relay information from the cerebellum to cortical regions and back to the cerebellum through pontine nuclei could lead to the "associative loosening" or aberrant mental connections that Bleuler proposed as the fundamental abnormality in schizophrenia. Early attempts to assess cognition in schizophrenia emphasized the use of neuropsychiatric research for the neural mechanism of schizophrenia, which could lead in turn to improved treatment and ultimately to early intervention or prevention.

REFERENCES:

1) Andreasen NC: Linking mind and brain in the study of mental illnesses: a project for a scientific psychopathology. Science 1997; 275:1586-1592.
2) Andreasen NC: Understanding the causes of schizophrenia (editorial). NEJM 1999; 340:645-647.

Lecture 11 **Saturday, October 30**
10:00 a.m.-11:30 a.m.

ADVOCATING FOR THE MENTALLY ILL

Edward F. Foulks, M.D., Ph.D., *Consultant, APA Institute Scientific Program Committee, and Sellars-Polchow Professor of Psychiatry and Associate Dean for Graduate Medical Education, Tulane University, 1430 Tulane Avenue, SL-77, New Orleans, LA 70112-2699*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participants should understand the cultural factors perpetuating stigma toward people with mental illness, understand

the mission of two major mental health advocacy organizations in the United States, and be knowledgeable about the role of the psychiatrist in building coalitions with advocacy groups.

SUMMARY:

The remarkable advances in biomedical technology over the past decade have ignited the public expectation of better more accessible health care. In psychiatry, the development of new-generation antipsychotic and antidepressant medications has inspired renewed hope in patient/consumers and their families that serious and prolonged mental illness can be treated effectively. Provided with these new effective treatments, people who suffer from mental illness can now recover, leave the hospital, and return to society.

Unlike people who are recovering from other illnesses, however, those with mental illness face a legacy of stigma and discrimination from acquaintances and neighbors and in obtaining housing, employment, and adequate follow-up care. Providers of psychiatric services and their patients have been "carved out" of governmental health care allocations, private insurance, and managed care policies. They have been treated differently, usually with more restricted resources and consideration than others in the health care system.

This presentation will address the social and cultural contexts that have been historically associated with stigma and discrimination toward people who have mental illness, as well as recent advocacy movements such as NAMI (formerly, the National Alliance for the Mentally Ill) and the National Mental Health Association. These groups have become increasingly effective in bringing about the social reforms required to insure the adequate treatment and care of people suffering from mental disorders in our society today. The current advocacy activities of each of these organizations will be presented for the purpose of exploring how psychiatrists are involved in active support of those issues.

REFERENCE:

1. Dain N: Reflections on antipsychiatry and stigma in the history of American psychiatry. Hospital & Community Psychiatry 1994; 45:1010-1014.
2. Sommer R: Family advocacy and the mental health system: the recent rise of the Alliance for the Mentally Ill. Psychiatric Quarterly 1990; 61:205-221

Lecture 12 **Saturday, October 30 1:30 p.m.-3:00 p.m.**

DISEASE MANAGEMENT AND THE FUTURE OF PSYCHIATRY

Arthur M. Freeman III, M.D., *Chair and Professor, Department of Psychiatry, Louisiana State University Medical Center at Shreveport, P.O. Box 33932, Shreveport, LA 71130-3932*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session the participant should be able to: understand the basics of disease management, understand how clinical and financial goals are intertwined, understand the essentials for development of a disease management program, learn to integrate evidence based medicine with clinical practice guidelines based on ongoing outcomes measurement, and learn how psychiatric disorders can be managed using these concepts.

SUMMARY:

In recent years disease management has been used for a number of medical conditions including several in psychiatry. The goal of this process is to bring together evidence-based medicine into state of the art practice guidelines which, in turn, are continuously improved by clinical outcomes measurement. Disease management involves integrating clinical information with financial data to support the best medical care at the most reasonable cost. Emphasis is placed upon prevention, education, and a reengineering of medical management. Population based medicine becomes more important than care for the individual. This paradigm shift is troubling to many physicians. Nonetheless, disease management is worthy of consideration in such psychiatric disorders as depression, schizophrenia, Alzheimer's disease, and ADHD. If done prudently, with physician acceptance of the concept, it may well prove to be of great benefit for the future of psychiatry.

REFERENCE:

1. Couch JB: The Physician's Guide to Disease Management. Aspen Publishing, Inc., 1997
2. Disease Management: A Systems Approach to Improving Patient Outcomes. Edited by Todd WE, Nash D. American Hospital Publishing, 1997.
3. Disease Management Directory and Guidebook. National Health Information, LLC, 1999.

Lecture 13 **Saturday, October 30 1:30 p.m.-3:00 p.m.**

MANAGING CARE IN EUROPE: SAME ANIMAL, DIFFERENT FUR?

John A. Talbott, M.D., *Consultant, Institute Scientific Program Committee, and Professor and Chair, Department of Psychiatry, University of Maryland School of Medicine, PP-AP, 701 West Pratt Street, Suite 388, Baltimore, MD 21201*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session the participant should understand how managed care is conceptualized and implemented in several European countries.

SUMMARY:

The presentation will discuss the history of the administrative and fiscal development of health, particularly mental health, services in Europe versus the United States. It will then deal with the similarities and differences between "managed care" and "managing care" on both sides of the Atlantic. Finally, it will make some predictions as to future directions for managed and managing care in Europe.

REFERENCES:

1. Talbott JA: Rehabilitation and managed care: how American developments can change European mental health. La Rehabilitacio Psicosocial Integral 1995; 1:80-84.
2. Talbott JA: De La Deinstitutionalization Au "Managed Care": Etude de l'impact aux Etats-Unis des changements economiques sur le traitement des malades mentaux depuis 1950. L'Information Psychiatrique 1997; 8:806-812.

Lecture 14 **Saturday, October 30**
3:30 p.m.-5:00 p.m.

SELLING SANITY THROUGH GENDER: THE VISUAL HISTORY OF PSYCHOTROPIC ADVERTISEMENTS

Jonathan M. Metzl, M.D., *Senior Lecturer, Departments of Psychiatry and Women's Studies, and Director, Interdisciplinary Institute, University of Michigan, 1150 West Medical Center Drive, Ann Arbor, MI 48109-0726*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to consider the ways in which pharmaceutical advertisements for psychotropic medications have used gender stereotypes to promote their products; to identify ways that the tools of visual analysis help us understand these stereotypes.

SUMMARY:

"Direct-to-the-consumer" advertisements for antidepressants that have appeared in many women's magazines have been the subject of much recent controversy. Industry representatives and a few academics (Levy) argue that the cartoon "Prozac Clouds" followed by "Prozac Suns" provide important sources of "information." Bioethecists (Parens, Murphy), meanwhile, assert that these images distort the truth and dangerously trivialize serious illnesses in the name of profit.

I contend that these advertisements must be understood in historical context—and that this context is visual. I employ a methodology based in visual analysis (Garb, Olin) and medical historiography to examine themes that have appeared in medical advertisements over time. The first part of my presentation involves a discussion of the construction of "visual knowledge." I then trace the visual history of 50 years of pharmaceutical advertisements from the pages of *The American Journal of Psychiatry,* from 1949 to 1999. I focus specifically on gender. I examine the ways women are depicted, both as patients and as doctors. How do these depictions change? What do these changes reveal about notions of mental health and mental illness? And what do they reveal about an "information" that is more cultural than clinical?

REFERENCES:

1. Garb T: Bodies of Modernity: Figure and Flesh in Fin-de-Siecle France. London, Thames and Hudson, 1998.
2. Josephson SG: From Idolatry to Advertising: Visual Art and Contemporary Culture. New York, M.E. Sharpe, 1996.

Lecture 15 **Saturday, October 30**
3:30 p.m.-5:00 p.m.

COMPLEXITIES IN THE TREATMENT OF PHYSICIANS AND THEIR FAMILIES

Michael F. Myers, M.D., *Member, APA Board of Trustees, and Clinical Professor of Psychiatry, University of British Columbia, 405-2150 West Broadway, Vancouver, BC Canada V6K 4L9*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to appreciate the many biopsychosocial stressors in the lives of today's physicians and their families; to understand the many obstacles to care when a physician is ill; to recognize the complexities of treating mood disorders in physicians; and to respect the many countertransference dynamics in the treatment of physicians and their families

SUMMARY:

When physicians or their loved ones become ill, myriad forces coalesce to inform or militate against their receiving exemplary care. After a review of common workplace and family stressors in today's physicians, I will outline some of the challenges for the symptomatic physician (or family member) and for us when we are called upon to help. These include appreciating the many

obstacles to care (denial and other defenses, stigma, privacy and confidentiality fears, licensing and reporting concerns, family pride); being aware of the unique strains for residents, women physicians, rural physicians, and international medical graduates (IMGs) or members of racial, ethnic, or religious minority groups; recognizing and treating mood disorders in physicians, especially what to do when physicians treat themselves and their family members; reaching out when physicians commit suicide; and understanding the many countertransference dynamics when physicians and their loved ones become our patients.

REFERENCES:

1. Miles SH: A challenge to licensing boards: the stigma of mental illness. JAMA 1998; 280:865.
2. Myers MF: Treatment of the mentally ill physician. Position Paper of the Canadian Psychiatric Association. Canadian Journal of Psychiatry 1997; 42:Insert.

Lecture 16 **Saturday, October 30**
3:30 p.m.-5:00 p.m.

ETHICS AND THE DOCTOR-PATIENT RELATIONSHIP

Donna M. Norris, M.D., *Past Speaker of the APA Assembly, and Medical Director, Parent's and Children's Services, Boston, MA, 54 Cartwright Road, Wellesley, MA 02181-7103*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should have knowledge of the historical origins of American medical ethics; the changes in health care delivery, which have offered critical challenges to physician's practices and his/her relationship with the patient; and be able to discuss means in a discussion of maintaining the viability of the patient-doctor relationship.

SUMMARY:

Changes in the access to and delivery of medical services, and the economics of health care in recent years, compared with those of the last century, have impacted the doctor-patient relationship. This lecture will review the historical ethical tenets of the physician's duty to the patient and the conflicts presented by these changes. Discussion will also highlight the role of the media and mass communication in the increasing demand by the public for greater control and involvement in the decision-making about their personal health care. Recent interest by physicians in forming unions will also be reviewed.

REFERENCES:

1. Massachusetts Medical Society Policy: Ethical Standards in Managed Care. Adopted by the Massachusetts Medical Society House of Delegates, Nov. 8, 1996.
2. Reinhardt U: The economist's model of physician behavior. JAMA 1999; 281:462-465.

Lecture 17 **Sunday, October 31**
8:00 a.m.-9:30 a.m.

INTEGRATED TREATMENT PLANNING FOR BORDERLINE PERSONALITY DISORDER

John M. Oldham, M.D., *Director, New York State Psychiatric Institute, 1051 Riverside Drive, Unit 4, New York, NY 10032*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, participants will learn to differentiate among patients with different types of borderline personality disorder and to design integrated, combined treatment plans for individual patients with BPD.

SUMMARY:

Borderline personality disorder (BPD) is a multisymptomatic, often severely disabling condition that can present complex treatment challenges. BPD frequently cooccurs with Axis I and/or other Axis II disorders. DSM-IV-defined BPD, based on a polythetic system and a minimum requirement of five out of nine criteria, can differ markedly in phenomenology from one patient to another. Four subtypes of BPD will be described, based on different theoretical etiologies and prototypic symptoms, and the implications of these subtypes for treatment planning will be presented. Individually tailored, integrated treatment planning combining psychotherapy, psychoeducation, and psychopharmacology will be reviewed. In addition, the current status of the development of a first draft of practice guidelines for BPD by the APA Work Group on Practice Guidelines for Borderline Personality Disorder will be summarized.

REFERENCES:

1. Gabbard GO: Psychotherapy of personality disorders. Journal of Practical Psychiatry and Behavioral Health 1997; 3:327-333.
2. Soloff PH: Symptom-oriented psychopharmacology for personality disorders. Journal of Practical Psychiatry and Behavioral Health 1998; 4:3-11.

Lecture 18 **Sunday, October 31**
8:00 a.m.-9:30 a.m.

MY PATIENT IS BETTER, NOW WHAT? ISSUES IN RECOVERY AFTER RESPONDING TO A NEW ANTIPSYCHOTIC

Peter J. Weiden, M.D., *Director, Neurobiological Disorders Service, St. Lukes-Roosevelt Hospital Center, 411 West 114th Street, Suite 3-B, New York, NY 10025*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, participants will have knowledge of some of the long-term psychologic and psychosocial effects that are observed after patients with schizophrenia respond to the newer "atypical" antipsychotic medications, some of the adaptive and maladaptive responses to these effects, and some clinical interventions that can help patients negotiate these psychologic changes and get the most from their medication response.

SUMMARY:

Many patients switched to one of the newer "atypical" antipsychotics experience dramatic symptom reductions. However, with symptom improvements come new challenges. This presentation is based on clinical observations of outpatients with schizophrenia who were successfully switched to one of the newer atypical antipsychotics and experienced dramatic symptom response. Many will then go through one or more of the following challenges during recovery:

- feeling "cured"
- trying to make up for lost time
- getting overwhelmed by emotions
- feeling disconected from others
- becoming aware of existential issues

Moving through these phases often leads to a clinical crisis, which can be mistaken as being from loss of efficacy of the new medication. However, the crisis may really be from *adapting* to the medication response, and is not a *loss* of response. How the crisis resolves often seems to depend on factors that have less to do with psychopharmacology and more to do with the person's intrinsic psychologic strengths, the presence of a social network that promotes healing, and the perseverance and skills of the patient's clinicians.

REFERENCES:

1. Weiden PR, Aquila M, Emanuel A: Long-term considerations after switching antipsychotics. Journal of Clinical Psychiatry 1998; 57(Suppl 19):36-49.
2. Weiden PR, Scheifler P, Diamond R, Rose R: Breakthroughs in Antipsychotic Medications: A Guide for Consumers, families, and clinicians. New York, Norton, 1999.

Lecture 19 **Sunday, October 31**
10:00 a.m.-11:30 a.m.

CREATING SANCTUARY: EFFICIENT TREATMENT OF DIFFICULT PATIENTS

Sandra L. Bloom, M.D., *Executive Director, The Sanctuary, 200 Apple Street, Suite 1, Quakertown, PA 18951-1645*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to describe the fundamental theoretical bases for a trauma-based approach to inpatient treatment; the basic assumptions underlying a trauma-based approach to short-term inpatient treatment of a variety of disorders; and a useful model for staging treatment during a short inpatient stay.

SUMMARY:

This presentation will describe the treatment of difficult patients in a short-term, open, inpatient psychiatric unit using a trauma-based approach. The current healthcare environment presents inpatient treatment staff with particularly difficult challenges and requires a more cohesive treatment team, an agreed-upon theoretical basis for treatment, a clearly staged model of intervention, and the establishment of attainable goals for patients. An integrated approach using many modalities of treatment can be of great utility, even if lengths of stay are brief, if treatment is highly managed and goal-directed, and set within the context of an environment that emphasizes safety and affect management, psychoeducation and personal responsibility. A shared value system and clearly defined stages of treatment make it possible for acute inpatient treatment to be integrated into an overall plan of recovery. The basic tenets of this inpatient model are also highly relevant to the partial hospitalization and intensive outpatient settings, since system continuity increases the likelihood of relapse prevention.

REFERENCES:

1. Bloom SL: Creating Sanctuary: Toward the Evolution of Sane Societies. New York, Routledge, 1997.
2. Bills LJ, Bloom SL: From Chaos to Sanctuary: Trauma-Based Treatment for Women in a State Hospital Systems. In Women's Health Services: A Public Health Perspective. Edited by Levin BL, Blanch AK, Jennings A. Thousand Oaks, CA, Sage Publications, 1998.

Lecture 20 **Sunday, October 31**
1:30 p.m.-3:00 p.m.

SEXUALITY AND PSYCHOTROPIC DRUGS

Richard Balon, M.D., *Member, APA Institute Scientific Program Committee, and Professor of Psychiatry and Behavioral Sciences, Wayne State University, 2751 East Jefferson Street, Suite 200, Detroit, MI 48207*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should become familiar with the effects of psychotropic drugs on human sexual functioning; learn how to manage the effects of psychotropic drugs on sexual functioning; and learn about current therapeutic advances in treating sexual disorders with psychotropic drugs.

SUMMARY:

This presentation will review the negative and positive effects of psychotropic drugs on human sexuality, the management of the negative effects of these drugs on sexuality, and their use in some sexual disorders. Various psychotropic drugs can lead to different sexual dysfunctions, including but not limited to changes in libido and sexual response, impotence, painful ejaculation and anorgasmia. Sexual dysfunction associated with antidepressants has been the most studied; however, antipsychotics, anxiolytics, and some mood stabilizers may also cause sexual dysfunction. Management approaches to sexual dysfunction associated with psychotropic drugs include waiting for spontaneous remission, dose adjustment, partial or full drug holidays, switching to another drug, and use of antidotes. Some psychotropic drugs may have a positive effect on sexual functioning, such as increased libido. In addition, various psychotropic drugs have been used in the management of sexual disorders such as premature ejaculation (serotonergic antidepressants) and paraphilias (antipsychotics, serotonergic antidepressants).

REFERENCES:

1. Harvey KV, Balon R: Clinical implications of antidepressant drug effects on sexual functioning. Annals of Clinical Psychiatry 1995; 7: 189-201.
2. Crenshaw TL, Goldgerg JP: Sexual Pharmacology. New York, W. W. Norton & Company, 1996.

Lecture 21 **Sunday, October 31**
3:30 p.m.-5:00 p.m.

COMMUNITY PSYCHIATRY: VALUES, POLITICS AND MANAGED CARE

Harold I. Eist, M.D., *Past President, American Psychiatric Association, 5705 Rossmore Drive, Bethesda, MD 20814-2227*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to document how social, economic, and political forces interact to negatively influence psychiatric care to the disadvantaged; to demonstrate that flawed value systems have profoundly negative effects on psychiatric care in the community; and to address action on the part of community psychiatrists that can help to reduce these negative influences.

SUMMARY:

This lecture will examine how politics and social values have impacted on community psychiatry and the role managed care has played in this.

REFERENCES:

1. Annas GJ: Patients' rights in managed care—exit, voice, and choice. N Eng J Med 1997; 337:210-215.
2. Eist HI: Treatment for major depression in managed care and fee-for-service systems. Am J Psychiatry 1998; 155:859-860.
3. Morgan RO, Virnig BA, DeVito CA, Persily NA: The Medicare-HMO revolving door—the healthy go in and the sick go out. N Eng J Med 1997; 337:169-175

Lecture 22 **Monday, November 1**
8:00 a.m.-9:30 a.m.

PSYCHIATRY IN THE COMMUNITY: PREVENTION, INTERVENTION AND TREATMENT IN COLLABORATION WITH THE POLICE DEPARTMENT

Howard J. Osofsky, M.D., Ph.D., *Professor and Chair, Department of Psychiatry, Louisiana State University Medical Center, 1542 Tulane Avenue, New Orleans, LA 70112-2825*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize symptoms and sequelae that children experience after witnessing or being victims of violence; and to gain knowledge of how to develop educational, evaluation, and consultation programs in collaboration with a police department.

SUMMARY:

During the past five years, LSUMC's department of psychiatry has played a progressively larger role in working with the New Orleans Police Department. Our department has devised improved methods of evaluating prospective police officers and then, together with the police department, of reevaluating recruits in the Police Academy and during the first probationary year. To date,

the results have been very encouraging, with consistencies over time and with findings that are helpful for remediation or, when necessary, discharge.

Our Violence Intervention Program educates police officers about child development and the impact of violence exposure, maintains a 24-hour hotline for police and families, and provides over 2000 hours of crisis intervention and clinical and school-based services for children each year. Closely linked to these efforts, the police department's Cops for Kids program works with adolescents in public housing developments after school and during the summer, which has been accompanied by major decreases in petty crimes. The presentation will focus on these and related efforts with the police, the schools, and the legal system.

REFERENCES:

1. Osofsky HJ: Psychiatry behind the walls: mental health services in jails and prisons. Bulletin of the Menninger Clinic, 1996.
2. Osofsky JD, Osofsky HJ: Developmental implications of violence in youth, in Developmental and Behavioral Pediatrics, 3rd edition. Edited by Levine M, Carey WB, Crocker AC. Philadelphia, W.B. Saunders & Co., 1999, pp. 493-498.

Lecture 23 **Monday, November 1**
10:00 a.m.-11:30 a.m.

THE NEED FOR LEADERSHIP TO GUIDE RESEARCH ADVANCES

Carl C. Bell, M.D., *President and Chief Executive Officer, Community Mental Health Council, Inc., and Professor of Psychiatry, University of Illinois School of Medicine, 8704 South Constance Avenue, Chicago, IL 60617-2746*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should learn principles for providing leadership to diverse stake holders in collaborative efforts such as multisite, multidiscipline, research projects, and principles for developing community infrastructure in social groups lacking such infrastructure.

SUMMARY:

Using a Frankenstein parable, Dr. Bell will discuss issues regarding how scientific discoveries can be used for good or evil purposes. In addition, he will discuss the problem of delivering a state-of-the-art intervention to a group of people lacking a community infrastructure. The solution to this dilemma will be outlined as mobilizing workers, developing infrastructure (i.e., organizational structure and capacity for action), the development of a game plan along with implementation, process refinement, and institutionalization. This leadership involved in managing the process of developing a community infrastructure will be described as helping individuals in the social group locate and develop their Ah-Ha experience, become mission driven, develop a sense of paradigms, understand ecological relationships, and learn through cooperative learning methods. Three examples of community consultation will be given to highlight these principles and illustrate the need for leadership to guide research advances.

REFERENCES:

1. Madison SM, Bell CC, Sewell SD, et. al: Collaborating with communities in intervention and research: approaching an "ideal" partnership. Psychiatric Services, in press.
2. Senge P: The Fifth Discipline. New York, Doubleday, 1994.

Lecture 24 **Monday, November 1**
1:30 p.m.-3:00 p.m.

PHARMACOLOGICAL TREATMENTS OF ALCOHOL USE DISORDERS: PRESENT AND FUTURE

Patricia I. Ordorica, M.D., *Associate Chief of Staff, Mental Health and Behavioral Sciences, James A. Haley Veterans Affairs Hospital, 13000 Bruce B. Downs Boulevard, Tampa, FL 33612*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to identify current state of the art pharmacological treatments for alcohol dependence and identify evolving medication strategies for the treatment of alcoholism.

SUMMARY:

As we approach the new millennium, advances in the field of alcohol and drug abuse and dependence are numerous and exciting. This lecture will present a comprehensive review of pharmacological treatments for alcoholism and evolving rational and medication development strategies will be highlighted. The importance of integrated treatment strategies for these disorders will be emphasized.

REFERENCES:

1. Schukit M: Recent developments in the pharmacotherapy of alcohol dependence. Journal of Consulting and Clinical Psychology 1996; 64:669-676.
2. Miller S, Frances R: Clinical Textbook on Addictive Disorders. New York, Guilford Press, 1992.

Lecture 25 **Monday, November 1**
3:30 p.m.-5:00 p.m.

RESTRAINT AND SECLUSION REVISITED

Daniel K. Winstead, M.D., *Heath Professor of Psychiatry, and Chair, Department of Psychiatry and Neurology, Tulane University School of Medicine, 1430 Tulane Avenue # SL-23, New Orleans, LA 70112-2699*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be aware of the alternative patient management techniques to avoid the use of seclusion and restraint and the pros and cons of restraint and seclusion of the psychiatric patient.

SUMMARY:

The use of seclusion and physical restraints have been a part of American medicine since the founding of the Public Hospital at Colonial Williamsburg. Recent media reports of deaths and physical or emotional injury from restraints have prompted a review of their use, safety, and regulation. Although these interventions can be life-saving and injury-sparing in an emergency, they are often viewed as barbaric and cruel. Nevertheless, a medical model can be used to delineate indications and contraindications for their use or to assess risk vs. benefit. A review of the literature to include legal and regulatory issues will be presented as support for a rational policy on the use of restraint and seclusion.

REFERENCES:

1. American Psychiatric Association: Task Force Report 22, Seclusion and Restraint: The Psychiatric Uses. Washington, D.C., APA, 1985.
2. Fisher WA: Restraint and seclusion: a review of the literature. Am J Psychiatry 1994; 151:1584-1591.

Lecture 26 **Tuesday, November 2**
10:00 a.m.-11:30 a.m.

CULTURAL COMPETENCE: CLINICAL, TRAINING AND SYSTEMS PERSPECTIVES

Francis G. Lu, M.D., *Clinical Professor of Psychiatry, University of California at San Francisco, and Director, Cultural Competence and Diversity Program, San Francisco General Hospital, 1001 Potrero Avenue, San Francisco, CA 94110-3518*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant will gain knowledge about recent guidelines for cultural competence used in clinical care, training of medical students and residents, and administration of mental health services.

SUMMARY:

This presentation will review guidelines for cultural competence from the clinical, training, and systems perspectives. At the clinical level, advances in cultural competence as seen in the DSM-IV and the APA Practice Guidelines for the Psychiatric Evaluation of Adults will be reviewed along with practice guidelines from the American Psychological Association. Cultural competence aspects of the new ACGME accreditation standards for psychiatry residency programs (effective January 2000) will be presented. Also discussed will be the Association of American Medical Colleges Medical School Objectives Project Part III, which focuses on spirituality, end-of-life, and cultural issues. Finally, two recent landmark documents on systems cultural competence from SAMHSA CMHS will be discussed.

REFERENCES:

1. Lu F: Cultural Competence Standards in Managed Care Mental Health Services for Four Underserved/ Underrepresented Racial/Ethnic Groups. Washington, D.C., CMAS, 1998.
2. Lu F: Cultural Competence Performance Measures for Managed Behavioral Healthcare Programs. Albany, New York: New York State Office of Mental Health, 1998.

Medical Update 1 **Friday, October 29**
8:00 a.m.-9:30 a.m.

MANAGING ALZHEIMER'S DISEASE AND OTHER DEMENTIAS

Benjamin Seltzer, M.D., *Professor of Neurology, Tulane University School of Medicine, 1430 Tulane Avenue, New Orleans, LA 70112-2699*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should know the differential diagnosis of and appropriate medical workup for dementia; learn about current theories on the etiology and pathogenesis of Alzheimer's Disease; and learn about current therapies for Alzheimer's Disease and other dementias.

SUMMARY:

The differential diagnosis of dementia will be addressed, including the definition of the dementia syndromes, differential diagnosis of dementia syndrome, classification of the dementias and the evaluation of the patient with dementia. An update on Alzheimer's Disease will then be presented, which will include the prevalence and importance of this disease, pathology, current theories on the etiology of Alzheimer's Disease, and current theories of pathogenesis. Finally, drug treatment for Alzheimer's Disease will be discussed to include cognitive symptoms, the design of drug studies and the treatment of non-cognitive symptoms.

REFERENCES:

1. Cummings JL, Vinters HV, Cole GM, Khachaturian ZS: Alzheimer's disease: etiologies, pathophysiology, cognitive reserve, and treatment opportunities. Neurology 51 1998, (suppl 1):S2-S17.
2. Wise MG, Gray KT, Seltzer B: Delirium, dementia, and amnestic disorder. American Psychiatric Press Textbook of Psychiatry, ed. by RE Hales, SC Yudofsky, and JA Talbott. Washington: American Psychiatric Press, 1999, pp 317-362.

Medical Update 2 **Saturday, October 30**
10:00 a.m.-11:30 a.m.

EPILEPSY MANAGEMENT

Tim Frederick, M.D., *Assistant Professor of Neurology, Tulane University School of Medicine, 1430 Tulane Avenue, New Orleans, LA 70112-2699*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: (1) recognize behavior of typical complex partial seizure types; (2) recognize criteria for declaring medical intractability; (3) learn about the safe use of antiseizure drugs using mg/kg dosing; and (4) review critical interactions of traditional and newer antiseizure medications.

SUMMARY:

Seizure behavior for any individual patient is usually very stereotyped. A reliable description by an eyewitness or patient, and disciplined observations by a physician can frequently distinguish behavior of complex partial seizures from psychiatricly mediated behavior. Temporal lobe seizures are the most common types of complex partial seizures. Frontal lobe seizures present greater variety in behavior and can be more difficlut to distinguish from nonepileptic behavior. Sometimes, EEG plays a critical role in distinguishing epileptic from nonepileptic behavior. Twenty percent of epilepsy patients are not readily controlled by today's medications. It is important to recognize when medical intractability occurs. Failure to successfully respond to three or more adequate antiseizure medication trials is a good predictor of medical intractability. An adequate trial of antiseizure medications requires intensive use of the medicines up to maximally tolerated concentrations. Use of mg/kg dosing improves the predictability and safety of these trials. Critical interactions of the seizure medications, among themselves, and with psychiatric medications will be reviewed. Non-pharmacological treatment will also be discussed.

Medical Update 3 **Sunday, October 31**
8:00 a.m.-9:30 a.m.

MANAGING PARKINSONISM AND OTHER MOVEMENT DISORDERS

Charles G. Shissias, M.D., *Department of Psychiatry and Neurology, Tulane University School of Medicine, 1440 Calhoun Street, TB-52, New Orleans, LA 70112*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should acquire knowledge about diagnostic criteria, treatment strategies, and algorithms for treatment of parkinsonism.

SUMMARY:

Criteria for the diagnosis of parkinsonism will be emphasized. Treatment strategies for symptomatic management and neuroprotections will be discussed. The natural history of parkinsonism plus the development of complications due to medication will be reviewed.

REFERENCES:

1. Stacy M: Treatment options for early parkinson disease. Am. Fam. Phy. 1996; 53:1281-87.

2. Quinn NL: Modern management of parkinson disease. J Neurology, Neurosurgery, Psychiatry. 1990; 53:93-103.

Medical Update 4 **Monday, November 1**
1:30 p.m.-3:00 p.m.

HEADACHE MANAGEMENT

Debra Elliott, M.D., *Assistant Professor of Neurology, Tulane University School of Medicine, 1430 Tulane Avenue, New Orleans, LA 70112-2699*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: (1) understand the impact of migraine on patients and their social environment; (2) use some tools to diagnose primary (tension-type, migraine, cluster) versus secondary headache; (3) understand the pathophysiology of migraine as it relates to treatment; and (4) manage migraine using a long-term, patient-centered stratified approach.

SUMMARY:

Migraine afflicts about 12% of the population, and is easily diagnosed by the constellation of symptoms patients present with. A comparison with cluster and chronic tension-type headache is given. Serious pathology is rare. There are specific "worrisome signs" the practitioner can use in diagnosing secondary headache. The pathophysiology of migraine leads us to more specicic pharmacologic treatments. Education, lifestyle adjustments, stress management, and other nonpharmacologic treatments are important to effective management. Defining specific patient needs during a headache and interictally are important. A patient-centered stratified approach usually brings about the most success in maintaining high functionality and a high quality of life. Managing this genetic neurologic disease is a life-long process in which the physician may help the patient at many different steps along the way. Managing migraine is a rewarding experience with the right tools at hand.

REFERENCES:

1. Smith R; Impact of migraine on the family: Headache 1998; 38:423-426.
2. Soloman GD, Skobieranda FG, Gragg LA: Quality of life and wellbeing of headache patients: Measurement by the medical outcomes study instrument. Headache 1993; 33:351-358.

Multimedia Session 1 **Friday, October 29**
8:00 a.m.-9:30 a.m.

VIDEO WORKSHOP: HELPING YOUNG MEN REFLECT ON THEIR EXPERIENCES

Michael Klein, Psy.M., *Rutgers Center for Applied Technology, Rutgers University, 445 East 68th Street, #10-S, New York, NY 10021*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be acquainted with: (1) the utilization of interview-based video as a mechanism of change, and (2) the application of therapeutic factors to multimedia interventions.

SUMMARY:

"Adam's Apple" consists of interviews with five college men candidly discussing topics ranging from alcohol to sexuality to relationships. The chair, who is also the filmmaker, will discuss the making of this project, its current use, and the utilization of video as an intervention for young men and other populations.

REFERENCES:

1. Dowrick PW: Practical Guide to Using Video in the Behavioral Sciences. New York, John Wiley & Sons, 1991, pp. 335.
2. Block S, Crouch E: Therapeutic Factors in Group Psychotherapy. Oxford, England, Oxford University Press, 1985, pp. 342.

Multimedia Session 2 **Friday, October 29**
10:00 a.m.-11:30 a.m.

VIDEO WORKSHOP: COLLABORATIVE HEALTH CARE, CHILDREN'S STORIES OF ILLNESS

Anita Menfi, R.N., M.Ed., *Department of Psychiatry, New York Hospital, Cornell Medical Center, 500 East 77th Street, #132, New York, NY 10162*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, participants should understand how children experience their own medical illnesses and how the "Child Life Program" provides outlets for children to process their memories and questions in the face of illness.

SUMMARY:

The diagnosis and treatment of childhood illnesses and the resulting medical interventions are often experienced as traumatic by children and their parents. Using several videotape segments representing the work of innovative children's programs, this video workshop will provide an opportunity to discuss how children can find outlets to process their feelings, memories, and questions in the face of illness.

REFERENCES:

1. Hobbes N, Perrin JN: Stories in the Care of Children with Chronic Illness. San Francisco, Jossey-Bass, 1985.
2. Robert MC, Wallender JL: Family issues in pediatric psychology. New York, Earlbaum, 1992.

Multimedia Session 3 **Friday, October 29**
1:30 p.m.-3:00 p.m.

VIDEO WORKSHOP: MUSIC THERAPY AND MEDICINE

H. James Lurie, M.D., *Clinical Professor of Psychiatry, University of Washington, 1417 East Aloha Street, Seattle, WA 98112-3931;* John S. McIntyre, M.D.; Bryan C. Hunter, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to define music therapy and identify illnesses that respond to music therapy.

SUMMARY:

"Music Therapy and Medicine: Partnerships in Care" is a video documentary that communicates how music therapy plays a vital role in the treatment of children and adults with a wide range of diagnoses. The video, which has won two national awards, was filmed at major medical centers in Cleveland and New York City, and captures actual music therapy sessions in progress. Interviews with patients, physicians, family members, and other health care professionals provide testimony regarding the use of music therapy to decrease depression, decrease pain, reduce medication requirements, increase relaxation, enhance positive attitudes toward hospitalization, and improve coordination and rhythmic gait. The documentary was designed for professional education, public awareness, and education, and to vividly portray the role of music as a healing art form. The presenters, a past president of the American Psychiatric Association and a past president of the American Music Therapy Association, will be available to answer questions and lead discussion following the presentation.

REFERENCES:

1. Ferman CE: Effectiveness of Music Therapy Procedures: Documentation of Research and Clinical Practice (2nd ed.). Silver Spring, MD, National Association for Music Therapy, 1996.

2. Taylor DB: Biomedical Foundations of Music as Therapy. St. Louis, MMB Music, 1997.

TARGET AUDIENCE:

Psychiatrists, psychologists, social workers, and nurses.

Multimedia Session 4 **Friday, October 29**
3:30 p.m.-5:00 p.m.

VIDEO WORKSHOP: MENTAL HEALTH SERVICES IN A COMMUNITY SCHOOL

1998-2000 APA/Bristol-Myers Squibb Fellows

Mark W. Wilson, M.D., *1998-2000 APA/Bristol-Myers Squibb Fellow, and Resident, Department of Psychiatry, New York State Psychiatric Institute, 301 West 53rd Street, #14-D, New York, NY 10019;* Mara S. Goldstein, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to see how mental health services in the schools have evolved and how one can maximize the cost-effectiveness of such services.

SUMMARY:

This video, supported by a grant from the American Academy of Child and Adolescent Psychiatry, features the formation of mental health services in a community school, Salome Urena De Henriques Intermediate School 218, in joint venture with the New York County District Branch of APA. Video footage that follows the school's primary and secondary prevention psychoeducation project emphasizes the cost-effectiveness of such a program while detailing components leading to a successful outcome.

REFERENCES:

1. Howard A: School-linked mental health interventions: toward mechanisms for service coordination integration. Journal of Community Psychology, 1963; 21:309-319.
2. Flaherty LT, Weist MD, Warner BS: School-based mental health services in the United States: history, current models and needs. Mental Health Journal 1966; 32:341-352.

TARGET AUDIENCE:

Community-oriented child and adolescent psychiatrists, including residents.

Multimedia Session 5 **Saturday, October 30**
8:00 a.m.-9:30 a.m.

VIDEO WORKSHOP: IN VITRO FERTILIZATION: A LOOK AT HUMANE REPRODUCTION

Group for the Advancement of Psychiatry's Committee on Social Issues

Ian E. Alger, M.D., *Multimedia Consultant, APA Institute Scientific Program Committee, and Clinical Professor of Psychiatry, New York Presbyterian Hospital-Cornell Medical Center, 500 East 77th Street, #132, New York, NY 10162;* H. James Lurie, M.D., *Clinical Professor of Psychiatry, University of Washington, 1417 East Aloha Street, Seattle, WA 98112-3931*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: (1) understand the current aspects of infertility and the assisted reproductive technologies, their psychosocial implications, and the role of mental health professionals in this field; and (2) consider some of the ethical issues raised by these technologies, such as gamete donation and surrogacy, postmenopausal conception and childbearing, use of antidepressant drugs in infertility patients, and the place of cloning in human reproduction.

SUMMARY:

Mental health professionals have always been interested in reproduction, and its relation to human development and behavior, sex, parenting, and children. Technology has had an enormous impact on infertility and reproduction, making family formation more complex than ever. Medical scientists can intervene in a variety of ways to make pregnancy and parenthood possible, but should they? The Group for the Advancement of Psychiatry's Committee on Social Issues has been studying some of these questions, mainly through literature review and clinical vignettes. This session will address the psychological, social, and ethical aspects of some of these questions such as ova and sperm donation, surrogacy, postmenopausal conception and childbearing, cloning of human embryos, and the use of antidepressant drugs in infertility patients. This session will utilize case presentations, including videos, with active audience participation. The goal of this session is to encourage the need for the involvement of mental health professionals in the care of these patients and in the formation of policy regarding such technologies.

REFERENCES:

1. Greenfeld D: Psychological issues in fertility. Infertility and Reproductive Medicine Clinics of North America, Philadelphia, W.P. Saunders, 1993.

2. Alpern KD: The Ethics of Reproductive Technology. NY, Oxford University Press, 1993.

Multimedia Session 6 Saturday, October 30 10:00 a.m.-11:30 a.m.

VIDEO WORKSHOP: INFORMANTS AND THE WAR ON DRUGS

Stephen M. Goldfinger, M.D., *Consultant, APA Institute Scientific Program Committee, and Vice Chair, Department of Psychiatry, State University of New York Downstate Medical Center, 450 Clarkson Avenue, Brooklyn, NY 11203*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to understand the nature of laws designed to reward informants in the war on drugs and the consequences that were visited on one particular American town and its inhabitants.

SUMMARY:

"Snitch," first seen on public television's highest-rated public affairs series, Frontline, is a 90-minute program probing America's war on drugs, which has created a new breed of witness—the informant. With the prospect of mandatory life sentences for drug crimes, the only option to escape their fate is to render assistance to federal prosecutors. This program takes a critical look at how the federal government uses informants in drug case prosecution and the effect it has had on the judicial system in the United States.

REFERENCES:

1. Cohen S: Marijuana in Psychiatry Update. American Psychiatric Association Annual Review; vol. 5. Washington, DC, American Psychiatric Press, Inc., 1986, p. 200.
2. Reuter P: Licensing Criminals: Police and Informants. Rand Corporation, Oct. 1982.

Multimedia Session 7 Saturday, October 30 1:30 p.m.-3:00 p.m.

COMPUTER WORKSHOP: ELECTRIC MEDICAL RECORDS: ENHANCING PATIENT CARE

Daniel A. Deutschman, M.D., *Medical Director, Behavioral Health, Southwest General Health Center, Cleveland, Ohio, and Associate Clinical Professor of Psychiatry, Case Western Reserve University School of Medicine, 7255 Old Oak Boulevard, Suite 303, Middleburg Heights, OH 44130*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: (1) understand relational databases, describe how they are created, and realize what variations are possible; (2) define how databases can enhance quality of care and office efficiency; and (3) realize what resources are required for their implementation and continual improvement.

SUMMARY:

This interactive multimedia presentation, developed by a psychiatrist, will introduce psychiatrists to an electronic medical record that enhances patient assessment, diagnosis, and treatment. The information system improves practice management, enhances medical records, and facilitates research. The psychiatrist enters data into more than 100 fields during the interview. A data entry form guides and prompts the interviewer so the record is more complete. The form carries forward important elements of the history into each subsequent visit. Very little typing is necessary. The complete data entry form prints as a report of the interview. Prescriptions, medication trial reports, and billing data are available using one keystroke. The basic principles in building such systems and the resources readily available to obtain or develop them will be discussed. When the psychiatrist programs the software, he/she is in a position to continually upgrade and strengthen the system. Quality and efficiency improve with each iteration.

REFERENCES:

1. Modai I, Rabinowitz J: Why and how to establish a computerized system for psychiatric case records. Hospital and Community Psychiatry 1993; 44:1091-1095.
2. Allen SI, Johannes RS: Prescription-writing with a PC. Computer Methods and Programs in Biomedicine 1986; 22:127-135.

Multimedia Session 8 Saturday, October 30 2:00 p.m.-5:00 p.m.

VIDEO WORKSHOP: VIRTUAL REALITY THERAPY UPDATED

Ian E. Alger, M.D., *Multimedia Consultant, APA Institute Scientific Program Committee, and Clinical Professor of Psychiatry, New York Presbyterian Hospital-Cornell Medical Center, 500 East 77th Street, #132, New York, NY 10162;* Donna Cunningham, M.A., O.R.T.; Larry Hodges, Ph.D.; Hunter Hoffman, Ph.D.; S. Marian Krishack, M.S.; Mayer L. Max, M.S.; Cheryl Trepagnier, Ph.D.; Suzanne Weghorst, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to show new advances in applications of virtual reality therapy in post-traumatic stress syndrome and stress and pain reduction in burn patients mitigated by virtual reality immersion.

SUMMARY:

Expert researchers and clinicians from several of America's advanced research centers will demonstrate the most recent clinical applications in virtual reality. Larry Hodges, Ph.D., associate director of the College of Computing at Georgia Institute of Technology, will explore prospects for adaptive perceptual aids, and will demonstrate virtual reality environments for exposure therapy, exemplified by the "Fear of Flying" virtual reality program. Mayer Max, M.S., and Cheryl Trepagnier, Ph.D., representing Vice President Gore's National Reinvention Initiative, have assembled a special presentation, which gives two perspectives on virtual reality assessment of autism and ADHD. One program shows how children can reach into virtual reality through their desktop PC and robotics, and as the children establish a hands-on link with a "Robotic Wand Avatar," they can explore synthetic worlds—feel faces, bounce balls, and otherwise demonstrate their cognitive potentials. Key indicators may also begin to emerge on how best to combine the sensory channels of feeling, sight, and auditory navigation of information in virtual reality for simulation, training, or remote live teleoperation and projection of "presence".

A second impressive study will be presented by a group from the National Rehabilitation Hospital in Washington, D.C., on its work in regard to virtual reality and eye-tracking in the investigation of face-gaze in autism, with the use of a head-mounted virtual reality display in which a gaze-angle sensor is also installed. Coming from the Human Interface Technology Laboratory (HIT Lab) in Seattle, Washington, out of which flows a continuing stream of new ideas and application in virtual reality, Suzanne Weghorst, Ph.D., director of research, will demonstrate the prospects for "Adaptive Perceptual Aids." Hunter Hoffman, Ph.D., a research scientist from the same HIT Lab, will demonstrate "The Use of Immersive Virtual Reality to Reduce Burn Pain During Wound Care and Physical Therapy." In another application of virtual reality technology and principles in clinical work, Donna Cunningham, M.A., O.R.T., and S. Marian Krishack, M.S., will demonstrate the use of virtual reality in a novel and effective approach in physical rehabilitation.

REFERENCES:

1. Rothbaum BO, Hodges LF, Kooper R, et al: Effectiveness of virtual reality graded exposure in treatment of acrophobia. American Journal of Psychiatry 1995; 152:626-628.
2. Hoffman HG, Prothero J, Wells M, Groen J: Virtual chess: the role of meaning in the sensation of presence. International Journal of Human-Computer Interaction, in press.
3. Wiederhold MD: Cyberpsychology and behavior: the impact of the internet, multimedia and virtual reality on behavior and society. Mary Ann Liebert, Inc., 1998; Vol. 1, Number 3.

Multimedia Session 9 **Saturday, October 30**
3:30 p.m.-5:00 p.m.

COMPUTER WORKSHOP: ELECTRIC MEDICAL RECORDS: PSYCHOPHARMACOLOGIC USE

Daniel A. Deutschman, M.D., *Medical Director, Behavioral Health, Southwest General Health Center, Cleveland, Ohio, and Associate Clinical Professor of Psychiatry, Case Western Reserve University School of Medicine, 7255 Old Oak Boulevard, Suite 303, Middleburg Heights, OH 44130*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: (1) understand electronic medical records-psychopharmacologic (EMR-P); (2) realize its advantages over handwritten records; and (3) learn about the resources available to build or buy EMR-P.

SUMMARY:

This multimedia presentation will demonstrate an electronic medical records-psychopharmacologic (EMR-P) developed by a practicing psychiatrist. More than 3,500 patients have been evaluated with this tool. EMR-P can enhance quality of care for medication-resistant patients by: (1) improving documentation of medication trials, (2) providing faster data entry via drop-down menus, and (3) producing preprogrammed prescriptions and reports that show details of all current and past medication trials in chronological order at the click of the mouse. Psychiatrists are no longer forced to rummage through stacks of chart notes. EMR-P can facilitate research by allowing cross-referencing of patients' medications, doses, combinations of medications, time intervals, side effects, and patient response. Data are entered via drop-down menus, and very little or no typing is necessary. This speeds documentation of evaluations, leaving more time for medication teaching and answering patient questions. Data entry forms prompt out. These forms become reports for communication with other members of the treatment team. This multimedia session will be interactive with discussion

that will include the process of designing and using EMR-P and the resources available to obtain or develop it. EMR-P has the potential to enhance patient care significantly.

REFERENCES:

1. Modai I, Rabinowitz J: Why and how to establish a computerized system for psychiatric case records. Hospital and Community Psychiatry 1993; 44:1091-1095.
2. Allen S, Johannes RS: Prescription-writing with a PC: computer methods and programs in biomedicine 1986; 22:127-135.

Multimedia Session 10 Sunday, October 31 8:00 a.m.-9:30 a.m.

VIDEO WORKSHOP: PHYSICIAN SUICIDE

H. James Lurie, M.D., *Clinical Professor of Psychiatry, University of Washington, 1417 East Aloha Street, Seattle, WA 98112-3931;* Michael F. Myers, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to treat survivors of physician suicide with respect and dignity and examine their personal feelings of loss when physicians commit suicide.

SUMMARY:

When physicians kill themselves the heartache for family, work colleagues, friends, and their patients is profound. Many "survivors" struggle with feelings of disbelief, guilt, remorse, and anger. Shame and a conspiracy of silence often preclude a wholesome and open discussion of the physician's life and legacy. In this videotape, survivors of physician loved ones who have committed suicide talk about their loss, their journey of healing, and the reactions of physician, colleagues, friends, and family—and make wise suggestions to us in the health professions who treat physicians and their families. Also included are the poignant works of a physician who struggled with major depression and attempted suicide during her residency. Grateful to be alive, she explains not only the pain of depression, but that it is a treatable illness. Her message is full of compassion and hope for physicians who live with depression. This videotape should further diminish the stigma associated with mental illness in physicians. This video is the winner of the 1999 Psychiatric Services Video Award.

REFERENCES:

1. Baumen KA: Physician suicide. Archives Family Medicine 1995; 4:672-673.
2. Lupin MH: Physician suicide: where the system fails. BC Medical Journal 1997; 39:126.

TARGET AUDIENCE:

Medical students and physicians (and their families), medical school deans, directors of training programs, medical licensing board personnel, physician well-being committees, hospital administrators, all professionals who treat ill physicians, and the countless survivors who have lost loved ones to suicide.

Multimedia Session 11 Sunday, October 31 10:00 a.m.-11:30 a.m.

VIDEO WORKSHOP: AN IN-DEPTH LOOK AT SHORT-TERM DYNAMIC PSYCHOTHERAPY

Manuel Trujillo, M.D., *Professor of Clinical Psychiatry, New York University School of Medicine, 550 First Avenue, Suite 22-North, New York, NY 10016;* Waguih W. Ishak, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should acquire knowledge about the process of learning short-term dynamic psychotherapy including: (1) familiarity with basic psychodynamic skills, (2) difficulties encountered in trainees, and (3) planned systematic ways to address them in supervision.

SUMMARY:

Short-term dynamic psychotherapy, a time-limited therapy, is gaining more attention as an effective and efficient treatment modality for a variety of psychiatric disorders. Training in this modality requires the trainee to have an adequate knowledge base of psychodynamic theory and to acquire new therapeutic skills throughout the process. The highlights of these skills include assuming an active role, helping the patient to develop specific dynamic focus or foci and be more specific, and challenging defensive styles. The ultimate goal is to help patients gain more insight into the way they react to both their outer and inner worlds. For trainees, learning these new skills can be initially difficult. The trainees have to change their stance from the traditional active listener role to active participants who confront defenses, evoke and tolerate intense emotions, and help develop insights. The supervisor's role is to help the trainees develop a psychodynamic understanding of the patient's problems, to identify the patient's responses in the therapeutic interaction, including verbal and nonverbal communication, and guiding the trainee in making the most appropriate interventions. The use of videotaped sessions for supervision has proven to be extremely helpful

in assisting the trainees in overcoming their initial difficulties. Attendees will have the opportunity to participate in an active discussion about the psychotherapy learning-teaching process.

REFERENCES:

1. Goldberg DA: Structuring training goals for psychodynamic psychotherapy. J Psychother Pract Res 1997; 1:10-22.
2. Trujillo M: Short-term dynamic psychotherapy in psychotherapists casebook, in Casebook: Theory and Techniques. Edited by Wolf I. San Francisco/London, Josey Bass Publishers, 1986.

TARGET AUDIENCE:

Residency directors and psychotherapy supervisors.

Multimedia Session 12 **Sunday, October 31**
1:30 p.m.-3:00 p.m.

COMPUTER WORKSHOP: BOOTING UP YOUR PRACTICE

Theron C. Bowers, M.D., *Diplomate of the American Board of Psychiatry and Neurology, 10600 Fondren, Suite 217, Houston, TX 77098*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize barriers in establishing a computer-based recordkeeping system and to recognize benefits and areas for using a clinical electronic database system in a psychiatric practice.

SUMMARY:

Although the computer is a common tool in many or most psychiatric practices, its use remains confined to primarily administrative jobs such as billing and scheduling. As a cognitive-based specialty with a primary task of collecting and evaluating patient information, electronic database management has numerous potential benefits for psychiatrists in all areas of practice. This presentation will explore issues regarding computerized clinical database management in psychiatric practices. This program will examine potential barriers and challenges in maintaining electronic records. It will also illustrate the benefits and goals of an efficient computerized clinical system by demonstrating a patient-tracking computer program based on a relational database. Using this program, the basic requirements of a patient-tracking system will be shown, such as records of progress notes, mental status examinations, and medications. More advanced and specialized features in tracking a patient's progress and monitoring medication side effects will also be demonstrated. Finally, there will be instructions on implementing a computerized recordkeeping system in private practice.

REFERENCES:

1. Lieff JD: Clinical databases. Psychiatric Annals 1994; 24:33-36.
2. Powsner SM: Clinical psychiatric software, limitation and problems. Advances in Medical Psychotherapy 1993; 6:89-98.

Multimedia Session 13 **Sunday, October 31**
1:30 p.m.-3:00 p.m.

VIDEO WORKSHOP: HUNTINGTON'S DISEASE

Tana A. Grady-Weliky, M.D., *Member, APA Institute Scientific Program Committee, and Associate Dean for Undergraduate Medical Education, University of Rochester School of Medicine and Dentistry, 601 Elmwood Avenue, P.O. Box 601, Rochester, NY 14642*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to understand how some patients cope with the potentiality of inherited disease and deal with possibilities of several generations in the family inheriting this disease.

SUMMARY:

This videotape, "Deadly Inheritance," is about a, 38-year-old woman who has lived with the knowledge that she may be carrying the gene that causes Huntington's disease. Now she faces a decision based on new advances in genetics that lets her learn whether she's going to live or die. This documentary follows her life and that of her family and friends, between her initial blood test and the unforgettable moment when she is told the results. There is great tension building as one waits to learn the outcome of the tests. The family members from several generations are included in the tape, from the grandmother who is suffering from Huntington's disease, down to the newest generation who are not anxious to know in their own situation yet. It would certainly be of great use to physicians and others who treat patients who have to deal with inherited diseases or people who are facing death. This is a real-life drama with gripping medical suspense, and this video is the winner of two important Canadian awards.

REFERENCES:

1. Folstein SE: Huntington's disease: a disorder of families. Baltimore, Johns Hopkins University Press, 1989.

2. Jason GW, Pajurkiva EM, Suchowersky O: Presymptomatic neuropsychological impairment in Huntington's disease. Arch Neurol 1988; 45:769-773.

TARGET AUDIENCE:

Psychiatrists and mental health professionals.

Multimedia Session 14 Sunday, October 31 3:30 p.m.-5:00 p.m.

VIDEO WORKSHOP: ABUSE OF WOMEN IN HISTORICAL PERSPECTIVE

Barbara Jo Brothers, M.S.W., C.G.P., *Diplomate, Clinical Social Work, National Association of Social Workers, 3500 St. Charles Avenue, New Orleans, LA 30015*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to identify the manifestations of this rampant psychosocial issue—the abuse of women—and will have developed increased sensitivity toward this important problem.

SUMMARY:

This video focuses on the abuse of women who are married and who find themselves increasingly being abused by their husbands. It demonstrates that there was some increase in awareness, but that more recently there has not been an active continuation of that trend, and the danger lies in women losing the somewhat slim gains that they had already made. This video includes statements by many abused women and the testimony of those who have become involved in the fight to provide remedies for this national disgrace.

REFERENCES:

1. Dickstein LJ: Spouse abuse and other domestic violence. Psychiatr Clin North Am 1988; 11:611-628.
2. Bernstein AE, Lenhart SA: The Psychodynamic Treatment of Women. Washington, DC, American Psychiatric Press, Inc., 1993.

Multimedia Session 15 Sunday, October 31 3:30 p.m.-5:00 p.m.

VIDEO WORKSHOP: POLITICAL CORRECTNESS

Harvey Bluestone, M.D., *Member, APA Institute Scientific Program Committee, and Director of Psychiatry, Bronx-Lebanon Hospital Center, 1285 Fulton Avenue, Bronx, NY 10456-3401*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to expand his or her awareness of influences originating from social structures and, in particular, how developing students in colleges and universities may have a special vulnerability to political influences.

SUMMARY:

John Leo talks about his recent book, "Two Steps Ahead of the Thought Police," which deals with origins and agenda of so-called "political correctness," and its detrimental effects, including repression and division, especially on college campuses.

REFERENCES:

1. Leo J: Two Steps Ahead of the Thought Police. Transaction Pub, May 1998.
2. Kors AC, Silverglate HA: The Shadow University: The Betrayal of Liberty on America's Campuses. Free Press, 1998.

Multimedia Session 16 Monday, November 1 8:00 a.m.-9:30 a.m.

VIDEO WORKSHOP: TREATING PSYCHOLOGICAL TRAUMA

Victor Sierra, M.D., *1998-2000 APA/Bristol-Myers Squibb Fellow, Liaison, APA Institute Scientific Program Committee, and Resident, Department of Psychiatry, Einstein-Montefiore Hospital, 1925 Eastchester Road, Apt. 3-F, Bronx, NY 10461*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: (1) recognize the current practice and proven effectiveness of eye movement desensitization and reprocessing (EMDR), and (2) demonstrate a framework for viewing EMDR from both clinical and research perspectives.

SUMMARY:

This video provides an insightful view of EMDR, probing both its widespread popularity and its controversial nature. Psychotherapy researcher Larry Beutler serves as commentator in a program that features EMDR's originator, Francine Shapiro, as well as other authorities in the field, including Terence Keane, Kim Muser, and Bessel van der Kolk, who present their own perspectives on a range of issues surrounding this approach. Designed for mental health clinicians, students, and researchers, the video includes simulated client sessions in which Dr. Shapiro demonstrates the eight-step EMDR protocol and discusses the relationship between EMDR and trauma.

REFERENCES:

1. Shapiro F: Eye Movement Desensitization and Reprocessing: Basic Principles, Protocols, and Procedures. New York, Guilford Press, 1995.
2. Keane TM: Psychological and behavioral treatment of post-traumatic stress disorder, in A Guide to Treatments that Work. Edited by Nathan PE, Gorman JM. New York, Oxford University Press, 1998, pp. 398-407.

Multimedia Session 17 Monday, November 1 10:00 a.m.-11:30 a.m.

VIDEO WORKSHOP: POST-TRAUMATIC STRESS SYNDROME IN VETERANS

Robert D. Maresh, M.D. *Department of Psychiatry, Tulane Medical Center, 1415 Tulane Avenue, New Orleans, LA 70112*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should have an understanding of the commonality of traumatic experience and grief and should be able to recognize the applicability of this therapeutic process to a broad range of clinical interventions.

SUMMARY:

PTSD has become a focus of increased clinical interest over the past decade, with the consequent development of a broader range of treatment modalities. The short- and long-range stressors especially related to war experiences have been the focus of significant therapeutic effort. Here, veterans of three different wars (World War II, Vietnam, and the Persian Gulf) participated in 20 group sessions providing a detailed therapeutic process to mental health providers. The video includes applicability to dynamics and clinical interventions for therapists interested in a much broader range of trauma exposure due to the topical areas that are documented.

REFERENCES:

1. Fullerton CS, Ursano RJ: Post-Traumatic Stress Disorder. Washington, DC, American Psychiatric Press, 1997.
2. Foy D: Etiology of post-traumatic stress disorder in Vietnam veterans: analysis of pre-military, military and combat exposure influences. J Consult Clin Psychology 1990; 20:1632-1642.

Multimedia Session 18 Monday, November 1 1:30 p.m.-3:00 p.m.

VIDEO WORKSHOP: COMMUNITY MENTAL HEALTH AND EDUCATION

Dennis B. Alters, M.D., *Author, Wizards Way, 2125 El Camino Real, Suite 104, Oceanside, CA 92054;* Kerry J. Kluner, M.D., *Medical Director, Children's Program, San Luis Rey Hospital, 345 Saxony Road, Suite 103, Encinitas, CA 92024*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to understand how Wizard's Way establishes a continuity of care through its application across multiple treatment settings, (e.g. inpatient, outpatient, school) and integrates managed care and DSM-IV symptomatology into childlike imagery, metaphor, and ritual word at the child's level by appealing to the child's natural resources of imagination, curiosity, and enthusiasm.

SUMMARY:

This presentation will analyze components of traditional child psychiatric programs, outlining the strengths and weaknesses of traditional programs, and then will offer a fresh, innovative approach to today's challenges of changing health care. Wizard's Way is an imaginative behavioral program for children in the maturational ages four to 14. Integrating DSM-IV diagnostic criteria into a game-like format, it emphasizes a multitiered, multimodal approach. The program organizes cognitive, behavioral, and dynamic therapy into a model that is appealing to children, adults, and therapists. This comprehensive approach, which includes the community, home, school, and outpatient and inpatient settings, is affordable, easy to implement, and uses preexisting community services. Wizard's Way can intersect into large-scale and small-scale community health systems with slightly modified versions. It appeals to all children, helping to destigmatize mental illness. The program is pre-operationally and operationally based. Children with learning disabilities receive help through the multimodal therapeutic activities. Even healthy children can gain problem-solving techniques, coping skills, self-esteem, and social-skill strategies.

REFERENCES:

1. Trad PV: Use of developmental principles to decipher the narrative of preschool children. Journal of American Academy of Child and Adolescent Psychiatry 1992; 31:4:581-592.
2. Hoagwood K, Jansen PS, Petti T, Burns BJ: Outcomes of mental health care for children and adolescents: a comprehensive conceptual model. Journal of the American Academy of Child and Adolescent Psychiatry 1996; 35:1055-1063.

Multimedia Session 19 Monday, November 1
3:30 p.m.-5:00 p.m.

VIDEO WORKSHOP: CYCLE OF URBAN UNEMPLOYMENT, CRIME, AND DRUGS

John W. Thompson, Jr., M.D., *Director, Department of Forensic Psychiatry, Tulane University Medical Center, 1440 Canal Street, New Orleans, LA 70112-2699*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to understand the interrelationship of increasing drug use, criminal behavior, and chronic unemployment in urban centers.

SUMMARY:

This work probes the devastating cycle of urban unemployment, crime, drugs, and incarceration as it follows two men and one woman from the time they are released from prison onto the streets of Newark, N.J., with no job skills and no legal source of income. The program charts their slide back into shoplifting and shooting up, the deterioration of their own lives, and the damage they inflict on their children. It exposes the brutal reality of crime and drug addiction while also contesting stereotypical explanations and mythic solutions. This outstanding film, Life of Crime—Part 2, provides an ideal educational tool for all studies of contemporary urban sociology. Those interested in topics such as crime and punishment, drug addiction and its impact on the family and community, teenage pregnancy, child abuse and neglect, and AIDS will find that this program offers a graphic point of departure for in-depth discussions.

REFERENCES:

1. Maddus JF, Desmond DP: Relapse and recovery in substance abuse careers. NIDA Research Monograph Series 72. Edited by Tims FM, Leukenfeld CG. US Department of Health and Human Services, Rockville, MD, 1986, p. 49.
2. Lewis DO: Adult antisocial behavior and criminality. in Comprehensive Textbook of Psychiatry V, vol. 2. Edited by Kaplan HI, Sadock BJ. Williams & Wilkins, Baltimore, 1989, p. 1400.

POSTER SESSION 1

Posters 1-30

CHILD AND ADOLESCENT PSYCHIATRY, EMERGENCY PSYCHIATRY, FORENSIC PSYCHIATRY, MEDICAL EDUCATION AND WOMEN'S MENTAL HEALTH

Poster 1 **Saturday, October 30 10:00 a.m.-11:30 a.m.**

ABSENCE OF ATTENTIONAL DEFICITS IN STABILIZED BIPOLAR YOUTH

Neera Datta, M.Ed., *Research Assistant, Department of Psychiatry, Dalhousie University, 5909 Jubilee Road, Suite 4083, Halifax, NS Canada B3H 2E2;* Diane C. Bird, B.S., Stanley P. Kutcher, M.D.

SUMMARY:

Objective: Research on comorbidity in bipolar disorder has suggested an association with attentional deficits. However, the role of current symptomatology in the assessment of attention in this group has not been elucidated. As part of a comprehensive follow-up study of mood-disordered youth, indices of attention were obtained from a sample of stabilized bipolar and unipolar youth and normal controls.

Method: There were 119 participants: 44 bipolar (B) (17M, 27F) and 30 unipolar (U) youth (9M, 21F), 45 controls (C) (19M, 26F). Mean ages were 19.5, 18.5 and 18.2 years, respectively. Instruments used were Connor's Continuous Performance Test (CPT) and Wechsler Intelligence Test (WISC III).

Results: No significant group/sex differences were observed on: Freedom from Distractibility subscale (WISC III) or on various CPT indices of attention (variability of attention, speed decrement over time, commission/omission errors, activation/arousal). Performance for the majority was well within age-appropriate norms. A small proportion of the total sample fit a typical ADHD profile, and most of these were controls.

Conclusions: These findings suggest attentional deficits reported in bipolar disorder may, in part, be a function of the time at which the assessment is made (euthymic vs. intra-episode or subsyndromal functioning).

REFERENCES:

1. Duffy A, Alda M, Kutcher S, et al: Psychiatric symptoms and syndromes among adolescent children of parents with lithium responsive or lithium nonresponsive bipolar disorder. Am J Psychiatry 1998; 155:431–433.
2. Faraone SV, Biederman J, Wozniak J, et al: Is comorbidity with ADHD a marker for juvenile onset mania? J American Academy of Child and Adolescent Psychiatry 1997; 36:1046–1055.

Poster 2 **Saturday, October 30 10:00 a.m.-11:30 a.m.**

FACTOR ANALYSIS OF CONSUMER SATISFACTION WITH A CHILD PSYCHIATRIC HOSPITAL

Stuart L. Kaplan, M.D., *Professor of Psychiatry, and Director, Division of Child and Adolescent Psychiatry, Saint Louis University School of Medicine, 1221 South Grand Boulevard, St. Louis, MO 63104;* Joan Busner, Ph.D.; John Chibnall, Ph.D.

SUMMARY:

Objective: To study consumer satisfaction in a child psychiatric inpatient hospital and to assess the relationship between consumer measures of clinical improvement and measures of consumer satisfaction.

Method: Child and adolescent psychiatric inpatients and their parents or guardians were administered investigator-developed consumer-satisfaction surveys in three sampling waves of approximately 50 patients in each wave. The surveys provided data about satisfaction with inpatient care and perceptions of clinical improvement. Overall, 157 patients were interviewed.

Results: 95% of the subjects contacted agreed to be interviewed. Parents and children were highly satisfied with all aspects of patient care. Twenty-eight percent of children and 21% of parents reported some form of abuse during the hospital stay. Those who reported abusive behavior by the staff were significantly less satisfied with the hospital experience than those who did not report abuse. Clinical improvement was only weakly related to consumer satisfaction.

Conclusions: Most child psychiatric patients and their parents will participate in consumer-satisfaction surveys about their inpatient care and will be critical of the hospital if specific prompts in the survey are provided. Clinical problem improvement is only weakly related to consumer satisfaction.

REFERENCES:

1. Lambert W, Salzer MS, Bickman L: Clinical outcome, consumer satisfaction and ad hoc ratings of improvement in children's mental health. J Consult Clin Psychol 1998; 66:270–279.
2. Bickman L, Gutherie PR, Foster EM, et al: Evaluating Managed Mental Health Services: The Fort Bragg Experiment. New York, Plenum, 1995.

Poster 3 **Saturday, October 30**
10:00 a.m.-11:30 a.m.

AN EPIDEMIOLOGICAL SURVEY OF PERSONALITY DISORDER AMONG UNDERGRADUATE STUDENTS IN BEIJING

Yueqin Huang, M.D., M.P.H., *Associate Professor and Chair, Department of Preventive Medicine, Beijing Medical University, 38 Xue Yuan Road, Beijing, P.R. China 100083;* Yang Wang, M.D., *Associate Professor, Department of Preventive Medicine, Beijing Medical University, 38 Xue Yuan Road, Beijing, P.R. China 100083;* Liming Li, M.D.; Xiufen Liu, M.D.

SUMMARY:

Objective: To investigate the personality characteristics and the prevalence of personality disorders among undergraduate students and to explore risk factors for personality disorder (PD).

Method: Personality Diagnotic Questionnaire-Revised (PDQ-R), International Personality Disorder Examination and General Information Questionnaire were given to 2205 freshmen in a key university in urban Beijing.

Results: The mean of total PDQ-R score was 23.91 ± 8.35, positive rate was 6.30%. Fifty-five cases with positive scores on the PDQ-R were diagnosed as PD; the prevalence of PD among the study population was 2.5% (95% CI2.2-2.8). Of 10 types of PDs, the prevalence of obsessive-compulsive disorder was the highest. Among related factors, sex, poor parental relationship, and single-parent family were risk factors for personality disorder.

Conclusions: PD among undergraduate students must be paid attention to. Poor family environment negatively influences occurrence of PD. Medication and intervention for PD should be used among the high-risk population.

TARGET AUDIENCE:

Psychiatrists and social psychiatrists, and social workers.

REFERENCES:

1. Byler SE, Skodol AE, Kellman HD, et al: Validity of the Personality Diagnostic Questionnaire-Revised: comparison with two structured Interviews. Am J Psychiatry 1990; 147:1043–1048.
2. Tang SW, Huang Y: Diagnosing personality disorders in China. International Medical Journal 1995; 2:291–197.

Poster 4 **Saturday, October 30**
10:00 a.m.-11:30 a.m.

HEROIN ADDICTION AND CRIME

Chandresh Shah, M.D., *Assistant Chief of Psychiatry, VA Outpatient Clinic, and Clinical Associate Professor of Psychiatry, University of Southern California, 351 East Temple Street, Los Angeles, CA 90012;* Elbert Y. Kellem; Carl L. Wong, L.C.S.W.

SUMMARY:

Heroin addicts often engage in criminal activities (CA) that are directly or indirectly related to their addiction. Methadone maintenance treatment (MMT) curtails heroin addiction. In our MMT program patients are assessed at time of admission regarding their CA. To study the effect of MMT upon CA, we randomly selected 82 patients with at least 12 months of MMT and interviewed them regarding their CA during MMT. There were 79 male patients (age = 51.46 ± 9.99 years) and three female patients (age = 51.46 ± 7.24 years) who had been in MMT for 3.84 ± 2.37 years. They were 67.07% Hispanic, 17.07% white, 14.64% black, and 1.22% Asian patients. Of these, 79.27% of the patients had a record of CA at the time of admission. Of these patients, 92.31% had drug charges during the pre-MMT period. The prevalence dropped to 4.62% during MMT ($p < 0.005$). The prevalence of shoplifting was reduced from 40.00% to 1.54% during MMT ($p < 0.001$) and that of parole/probation violation dropped from 23.08% to 1.54% during MMT ($p < 0.05$). There were similar significant reductions in incidences of charges (for various CA) per patient. The reductions in CA related to forgery and burglary were nonsignificant. This shows that significant reduction occurs in CA among heroin addicts who receive MMT.

TARGET AUDIENCE:

Psychiatrists, addiction therapists and law enforcement agents.

REFERENCES:

1. Nurco DN, Shaffer JW, Ball JC, Kinlock TW: Trends in the commission of crime among narcotic addicts over successive period of addiction and nonaddiction. Am J Drug Alcohol Abuse 1984; 10:481–489.
2. Ball JC, Ross A: The Effectiveness of Methadone Maintenance Treatment. New York, N.Y., Springer-Verlag, Inc., 1991.

Poster 5 **Saturday, October 30**
10:00 a.m.-11:30 a.m.

FIRE SETTING IN COMORBID ADOLESCENTS

Pe Shein Wynn, M.D., M.P.H., *Assistant Professor, Department of Psychiatry, New York Medical College, Be-*

havioral Health Center, Valhalla, NY 10595; Mary Anne Pressman, M.D., *Director, Westprep Dual Diagnosis Program, and Department of Psychiatry, New York Medical College, Behavioral Health Center, 286 Soundview Avenue, White Plains, NY 10606-3822*

SUMMARY:

Objective: To evaluate the correlation between fire setting and comorbid substance abuse and psychiatric diagnoses (SA/PD) in adolescents.

Method: Retrospective review of all cases evaluated in 1997 (N = 212) at the comprehensive psychiatric emergency program. A total of 43 cases, aged 12–18, were identified as SA/PD. Forty-three controls, randomly selected from the non-substance-abusing adolescents, and matched on age, gender, and ethnicity, were chosen. Student t-test, Chi-square tests, Spearman correlation, and Logistic Regression Analysis (LRA) were used.

Results: Fire setting was significantly associated with SA/PD adolescents (21% vs. 0%, $p < 0.01$). It was significantly correlated with past and current substance use (Spearman's correlation coefficient = 0.37, $p < 0.001$ and 0.28, $p < 0.01$, respectively) after partialling out the influence of psychiatric symptoms. Substance history was a significant predictor of fire setting ($P < 0.01$) in a LRA.

Conclusion: Patients with a history of fire setting should be carefully evaluated for substance abuse, and conversely, the SA/PD adolescent frequently has a history of fire setting. Substance abuse may be a fourth element to be added to the classical triad of fire setting, enuresis, and cruelty to animals. Unfulfilled needs for nurturance early in childhood, resulting in impulsivity and poorly controlled aggression, may be a dynamic common to all these symptoms.

REFERENCES:

1. Repo E, Virkkunen M: Criminal recidivism and family histories of schizophrenic and nonschizophrenic fire setters: comorbid alcohol dependence in schizophrenic fire setters. J Am Acad Psychiatry Law 1997; 25:207–215.
2. Puri BK, Baxter R, Cordess CC: Characteristics of fire setters: a study and proposed multiaxial psychiatric classification. Br J Psychiatry 1995; 166:393–396.

Poster 6 **Saturday, October 30 10:00 a.m.-11:30 a.m.**

PERSONAL ADVOCACY IN INVOLUNTARY TREATMENT: AN EMPIRICAL STUDY OF EFFICACY

Stephen Rosenman, M.D., *Canberra Psychiatry Group, G.P.O. Box 610, Canberra ACT, Australia 2614*

SUMMARY:

Objective: To compare the utility of routine rights advocacy with an experimental model of personal advocacy based on needs and best interest, which accompanied involuntarily treated patients throughout the period of their treatment.

Method: Fifty-three consecutively involuntarily hospitalized subjects received experimental personal advocacy from soon after compelled hospitalization through committal to the time of discharge from involuntary care. They were compared with 52 consecutively involuntarily hospitalized control subjects who received routine rights advocacy from soon after compelled hospitalization through to committal.

Results: Satisfaction with hospital care was similar in both experimental and control subjects at the outset of care but improved significantly in the experimental subjects while it declined in the controls. Compliance with aftercare was significantly better in the experimental group. The experimental subjects' risk of subsequent involuntary hospitalization was less than half the risk of control subjects, and community tenure was significantly increased. Staff reported that personal advocacy improved their care of patients.

Conclusions: Personal advocacy based on needs and best interests, which accompanies patients throughout involuntary hospitalization, significantly improves patients' and staff's experience of involuntary hospital care. The resulting better compliance with aftercare produces a statistically and economically significant reduction in rehospitalization compared with routine rights advocacy in involuntary treatment.

REFERENCES:

1. Stone AA: The myth of advocacy. Hospital and Community Psychiatry 1979; 30:819–22.
2. Bennett NS, Lidz CW, Monahan J, et al: Inclusion, motivation and good faith: the morality of coercion in mental hospital admission. Behavioural Sciences and the Law 1993; 11:295–3056.

Poster 7 **Saturday, October 30 10:00 a.m.-11:30 a.m.**

RESOURCE UTILIZATION OF INMATES ON ANTIPSYCHOTICS

Steven R. Harris, R.Ph., *Director of Pharmacy, Corrections Health Services, Miami Dade County Public Health Trust, 1321 N.W. 13th Street, Miami, FL 33125;* Michael B. Durkin, M.S., *Assistant Director, Outcomes Research, Janssen Pharmaceutica and Research Foundation, 1125 Trenton-Harbourton Road, Titusville, NJ 08560;* Timothy J. Bell, M.H.A.

SUMMARY:

Objectives: To better understand the cost drivers and practice patterns in a large jail system, utilization of health care resources by inmates treated with antipsychotic medications was measured retrospectively, and patterns of treatment with psychotropic medications were analyzed.

Methods: As part of a drug utilization review, medical charts for a sample of 50 jail inmates discharged between September 1998 and February 1999 who received at least one antipsychotic prescription were reviewed. Data on the use of health care services were tabulated, including psychiatric consults, clinic visits, admissions to hospital, and emergency medical treatment. Data on events such as medication refusals and use of four-point restraint were also collected. Pharmacy practice patterns were extensively characterized for the study patients.

Results: On average, study patients were incarcerated for 90 days. The mean number of psychiatric consults and clinic visits per patient were 2.2 and 3.1, respectively. Medication refusals were recorded for 50% of the patients. Eighteen percent of patients had more than one antipsychotic medication, and 82% used concomitant anticholinergics.

Conclusions: Little information is known about the resource utilization of mentally ill prisoners. Opportunities to improve care by reducing medication refusals and the use of concomitant side effect drugs were identified.

REFERENCES:

1. Casey DE: How antipsychotic drug pharmacology relates to side effects. J Clin Psychiatry 1997; Monogr Ser 15:30–34.
2. Richelson E: Preclinical pharmacology of neuroleptics: focus on new generation compounds. J Clin Psychiatry 1996; 57(suppl 11):4–11.

Poster 8 **Saturday, October 30**
10:00 a.m.-11:30 a.m.

RIGHT TO REFUSE PSYCHOTROPIC MEDICATIONS: EIGHT YEARS OF SOUTHERN ILLINOIS' EXPERIENCE

Jagannathan Srinivasaraghavan, M.D., *Professor of Psychiatry, Southern Illinois University School of Medicine, and Medical Director, Choate Mental Health and Development Center, 1000 North Main Street, Anna, IL 62906;* Nancy Watkins, B.S., *Choate Mental Health and Development Center, 1000 North Main Street, Anna, IL 62906*

SUMMARY:

Background: The Illinois Mental Health & Developmental Disabilities Code 2:107.1 allowing for judicial ordering of psychotropic medications to nonconsenting patients in nonemergency situations was enacted on August 13, 1991. Choate Mental Health Center, with about 100 adult psychiatric beds, serves almost all treatment refusers in the southern 28 counties of Illinois with a population of approximately 619,000.

Objective: To understand the number of cases filed, unique patients, physicians involved, and outcome in the last eight years in Southern Illinois.

Subjects: All the cases filed from Choate Mental Health Center in the Circuit Court of Union County from enactment of statute in 1991 until December 31, 1998.

Method: Collection of demographic data from hospital records of petitions submitted to the Circuit Court for favor of psychotropic medication.

Results: From 1991–1998 there were 0, 6, 26, 51, 28, 29, 43, and 38 petitions in each calendar year for a total of 221 cases in eight years. Of the 221 petitions, 42% were granted, 7% were denied, and 50% were either withdrawn or dismissed. Fifty-two percent were men and 79% were white. There were 145 unique patients. Forty-one recidivists used this statute from two to eight times, a mean of 2.8 times. There were 13 physicians involved, and about 95% of cases were decided by one judge.

Conclusions: 1) Denial of petition for medication is much higher compared with Cook County (most populous county) of Illinois.[1] 2) Twenty-eight percent of recidivists accounted for 53% of petitions.

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1. Srinivasaraghavan J, Mahableshwarkar A: Forced Psychotropic Medication: Five Years Illinois USA Data. Xth World Congress of Psychiatry, Abstracts 1996; 2:397.
2. Srinivasaraghavan J, Mahableshwarkar A, Rockwell M, et al: Judicially-Forced Psychotropic Medications in Illinois. 50th Institute on Psychiatric Services, Syllabus and Proceedings Summary 1998; Poster 133, 138–139.

Poster 9 **Saturday, October 30**
10:00 a.m.-11:30 a.m.

SEXUAL PREDATOR REVIEW: JUVENILES' RISK FACTORS

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SUMMARY:

Objective: To identify the risk factors that differentiated a prerelease review committee's decision to refer juveniles for further proceedings as sexual predators.

Method: The sample (N-38) comprised every juvenile sex offender released from a South Carolina facility from June, 1998 to April, 1999. Demographic, delinquency history, sex offense, and clinical risk factors of referred juveniles (Group R) were compared with those not referred (Group NR) for further sexual predator commitment proceedings.

Results: Seven juveniles (18%) were referred (Group R). Group R juveniles were significantly more likely to have been referred in the first two case-review meetings, to be older at release from confinement, to be a childhood victim of sexual assault, and to have failed to complete sex offender treatment while confined.

Conclusions: Application of sexual predator laws to adolescent sex offenders raises many clinical issues of consent to treatment and disclosure of records and public policy issues of developing pre- and post-adjudication treatment programs for juvenile "victim-perpetrators", training of case review members, and funding for research on juvenile sex offender risk factors and treatment efficacy.

TARGET AUDIENCE:

Psychiatrists, administrators, legislators and clinicians.

REFERENCES:

1. Araji SK: Sexually Aggressive Children. Thousand Oaks, CA, Sage Press, 1997.
2. The Juvenile Sex Offender. Edited by Barbaree HE, Marshall WE, Hudson S: New York, Guilford Press, 1993.

Poster 10 **Saturday, October 30 10:00 a.m.-11:30 a.m.**

PREGNANCY AND THE POSTPARTUM PERIOD: PROSPECTIVE COURSE OF PANIC DISORDER, GENERALIZED ANXIETY DISORDER, AND SOCIAL PHOBIA

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SUMMARY:

Introduction: Research on the course of anxiety disorders during pregnancy has focused largely on panic disorder, has been retrospective, and has shown inconsistent findings. The one prospective study conducted found no change in panic symptoms during pregnancy compared with prepregnancy.

Methods: We explored the course of panic disorder, GAD, and social phobia during pregnancy and the postpartum period using data from the Harvard/Brown Anxiety Research Project, a longitudinal, prospective study of 711 patients who met DSM-III-R criteria for an anxiety disorder. Mean severity of symptoms for the 32 women who gave birth during follow-up were compared prior to conception, during pregnancy and postpartum. We also present descriptive data on medication received.

Results: Of the 15 women with panic disorder, four showed no change in symptom severity from preconception to pregnancy, six improved, and five worsened. Four women showed no change in severity during pregnancy compared with postpartum, five improved, and six worsened. Of the seven women with GAD and the four women with social phobia, most women showed no change in severity from preconception compared with pregnancy or from pregnancy to postpartum.

Conclusion: Findings are consistent with the only other prospective study, which suggests that pregnancy may not protect against panic symptoms, and panic symptoms may not increase postpartum. Also, symptom severity does not appear to change for GAD or social phobia.

TARGET AUDIENCE:

Treatment providers

REFERENCES:

1. Cohen LS, Sichel DA, Faraone SV, et al: Course of panic disorder during pregnancy and the puerperium: a preliminary study. Biol Psychiatry 1996; 39:950–954.
2. Shear MK, Mammen O: Anxiety disorders in pregnant and postpartum women. Psychopharmacology Bulletin 1995; 31:693–703.

Poster 11 **Saturday, October 30 10:00 a.m.-11:30 a.m.**

POST-DISCHARGE COMPLIANCE WITH MOOD STABILIZERS IN ADOLESCENT PSYCHIATRIC PATIENTS

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partment of Psychology, Four Winds Hospital, 800 Cross River Road, Katonah, NY 10536; Susan R. Borgaro, Ph.D.; David L. Pogge, Ph.D.

SUMMARY:

A recent development in psychopharmacology is the use of antiseizure medication for the treatment of affective disorders. These medications have few side effects, demonstrated efficacy for some types of affective disorders, and are under investigation for the treatment of other conditions, such as labile affect and personality disorders. The use of these medications in adolescent patients has not been studied in much detail, however. This study examined treatment compliance after discharge from inpatient treatment for adolescents with affective disorder diagnoses treated with SSRI antidepressants, antiseizure medication, and novel antipsychotic medications. In a whole-hospital, random-selection, follow-up study, 98 adolescent patients were followed up 30 and 120 days after discharge, examined for their symptom status relative to discharge, and for their treatment compliance. Sixty-five patients were treated with SSRI antidepressants, 51 with antiseizure medications, and 22 with risperidone.

Treatment compliance with SSRIs was 90% at 30 days and 80% at 120 days, while compliance with risperidone treatment was 90% at 30 days and 86% at 120 days. In contrast, only 36% of the patients receiving antiseizure medication were compliant at 30 days, and 28% were compliant at 120 days. No evidence of symptomatic worsening was found at follow-up as a function of medication noncompliance. These data suggest the need for increased attention to medication-specific compliance with different aspects of treatment and also suggest the need for more systematic research on the efficacy of antiseizure medication in adolescent psychiatric patients.

TARGET AUDIENCE:

Institutions treating children and adolescents with bipolar disorder.

REFERENCES:

1. Lloyd A, Horan W, Borgaro SR, et al: Predictors of medication compliance after hospital discharge in adolescent psychiatric inpatients. Journal of Child and Adolescent Psychopharmacology, 1998; 8:133–141.
2. Papatheodorou G, Kutcher SP, Katic M, Szalai JP: The efficacy and safety of divalproex sodium in the treatment of acute mania in adolescents and young adults: an open clinical trial. Journal of Clinical Psychopharmacology, 1995; 15:110–16.

Poster 12 **Saturday, October 30**
10:00 a.m.-11:30 a.m.

CLINICAL VERSUS RESEARCH DIAGNOSIS OF BIPOLAR DISORDER IN ADOLESCENTS: IMPLICATIONS FOR TREATMENT AND OUTCOME

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SUMMARY:

As a component of a longitudinal study of outcome in adolescent psychiatric inpatients, a sample of consecutive admissions received a full research-quality diagnostic assessment as well as a comprehensive assessment of symptoms and treatments received at admission, discharge, as well as 30 and 120 days post discharge. Twenty-eight of 114 adolescents were diagnosed as having bipolar I disorder by their treating psychiatrists, while only 14 of the 114 subjects were so diagnosed by the research-based criteria. Diagnostic agreement was only 53% of the cases clinically diagnosed with bipolar disorder. Patients who were diagnosed as bipolar by clinicians but not by research criteria had significantly lower scores on the symptom ratings of euphoria ($p < .05$) and activation ($p < .05$) and significantly higher scores on depression ($p < .01$) at the time of admission. The cases diagnosed as bipolar by the clinical psychiatrists were largely treated with valproate or lithium (80%) and rarely were treated with SSRI antidepressants (16%). Clinical change data suggested that patients for whom there was disagreement between research and clinical diagnoses responded significantly less in terms of their depression symptoms during treatment ($p < .01$) and had statistically significant worsening in depression after discharge ($p < .01$). These data suggest that clinical diagnoses of bipolar disorder may be overly common among patients of adolescent psychiatrists. Although treatment with anticonvulsant mood stabilizers may not produce high levels of side effects, one of the possible consequences of these diagnostic practices may be undertreatment of depression in these patients.

TARGET AUDIENCE:

Institutions treating children and adolescents with bipolar disorder.

REFERENCES:

1. Geller B, Luby J: Child and adolescent bipolar disorder: a review of the past 10 years. Journal of the

American Academy of Child and Adolescent Psychiatry 1997; 7:1168–1176.
2. Lloyd A, Horan W, Borgaro SR, et al: Predictors of medication compliance after hospital discharge in adolescent inpatients. Journal of Child and Adolescent Psychopharmacology 1998; 8:133–141.

Poster 13 **Saturday, October 30 10:00 a.m.-11:30 a.m.**

EFFECT OF EDUCATION ON RESIDENT TRAINING

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SUMMARY:

Clinical psychopharmacology is an important focus in our psychiatry resident training program. We emphasize drug selection on the basis of differential pharmacology, the potential for causing drug-drug interactions. To assess the impact of this education effort, we examined the changes in the prescribing pattern of antidepressants (ADs) in the context of other co-prescribed medications in our resident psychiatric outpatient clinic (RPOC) between 1995 and 1999. Only patients on at least one AD were selected. Analysis of the data showed:

Table 1. Frequency of co-pharmacy/ polypharmacy in patients on ADs at RPOC

	1995 (n=221)	*1999 (n=158)*
Pts., on 1 drug	31%	16%
Pts., on 3 drugs	15%	25%
Pts., on ≥5 drugs	20%	7%
—		
X of drugs	3	3

Table 2. Frequency of use of top five ADs at RPOC vs. national data in 1998

ADs	*RPOC*	*National Data*
sertraline	26%	16%
nefazodone	14%	3.5%
bupropion	10%	8%
fluoxetine	10%	17.5%
mirtazapine	9%	2%

Monotherapy decreased from 31% to 16% and polypharmacy (i.e., ℓ5 drugs) from 20% to 7% in four years. RPOC used a higher percentage of non-SSRIs than the national data. Use of SSRIs has decreased from 71% to 48% and non-SSRIs has increased from 13% to 44%, which is much greater than national data. In comparison, SSRIs are used to a lesser extent most likely on the basis of using ADs with different putative mechanism of action in patients who have not benefited from a previous trial of an SSRI.

REFERENCES:

1. Shad MU, Carmichael C, Preskorn SH, Horst D: Prevalence of polypharmacy in different clinical settings and its relation to drug-drug interactions. Abstract presented at the annual meeting of American Psychiatric Association, 1999, Washington, D.C.
2. West JC, Zarin DA, Pincus HA: Treatment issues in clinical psychopharmacology. Psychopharmacology Bulletin 1997; 33:79–85.

Poster 14 **Saturday, October 30 10:00 a.m.-11:30 a.m.**

RISK FACTORS FOR ALCOHOL USE IN PREGNANCY

Heather Flynn, Ph.D., *Assistant Research Scientist, University of Michigan Alcohol Research Center, 400 E. Eisenhower Parkway, Suite A, Ann Arbor, MI 48108;* Sheila M. Marcus, M.D.; Frederic C. Blow, Ph.D.; Kristen L. Barry, Ph.D.

SUMMARY:

Alcohol use by women during pregnancy remains a major public health concern due to the potential for harm to the developing fetus. Although many women who use alcohol while pregnant present in general medical and specialty care settings, they remain largely undetected by health care providers. This study aimed to demonstrate the feasibility of screening for alcohol use and depression among pregnant women in primary care and ob/gyn settings and to identify risk factors that are associated with alcohol use during pregnancy. Thus far, 738 women have been screened for this study in primary care waiting areas to identify rates of alcohol use and associated risk factors. Included in screening measures were demographic information, use of alcohol and tobacco during pregnancy, history of depression and current depressive symptomatology, as well as screening for generalized anxiety.

We found that 16% of women reported alcohol use during pregnancy. Preliminary analyses show current depressive symptomatology as well as marital status are significant risk factors for alcohol use during pregnancy. These findings provide preliminary evidence that these factors must be considered when developing targeted secondary prevention strategies. This work will continue to identify risk factors for alcohol use during pregnancy, which will serve as a crucial step in developing intervention strategies for use by health care providers.

REFERENCES:

1. Elhassani SB, Ferlautto JJ, Purohit DM: Maternal use of alcohol during pregnancy is a risky lifestyle. Journal of the South Carolina Medical Association 1996; 128–132.
2. Wilsnack SC: Patterns and trends in women's drinking: recent findings and some implications for prevention. Women and Alcohol: Issues for prevention

research. National Institute on Alcohol Abuse and Alcoholism. Monograph No. 32. DHHS publication no. 96-3817, 1996.

Poster 15 **Saturday, October 30**
10:00 a.m.-11:30 a.m.

PREDICTORS OF RISK: WHEN DOES DEPRESSION RELAPSE IN PREGNANCY?

Sheila M. Marcus, M.D., *Clinical Assistant Professor of Psychiatry, University of Michigan, 432 Onaway Place, Ann Arbor, MI 48104-1827;* Heather Flynn, Ph.D., *Assistant Research Scientist, University of Michigan Alcohol Research Center, 400 E. Eisenhower Parkway, Suite A. Ann Arbor, MI 48108;* Kristen L. Barry, Ph.D.; Karla A. Blackwood, M.D.

SUMMARY:

Background and Objectives: Depression is a recurrent disorder that is nearly ubiquitous in childbearing women. Up to 10% of women will experience depression during pregnancy, but there is little information about the specific risks of relapse in pregnancy, especially when medications are discontinued (Altshuler 1996). Thus, it is critical to understand which risk factors make women vulnerable to relapse to inform treatment decisions and develop prevention strategies.

Method: This paper is part of a large project designed to improve detection, prevention, and treatment of depression in women. To date 1,000 women have been screened in primary care for depression and alcohol abuse during pregnancy. Screening tools included CESD and TWEAK, which were correlated with a variety of demographic and health variables.

Results: Preliminary analyses of baseline data showed significant correlations between both recent and lifetime history of depression and elevated CES-D. Analyses also revealed a significant but low correlation between risk for alcohol related problems and elevated CES-D. Marital status was also correlated with depression in pregnancy in the ongoing study, but there was no significant correlation with other health behaviors or socioeconomic status.

Clinical Implications: Preliminary results identify women at risk for depression in pregnancy. This project is ongoing and results will be used to inform providers, administrators, and policy makers regarding strategies to minimize relapse in this vulnerable population. Throughout the study, clinical outcomes of the mothers and infants will be monitored and targeted interventions and prevention strategies elaborated by the study team.

REFERENCES:

1. Altshuler LL, Hendrick V, Cohen LS: Course of mood and anxiety disorders during pregnancy and the postpartum period. Journal of Clinical Psychiatry 1998; 59:2.
2. Marcus S, Tandon R: Psychotropic drugs during pregnancy. Submitted for publication to Primer on Psychopharmacology, Buckley PF, Waddington, JL. Butterworth-Heinemann, in progress, 1998.

Poster 16 **Saturday, October 30**
10:00 a.m.-11:30 a.m.

PREVALENCE OF DEPRESSION AMONG PREGNANT WOMEN

Karla A. Blackwood, M.D., *Department of Psychiatry, University of Michigan, 432 5th Street, #2, Ann Arbor, MI 48103-4837;* Sheila M. Marcus, M.D., *Clinical Assistant Professor of Psychiatry, University of Michigan, 432 Onaway Place, Ann Arbor, MI 48104-1827;* Heather Flynn, Ph.D.; Kristen L. Barry, Ph.D.

SUMMARY:

Background: Depression has a lifetime prevalence in women of 20%. The onset frequently occurs during childbearing years. Pregnancy is a time when up to 10% of women may experience depression. Furthermore, literature on the prevalence of depression during pregnancy is complicated by various methodologies and populations assessed. It is critical to have a better understanding of the prevalence of depression during pregnancy in order to improve detection, treatment, and to prevent negative infant and maternal outcomes.

Method: This poster is part of a larger study designed to systemically evaluate the course of depression in pregnant women in a primary care setting. To date, 1000 woman have been screened using CESD, demographic, and other health-related information.

Results: Preliminary data available on 581 pregnant women show a prevalence rate of 20.4%. CESD scores ranged between 0-49, mean of 10, and standard deviation of 8. Fifty-three percent of people with elevated CESD had a prior episode of depression, chi-square (1) = 64.9, p = 0.00, showing a correlation between lifetime depression and elevated CESD.

Conclusion: Further data about prevalence of depression in women is needed in order to allow more thoughtful treatment planning and exploration of specific preventive strategies to minimize rates to those at risk.

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1. Altshuler LL, Hendrick V, Cohen LS: Course of mood and anxiety disorders during pregnancy and the postpartum period. Journal of Clinical Psychiatry 1998; 59:9–3.
2. Cohen LS, Rosenbaum JF: Psychotropic drug use during pregnancy: weighing the risks. Journal of Clinical Psychiatry 1998; 59:18–28.

Poster 17 **Saturday, October 30 10:00 a.m.-11:30 a.m.**

PROVIDER ADVICE TO PREGNANT DRINKERS: RATES/TYPES

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SUMMARY:

Maternal alcohol use during pregnancy remains a major public health and medical concern due to the potential for harmful effects on the developing infant. Many women who use alcohol will present to their primary care or ob/gyn, providing an ideal setting for focused intervention efforts. Despite the risks and possibility of effective screening and intervention strategies to prevent negative consequences, health care providers may not be taking adequate steps to address this problem. This paper presents preliminary data from an ongoing screening and intervention project targeting alcohol use and depression among pregnant women in primary care. The study focuses on the messages of health care providers during routine prenatal care visits by pregnant women who are using alcohol while pregnant.

A total of 738 women were screened in the waiting areas and asked about their use of alcohol during pregnancy and messages from physicians and significant others regarding their alcohol use. Among the pregnant women who reported alcohol use (n = 92; 15.5%), 58% indicated that their health care provider has talked to them about alcohol use and only 16% suggested that they cut down (25% suggested they quit). These data suggest that there may be a substantial number of women who are using alcohol during pregnancy whose physicians may not inquiring or providing advice about alcohol use.

REFERENCES:

1. Ebrahim SH, Luman ET, Floyd RL, et al: Alcohol consumption by pregnant women in the United States during 1988–1995. Obstetrics & Gynecology 1998; 92:187–192.
2. May PA: Research issues in the prevention of fetal alcohol syndrome and alcohol related birth defects. patterns and trends in women's drinking: recent findings and some implications for prevention. Women and Alcohol: Issues for prevention research. National Institute on Alcohol Abuse and Alcoholism. Monograph No. 32, DHHS publication no. 96-3817, 1996.

Poster 18 **Saturday, October 30 10:00 a.m.-11:30 a.m.**

PHARMACEUTICAL INDUSTRY IMPACT ON PSYCHIATRIC RESIDENTS' PRESCRIBING PRACTICES

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SUMMARY:

Introduction: The last decade has seen an increase in the number of psychotropic medications, research and development costs, and marketing pressures. This has led to increased interaction between pharmaceutical representatives and psychiatric residents. There is scant literature looking at residents attitudes about these, and none about the impact that sales representatives have on residents prescribing practices.

Methods: We retrospectively reviewed 100 random charts from an adult psychiatry residency clinic and collected demographic and prescription data. We reviewed residents appointment calendars and collected data about pharmaceutical sales visits. We analyzed the data chronologically by comparing the date of visit versus the amount of new prescriptions for each company's product two, four, eight, and 12 weeks after their visit.

Results: Chi square analyses compared the number of patients on 14 medications four weeks prior and two, four, eight, and 12 weeks after each company's visit. There were no statistical differences at any time period. The timing, length, or number visits did not lead to any change in prescribing practice.

Conclusions: Despite alarm in the medical literature about pharmaceutical sales pressure, it does not appear that these practices lead to an increase in patients being started on a particular medication within 12 weeks of sales visits.

REFERENCES:

1. Interactions with the pharmaceutical industry: experience and attitudes of psychiatry residents, interns, and clerks. CMAJ 1995; 153:553–9.
2. Pharmaceutical marketing: implications for medical residency training. Pharmacotherapy 1996; 16:103–7.

Poster 19 **Saturday, October 30 10:00a.m.-11:30a.m.**

DISTRIBUTION OF PSYCHIATRIC DIAGNOSES IN AN URBAN JAIL

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SUMMARY:

Every year, tens of thousands of inmates enter the Los Angeles County Jail system. A significant number of these inmates suffer from mental illness. The IRC serves as the primary mental health screening and triage location with the jail system. Mental health screenings take place at the IRC on a 24-hour basis. A multidisciplinary mental health staff works toward the goal of screening inmates with significant mental health needs.

In this study, we review the IRC charts of all inmates sent through the IRC during a one-month interval. Data regarding the distribution of psychiatric diagnoses were obtained and analyzed. Of particular interest in these data is the frequency of substance abuse as either a primary or comorbid psychiatric diagnosis in the jail population.

Because the IRC is such a rich and potentially instructive source of data for understanding the problems and needs of mentally ill inmates, we also critically review the screening forms and admission notes used at this time to further improve data collection to better serve the needs of the inmates. Improvements in the screening for primary substance use disorders and malingering appear to be potentially useful.

Developing an efficient and useful system for screening mental illness in jails is an ongoing process. We hope that these initial data will serve to raise important questions about what types of mental illnesses inmates tend to have, how to best screen for them, and ultimately how to best treat them so that inmates receive excellent mental health care.

TARGET AUDIENCE:

Community and institutional mental health workers

REFERENCES:

1. Veysey BM, Steadman HJ, Morrisey JP, et al: Using the Referral Decision Scale to screen mentally ill jail detainees: validitiy and implementation issues. Law and the Human Behavior 1998; 22:205–215.
2. DiCataldo FC, Greer A, Profit WE: Screening prison inmates for mental disorder: an examination of the relationship between mental disorder and prison adjustment. Bull Am Acad Psychiatry Law 1995; 23:573–585.

Poster 20 **Saturday, October 30 10:00a.m.-11:30a.m.**

CHARACTERISTICS OF PATIENTS PRESENTING TO THE PSYCHIATRIC TRIAGE CLINIC AT THE MEDICAL CENTER OF LOUISIANA

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SUMMARY:

Psychiatric emergency services have seen a dramatic increase in numbers and utilization patterns in the past 30 years. In 1963 an estimated 200 programs provided emergency psychiatric services compared with nearly 2,000 in 1985.

Studies have examined characteristics of patients presenting to psychiatric emergency services in an effort to predict various factors: violence potential, referrals, treatment compliance, recidivism, and others.

Other studies have investigated the effect of race on diagnosis and disposition of patients from the psychiatric ER, finding that black patients were more likely to be diagnosed with schizophrenia and substance abuse and more likely to be hospitalized. Another study examined 2,200 retrospective involuntary admissions to psychiatric units from psychiatric ERs. Results suggested a profile of the patient with a heightened risk of hospitalization: a young, single, black, male diagnosed with schizophrenia but without comorbid substance abuse.

In this project, we took a retrospective look at over 8,000 presentations in 1996 to the psychiatric triage clinic at the Medical Center of Louisiana. This clinic is the first step in a series of evaluations that patients receive. Our goal was to determine overall characteristics of these patients, including demographic and diagnostic information, the time spent in the evaluation process, referrals and dispositions, and predictors of admission.

A summary of the main findings is presented and discussed.

REFERENCES:

1. Sanguineti VR, Samuel SE, Schwartz SL, Robeson MR: Retrospective study of 2,200 involuntary psychiatric admissions and readmission. Am J Psychiatry, 1996; 153:392–396.
2. Strakowski SM, Lonczak HS, Sax KW, et al: The effects of race on diagnosis and disposition from a

psychiatric emergency service. J Clin Psychiatry 1995; 56:101–107.

Poster 21 **Saturday, October 30 10:00a.m.-11:30 a.m.**

PILOT OUTCOME STUDY OF FORENSIC ADMISSIONS TO A MINIMUM SECURITY UNIT: LEGAL AND CLINICAL PERSPECTIVES

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SUMMARY:

Introduction: With an increase in alleged criminal offenses among the severe and persistent mentally ill clients the issue arises as to whether the increased number of forensic referrals and assessments yield the expected dual outcomes in both legal and clinical domains. Very few systematic studies have been conducted to examine the outcome issue.

Objective: Our pilot study attempted to analyze the clinical-demographic profiles of 50 consecutive admissions over the 12-month period for forensic assessment, triage, and treatment (fitness to stand trial, restoration of competency, criminal responsibility). Clinical Global Impression improvement score (CGI), the Length of Stay (LOS), and the percentage of community discharge within three months were used as the clinical outcome measures. In the legal domain, the percentage of clients restored to fitness to stand trial, the concordance between judicial decision regarding criminal responsibility and conditional release, and the recommendations of the forensic service team were used as legal outcome measures.

Setting and design: A minimum security unit under the forensic service team of a regional psychiatric hospital in the province of Ontario, Canada. The design was prospective and naturalistic.

Results: The psychiatric diagnoses consisted of psychotic disorders (48%), mood disorders (38%), personality disorders (4%), and others (10%). Substance abuse comorbidity accounted for 60% of the clients. Assault (aggravated assault, assault with weapon, simple assault) was the commonest offense, and 92% of the clients had more than one offense. Regarding clinical outcome, 16% were markedly improved, 46% moderately improved, 26% minimally improved, and 12% worsened; 58% of the clients were discharged to the community after a minimum period of two months. As to the legal outcome, 98% of the clients were found to be fit to stand trial after combined pharmacotherapy and psychoeducational interventions. Fifty percent of the court-mandated assessment for criminal responsibility resulted in NC R-MD (Not Criminally Responsibility on account of Mental Disorder) in accordance with the Criminal Code of Canada. There was a 98% concordance rate between judicial decision and the forensic service team evaluation and recommendation.

Conclusion: Our initial results suggest positive clinical and legal outcomes can be achieved through optimal functioning of a forensic service team working in proactive collaborative partnership with the criminal justice system, within the context of a minimum security unit of a regional psychiatric hospital embracing both client-centered care and community safety. The model can be extended to forensic service team conducting in situ assessment in detention center/lock-up areas and criminal court settings.

REFERENCES:

1. Ohayon MM, Crocker A, St-Onge B, Caulet M: Fitness, responsibility and judicially ordered assessments. Canad J. Psychiatry, 1998; 43:491–495.
2. Lamb HR, Weinberger LE: Persons with severe mental illness in jails and prisons: a review. Psychiatric Services 1998; 49:483–492.

Poster 22 **Saturday, October 30 10:00 a.m.-11:30 a.m.**

INCIDENCE AND BIOPSYCHOSOCIAL CORRELATES OF VIRAL HEPATITIS AND HIV SIEROPOSITIVITY IN ADOLESCENTS HOSPITALIZED IN AN ACUTE PSYCHIATRIC UNIT

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SUMMARY:

Several recent reports have indicated an increase in the incidence of viral hepatitis, hepatitis C in particular, in the general population. HIV infection is reported to be increasing in women, youth, and children. The improvements in the treatment options and the public health concerns make early detection and treatment very important.

Objectives: The first purpose of this study was to determine the incidence of hepatitis A,B,C, and HIV seropositivity in a population of adolescents hospitalized in an acute psychiatric unit. The second purpose was to determine the relationship between HIV and hepatitis

infection with various biopsychosocial correlates, such as diagnosis at admission, comorbidity, history of trauma and/or substance abuse, age, and gender.

Methods: This study was performed in the acute adolescent unit at DePaul/Tulane Behavioral Center, a psychiatric facility serving the New Orleans area. Every patient admitted to the unit was subjected to a routine screening for viral hepatitis and HIV.

Results: During a 12-months period we detected three cases of hepatitis B, one case of chronic hepatitis B, two cases of hepatitis C, and one case of HIV. Details about the relationship between hepatitis and HIV and age, gender, diagnosis at admission, history of trauma, and/or substance abuse will be presented at the meeting.

Conclusions: Our study has detected a substantial number of previously undiagnosed cases of hepatitis and HIV, which suggests that the incidence of hepatitis and HIV might be higher than what is reported in the literature.

REFERENCES:

1. CDC: Update: trends in AIDS incidence, United States, 1996. Morbidity and Mortality Weekly 1996; Report 46, 37:861–867.
2. Chung JY, et al: Psychiatric patients and HIV. Psychiatric Services 1999; 50:487.

Poster 23 **Saturday, October 30 10:00 a.m.-11:30 a.m.**

LEARNING ABILITIES, COGNITIVE FUNCTION AND MOOD IN A POPULATION OF ADOLESCENTS HOSPITALIZED IN AN ACUTE PSYCHIATRIC UNIT

Carrie Wiesenmeyer, B.S., *Psychiatry Technician, Tulane University, 1040 Calhoun Street, New Orleans, LA 70118;* Siham Muntasser, M.D., *Resident in Psychiatry, Tulane University, 3123 Camp Street, New Orleans, LA 70115;* Lee Matthews, Ph.D.; James W. Lowe, M.D.

SUMMARY:

Eighty adolescent psychiatric inpatients between the ages of 13 and 18 were administered cognitive, achievement, and psychological testing during hospitalization. Participants were diagnosed with severe emotional, behavioral, and/or substance abuse problems. Specific measures included the Wide Range Achievement Test–Revised (WRAT-R), Kaufman Brief Intelligence Test (K-BIT), and Beck Depression Inventory (BDI). Patterns of cognitive and achievement performance will be determined in this study to determine if nonverbal deficits correlate with increased depressive symptomatology. The purpose of this study is to expand upon previous research studies (Iverson, Turner & Green, 1999) (Cleaver & Whitman) that have attempted to demonstrate the predictive validity of nonverbal-verbal discrepancy and deficit scores.

REFERENCES:

1. Cleaver R, Whitman RD: Right hemisphere, white-matter learning disabilities associated with depression in an adolescent and young adult psychiatric population. Journal of Nervous and Mental Disease 1998; 186:561–565.
2. Iverson GL, Turner RA, Green P: Predictive validity of WAIS-R VIQ splits in persons with major depression. Journal of Clinical Psychology 1999; 55:519–524.

Poster 24 **Saturday, October 30 10:00 a.m.-11:30 a.m.**

A CASE-CONTROLLED STUDY OF 75 VIRGIN SEX OFFENDERS: AN INCREASED INCIDENCE OF ASPERGER'S SYNDROME

J. Paul Fedoroff, M.D., *Centre for Addiction and Mental Health Services, University of Toronto, 250 College Street, Toronto, ON Canada M5T 1R8;* Kathy Smoleska, *Department of Forensics, University of Toronto, 250 College Street, Toronto, ON Canada M5T 1R8;* Beverley Moran, B.S.

SUMMARY:

Sex offenders are often assumed to be highly sexually experienced. However, since sex offenders are by definition socially inept, and since most paraphilics have unconventional sexual interests, it was hypothesized that there should be a subgroup of sex offenders who are virgins.

The first 75 men who said they had never had sexual intercourse with anyone (virgins) and who had been referred to a forensic clinic because of concerns about their sexual behaviors were age-matched to 75 men from the same clinic who had past experience with sexual intercourse (non-virgins).

Out of a clinic sample of 238 men referred for sexual concerns, 32% claimed to be virgins. Virgins were found to be significantly more likely than nonvirgins to have "courtship disorder" paraphilias (28% vs. 15%) ($\times 2 = 4.0$ df-1 $p < 0.05$). Virgins were also more likely to show signs or symptoms of Asperger's syndrome 21% vs. 4% ($\times 2 = 10.2$ df = 1 $p < 0.001$). A third of sex offenders are virgins. Of these, a third may have Asperger's syndrome, which can predispose these men to misperceive social situations. Some sex crimes may be due to asocial rather than antisocial behavior.

REFERENCES:

1. Fedoroff P, Moran B: Myths and misconceptions about sex offenders. The Canadian Journal of Human Sexuality 1997; 6:262–275.
2. Schopler E, Mesibou G, Kunca LJ (eds): Asperger's Syndrome or High-functioning Autism. New York, Plenum, 1998.

Poster 25 **Saturday, October 30**
10:00 a.m.-11:30 a.m.

ANXIETY ASSOCIATED WITH MAMMOGRAPHY

Theresa M. Miskimen, M.D., *Assistant Professor of Psychiatry, University Medical and Dental of New Jersey, 11 Graham Place, Englishtown, NJ 07726-9104;* Teresa Karcnick, M.D.; Arthur T. Meyerson, M.D.

SUMMARY:

Purpose: To explore possible differences in anxiety before and after a mammogram, testing the hypothesis that African-American and Hispanic women would have higher anxiety than nonminority women. The role of family history of breast cancer, presence or absence of breast symptoms (symptoms status), previous mammogram, income, and education was also explored.

Patients and Methods: Subjects included women between 35 and 65 years old without major psychiatric or medical illnesses. Instruments were the SCID-III-R implemented prior to mammogram and Hamilton Rating Scale for Anxiety, which was given before mammogram and after a negative result was conferred.

Results: ANOVA revealed no significant difference in anxiety by ethnicity (before mammogram: $F = .582, df = 3, p = .630$, after:$F = 1.147$, $df = 3, p = .340$). Symptom status was significant ($F = 8.317$, $df = 1$, $p = .006$). Women with breast symptoms had higher anxiety compared with women without symptoms before mammography ($t[47] = -2.441$, $p = .018$). Once the mammogram was read as negative, women with symptoms were not significantly different from those without ($t[47] = -.645$, $p = .522$). There were no statistically significant differences in anxiety when analyzing by family history, income, or education level.

Conclusion: The results of this study underscore the importance of prompt notification of results to decrease anxiety in women with breast symptoms.

TARGET AUDIENCE:

Residents, psychiatrists, primary care physicians and radiologists.

REFERENCES:

1. Fine MK, Rimer BK, Watts P: Women's responses to the mammography experience. Journal of the American Board of Family Practice 1993; 6:546–555.
2. Rimer BK, Bluman LG: The psychosocial consequences of mammography. Journal of the National Cancer Institute Monographs 1997; 22:131–138.

Poster 26 **Saturday, October 30**
10:00 a.m.-11:30 a.m.

PTSD AS A PREDICTOR OF TREATMENT OUTCOME IN A FEMALE VETERAN POPULATION

Fe E. Festin, M.D., *Department of Psychiatry, Brockton VAMC, 940 Belmont Street, Brockton, MA 02301;* Alexandra L. Berezovskaya, M.D., *Resident in Psychiatry, Brockton VAMC, 62 Pleasant Street, Brookline, MA 02446;* John Pepple, Ph.D.; Dan O. Ioanitescu, M.D.

SUMMARY:

This was a retrospective study of 52 females consecutively admitted to the Brockton VAMC inpatient unit in 1996–97 that examined outcome during one-year follow up. Principal outcome measure was the number of inpatient days per year.

Results: Diagnostic categories included major depression (38.5%), bipolar disorder (19%), schizoaffective disorder (19%), schizophrenia, and others. There was a high rate of comorbidity for personality disorder (55.8%), substance abuse (51.9%), and non-combat PTSD (61.5%). Longer inpatient stays were found for comorbid Axis II diagnoses (34.7 days vs. 10.7 days $p < 0.02$) and comorbid PTSD (30.8 days vs. 12.9 days, $p = 0.084$). There was a statistically significant relationship between comorbid PTSD and personality disorders; 71.9% of patients with PTSD had personality disorders. The presence of PTSD due to childhood trauma was associated with 88.9% of all personality disorders and 61.1% of borderline personality disorder. Patients with comorbid PTSD who were treated with mood stabilizers had a shorter inpatient stay (25.5 days/year vs. 65.8 day/year, $p = 0.088$) unrelated to their primary diagnosis.

Conclusion: Our study suggests that in the inpatient female veteran population we need to focus our treatment on comorbid substance abuse, personality disorder, and non-combat-related PTSD. Mood stabilizers may have a specific role in the treatment of PTSD.

REFERENCES:

1. Fontana A, Rosenhech R: Duty-related and sexual stress in the etiology of PTSD among women veterans who seek treatment. Psychiatric Services 1998; 49:658–662.

2. Fesler FA: Valproate in combat-related posttraumatic stress disorder. J Clin Psychiatry 1991; 52:361–364.

Poster 27 **Saturday, October 30 10:00 a.m.-11:30 a.m.**

A STANDARD PSYCHIATRIC EMERGENCY ASSESSMENT TOOL DEVELOPED BY CONSENSUS

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SUMMARY:

The American Association for Emergency Psychiatry (AAEP) has identified a need for an assessment standard for full-service psychiatric emergency services (PES) and an instrument meeting this standard. Ultimately, an electronic repository of data derived from North American services using the instrument is envisioned. The instrument is designed to address concerns about quality of care in an increasingly complex practice environment. The planned database will permit monitoring of national and regional trends in utilization, comparison of clinical activity between sites, development of research collaboration, and will facilitate development of benchmarks. The instrument contains structured and unstructured sections and is modular in design to allow for local customization and varying levels of assessment. While a variety of instruments exist designed for single sites or specific problems, NIMH has published data standards, and there are commercial electronic medical records available, this is the first effort known to the authors to utilize a consensus development process in this area of interest.

Development began with a content analysis of a random sample of patient records at a single PES, review of existing data-collection tools from other locations, and a review of the literature. This led to a minimum data set (MDS) for emergency psychiatry, which was then translated back into a form that was piloted by experienced PES clinicians. Feedback from these clinicians and emergency psychiatrists elsewhere was incorporated into a second major draft. This draft has been circulated within AAEP, and that version is now offered for review and comment as a part of the consensus development process.

REFERENCES:

1. Way BB, Allen MH, Mumpower JL, et al: Interrater agreement among psychiatrists in psychiatric emergency assessments. American Journal of Psychiatry 1998; 155:1423–28.
2. Lepinski W, Croze C, Driggers J, et al: Data Standards for Mental Health Decision Support Systems. Washington, DC, US Government Printing Office, 1989.

Poster 28 **Saturday, October 30 10:00 a.m.-11:30 a.m.**

AMERICAN ASSOCIATION FOR EMERGENCY PSYCHIATRY SURVEY I: PSYCHIATRIC EMERGENCY SERVICE STRUCTURE AND FUNCTION

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SUMMARY:

Although psychiatric emergency services (PES) are widely acknowledged as central to the modern mental health "system", no consensus model for these services exists, and there are few benchmarks, national standards, or guidelines relevant to practice in this critical area. To address this problem, the American Association for Emergency Psychiatry (AAEP) conducted a comprehensive survey of PES characteristics during 1998. A 70-item questionnaire elicited data on a range of topics concerning the respondents' practice settings and patterns. Participants were selected on the basis of membership in AAEP, the emergency psychiatry subspecialty organization, and administrative responsibility for a PES. More than 90% were in academic settings, and the average tenure in a leadership position was 6.8 years. The response rate was 91% and included urban and rural settings around the country. In this report, we present the highlights of provider and site characteristics including data on numbers of beds, visits, hospital admissions, locked capacity, local regulations, physical restraint, length of observation, stay, treatment available in the PES, aftercare arrangements, mobile outreach, crisis respite, payor sources, recidivism, formal protocols, consultation to emergency medicine, and medical "clearance" procedures. Respondents reported an average of 400 visits per month, a mean of 9.2 beds, and a mean length of stay of 9.0 hours. Medications are initiated in 82%, and 51% provide their own aftercare for a mean of 2.6 visits. The data suggest psychiatric emergency services are increasingly complex and organizationally unique.

REFERENCES:

1. Allen MH: Definitive treatment in the psychiatric emergency service. Psychiatric Quarterly 1996; 67:247.
2. Gerson S, Bassuk E: Psychiatric emergencies: an overview. American Journal of Psychiatry 1980; 137:1.

Poster 29 **Saturday, October 30 10:00 a.m.-11:30 a.m.**

FACTORS ASSOCIATED WITH CHANGES IN PSYCHIATRIC EMERGENCY SERVICE VISITS

Peter L. Forster, M.D., *Associate Clinical Professor of Psychiatry, University of California at San Francisco, 211 Gough Street, Suite 211, San Francisco, CA 94102;* Ralph Catalano, Ph.D., William McConnell, Ph.D.

SUMMARY:

Public sector utilization of psychiatric emergency services (PESs) has risen dramatically in the last two decades, but there has been little research related to changes in PES utilization. This study tested several hypotheses related to the possible causes of changes in psychiatric emergency service visits over time.

Data on adult admissions to San Francisco's three public psychiatric emergency services from January 1994 through March 1998 were collected from administrative databases and cross-referenced with data from other sources (totaling 35,520 visits). These sources include San Francisco Community Mental Health Services, the State of California Department of Employment Security, City and County of San Francisco arrest records, and the National Oceanographic and Atmospheric Administration. Statistical methods that draw on models that include autoregressive, integrated, or moving average (ARIMA) filters were used.

It was found that psychiatric emergencies exhibited cycles; namely, that higher or lower than average admissions were followed the next week by elevated or depressed values. These values, though, were not as large or small as those of the first week ($\phi_1 B = 0.209$, $p < .01$). Enhanced psychiatric emergency service access increased the number of admissions (No Lag = −21.92, $p < .01$). Employment factors, such as layoffs (Lag 3 = 8.04, $p < .01$) and the receipt of income (the "check effect") (Lag 0 = −1.27, $p < .01$) elevated admissions. Social factors affect admission rates—there was a reduction in visits on weekends and major holidays (Lag 0 = −2.81, $p < 0$). Conversely, there was an increase in psychiatric emergencies when knowledge of a suicide or violent event within the community existed. The hypothesis that the disruption of outpatient treatment access would elevate the number of psychiatric emergencies (No Lag = −7.05, $p < .05$) was also supported.

TARGET AUDIENCE:

Emergency psychiatrists, psychiatric emergency services care managers and providers, and mental health/substance abuse division administrators.

REFERENCES:

1. Borges WJ, Summers LC, Karshmer J: Psychiatric emergency service: using available resources. JONA, 1990; 25:31–37.
2. Oldham JM, Lin A, Breslin L: Comprehensive psychiatric emergency services. Psychiatric Quarterly 1990; 60:57–67.

Poster 30 **Saturday, October 30 10:00 a.m.-11:30 a.m.**

PREVALENCE OF LOW LITERACY IN A PSYCHIATRIC POPULATION

Richard C. Christensen, M.D., *Senior Physician, Northeast Florida Hospital, Florida Department of Children and Families, and Former APA/Bristol-Myers Squibb Fellow, Route 1, Box 519, Macclenny, FL 32063;* Glenn D. Grace, Ph.D., *Director of the Psychology Training Program, Gainesville VA Medical Center, 2400 S.W. Archer Road, Gainesville, FL 32610*

SUMMARY:

The National Adult Literacy Survey, sponsored by the Department of Education in 1992, found that 40 million to 44 million adults in the U.S. lack the necessary reading skills to understand basic written materials. For a variety of reasons, low literacy represents a profound obstacle to the effective negotiation of the current mental health care system. However, few studies have specifically examined the prevalence of low literacy in a psychiatric population.

In a study of the prevalence of low literacy in an indigent psychiatric population, 45 consecutive patients seeking mental health services at a shelter-based clinic for the homeless were given the Rapid Estimate Adult Literacy in Medicine (REALM) screening test. A sampling of the results reveal that 34 participants (76 percent) read at or below the seventh- to eighth-grade level. Ten participants in this low literacy group (29 percent) reported that they read "very well," 16 (47 percent) that they read "well," and eight (24 percent) that they read "not well." The complete findings from the study, which will be presented during the poster session, underscore the need for clinicians to be aware of, and consider formal screening for, low literacy in mental health care settings.

REFERENCES:

1. Grace GD, Christensen RC: Literacy and mental health care. Psychiatric Services 1998; 49:7.
2. Christensen RC, Grace GD: The prevalence of low literacy in an indigent psychiatric population. Psychiatric Services, in press.

POSTER SESSION 2

Posters 31-60

PSYCHOPHARMACOLOGY I

Poster 31 **Saturday, October 30 3:30 p.m.-5:00 p.m.**

EFFICACY OF SERTRALINE IN THE LONG-TERM TREATMENT OF PANIC DISORDER: RESULTS OF A MULTICENTER STUDY

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SUMMARY:

Objective: Panic disorder often requires long-term treatment. Sertraline has been proven effective in several acute studies of panic disorder, with or without agoraphobia. The current study was undertaken to evaluate long-term efficacy and safety of sertraline treatment in panic disorder.

Methods: Outpatients with DSM-III-R panic disorder who had completed one of three double-blind, placebo-controlled, 10-week studies were treated for 52 weeks with open-label sertraline followed by randomization of responders (CGI-Improvement of 1 or 2) to 28 weeks of double-blind, placebo-controlled treatment. Efficacy was evaluated by number, intensity, and duration of full-blown panic attacks, number of limited symptom attacks, percent time worrying, MC-PAS, CGI-Severity, HAM-A, and PGE ratings.

Results: 398 subjects from 31 U.S. centers entered the study; at Week 52, 183 subjects were randomized, 93 to sertraline, 90 to placebo. Less than 5% of subjects discontinued the study due to insufficient clinical response during 52 weeks of open-label treatment. Rates of discontinuation due to relapse or insufficient clinical response (12% in sertraline group vs. 24% in placebo group), and rates of acute exacerbation of panic disorder (13% in sertraline group vs. 30% in placebo group) were each statistically significant ($p < 0.05$). Sertraline was statistically more effective than placebo as measured by change in the double-blind baseline to endpoint on percent time worrying, CGI-Severity, CGI-Improvement, and PGE scores.

Conclusions: Sertraline was effective in long-term treatment of panic disorder for up to 80 weeks. Sertraline was substantially better than placebo in prevention of worsening of panic disorder symptoms.

REFERENCES:

1. Pohl RB, Wolkow RM, Clary CM: Sertraline in the treatment of panic disorder: a double-blind multicenter trial. Am J Psychiatry 1998; 155(9):1189–1195.
2. Pollack MH, Otto MW, Worthington JW, Manfro GG, Wolkow R: Sertraline in the treatment of panic disorder: a flexible-dose multicenter trial. Arch Gen Psychiatry 1998; 55(11):1010–1016.

Poster 32 **Saturday, October 30 3:30 p.m.-5:00 p.m.**

EFFICACY OF SILDENAFIL CITRATE FOR THE TREATMENT OF SEXUAL DYSFUNCTION IN MEN TAKING SSRIS

H. George Nurnberg, M.D., *Department of Psychiatry, University of New Mexico, 15 Camino Redondo, Placitas, NM 87043-9006;* Alan J. Gelenberg, M.D., *Chair, Department of Psychiatry, University of Arizona, 1501 North Campbell Avenue, Tucson, AZ 85724-5002;* Tim B. Hargreve, M.D.; Richard L. Siegel, M.D.

SUMMARY:

Objective: Sexual dysfunction (SD) is a common adverse event in men receiving antidepressant therapy with selective serotonin reuptake inhibitors (SSRIs) and may contribute to noncompliance with treatment regimens. SSRIs can be associated with absent or delayed orgasm, delayed ejaculation or the inability to ejaculate, decreased libido, and erectile dysfunction (ED). We evaluated whether sildenafil, approved for the treatment of ED, can alleviate the symptoms of SD in men with ED who were taking concomitant SSRIs.

Method: A retrospective analysis of combined data from 10 Phase II/III double-blind, placebo-controlled, fixed- and flexible-dose trials identified a subgroup of men with ED who were receiving 5-200 mg of sildenafil (S) or placebo (P) and taking concomitant SSRIs. Analysis of efficacy (ANCOVA) included responses to question 9 (Q9; frequency of ejaculation) and question 10 (Q10; frequency of orgasm) of the International Index of Erectile Function. Each question was scored from 0 to 5, with lower scores indicating greater SD. Results are expressed as mean baseline scores (±SEM) and mean change from baseline (±SEM) at the end of treatment (6 to 24 weeks).

Results:

Subgroup	N	S (baseline)	S (change)	N	P (baseline)	P (change)	P value
Q9: With SSRIs	62	2.42 ± 0.23	1.16 ± 0.25	30	2.67 ± 0.37	0.13 ± 0.29	<0.05
Without SSRIs	2041	2.74 ± 0.04	0.90 ± 0.04	1112	2.69 ± 0.06	0.05 ± 0.05	<0.001
Q10: With SSRIs	62	2.24 ± 0.22	1.34 ± 0.27	30	2.53 ± 0.34	0.23 ± 0.37	<0.01
Without SSRIs	2050	2.65 ± 0.04	0.93 ± 0.04	1112	2.61 ± 0.05	0.11 ± 0.05	<0.001

Conclusion: Sildenafil significantly improved the frequency of ejaculations and orgasm in patients with ED taking concomitant SSRIs. Funded by Pfizer Inc.

REFERENCES:

1. Goldstein I, Lue T, Padma-Nathan H, et al: Oral sildenafil in the treatment of erectile dysfunction. New England Journal of Medicine 1998; 338(20):1397–1404.
2. Rosen R, Riley A, Wagner G, Osterloh I, et al: The international index of erectile function (IIEF): a multidimensional scale for assessment of erectile dysfunction. Urology 1997; 49(6):822–830.

Poster 33 **Saturday, October 30 3:30 p.m.-5:00 p.m.**

SILDENAFIL FOR ANTIDEPRESSANT-INDUCED SEXUAL DYSFUNCTION IN FEMALE PATIENTS

Paula L. Hensley, M.D., *Assistant Professor of Psychiatry, University of New Mexico, 440 Maple Street, N.E., Albuquerque, NM 87106-4560;* H. George Nurnberg, M.D., *Department of Psychiatry, University of New Mexico, 15 Camino Redondo, Placitas, NM 87043-9006;* John Lauriello, M.D.; Lynda M. Parker, M.D.; Samuel J. Keith, M.D.

SUMMARY:

Objective: Sexual dysfunction is one of the more common and troublesome side effects associated with selective serotonin reuptake inhibitors (SSRIs) as well as the other classes of antidepressants. It frequently results in medication switching, discontinuation, or dose reductions to ineffective levels. Approximately 50% of patients of both genders reportedly experience some degree of sexual dysfunction with SSRIs. In women, the most common complaints include decreased libido, difficulty with lubrication, dispareunia, and anorgasmia. We report the use of sildenafil for antidepressant-induced sexual dysfunction in women.

Method: Ten female outpatients who developed sexual dysfunction, specifically anorgasmia with or without associated disturbances, during antidepressant treatment (primarily SSRIs) were selected. In open fashion, each subject was prescribed sildenafil 50mg. to be taken approximately one hour before sexual activity. For a partial or lack of response, the dose was increased to 100mg for the next occasion.

Results: Nine patients who took sildenafil showed significant reversal of sexual dysfunction, usually with the first dose of 50mg. One patient declined the trial on reconsideration.

Conclusion: Sildenafil appears to be a promising approach for management of antidepressant-induced sexual dysfunction and deserves further evaluation in randomized placebo-controlled studies.

REFERENCES:

1. Goldstein I, Lue TF, Padma-Nathan H, Rosen RC, Steers WD, Wicker PA: Oral sildenafil in the treatment of erectile dysfunction. The New England Journal of Medicine 1998; 338(20):1397–1404.
2. Montejo-Gonzalez AL, Llorca G, Izquierdo JA: SSRI-induced sexual dysfunction: fluoxetine, paroxetine, sertraline and fluvoxamine in a prospective, multicenter, and descriptive clinical study of 344 patients. J Sex & Marital Therapy 1997; 23:176–194.

Poster 34 **Saturday, October 30 3:30 p.m.-5:00 p.m.**

EFFECT OF SILDENAFIL CITRATE IN MEN WITH ERECTILE DYSFUNCTION AND DEPRESSION

Stuart N. Seidman, M.D., *Department of Psychiatry, Columbia Presbyterian Medical Center, 171 West 79th Street, New York, NY 10024;* Raymond Rosen, Ph.D., *Professor of Psychiatry, Robert Wood Johnson Medical School, 675 Hoes Lane, Piscataway, NJ 08854;* Matthew A. Menza, M.D.; Steven P. Roose, M.D.

SUMMARY:

Objectives: Erectile dysfunction (ED) and depression are highly prevalent conditions that are frequently comorbid; however, the causal relationship is unclear. This study assessed the change in depressive symptoms in men with ED and subthreshold major depression in a randomized controlled trial of sildenafil citrate versus placebo.

Methods: 146 men who presented to urologists with ED, and had SCID diagnoses of depressive disorder NOS with 24-item Hamilton Depression Rating Scale (HAM-D) scores of ℓ12, were randomized to receive

flexible-dose sildenafil (Sild; 25-100 mg; N = 70) or placebo (Pbo; N = 76) for 12 weeks in a double-blind trial. Patients were classified as responders for ED if they (1) answered "yes" to two global efficacy questions that asked whether treatment improved erections and the ability to have sexual intercourse, and (2) had erectile function (EF) domain scores of 22-30 (range 1-30; higher scores indicate better EF) on the International Index of Erectile Function questionnaire. Symptoms of depression were assessed at baseline and after 8 and 12 weeks of treatment using the HAM-D, Beck Depression Inventory (BDI), and Clinical Global Impression (CGI) scales.

Results: Results (intention-to-treat) at week 12 were:

	Mean (±SE) HAM-D	Mean (±SE) BDI	Mean (±SE) CGI	Total N	Sild N (%)	Pbo N (%)
Baseline	16.7 (0.3)	15.6 (0.7)	—	136	66	70
ED responders (wk 12)	6.4 (0.8)[4]	6.4 (0.9)[4]	1.8 (0.2)[4]	58	48 (83%)†	10 (17%)†
ED nonresponders (wk 12)	14.2 (0.9)	13.7 (1.0)	3.7 (0.2)	78	18 (23%)†	60 (77%)†

[4]P < 0.0001 vs ED nonresponders (ANCOVA); †P = 0.001 for treatment effect (chi-square).

Conclusions: After 12 weeks of treatment, patients classified as ED responders had significant improvements in mean HAM-D, BDI, and CGI scores compared with patients classified as ED nonresponders. Among ED responders, 83% were treated with sildenafil and 17% were treated with placebo. Funded by Pfizer Inc.

REFERENCES:

1. Goldstein I, Lue T, Padma-Nathan H, Rosen R, et al: Oral sildenafil in the treatment of erectile dysfunction. New England Journal of Medicine 1998; 338(20):1397–1404.
2. Morales A, Gingell C, Collins M, et al: Clinical safety of oral sildenafil citrate (VIAGRA®) in the treatment of erectile dysfunction. International Journal of Impotence Research 1998; 10(2):69–74.

Poster 35 **Saturday, October 30 3:30 p.m.-5:00 p.m.**

RISPERIDONE TREATMENT FOR SCHIZOTYPAL PERSONALITY DISORDER

Ifeoma J. Anwunah, M.D., *Department of Psychiatry, Bronx VA Medical Center, 116-A, Bronx, NY 10468;* Vivian Mitropoulou, M.A., *Department of Psychiatry, Bronx VA Medical Center, 116-A, Bronx, NY 10468;* Liza Bushnoe, M.A.; Larry J. Siever, M.D.

SUMMARY:

Background: While atypical antipsychotic agents have been increasingly utilized in the treatment of schizophrenia, they also may have unique advantages for the treatment of patients with personality disorders as they may be less likely to cause unwanted side effects such as dry mouth, sedation, and extrapyramidal symptoms, which reduce compliance in this patient population. Traditional antipsychotic medications have proven to be beneficial for both borderline and schizotypal personality disorder. While anecdotal case reports and ongoing preliminary studies (Schulz et al, 1998) suggest that these agents may be efficacious in treating borderline personality disorder, there have been no studies of atypical antipsychotic agents in schizotypal personality disorder, characterized by both psychotic-like and deficit-related symptoms similar, but milder than those seen in schizophrenia. It was hypothesized that risperidone, an atypical antipsychotic with both D_2 antagonism and $5\text{-}HT_2$ antagonism, would reduce the psychotic-like or positive symptoms of schizotypal personality disorder and perhaps ameliorate the negative symptoms and cognitive impairment as well.

Methods: In an ongoing trial of risperidone in schizotypal personality disorder 14 patients were administered risperidone/placebo in doses starting at 0.25mg QD titrated up to 1mg QD at week 6 in a double-blind fashion. Six patients were randomized to active drug and eight patients were randomized to placebo.

Results: At week 6, three patients (or 50%) receiving medication demonstrated a 20% decrease of their positive symptoms, while one patient demonstrated a 20% reduction in his negative symptoms. Out of the eight patients receiving placebo, one "responded" (a 20% reduction in positive symptoms). Preliminary results suggest that risperidone improves cognitive performance since all patients who received cognitive testing and were on active medication showed an improvement in verbal learning. Results will be updated to include data from the full 12-week trial on positive/negative symptoms and cognitive performance.

REFERENCES:

1. Coccaro EF: Clinical outcome of psychopharmacologic treatment of borderline and schizotypal personality disordered subjects. J Clin Psychiatry 1998; 59 suppl: 30–5.
2. Colloborative working group on clinical trial evaluations: Evaluating the effects of antipsychotics on cog-

nition in schizophrenia. J Clin Psychiatry 1998; 59 suppl 12:35–40.

Poster 36 **Saturday, October 30 3:30 p.m.-5:00 p.m.**

GABAPENTIN AS AN ANTI-DYSKINESIA AGENT

M. Carolina Hardoy, M.D., *Institute of Psychiatry, University of Cagliari, Italy, Via Liguria 13, Cagliari, Italy 09127;* Julieta Hardoy, M.D.; Mauro G. Carta, M.D.; Pier Luigi Cabras, M.D.

SUMMARY:

Objective: Gabapentin (GBP) is a novel antiepileptic compound that has recently been reported to be effective in the treatment of psychiatric disorders. The beneficial effect of GBP in two cases with previous antipsychotic-induced blepharospasm and involuntary mandibulo-oral movements was serendipitously observed during an open-label trial to further investigate the potential clinical spectrum of this drug in affective disorders. The aim of this study was to investigate the efficacy and tolerability of GBP in patients with blepharospasm.

Method: Ten patients underwent a 16-week open trial treatment with adjunctive GBP. All patients were initially escalated up to 300 mg of GBP three times a day.

Results: A dramatic improvement of evident movements occurred following treatment with GBP. The most common dose-limiting adverse effect was sedation, decreasing with continuing treatment. Other findings will be discussed.

Conclusions: Data indicate GBP to be an attractive compound for patients with signs of tardive dyskinesia. Further studies are warranted.

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Poster 37 **Saturday, October 30 3:30 p.m.-5:00 p.m.**

A RANDOMIZED, CONTROLLED TRIAL OF RISPERIDONE FOR PSYCHOTIC FEATURES IN PTSD

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SUMMARY:

Psychotic features may occur frequently in patients with chronic posttraumatic stress disorder (PTSD). Surprisingly, there has been little systematic study of the role of antipsychotics in PTSD. In a prospective, randomized, double-blind, placebo-controlled, flexible-dose trial we assessed the efficacy of the atypical antipsychotic risperidone added to existing medications in 40 patients with chronic PTSD and well-characterized comorbid psychotic features. Following a one-week single-blind placebo lead-in, patients were randomized to five weeks of double-blind treatment. Two patients discontinued prior to the initial assessment and 38 patients completed at least one week of treatment with risperidone (N = 19) or placebo (N = 19). The Positive and Negative Syndrome Scale (PANSS) was the primary outcome measure. Secondary measures included the Clinician Administered PTSD Scale (CAPS) and other assessments. Preliminary data analysis of end-point measures showed a significant reduction in global psychosis (PANSS ratings) in the risperidone-treated patients but not in the placebo group. Hallucinations and delusions declined significantly only in the risperidone group. The risperidone group also had a significant reduction in CAPS reexperiencing symptom subscale scores. The average dose of risperidone was 2.8 ± 1.7 mg. There were minimal extrapyramidal symptoms in either group. These data support the potential efficacy of risperidone in treating psychotic features associated with PTSD and suggest that core PTSD reexperiencing symptoms may also be responsive.

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Poster 38 **Saturday, October 30 3:30 p.m.-5:00 p.m.**

CHRONIC DEPRESSION: UNIPOLAR AND BIPOLAR II

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SUMMARY:

Lower age at onset and more atypical features in bipolar II versus unipolar depression are reported.

Study aim: To compare chronic/nonchronic bipolar II depression with chronic/nonchronic unipolar depression, to find chronicity effect on these differences.

Methods: 312 consecutive bipolar II/unipolar major depressive episode (MDE) outpatients were interviewed with the Structured Clinical Interview for DSM-IV. Variables included age, gender, diagnosis, age at MDE onset, MDE recurrences, atypical features, psychosis, comorbidity, and MDE severity. T test, two-sample test for proportion, two-way ANOVA, and odds ratios were used (STATA 5). Two-tailed $p < 0.01$.

Results: There was no significant difference between chronic bipolar II and chronic unipolar depression. There was a significantly lower age at onset and more atypical features in chronic/nonchronic bipolar II versus nonchronic unipolar depression. No interaction was found between chronicity and diagnosis on age at onset, and significant effect of diagnosis on age at onset. Odds ratios of atypical features in chronic bipolar II/chronic unipolar depression was (OR 1.7), versus nonchronic bipolar II/nonchronic unipolar depression (OR 4.9), a significant difference.

Conclusions: Differences in age at onset and atypical features between bipolar II and unipolar depression appear mainly due to nonchronic unipolar depression. Chronic unipolar depression appears to be intermediate between bipolar II depression and nonchronic unipolar depression.

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Poster 39 **Saturday, October 30 3:30 p.m.-5:00 p.m.**

INTERACTION OF HALOPERIDOL SOLUTION AND COFFEE

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SUMMARY:

We report and comment upon an unsuccessful effort to treat a behaviorally agitated, psychotic patient with haloperidol solution concealed in coffee. The patient suffered from metastatic small cell carcinoma of the lung with brain involvement and was deemed by civil court to be legally incompetent to make medical decisions. Because offered medications, including haloperidol, were refused, haloperidol (and dexamethasone) solutions were administered concealed in coffee, with the consent of his court-appointed conservator. After one week of treatment the patient showed no indications of either clinical improvement or side effects from this effort. An extensive literature search and consultation with the drug manufacturers revealed significant interactions between coffee and haloperidol, as well as a lack of available data to verify the absence of drug-drug interactions between dexamethasone and coffee. After obtaining consent by the conservator, the routes of administration were changed to intramuscular injections for haloperidol and methylprednisolone (as substitution for dexamethasone solution). The patient's mental status significantly improved within a short period of time. This case emphasizes the importance of carefully considering the physicochemical properties of a drug and consulting known medical references when innovative routes of drug administration are contemplated.

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2. Lasswell WL Jr, Weber SS, Wilkins JM: In vitro interaction of neuroleptics and tricyclic antidepressants with coffee, tea, and gallotannic acid. J Pharm Sci 1984; 73:1056–1058.

Poster 40 **Saturday, October 30 3:30 p.m.-5:00 p.m.**

RISPERIDONE AND SUPPRESSION OF CHOREOATHETOSIS IN HUNTINGTON'S DISEASE AND LEVODOPA-INDUCED DYSKINESIA IN PARKINSON'S DISEASE

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SUMMARY:

This study was intended to evaluate the suppressibility of choreoathetoid movements, jerky and slower sinuous involuntary movements associated with hyperdopa-minergic states, in HD and levodopa-induced dyskinesia in PD with risperidone therapy. Two groups of patients with choreoathetosis were treated with open-label risperidone. Risperidone was started at 0.5 mg/day, and increased as clinically indicated/tolerated by daily increments of 0.5 mg. The first group included five genetically confirmed HD patients with moderate to severe motor

abnormalities. Risperidone therapy was sustained for a period of 5–6 months. The Abnormal Involuntary Movement Scale (AIMS), and the Marsden and Quinn Severity Chorea Scale (MQSCS) measured changes in the severity of motor disability. The second group involved three patients with idiopathic PD, who suffered from levodopa-induced dyskinesia. Risperidone therapy was sustained for 3–4 weeks. The AIMS and Simpson Scale measured changes in the severity of choreoathetosis and parkinsonism, respectively. In both groups, cognitive status was evaluated by the Mini-Mental State Examination (MMSE) at baseline and endpoint. All the HD patients showed dramatic improvement in choreoathetoid movements, with an average improvement of 65.1% on AIMS and an average improvement of 56.2% on MQSCS. Average dose of risperidone was 4.5 mg/day. All the PD patients showed marked reduction in dyskinetic movements (as measured by a reduction from baseline to endpoint on the AIMS total score) without any significant worsening in parkinsonism. The risperidone dose ranged from 1 to 2 mg/day. There were no significant changes in the MMSE total scores from baseline to endpoint, in either HD or PD patients.

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2. Bennett JP, et al: Suppression of dyskinesia in advanced Parkinson's disease. Neurology 1993; 43:1545–1555.

Poster 41 **Saturday, October 30 3:30 p.m.-5:00 p.m.**

PROLACTIN ELEVATIONS IN PATIENTS TREATED WITH OLANZAPINE

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SUMMARY:

Objective: With the advent of novel antipsychotic compounds relatively free of extrapyramidal symptoms, increased interest is now directed to other side effects and their clinical relevance. However, systematic studies of such side effects are limited. The authors evaluated the prolactin response in patients receiving a fixed titration schedule of olanzapine.

Method: All patients were enrolled in an academically affiliated state hospital adult impatient unit and all met DSM-IV criteria for schizophrenia. This was a six-week open-label study with dose of 30/mg day of olanzapine achieved in two weeks. Serial serum assays were obtained from fasting samples drawn consistently to control for diurnal fluctuations and possible post-prandial effects.

Results: Results of preliminary data analysis in the first 10 subjects reveal acute and marked prolactin elevations associated with olanzapine in 40% of patients, including dramatic elevation in one neuroleptic-naïve patient studied. The study is being extended in subject number and duration to clarify if these findings are replicated in a larger study population and sustained beyond six weeks.

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Poster 42 **Saturday, October 30 3:30 p.m.-5:00 p.m.**

A COMPARATIVE ANALYSIS OF RISPERIDONE AND OLANZAPINE DOSING PATTERNS IN THE SOUTH CAROLINA MEDICAID PROGRAM

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SUMMARY:

Objective: This study investigates dosing patterns from a "real world" practice setting to compare how actual prescription costs differ from package insert recommendations for risperidone and olanzapine.

Methods: Patients with initial prescriptions for risperidone (n = 443) and olanzapine (n = 861) in the 1997 South Carolina Medicaid database were identified. The average dose of medication per day was calculated as a percentage change from package insert guidelines. Factorial analysis of covariance was used to test for differences between the average percentage of dose per day for medication and diagnostic categories. Covariates were compliance, total preperiod costs, and eligibility.

Results: There were no statistically significant between-group differences in age, race, sex, eligibility, or compliance. In the year before initial antipsychotic use, both groups had similar total health-care costs ($p = 0.07$) and number of comorbid conditions ($p = 0.06$). Patients treated with olanzapine had received a higher number

of different neuroleptics (2.09 vs. 1.71, p = 0.001). The average dose of risperidone was 48% of its recommended package insert dose while olanzapine was 122% (p = 0.0001). Average cost per day from these data was $4.88 for risperidone and $9.44 for olanzapine.

Conclusions: Relative to package insert guidelines, risperidone patients were prescribed significantly lower doses than were olanzapine patients. Comparing "real world" doses and recommended package insert doses, average costs per day were higher than expected for the olanzapine group and lower than expected in the risperidone group. When making formulary decisions or selecting preferred products, decision makers should consider actual dosing patterns.

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Poster 43 **Saturday, October 30 3:30 p.m.-5:00 p.m.**

USE OF ATYPICAL ANTIPSYCHOTICS IN A VA MEDICAL CENTER

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SUMMARY:

Records of all patients treated with clozapine, risperidone, olanzapine, or quetiapine during 1998 in the Cleveland VA Medical Center were reviewed to assess concurrent medication use, length of stay, hospital admissions, and costs of treatment. Clozapine was received by 145 patients, risperidone by 636, olanzapine by 395, and quetiapine by 40. The patients' mean ages ranged from 49 to 54 years; >90% were men. Their diagnoses included schizophrenia, schizoaffective disorder, bipolar disorder, and posttraumatic stress disorder. Concurrent antipsychotic medications were received by 39% of the clozapine patients, 24% of the risperidone patients, 47% of the olanzapine patients, and 73% of the quetiapine patients (the difference between risperidone and the other three groups was significant; $p < 0.05$). Psychiatric admissions were significantly more frequent in the clozapine group (1.1 admissions/patient/year) and the quetiapine group (1.5) than the risperidone or olanzapine group (0.8 in both; $p < 0.05$). Length of hospital stay after psychiatric admissions was shorter in the risperidone group (17.8 days) than the clozapine (40.5 days), olanzapine (20.1 days) or quetiapine groups (31.2 days). Total costs of treatment (antipsychotic drug + concurrent psychotropics + psychiatric admission and visit costs/patient/year) were lower for risperidone ($13,012) than clozapine ($30,665), olanzapine ($14,502), or quetiapine ($21,988).

REFERENCES:

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Poster 44 **Saturday, October 30 3:30 p.m.-5:00 p.m.**

SWITCHING FROM RISPERIDONE TO ZIPRASIDONE: AN INTERIM ANALYSIS OF A SIX-WEEK STUDY

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SUMMARY:

Objective: To investigate outpatients with chronic schizophrenia or schizoaffective disorder who were switched from risperidone to ziprasidone.

Methods: An interim analysis of a six-week, randomized study in which stable outpatients (n = 23) were switched from risperidone to ziprasidone 40–160 mg/day. Assessments included the PANSS, CGI, and a battery of cognitive tests, as well as standard safety and tolerability monitoring.

Results: Statistically significant improvements were seen in the PANSS total score and the negative, positive, and cognitive subscales. The majority of patients (n = 14, 64%) were rated as improved on the CGI and only one (4%) discontinued due to inadequate efficacy. Also notable were the significant improvements in assessments of cognitive function, specifically a computerized Continuous Performance Test, the Rey Verbal-Learning Test, Verbal Fluency, Digit Span Distraction, and the Wisconsin Card Sorting Task. In addition, prolactin and triglyceride levels decreased substantially (85% and 13%, respectively) with ziprasidone treatment.

Conclusions: The significant improvements in psychopathology and cognitive function in these patients switched from risperidone to ziprasidone are encouraging. Improvements in attention, vigilance, verbal learning and recall, and executive function indicated by these results, suggest that ziprasidone has a beneficial effect on cognitive function in patients with schizophrenia. In addition, ziprasidone was well tolerated.

REFERENCES:

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Poster 45 **Saturday, October 30 3:30 p.m.-5:00 p.m.**

ZIPRASIDONE REDUCES OVERALL PSYCHOPATHOLOGY AND SYMPTOMS OF DEPRESSION IN THE ACUTE TREATMENT OF SCHIZOAFFECTIVE DISORDER

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SUMMARY:

Objective: To investigate the efficacy of ziprasidone in the treatment of affective and psychotic symptoms in acute exacerbation of schizoaffective disorder.

Methods: Data from subsets of patients with schizoaffective disorder from two double-blind, placebo-controlled, parallel-group studies were analyzed. A total of 115 patients received either fixed oral doses of ziprasidone 40 mg/day (n = 17) or 120 mg/day (n = 20) for four weeks, ziprasidone 80 mg/day (n = 24) or 160 mg/day (n = 25) for six weeks, or placebo (n = 34) for four or six weeks.

Results: Ziprasidone 40–160 mg/day produced dose-related reductions in BPRS total, BPRS core items, BPRS manic items, and CGI-S scores ($P \leq 0.01$). Ziprasidone 160 mg/day significantly reduced mean BPRS total, BPRS core items, BPRS manic items, and CGI-S scores compared with placebo ($P < 0.01$). Ziprasidone 120 mg/day significantly reduced mean CGI-S score compared with placebo ($P < 0.05$). Dose-related improvements in mean BPRS depression cluster and MADRS scores were noted with ziprasidone 40–160 mg/day compared with placebo. The total incidence of adverse events with ziprasidone was low. Movement disorders were either absent or very infrequent in all treatment groups. No treatment-emergent mania was reported in any ziprasidone treatment group.

Conclusions: Ziprasidone appears to reduce overall psychopathology as well as manic and depressive symptoms in an acute exacerbation of schizoaffective disorder, and appears to be very well tolerated. Therefore, further study in schizoaffective disorder as well as other disorders, such as acute mania and bipolar disorder, appear to be warranted.

TARGET AUDIENCE:

General clinical audience

REFERENCES:

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Poster 46 **Saturday, October 30 3:30 p.m.-5:00 p.m.**

SWITCHING FROM OLANZAPINE TO ZIPRASIDONE: AN INTERIM ANALYSIS OF A SIX-WEEK STUDY

David G. Daniel, M.D., *Clinical Studies, Limited, 6066 Leesburg Pike, 6th Floor, Falls Church, VA 22041;* Robert Stern, M.D.; Thomas A.M. Kramer, M.D.

SUMMARY:

Objective: To investigate switching, from olanzapine to ziprasidone, patients with schizophrenia or schizoaffective disorder who had achieved only a partial response to treatment with olanzapine and/or who experienced troublesome side effects.

Methods: An interim analysis of a randomized study in which stable outpatients (n = 58) discontinued olanzapine and received ziprasidone 40–160 mg/day for six weeks. Standard psychopathology rating scales and a cognitive battery were administered as part of the clinical assessment.

Results: After six weeks of treatment, there were significant reductions in PANSS total, and the PANSS positive and negative subscale scores as well as the CGI-Severity score ($P < 0.05$). Almost half the patients were rated as improved on the CGI (CGI-Improvement = 1,

2, or 3) and only 5% (n = 3) discontinued ziprasidone due to insufficient response. Significant improvements were seen in tests of verbal learning and memory. Mean movement disorder assessment scales scores and anticholinergic use were low on entry and remained so on ziprasidone treatment. Mean body weight decreased significantly and median cholesterol and triglyceride levels decreased. Treatment-emergent extrapyramidal side effects were rare.

Conclusions: Patients who may require a change from olanzapine therapy appear to benefit on several important domains from switching to ziprasidone. Symptoms improved in many patients and ziprasidone was well tolerated. The significant improvement in verbal learning and memory, a key domain of cognitive function, with ziprasidone treatment is noteworthy because this has been linked with functional outcome. Beneficial changes in markers of health status after six weeks of ziprasidone therapy are also noteworthy.

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2. Weiden PJ, Aquila R, Dalheim L, Standard JM: Switching antipsychotic medications. J Clin Psychiatry 1997; 58(suppl 10):63–72.

Poster 47 **Saturday, October 30 3:30 p.m.-5:00 p.m.**

THE UNIQUE HUMAN RECEPTOR BINDING PROFILE MAY BE RELATED TO LACK OF WEIGHT GAIN WITH ZIPRASIDONE

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SUMMARY:

Objective: To compare the affinities of antipsychotics at receptor and neurotransmitter reuptake sites and deduce differences that might underlie the low incidence of weight gain observed with ziprasidone relative to other agents.

Method: Ziprasidone, olanzapine, risperidone, clozapine, quetiapine, and haloperidol were evaluated in human or bovine radioligand binding and rat synaptosomal neurotransmitter reuptake studies.

Results: Relative to D_2 receptor affinities, clozapine has higher affinity for $5HT_{2A}$ $5HT_{2C}$, m_1 cholinergic, H_1 histamine, α_1 adrenergic, and α_2 adrenergic; olanzapine for $5HT_{2A}$ $5HT_{2C}$, m_1 cholinergic, and H_1 histamine; risperidone for $5HT_{2A}$ and α_1 adrenergic; and quetiapine for H_1 histamine, m_1 cholinergic, and α_1 adrenergic receptors. In contrast, ziprasidone has higher affinity for the combination of serotonin $5HT_{2A}$, $5HT_{2C}$, $5HT_{1A}$, and $5HT_{1D}$ and has reduced relative affinity for α_1 adrenergic receptors. Like risperidone, ziprasidone also has reduced relative affinity for H_1 histamine receptors. Only ziprasidone moderately inhibits 5HT and norepinephrine (NE) reuptake and has high affinity for both $5HT_{1A}$ and $5HT_{1D}$ receptors. In clinical studies ziprasidone is associated with considerably less weight gain than clozapine and olanzapine and also less than quetiapine and risperidone.

Conclusion: The differences observed with ziprasidone suggest that the reduced H_1 histamine and α_1 adrenergic receptor binding affinities as well as its unique profile of potent 5HT receptor interactions (including $5HT_{1A}$ receptor agonism) and its moderate inhibition of 5HT and NE neuronal reuptake all might contribute to its low potential for weight gain.

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Poster 48 **Saturday, October 30 3:30 p.m.-5:00 p.m.**

A 28-WEEK COMPARISON OF FLEXIBLE-DOSE ZIPRASIDONE WITH HALOPERIDOL IN OUTPATIENTS WITH STABLE SCHIZOPHRENIA

Rory O'Connor, M.D., P.P.G. *Department, U.S. Pharmaceuticals, Pfizer Inc., 235 East 42nd Street, New York, NY 10017;* Steven Hirsch, M.D.; Aidan Power, M.D.

SUMMARY:

Objective: A randomized, double-blind study to compare flexible-dose oral ziprasidone 80–160 mg/day (n = 148) with haloperidol 5–15 mg/day (n = 153) over 28 weeks in outpatients with stable, chronic, or subchronic schizophrenia.

Method: Patients with a baseline PANSS negative subscale score ≥10 out of 49 and a GAF score >30 out of 100 were assessed using the PANSS, CGI-S, MADRS, Simpson-Angus, Barnes Akathisia, and AIMS scales.

Results: Modal doses at endpoint were 80 mg/day and 5 mg/day for ziprasidone and haloperidol, respectively. Robust improvements in all efficacy variables with both

ziprasidone and haloperidol were observed. Forty-eight percent of patients were categorized as negative symptom responders (ℓ20% reduction) in the ziprasidone group compared with 33% in the haloperidol group ($p < 0.05$). A trend for greater efficacy in improving depressive symptoms was also observed with ziprasidone. Ziprasidone was associated with fewer adverse events and discontinuations than haloperidol. Ziprasidone had clear advantages over haloperidol in all evaluations of movement disorders. Changes in body weight were negligible with both treatments.

Conclusions: Ziprasidone and haloperidol were both effective in reducing overall psychopathology. Ziprasidone was superior in the treatment of negative symptoms and was better tolerated than haloperidol. Thus, ziprasidone appears to offer a superior alternative to haloperidol in the medium-term treatment of stable outpatients with schizophrenia.

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Poster 49 **Saturday, October 30 3:30 p.m.-5:00 p.m.**

RISPERIDONE VERSUS HALOPERIDOL FOR PREVENTION OF RELAPSE IN SCHIZOPHRENIA AND SCHIZOAFFECTIVE DISORDERS: A LONG-TERM, DOUBLE-BLIND COMPARISON

John G. Csernansky, M.D., *Washington University School of Medicine, Metropolitan St. Louis Psychiatric Hospital, 5351 Delmar Boulevard, St. Louis, MO 63112;* Akiko Okamoto, Sc.D.; Martin B. Brecher, M.D.

SUMMARY:

A multicenter, randomized, double-blind comparison of RIS and HAL in stable outpatient schizophrenics and patients with schizoaffective disorder was conducted to compare the time to relapse. Patients continued double-blind treatment until the last patient had completed one year. Assessments were made weekly for the first four weeks and at four-week intervals thereafter. Scales used to assess efficacy included the total score on PANSS and all PANSS subscale scores. Safety evaluations included ESRS and clinical laboratory tests, including weight gain. Of 365 treated patients in the trial, 41 (23.2%) in the RIS and 65 (34.6%) in the HAL groups relapsed by the end of the first year ($P = .009$). During the entire trial, 45 (25.4%) patients on RIS and 75 (39.9%) patients on HAL relapsed ($P = .002$). This study provides evidence for the long-term effectiveness of RIS and corroborates earlier pivotal trials in which RIS was found to be significantly superior to HAL against both (+) and (−) symptoms. Previous short-term trials have shown RIS to be statistically superior to HAL in the control of (+) and (−) symptoms. This trial confirms the superior efficacy of RIS over HAL in long-term treatment. Patients treated with RIS experienced a desirable safety profile in long-term treatment. This included only a modest degree of weight gain (5.0 lbs at endpoint), a low rate of TD (0.6%), and a low rate of EPS.

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Poster 50 **Saturday, October 30 3:30 p.m.-5:00 p.m.**

EFFICACY OF SERTRALINE TREATMENT ON LONG-TERM OCD

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SUMMARY:

Objective: Obsessive-compulsive disorder (OCD) typically requires long-term treatment. The current study was undertaken to evaluate long-term efficacy and safety of sertraline treatment in OCD.

Methods: Outpatients with DSM-III-R OCD were treated for 52 weeks with single-blind sertraline followed by randomization of responders (Y-BOCS decreased by at least 25% and CGI-Improvement of 1, 2 or 3) to 28 weeks of double-blind, placebo-controlled treatment. Efficacy was evaluated by the Y-BOCS, NIMH global scale, CGI-Severity, CGI-Improvement, and Q-LES-Q (quality of life) ratings.

Preliminary Results: A total of 649 subjects from 21 U.S. centers entered the study; at week 52, 224 subjects were randomized, 110 to sertraline and 114 to placebo. More than 90% of responders to the first 16 weeks of therapy maintained considerable improvement during weeks 17–52 of single-blind treatment. Rates of discontinuation due to relapse or insufficient clinical response (9% in sertraline group vs. 24% in placebo group) and

rates of acute exacerbation of OCD (12% in sertraline group vs. 35% in placebo group) were each statistically significant ($p < 0.001$). Sertraline was statistically more effective than placebo as measured by change from double-blind baseline to endpoint on all the efficacy and the Q-LES-Q scores.

Conclusion: Sertraline was effective in long-term treatment in OCD for up to 80 weeks. Sertraline treatment was substantially better than placebo in prevention of worsening of OCD symptoms. In addition to the efficacy, the safety profile of long-term sertraline treatment will also be reported.

REFERENCES:

1. Koran LM: Obsessive-compulsive and related disorders in adults: a comprehensive clinical guide. Cambridge, England, Cambridge University Press, 1999.
2. Greist J, Chouinard G, Duboff E, et al: Double-blind parallel comparison of three dosages of sertraline and placebo in outpatients with obsessive-compulsive disorder. Arch Gen Psychiatry 1995; 52:289–295.

Poster 51 **Saturday, October 30**
3:30 p.m.-5:00 p.m.

IMPACT OF OLANZAPINE ON SERUM BLOOD GLUCOSE LEVEL

Leslie G. Smith, M.D., *Assistant Director of Research, Arkansas Mental Health Research and Training Institute, 2413 Shenandoah Valley Drive, Little Rock, AR 72212-3523*

SUMMARY:

Objective: Data exist supporting the hypothesis that re-uptake inhibition improves the condition of non-insulin-dependent diabetes mellitus. This study assesses the impact of olanzapine on the stability of blood glucose in a chronically mentally ill population. Olanzapine is a new generation neuroleptic that blocks brain 5HT2a and theoretically modulates dopamine function through direct and indirect action.

Method: As part of a naturalistic study, 52 patients were followed for evaluations in blood glucose, pre/post-treatment with olanzapine, within an assertive community treatment program. Demographic data are: 46.2% African American, 53.8% Caucasian; average age 41.4 years; and 25% diabetic. Baseline and follow-up blood glucose levels were obtained during treatment exposure.

Results: At baseline and follow-up, 1% and 33%, respectively, demonstrated blood glucose greater than 140. When controlling for diabetes at baseline, 77% diabetic vs. 18% non-diabetic patients demonstrated increased blood glucose with olanzapine exposure.

Conclusions: Patients with baseline diabetes prior to olanzapine exposure had a higher incidence of subsequent blood glucose elevations. There may be a relationship between decreased insulin sensitivity in patients with diabetes and treatment with olanzapine.

TARGET AUDIENCE:

Clinicians and psychiatric researchers.

REFERENCES:

1. Leibowitz SF, Alexander JT: Hypothalamic serotonin in control of eating behavior, meal size, and body weight.
2. Wirshing DA, Spellberg BJ, Erhart SM, Marder SR, Wirshing WC: Novel antipsychotics and new onset diabetes.

Poster 52 **Saturday, October 30**
3:30 p.m.-5:00 p.m.

DIAGNOSTIC REEVALUATION IN CHRONIC SCHIZOPHRENIC PATIENTS

Iliyan S. Ivanov, M.D., *Resident in Psychiatry, Maimonides Medical Center, 464 49th Street, #F-7, Brooklyn, NY 11219;* Akintay O. Akinlawon, M.D., *Resident in Psychiatry, Maimonides Medical Center, 1016 49th Street, Brooklyn, NY 11219*

SUMMARY:

This is a study that reviewed 37 patients with an axis I diagnosis Pf schizophrenia paranoid type over 24 months. Literature review indicated that the most common reasons for rehospitalization were command auditory hallucinations and intense paranoid ideations. Thirty-one patients exhibited a steady clinical course; 20 of them didn't require any hospital stay or changes in medication, while 11 patients were hospitalized once. The length of stay varied from eight to 24 days. Readjustment of anti-psychotic dosage was the primary/only treatment approach. Six patients exhibited complex clinical courses, of which five required multiple admissions ranging from three to eight times. All these patients had medication regimens that included antipsychotic, anxiolitics, and mood stabilizing drugs. One patient had a single admission of 82 days. Chart review, revealed that patients with complicated clinical course had a variety of affective disturbances combined with symptoms of psychosis and this clinical picture was associated with more patient rehospitalizations. Five patients with stable clinical course had their diagnosis changed. The study suggests that patients with complicated clinical course require careful evaluation to establish criteria for diagnosis and a diagnosis of schizo-affective disorder should be strongly considered.

REFERENCES:

1. Johnson D: The significance of depression in the prediction of relapse in chronic schizophrenia. Br J Psychiatry 1988; 152:320–323.
2. Linszen, et al: Patient attributes and expressed emotions as risk factors for psychotic relapse. Schizophrenia bulletin 1989; 23(1)119–130.

Poster 53 **Saturday, October 30 3:30 p.m.-5:00 p.m.**

UNIPOLAR MANIA: FACT OR FICTION?

Vishal K. Adma, M.D., *Resident in Psychiatry, University of Kansas Medical Center, 7622 Halsey, #102, Lenexa, KS 66216;* Ekkehard Othmer, M.D., *Professor of Psychiatry, University of Kansas Medical Center, 5709 Northwest 64th Terrace, Kansas City, MO 64151-2382;* Elizabeth C. Penick, Ph.D.; Elizabeth J. Nickel, M.A.; Cherilyn M. De Souza, M.D.; Barbara J. Powell, Ph.D.; William F. Gabrielli, M.D., Ph.D.; Marsha R. Read, Ph.D.; Edward E. Hunter, Ph.D.; Laurie L. Krambeer, Ph.D.

SUMMARY:

Objective: Unipolar mania refers to the presence of one or more manic episodes in the absence of major depression. Unipolar mania is not specifically recognized as a separate diagnosis in DSM-IV but is recognized in the ICD-9-CM. We examined the clinical validity of unipolar mania as a possible diagnostic entity distinct from bipolar mania.

Method: During a five-year period, we studied 1458 admissions to an outpatient psychiatric clinic with structured interviews, rating scales, and self-report measures. Three hundred nineteen patients (22%) met lifetime inclusive DSM-III criteria for at least one manic episode. Only 44 of these did not also meet criteria for major depression. We compared unipolar manic patients with bipolar manic patients on multiple clinical dimensions.

Results. Unipolar and bipolar mania patients did not differ according to age, race, marital status, or education. Proportionally more of the male patients had unipolar mania. Approximately one-half of each group had been hospitalized psychiatrically. Onset of mania was six years earlier in bipolar mania (22 vs. 28 years). Bipolar manics reported higher levels of symptom severity, greater social interference, and more comorbid schizophrenia, somatization, and anxiety disorder. Bipolar manics reported more mania and depression among first-degree relatives. Mood stabilizers were more often prescribed to unipolar than bipolar manic patients (37% vs. 20%); otherwise, treatment utilization was the same in the two groups.

Conclusions. Our data offer support for unipolar mania as a distinct clinical syndrome.

REFERENCES:

1. Nurnberger J, Roose SP, Dunner DL, Fieve RR: Unipolar mania: a distinct clinical entity? American Journal of Psychiatry 1979; 136:1420–1423.
2. Shulman KI, Tohen M: Unipolar mania reconsidered: evidence from an elderly cohort. British Journal of Psychiatry 1994; 164:547–549.

Poster 54 **Saturday, October 30 3:30 p.m.-5:00 p.m.**

SCHIZOPHRENIA TRIAL: PARTICIPANTS VERSUS NONPARTICIPANTS

Scott W. Woods, M.D., *Associate Professor of Psychiatry, Yale University, 38 Avon Street, #1, New Haven, CT 06511-2523;* Douglas M. Ziedonis, M.D.; Michael J. Sernyak, M.D.; Esperanza Diaz, M.D.; Robert A. Rosenheck, M.D.

SUMMARY:

Are patients enrolled in efficacy trials representative of those seen in practice settings? We sought to compare characteristics of schizophrenic participants from dual diagnosis or standard schizophrenia efficacy trials with the other schizophrenic patients in the clinical population from which the trial participants had been drawn.

Methods: Ten efficacy trials were conducted in the early and mid 1990s at our center, subdivided into "dual diagnosis" trials (four trials) or "standard" schizophrenia trials (six trials). Participants were compared with nonparticipants on measures available in the center's administrative database.

Results: Participants in both types of trial were about six to eight years younger, two to four times less likely to have ever married, and used more services than nonparticipants. Participants in standard trials were more likely to be high school graduates, and four times more likely to work full time than nonparticipants. Participants in dual diagnosis trials were more likely to be minorities and less likely to have medical comorbidities than nonparticipants.

Conclusions: Efficacy trial participants differed substantially from nonparticipants, and some differences appear to be predictive of better outcome and some of poorer outcome. Effectiveness studies may be needed to confirm that efficacy results generalize to the intended target population.

TARGET AUDIENCE:

Psychiatrists, researchers, and mental health professionals.

REFERENCES:

1. Spohn HE, Fitzpatrick T: Informed consent and bias in samples of schizophrenic subjects at risk for drug withdrawal. J Abnorm Psychol 1980;89:79–92.
2. Wells KB: Treatment research at the crossroads: the scientific interface of clinical effectiveness research. American Journal of Psychiatry 1999; 156:5–10.

Poster 55 **Saturday, October 30 3:30 p.m.-5:00 p.m.**

DEPRESSION SCREENING USING DRUG UTILIZATION PROFILES

George Fulop, M.D., *Medical Policy and Programs Director, Merck & Company, Inc., 1 Kitchel Road, Mount Kisco, NY 10549-4517;* Donald W. Robinson, Jr., M.S.P.H.; Laurence J. Hirsch, M.D.

SUMMARY:

Background: Despite yearly increases in antidepressant use, over 33% of depressed patients in primary care practice remain unrecognized and untreated. We report preliminary results from one module of our Depression Disease Management Program that screens patients for depression, notifies their primary physician of the results, and records whether the physician evaluates the patient and initiates antidepressant therapy.

Methods: Using a clinical rule derived from evidence-based literature, drug utilization profiles were reviewed between 7/98–10/98 to identify patients at increased risk for depression. Of 1306 eligible patients, 723 (55%) consented to participate in the telephonic screen administered by trained psychiatric nurses using a depression screening instrument developed from DSM-IV criteria. Physicians of patients who screened positive were mailed the results and AHCPR guidelines on recognition and management of depression. A follow-up call encouraged the evaluation of depression. A final reminder mailing was sent if antidepressant therapy was not started within two months.

Results: Sixty-three (9%) of the 723 "at risk" patients screened positive for depression. They were 67.8 +/– 10.5 years old and 63.1% female; 20.7% received a new antidepressant prescription within six months compared with 7.7% of patients who screened negative, and 6.9% of patients not screened.

Conclusion: Using a computerized prescription database and a clinical algorithm based on prescription utilization profiles, a prescription benefits manager can identify and screen patients at risk for depression and successfully message their physician to evaluate the patient. Patients who screened positive were three times as likely to subsequently begin antidepressant therapy. The impact of this intervention on medical resource utilization and patient outcomes will be evaluated.

TARGET AUDIENCE:

Medical directors and quality improvement staff.

REFERENCES:

1. Mulrow CD, Williams Jr. JW, Gerety MB, Pamirez G, et al: Care-finding instruments for depression in primary care settings. Am Intern Med 1995; 122:913–921.
2. Katon W, Von Korff M, Lin E, Lipscomb P, et al: Distressed high utilizers of medical care: DSM-III-R diagnoses and treatment needs. Gen Hosp Psych 1990; 12:355–362.

Poster 56 **Saturday, October 30 3:30 p.m.-5:00 p.m.**

A NATURALISTIC STUDY OF ANTIPSYCHOTIC MEDICINES

Robert Crane, M.S.W., *Program Director, Metropolitan State Hospital, 11400 Norwalk Boulevard, Norwalk, CA 90650;* Sarath Gunatilake, M.D., *Medical Director, Metropolitan Hospital, 11400 Norwalk Boulevard, Norwalk, CA 90650;* Thushara Fernando, M.D.; Steve Brown, Ph.D., J.D.

SUMMARY:

The newer atypical antipsychotic medicines hold considerable promise for treating schizophrenia and schizoeffective disorders. The higher up front cost of these medications is believed to be justified on the basis of social and economic advantages, and by the expectation of improved patient outcomes with the decreased risk of drug toxicity and other side effects.

In this study 45 chronic mentally ill patients with diagnoses of schizophrenia or schizoaffective disorder were followed up for approximately one year. Of this group, 24 patients were treated with atypical antipsychotic medications and 21 were put on conventional antipsychotic medications. Patients were evaluated at regular intervals throughout the course of this study. The results from a rapid assessment instrument demonstrated that the group receiving atypical antipsychotic medications showed significantly greater improvements in the areas of cognitive functioning (understanding of psychiatric condition); quality of life (social skills) and selfcontrol (medication compliance; management of aggressive behavior) than did the group that received conventional medications. These results are discussed in terms of their economic and social significance.

TARGET AUDIENCE:

Psychiatrists, psychologists, and administrators.

REFERENCES:

1. Buckley P: Treatment of schizophrenia: let us talk dollars and sense. Amer Journal of Managed Care 1998; 4(3):369–381.
2. Fichtner CG, Hanrahan P, Luchins D: Pharmacoeconomic studies of antipsychotics: review and perspective: Psychiatric Annals 1998; 28(7):381–395.

Poster 57 **Saturday, October 30 3:30 p.m.-5:00 p.m.**

DESIGNING EDUCATION MATERIALS FOR INPATIENT USE

Thushara Fernando, M.D., *Public Health Physician, Metropolitan State Hospital, 11400 Norwalk Boulevard, Norwalk, CA 90650;* Sarath Gunatilake, M.D., *Medical Director, Metropolitan Hospital, 11400 Norwalk Boulevard, Norwalk, CA 90650;* Steve Brown, Ph.D., J.D.; Jerome F. Costa, M.D., M.P.H.

SUMMARY:

This poster presentation describes the development and preliminary evaluation of a comprehensive patient education program at a state mental hospital. The material was designed to help chronic schizophrenic patients gain insight into their illness and an understanding of their treatment regimen. Observations, interviews, and chart reviews were used to assess patients' learning needs. Educational needs assessment became an integral part of the treatment planning process. It was discovered that chronic schizophrenic patients have significant educational needs for which the existing resources were inadequate. Two levels of educational materials were developed. One level was designed for people with minimal educational skills. The other level was designed to be used by people who had at least a 6th grade reading ability. All material was developed using a patient-centered instructional design process.

Pilot testing and evaluations by patients and staff showed high acceptance and high teaching efficacy. This program will be expanded to provide educational materials for other psychiatric diagnostic categories.

TARGET AUDIENCE:

Psychiatrists, psychologists and administrators.

REFERENCES:

1. Lorig K: Patient Education: A Practical Approach. Thousand Oaks, CA: SAGE Publications, 1996.
2. Redman BK: Patient education at 25 years. Journal of Advanced Nursing 1993; 728.

Poster 58 **Saturday, October 30 3:30 p.m.-5:00 p.m.**

GENERAL HEALTH IN PRIMARY CARE PATIENTS WITH PTSD

Risa B. Weisberg, Ph.D., *Project Director, Department of Psychiatry, Brown University, 700 Butler Drive, Box G-BH, Providence, RI 02906;* Martin B. Keller, M.D., *Chairman, Department of Psychiatry and Human Behavior, Brown University and Butler Hospital, 345 Blackstone Boulevard, Providence, RI 02906;* Steve Bruce, Ph.D.; Regina T. Dolan, Ph.D.; Larry Culpepper

SUMMARY:

Introduction: We report preliminary data from the Primary Care Anxiety Project (PCAP), a naturalistic, longitudinal study of anxiety disorders in primary care patients. General health is examined in primary care patients with anxiety disorders.

Method: Twelve hundred potential participants at 14 primary care offices completed a questionnaire screening for anxiety symptoms. Those who screened positive were assessed with the Structured Clinical Interview for the DSM-IV. Two-hundred-fifty participants met criteria for one or more anxiety disorder; 78 of these subjects met criteria for PTSD. Health status was examined using a medical history form designed for our study.

Results: Chi-square analyses indicated that patients with PTSD reported significantly higher rates of most medical problems (e.g., back pain, asthma, diabetes) than did participants with other anxiety disorders but without PTSD. A possible explanation for the greater rates of medical problems was that a physical trauma might have led to both PTSD and physical injury. Multiple regression revealed that, after accounting for age, gender, and a history of injury, the presence of PTSD was associated with a significant increase in the number of medical conditions and accounted for a greater proportion of the variance (nearly 10%) than any of the other predictors.

Conclusion: Findings suggest that PTSD is uniquely associated with increased general medical complaints. Results will be discussed with regard to implications for health care utilization and the well-being of PTSD patients.

TARGET AUDIENCE:

Mental health and primary care practitioners and psychiatry researchers.

REFERENCES:

1. First MB, Spitzer RL, Gibbon M, Williams JBW: Structured Clinical Interview for DSM-IV Axis I Disorders. Biometrics Research Department, New York State Psychiatric Institute, 1996.

2. Hankins CS, Aburg FR, Gallaher-Thompson D, Laws A: Dimensions of PTSD among older veterans seeking outpatient medical care: a pilot study. J of Clinical Geiopsychology 1996; 2:239–246.

Poster 59 **Saturday, October 30 3:30 p.m.-5:00 p.m.**

FUNCTIONING AND WELL BEING OF PRIMARY CARE PTSD PATIENTS

Risa B. Weisberg, Ph.D., *Project Director, Department of Psychiatry, Brown University, 700 Butler Drive, Box G-BH, Providence, RI 02906;* Martin B. Keller, M.D., *Chairman, Department of Psychiatry and Human Behavior, Brown University and Butler Hospital, 345 Blackstone Boulevard, Providence, RI 02906;* Regina T. Dolan, Ph.D.; Ingrid Dyck; Larry Culpepper

SUMMARY:

Introduction: Functioning and well-being are examined in primary care patients with PTSD and compared with that of individuals with other chronic conditions.

Method: We report on the functioning and well-being of individuals with PTSD, using preliminary data from the Primary Care Anxiety Project (PCAP), a naturalistic, longitudinal study of anxiety disorders in primary care patients. Functioning and well-being of 78 subjects with PTSD is measured using the Rand 36-Item Health Survey. These scores are compared with those of subjects from the Medical Outcomes Study (MOS) who had general medical and psychiatric conditions including hypertension, recent myocardial infraction, diabetes, and depression, and to subjects from a general population sample.

Results: Analyses revealed that patients with PTSD reported functioning that was as poor or significantly worse than that of the MOS subjects with medical conditions, typically falling below the 25th or 50th percentile of scores for these samples. Subjects with PTSD scored worse than those with depression on measures of physical functioning, but better on scales of emotional health. However, primary care subjects with both PTSD and major depression reported significantly worse functioning on all subscales than did MOS subjects with depression alone.

Conclusion: Findings suggest that PTSD is associated with poor functioning and well-being. Results will be discussed with regard to implications for the severity of impairment in PTSD patients.

TARGET AUDIENCE:

Mental health and primary care practitioners and psychiatry researchers.

REFERENCES:

1. Ware JE, Snow KK, Kosinski M, Gandek B: SF-36 Health Survey Manual and Interpretation Guide. Boston, Mass, Health Institute, New England Medical Center, 1993.
2. Stewart AL, Greenfield S Hays, RD, Wells K, et al: Functional status and well-being of patients with chronic conditions: results from the Medical Outcomes Study. JAMA 1989; 7:907–913.

Poster 60 **Saturday, October 30 3:30 p.m.-5:00 p.m.**

WEIGHT MONITORING AND MANAGEMENT IN SCHIZOPHRENIA

John A. Chiles, M.D., *Professor of Psychiatry, University of Texas Health Sciences Center at San Antonio, 127 West Fairoaks Place, San Antonio, TX 78209;* Alexander L. Miller, M.D., *Professor of Psychiatry, University of Texas Health Sciences Center, 7703 Floyd Curl Drive, San Antonio, TX 78284-6200;* Judith K. Chiles

SUMMARY:

Weight, and its more sophisticated assessment by body mass index (BMI), are not generally monitored in the treatment of schizophrenia. Atypical antipsychotics may increase body weight by 20 to 50 lbs, and, in doing so, increase a patient's risk for a number of adverse medical conditions. The Schizophrenia Algorithm within the Texas Medication Algorithm Project has monitored weight and BMI in 150 patients over three to 12 months, and is instituting a weight control program tailored to the patient with schizophrenia. Eighty-six percent of our patients are overweight (BMI>25) at entry, and 43% are obese (BMI>30). This poster will present the schizophrenia program weight monitoring data over one year, and will relate change in BMI to type of medication treatment. The clinician and patient components of the TMAP weight control program will be presented.

REFERENCES:

1. Chiles J, Miller AL, Crismon ML, et al: The Texas Medication Algorithm Project: Development and Implementation of the Schizophrenia Algorithm.
2. Allison DB, Mentore JL, Heo MS, et. al: Weight gain associated with conventional and newer antipsychotics: a meta analysis. Eur Psychiatry 1998; 13:302.

POSTER SESSION 3

Posters 61-90

CONSULTATION/LIAISON, HEALTH ECONOMICS AND HEALTH SERVICES

Poster 61 **Sunday, October 31**
10:00 a.m.-11:30 a.m.

PHARMACOTHERAPY IN PSYCHIATRIC PRACTICE

Ivan D. Montoya, M.D., M.P.H., *Director, Practice Research Network, Office of Research, American Psychiatric Association, 1400 K Street, N.W., Washington, DC 20005;* Max Sederer, B.A., *Research Assistant, American Psychiatric Association, 1400 K Street, N.W., Washington, DC 20005;* Ana P. Suarez, M.P.H.; Harold Alan Pincus, M.D.

SUMMARY:

The purpose of this study is to characterize the practice and caseload profile of psychiatrists reporting different patterns of prescribing psychotropic medications. Data were collected through self-administered questionnaires mailed to a randomly selected sample of American Psychiatric Association members. Questions about their psychiatric practice were asked on an aggregate level. Data were weighted and analyzed using SUDAAN and SAS software. Results indicate that, on average, psychiatrist prescribed medications to 81% of their patients. Comparisons were made between the higher prescribing group (HPG) who treated >90% of patients with medications (n = 428) and the lower prescribing group (LPG) who treated ≤90% of patients with medications (n = 486). The HPG was significantly more likely to be younger, nonwhite, from the South and Midwest, international medical graduate, and to receive income from salary. This group had significantly higher average of patients with public assistance, with non-managed care health plans, and patients with diagnoses of mood, psychotic, and substance use disorders. These results suggest that the proportion of patients to whom psychiatrists prescribe psychotropic medications may be affected by the characteristics of the psychiatrists, their patient caseload, and their practice profile.

TARGET AUDIENCE:

Clinical psychiatrists who are involved in direct patient care.

REFERENCES:

1. Pincus HA, Tanielian TL, Marcus SC, et al: Prescribing trends in psychotropic medications: primary care, psychiatry, and other medical specialties. JAMA 1998; 279:526–31.
2. Olfson M, Pincus HA, Sabshin M: Pharmacotherapy in outpatient psychiatric practice. Am J Psychiatry 1994; 151:580–5.

Poster 62 **Sunday, October 31**
10:00 a.m.-11:30 a.m.

COGNITION, CARDIAC SURGERY AND THE HIGH-RISK ELDERLY PATIENT: TOWARDS A NEW RATING SCALE

Bogdan P. Sasaran, M.D., *Department of Psychiatry, Beth Israel Medical Center, First Avenue at 16th Street, New York, NY 10003;* Robert M. Homer, M.D., *Department of Psychiatry, Beth Israel Medical Center, First Avenue at 16th Street, New York, NY 10003;* Joshua Ding, M.D.

SUMMARY:

Purpose: Patients who undergo cardiac surgery often subsequently develop cognitive impairment. The utility of pre- and postoperative psychiatric evaluation and its cost offset benefit is suggested. A simple, cost-effective risk assessment scale is proposed.

Method: A qualitative, exploratory meta-analysis spanning the last 15 years is presented. Age, blood pressure, cerebrovascular disease, cardiac disease, cognitive status, brain imaging studies, and biological markers are the risk factors considered. Separation into relative and absolute high-risk patients is achieved with the new Cognitive Impairment Risk Assessment Scale (CIRAS).

Results: Age ≥70, duration of hypertension >10 years, evidence of cerebrovascular disease, and cardiac disease with left ventricular dysfunction are the major criteria; MMSE scores ≤25, positive findings on brain imaging studies including QEEG, systolic blood pressure ≤130–140, presence of ApoE-4 and AD7C-NTP, and ejection fraction ≤30% constitute minor criteria. The high-risk patient is defined by a minimum of the major or one major and two minor criteria. The CIRAS is defined by age, duration of hypertension, MMSE score, and systolic blood pressure value.

Conclusion: While the major and minor criteria can have immediate clinical applications, the CIRAS needs further validation by conducting a quantitative, hypothesis-driven meta-analysis. Ethical and clinical considerations are discussed.

TARGET AUDIENCE:

Consultation-liaison psychiatrists, surgeons, and internists.

REFERENCES:

1. Konishi A, Kikuchi K, Igarachi T: Change of the cognitive function after open heart surgery. Japanese J Anesth 1995; 44:1107–12.
2. McKhann GM: Depression and cognitive decline after coronary artery bypass grafting. Lancet 1997; 349:1282–4.

Poster 63 **Sunday, October 31**
10:00 a.m.-11:30 a.m.

PSYCHOPATHOLOGY AFTER PROLONGED ICU TREATMENT

Jens C. Richter, M.D., *Department of Psychiatry, University of Hamburg, Germany, Steinweg Passage 1, Hamburg, Germany 20355;* Frank G. Pajonk, M.D.; Christian Waydhas, M.D.

SUMMARY:

Introduction: Prolonged Intensive Care Unit (ICU) treatment subjects patients to considerable somatic, emotional, social stress. Aim of the study was to determine the role of ICU treatment in the prevalence of psychiatric disorders in the long term.

Methods: Patients from a four-year period who had an ICU length of stay (LOS) of 30 days or longer in the Department of Surgery, University of Munich, were included. The surviving patients completed several self-report questionnaires (SCL-90-R; POMS; Spitzer Quality of Life) and underwent a physical exam and semi-structured psychiatric interview, including completion of the HAMD and GAF by an experienced psychiatrist.

Results: Forty-one of 46 survivors (m = 31/f = 10) were eventually seen 35 ± 14 months after discharge from the ICU. Mean LOS was 51 ± 19 days, mean age 41 ± 17 years. At the time of follow-up, 59% of the patients had psychiatric ICD-10 diagnoses, mostly substance-abuse related. In general, scales showed elevated scores compared with the normal population. In the HAMD, seven patients had scores suggestive of depressive disorders. Case-by-case analysis revealed that a small subgroup of patients (n = 7) had highly elevated scores in most subjective and objective scales while the majority remained within a normal range of values. Taking into account comorbidity, the patients in the subgroup suffered from depressive disorder (n = 3), anxiety disorder (n = 1), organic mental disorder (n = 1), substance abuse disorder (n = 3), other (n = 1).

Conclusions: Prolonged ICU treatment can result in persisting psychological disturbances and psychiatric disorders even years after discharge, at least in a subgroup of patients. Vulnerability seems particularly high for multiple trauma victims and for patients who reported a deterioration of their social situation. Patients at risk can be easily detected in early stages through questions covering psychological and social issues; intervention should be initiated immediately.

REFERENCES:

1. Fakhry SM, Kercher KW, Rutledge R: Survival, quality of life, and charges in critically ill surgical patients requiring prolonged ICU stays. J Trauma 1996; 41:999–1007.
2. Landsman IS, Baum CG, Arnkoff DB, Craig MJ, et al: The psychosocial consequences of traumatic injury. J Behav Med 1990; 13:561–581.

Poster 64 **Sunday, October 31**
10:00 a.m.-11:30 a.m.

STRATEGIES OF SHARED MENTAL HEALTH CARE IMPLEMENTATION BETWEEN GENERAL PRACTITIONERS AND PSYCHIATRISTS

Ricardo J.M. Lucena, M.D., *Department of Psychiatry, University of Montreal, 450 Sherbrooke East, #809, Montreal, PQ Canada H2L 1J8;* Alain D. Lesage, M.D.; Claude Beaudoin, M.D.; Jean M.V.D. Maren, Ph.D.

SUMMARY:

The specific purpose of our exploratory study is to identify the strategies of shared mental health care implementation between general practitioners and psychiatrists. The data were collected from a purposefully selected sample of five general practitioners and five psychiatrists. Ten individual in-depth interviews and one focus group session were conducted. The data treatment process consisted of discourse analysis and was guided by a preestablished coding system, which showed 98% and 87% intra/intercoder reliability, respectively. The results suggest three broad intertwined strategies: (1) improving communication, (2) building educational linkages between general practitioners and psychiatrists, and (3) developing alternate methods of remuneration to support shared care activities. The first two strategies are local-based, simple, and rapid to implement; they bring rich dividends to all concerned. The last one is fundamental and requires long-term complex changes to be achieved. However, the current discussions, in Canada and Quebec, between governments and physicians' associations concerning capitation payments for GPs and a vacation payment system for specialists, could pave the way to resolve, in the near future, the financial barriers to better shared mental health care.

Acknowledgments: CRFS (Centre de Recherche Fernand-Séguin)

CAPES (Ministério da Educação, Brasil)

REFERENCES:

1. Kates N, Craven M, Bishop J, Clinton T, Kraftcheck D, et al: Shared mental health care in Canada. Canadian Journal of Psychiatry 1997; 42(8).
2. Goldberg D, Huxley P: Mental Illness in the Community: The Pathways to Psychiatric Care. London, Tavistock Publications, 1980.

Poster 65 **Sunday, October 31**
10:00 a.m.-11:30 a.m.

THE EXPERIENCE OF PSYCHIATRISTS AND PSYCHOTHERAPISTS IN A SOMATIC HOSPITAL

Vladimir N. Prokudin, D.M.S., *Associate Professor of Psychiatry and Medical Science, Russia State Medical University and Somatic Hospital, Leningradskow Shosse 31–91, Moscow, Russia 125212;* Pavel Sharaev, D.M.S., *Medical Director and Therapist, Somatic Emergency Hospital, N-36, Fortuntovskaya 1, Moscow, Russia 105058;* Yuri S. Savenko, M.D.; Alexander P. Muzichenk, M.D.

SUMMARY:

Usually there is a psychiatrist in each large somatic hospital in Russia. Moreover, since 1995 the Ministry of Health has ordered psychotherapeutic service in somatic hospitals in addition to psychiatric service. In this report we would like to analyze the 15 years' experience of psychiatric service in the 50 large Moscow somatic hospitals and the two years' experience of psychotherapeutic service in the 36 somatic emergency hospitals. The functions of the psychiatrist in the somatic hospital are the following: (1) emergency consultations of somatic patients in connection with appearance of acute psychosis (exogenic, psychogenic, or endogenic; (2) if it is necessary, organization of transference of psychotic patients into a special psychosomatic department or in a psychiatric hospital; (3) regular consultations of somatic patients suffering from light psychical disorders (neurotic and neurotic-like disorders) and variety therapy of these patients with psychothropic drugs; (4) carrying out the simple types of psychotherapy with neurotic patients. The alcohol abstinent deliriums in patients with heavy drinking (at two to three days after their admission), and confusional of consciousness in patients with cerebral sclerosis are the most frequently observed cases of psychosis in somatic patients. The most frequently observed nonpsychotic disorders—psychosomatical, hystherical, hypohondriacal, and neurastenical. Psychotherapeutic service in somatic hospitals is usually performed by a psychiatrist with specialization in psychotherapy and this service includes, in addition to the above mentioned functions, the following specific psychotherapeutic ones: special types of psychotherapy (individual and group hypnotherapy, behavioral, cognitive and dynamic etc.), computer-psychodiagnostic and other functions (with help of a medical psychologist).

REFERENCES:

1. Prokudin V, Yakubuv A, Sharaev P: The role of psychiatric service in Moscow somatic hospital, No 36. Abstracts "5th World Congress on "Innovation in Psychiatry- 1998"; 64.
2. Prokudin V, Yakybov Ae, Sbaraev P: The necessity of psychotherapeutic service for geriatric patients in the somatic hospitals. Abstracts "Worldwide Revolution in Longevity & Quality of Life" 1998; 104.

Poster 66 **Sunday, October 31**
10:00 a.m.-11:30 a.m.

CLOSE PERSONAL ADVOCACY FOR INVOLUNTARY PATIENTS: IMPROVING OUTCOMES AND SAVING MONEY

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SUMMARY:

Background: Coercion in psychiatry is frequently necessary but is resented by the patient and promotes one-size-fits-all treatment. This militates against a continuing therapeutic relationship needed for good outcomes in major psychiatric illness. Current advocacy protects civil rights at entry to treatment but does not improve the therapeutic relationship or help patients make their needs known and addressed by the tailoring of care.

Objective: To show that close personal advocacy, which stays beside the patient through treatment, improves the experience of treatment, increases cooperation with aftercare, and reduces readmission.

Method: Fifty-two control involuntary patients received statutory, civil rights protecting advocacy during hospitalisation; 53 experimental involuntary patients received, in addition, close personal advocacy throughout their hospitalization. Measures: Patient satisfaction, impact of advocacy, compliance with aftercare, rehospitalization.

Results: The experimental and control groups were equivalent in demographic and severity measures. Patients receiving close personal advocacy showed: (1) improved patient satisfaction with care and staff satisfaction, (2) improved attendance for aftercare, (3) halving of risk of early involuntary readmission. All results were substantial and statistically significant.

Implication: The study strongly demonstrated the utility of continuing, personal, needs-based advocacy, which improved the experience of hospitalization and satisfac-

tion with care and aftercare, which are the foundation of good outcomes. This form of advocacy pays for itself in reduced hospital demand.

REFERENCES:

1. Hatfield AB, Lefley HP: Surviving Mental Illness: Stress, Coping, and Adaptation. New York, N.Y., Guilford Press, 1993.
2. Woolis R: When Someone You Love Has A Mental Illness, A Handbook for Family, Friends, and Caregivers. New York, N.Y., G.P. Putnam and Sons, 1992.

Poster 67 **Sunday, October 31**
10:00 a.m.-11:30 a.m.

CHARACTERISTICS OF CANDIDATES FOR GASTRIC BY-PASS SURGERY

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SUMMARY:

Objective: Severe obesity is becoming more common in this country. Treatment of obesity is often minimally successful. Bariatric surgery is a treatment option for those who fail other treatment techniques. The selection of appropriate candidates and identifying risk factors for unfavorable outcome is imperative as more patients seek out this procedure. The objective of this study is to examine the demographics of candidates for gastric by-pass surgery.

Method: Thirty-five consecutive patients referred in 1998 by a university hospital-based bariatric surgeon were evaluated. A clinical assessment was performed for psychiatric disorder and for risk factors that would contraindicate gastric by-pass surgery. Demographic data were collected and a DSM-IV diagnosis was recorded.

Results: The age range is 19–58 years; 58% are males and 42% females; 37% are married; 12% have a history of incarceration. All meet criteria for adjustment disorder (related to their obesity). There are 50% who are unemployed; 63% have a positive psychiatric history for DSM-IV Axis I disorder; 14% have a history of substance abuse.

Conclusions: The patients evaluated for gastric by-pass surgery have a significant degree of psychosocial stressors and substantial histories of psychiatric disorder. Further studies are needed to refine patient selection and to understand the impact of by-pass surgery on this growing patient population.

TARGET AUDIENCE:

Psychiatrists, nutritionists, psychiatric nurses, consultation-liaison psychiatrists, and psychologists.

REFERENCES:

1. Blankmeyer BL, et al: A replicated five cluster MMPI typology of morbidly obese female candidates for gastric bypass. International Journal of Obesity 1990; 14 (3):235–47.
2. Hsu, LK, Benotti PN, Dwyer, J, et. al: Nonsurgical factors that influence the outcome of bariatric surgery: a review. Psychosomatic Medicine 1998; 60 (3):338–46.

Poster 68 **Sunday, October 31**
10:00 a.m.-11:30 a.m.

HYPERCALCEMIA, ARRHYTHMIA AND MOOD STABILIZERS

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SUMMARY:

Calcium and lithium play an important role in the genesis of arrhythmia. The finding of a severe bradyarrhythmia in a hypercalcemic bipolar patient on maintenance lithium therapy prompted us to conduct a retrospective study of bipolar patients with lithium-associated hypercalcemia. Information Resource Management at our medical center generated a printout of all hypercalcemias during a one-year period. After elimination of spurious hypercalcemias or those associated with IV fluids, we identified 18 non-lithium-treated patients with hypercalcemia related to malignancies and other medical conditions (group A), and 12 patients with lithium-induced hypercalcemia (group B). Patients in group B were not comparable with those in group A as the latter were medically compromised and receiving multiple pharmacotherapies. Thus, two control groups were generated, Group C1 that included age- and sex-comparable bipolar normocalcemic patients, and Group C2 that included bipolar patients treated with anticonvulsant mood stabilizers. The ECG findings in patients in group B were compared with those in group C1 and C2. It was found that these groups did not differ in their overall frequency of ECG abnormalities; however, there were significant differences in the frequency of conduction defects. Bipolar patients with lithium-induced hypercalcemia had the highest frequency of bradycardia and/or conduction defects. Patients in Group A had a significant mortality

rate at a two-year follow-up (28%) in agreement with the figures reported in the literature and in contrast with zero mortality among patients in the other three groups. The clinical implications of these findings will be discussed.

REFERENCES:

1. Wolf ME, Moffat M, Ranade V, Somberg JC, et al: Lithium, hypercalcemia and arrhythmia. J Clin Psychopharmac 1998; 18:420–423.
2. Bendz H, Sjodin L, Toss G, Berglund K: Hyperparathyroidsim and long-term lithium therapy: a cross-sectional study and the effect of lithium withdrawal. J Inter Med 1996; 2410:357–365.

Poster 69 **Sunday, October 31 10:00 a.m.-11:30 a.m.**

CHARACTERISTICS OF REFERRALS TO PSYCHIATRISTS FROM NON-PSYCHIATRIC PHYSICIANS

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SUMMARY:

Purpose: To understand the communication and referral interface between psychiatry and primary care by focusing on the specific referral process for patients referred to psychiatrists by nonpsychiatric physicians.

Methods: The American Psychiatric Practice Research Network (PRN) developed a two-phase study to examine the referral process. *Phase II* (reported here) collected data on up to three new outpatients per psychiatrist to examine the method of referral and to assess the types and frequency of communication between physicians. The 34-item survey collected data regarding referred patients' demographic, clinical, treatment, and system/setting characteristics as well as information about the referral.

Results: 76% of PRN members completed the Phase II survey, yielding detailed data on 175 patients. More than half (55.2%) of patients were female; 36.0% of patients were referred directly by a general internist and 32.0% from a family practitioner; 62.1% of patients were seen by the psychiatrist within 10 days of the appointment request. The most common reason for referral was for psychiatric treatment (37.8% of patients); 23.8% were referred for advice on diagnosis and treatment, and 23.8% were referred for psychopharmacologic management/treatment; 77.8% of patients were referred with the expectation that the psychiatrist would assume responsibility for the ongoing management of the patient's psychiatric condition. Psychiatrists prescribed medications to 77.1% of the patients. 68.5% of patients were scheduled to return to the psychiatrist at a specific time and 16.5% were to return to the referring physician. 53.7% of patients had some form of managed health care plan, and 74.4% utilized their health plan to pay for all or part of the psychiatrist's services.

Conclusions: Understanding why patients are referred as well as the expectations of referrals from non-psychiatric physicians can help inform methods and strategies to improve the communication interface between primary care and psychiatry.

REFERENCES:

1. Grembowski DE, Diehr P, Novak LC, Roussel AE, et al: Measuring the managedness of health plans in ambulatory care. Submitted, Health Services Research 1998.
2. Pincus HA: Patient-oriented models for linking primary care and mental health care. General Hospital Psychiatry 1987; 9:95–101.

Poster 70 **Sunday, October 31 10:00 a.m.-11:30 a.m.**

CONFORMANCE TO SCHIZOPHRENIA GUIDELINES IN A COMMUNITY MENTAL HEALTH CLINIC

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SUMMARY:

The growing interest in psychiatric practice guidelines results from their promise of reducing treatment variation and costs and improving the quality of health care for persons with severe mental illness. Although several guidelines and algorithms have been published nationally, few have been implemented in clinic settings. This may be due to the complexity of the guidelines or the difficulty of obtaining data to evaluate their impact or both. In this study we examined the utility of a cross-sectional and retrospective medical record review to evaluate current variation in pharmaceutical practices patterns and conformance to published clinical guidelines in a community mental health center. Records were reviewed for a random sample of one-third of all patients currently diagnosed with schizophrenia and schizoaffective disorder (n = 173). An examination of three pub-

lished sets of guidelines produced only seven specific guidelines that were relevant and measurable with this study design. While all records contained information on current medications including dosages, the presence or absence of any symptom was noted in 66%, side effects in 54%, and compliance in 5%. Rates of conformation with the seven guidelines ranged from 97% conformance to a guideline recommendation of antipsychotic medications for all patients, to 38% of patients receiving a guideline recommended maintenance dose in the range of 300–600 CPZ equivalents. We conclude that rigorous and comprehensive evaluation of clinical guidelines in community settings requires both a prospective study design and additional data sources (i.e. patients and providers).

REFERENCES:

1. Lehman AF, Steinwachs DM: Patterns of usual care for schizophrenia: initial results from the Schizophrenia Patient Outcomes Research Team (PORT) client survey. Schizophr Bull 1998; 24:11–20.
2. Young AS, Sullivan G, Burnam MA, Brook RH: Measuring the quality of outpatient treatment for schizophrenia. Arch Gen Psychiatry 1998; 55:611–617.

Poster 71 **Sunday, October 31**
10:00 a.m.-11:30 a.m.

PSYCHIATRIC MORBIDITY IN THE INSTITUTIONALIZED ELDERLY

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SUMMARY:

The institutionalized elderly is a subgroup rapidly increasing with urbanization, nuclear family systems, and economic constraints. Studies report serious psychopathology in this subgroup.

AIMS: To assess the prevalence of psychiatric morbidity in a group of institutionalized elderly. To study stressful life events, sensory impairment, and degree of social integration in this population.

Method: Forty men and 40 women, all 65 years and above were randomly selected.

Instruments: (1) GHO-5, (2) SCID-I, (3) DSM III-R criteria for organic brain syndrome, (4) social integration assessment schedule, sociodemographic data, auditory/visual impairment, and type and number of stressful events obtained.

Results: High prevalence of psychiatric disorders with 76.25% meriting an Axis I disorder; 50% had only visual impairment, while 25% had both visual and auditory impairment, 51.4% of the elderly were not integrated or somewhat integrated socially. Medical illness (37.7%), lack of financial resources (38.8%), and restricted mobility (33.1%) were some of the common stressful life events.

REFERENCES:

1. Rovner BW, Kafonek S, Filipp L, et al: Prevalance of mental illness in a community nursing home. Am J Psychiatry 1986; 143:1446–1449.
2. Gomez GE, Gomez GA. Depression in the elderly. J Psychosoc Nurs Ment Health Serv 1998; 31(5):28–33.

Poster 72 **Sunday, October 31**
10:00 a.m.-11:30 a.m.

SCHIZOPHRENIA CARE AND ASSESSMENT PROGRAM (SCAP): BASELINE CHARACTERISTICS

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SUMMARY:

Objective: To establish a baseline assessment of participants in the SCAP study, a prospective, naturalistic research initiative implementing a comprehensive effectiveness research infrastructure in six large systems of care in the U.S.

Method: Baseline data from clinical assessment, self-report, and medical record abstraction are used (n = 562). Disease specific, functional, quality of life, pharmacotherapy patterns, and inpatient and outpatient utilization measures are evaluated. Descriptive and contingency analyses are conducted and gender and cohort differences are examined.

Results: Age of disease onset is later for women than men. Findings from the positive symptom scale, and the thought disturbance and activation scales indicated greater symptom severity among men. Serious impairment in functioning was noted and women exhibited a higher level of functioning than men. Higher scores on the AIMS scale were observed for men. Twenty percent of participants had an inpatient stay and 89% had at least one psychotherapy visit. Inpatients exhibited higher depression scores than outpatients and outpatients experienced higher scores on the AIMS scale than inpatients.

Over half of the participants received an atypical antipsychotic as part of their treatment regimen.

Conclusions: The SCAP population characteristics are consistent with those of a general cross-section of persons with schizophrenia. The study results are likely to be generalizable.

Educational Objectives: Participants will be informed about the SCAP study and the baseline characteristics of the study population.

TARGET AUDIENCE:

Psychiatrists, psychologists, nurse clinicians, social workers, and health services researchers.

REFERENCES:

1. Bardstein KK, McGlashan TH: Gender differences in affective, schizoaffective, and schizophrenic disorders: a review. Schizophrenia Research 1990; 3:159–172.
2. Miller DD: Schizophrenia: its etiology and impact. Pharmacotherapy 1996; 16(1):2–5.

Poster 73 **Sunday, October 31**
10:00 a.m.-11:30 a.m.

CLINICAL OUTCOMES AFTER DEPRESSION: IMPROVEMENT IN CLINICAL AND ECONOMIC OUTCOMES AFTER IMPLEMENTING A DISEASE MANAGEMENT PROGRAM FOR PATIENTS WITH DEPRESSION

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SUMMARY:

This study describes the preliminary results of implementing a relatively intense disease management program for patients with depression piloted in a staff-model managed care plan.

Objective: To examine humanistic, clinical, and economic outcomes at six months.

Methods: Patients with depression were identified from risk algorithms applied to diagnosis and prescription data, screened for inclusion appropriateness, and randomized as cases (n = 1317) and controls (n = 1471). Enrolling patients (n = 357) received educational materials about disease self-management. Nurses provided continuous telephonic support and training about adherence to therapeutic regimen while monitoring therapy compliance and depression severity. Personal support persons were enlisted to assist compliance. Emergency situations and status were communicated to providers. Depression severity using the BDI®-PC was assessed at intervals, as was service use, compliance, physical and emotional health, and productivity.

Results: Moderate reductions in depression severity (6.8 to 5.4, $p < .01$) were observed, along with improvements in health status (3.4 to 3.6, $p < .05$) and socialization (visit frequency 2.6 to 2.8, $p < .01$; positivity 87% to 96%, $p < .001$). Reductions in mean days per month lost from work or usual activities were observed (2.8 to 2.0).

Conclusion: Interim results suggest that personal contact by nurses as well as designated support supplements usual mental health care, improves outcomes and relieves symptomatology.

REFERENCES:

1. Salkever D, Domino ME, Burns BJ, et al: Assertive community treatment for people with severe mental illness: the effect on hospital use and costs. HSR 1999; 34:577–601.
2. Simon G, Ormel J, Vonkorff M, Rarlow W: Health care costs associated with depression and anxiety disorders in primary care. Am J Psychiatry 1995; 152:352–357.

Poster 74 **Sunday, October 31**
10:00 a.m.-11:30 a.m.

ANNUAL HEALTH CARE EXPENDITURES AND COMPLIANCE WITH ANTIDEPRESSANT TREATMENT IN A MANAGED CARE ORGANIZATION

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SUMMARY:

Treatment failure due to poor compliance in individuals with depression may increase health care costs by increasing outpatient visits and hospital admissions. The objectives of this study were to assess whether compliance with SSRIs is different than with TCAs and atypical/heterocyclic antidepressants, and if improved compliance reduces non-depression-related medical costs.

Claims data from a large managed care organization (MCO) in the Southwestern U.S.A. over the period 1994–96 were used to identify patients diagnosed with a depressive disorder who began treatment with an SSRI, TCA, or atypical/heterocyclic antidepressant. Treatment duration, nondepression-related medical costs and total

health care costs by drug class and AHCPR compliance category were examined during the subsequent 12-month period.

The analysis showed:

- Depressed patients prescribed SSRIs were more likely to be treated in accordance with AHCPR treatment duration guidelines (61% ≥ 150 days, $p < .001$) and had lower nondepression-related medical costs ($p < 0.001$).
- Increased treatment duration with SSRIs but not TCAs or atypicals was associated with lower nondepression-related medical expenditures ($p = 0.039$ for 1 Rx vs ≥ 150 days).
- In patients treated in accordance with AHCPR treatment duration guidelines (≥150 days), total annual health care costs were lower for patients treated with SSRIs than for patients treated with atypical antidepressants ($p = 0.031$) and comparable with those of patients treated with TCAs ($p = 0.481$).
- Nondepression-related medical costs were lowest in SSRI-treated patients and these costs declined as compliance improved.

TARGET AUDIENCE:

Physicians, pharmacists, managed care organizations and individuals interested in health care policy and disease management.

REFERENCES:

1. Thompson D, Buesching, D, Gregor KJ, Oster G: Patterns of antidepressant use and their relation to costs of care. Am J Man Care 1996; 2:1239–1246.
2. Simon GE, VonKorff M, Heiligenstein JH, et al: Initial antidepressant choice in primary care. JAMA 1996; 275; 1897–1902.

Poster 75 **Sunday, October 31**
10:00 a.m.-11:30 a.m.

THE SOCIOECONOMIC BURDEN OF PTSD

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SUMMARY:

Objective: To report preliminary findings regarding the socioeconomic burden of PTSD from the Primary Care Anxiety Project, the first large-scale longitudinal, prospective, naturalistic study of anxiety disorders in patients presenting for general medical treatment.

Method: Data will be presented from the first 250 subjects enrolled in this study. Using structured interview methods (i.e., SCID), 78 subjects met criteria for PTSD and the remaining met criteria for one or more of the following DSM-IV diagnoses: panic disorder, agoraphobia without panic, generalized anxiety disorder, social phobia, and mixed anxiety-depression. Data were also collected regarding history of medical illnesses, health care resource utilization, and work impairment.

Results: Subjects with PTSD were significantly more likely than subjects with other anxiety disorders to visit their primary care physician four or more times in the past six months. Controlling for medical conditions and major depression, PTSD was the only anxiety disorder predictive of increasing numbers of lifetime hospitalizations. Subjects with PTSD reported more days of work missed and more impairment "due to anxiety" than did other subjects.

Conclusion: Subjects with PTSD experience and present a greater socioeconomic burden than do subjects with other anxiety disorders, confirming that PTSD is indeed a pernicious disease that warrants societal attention.

TARGET AUDIENCE:

Mental health practitioners, primary care practitioners and psychiatry researchers.

REFERENCES:

1. Brown PJ, Stout RL, Mueller T: Substance use disorder and PTSD comorbidity: addiction and psychiatric treatment rates. Psychology of Addictive Behaviors (in press).
2. Greenbert PE, Stiglin LE, Berndt ER, Finkelstin SN: The economic burdent of depression in 1990. Journal of Clinical Psychiatry 1993; 54:405–426.

Poster 76 **Sunday, October 31**
10:00 a.m.-11:30 a.m.

SSRI TREATMENT OF ALPHA INTERFERON-INDUCED DEPRESSION

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SUMMARY:

Alpha Interferon (IFN) has shown to be effective prophylactic therapy for chronic myelogenous leukemia,

melanoma, and more recently is used to treat hepatitis C. Side effects commonly leading to discontinuation of therapy include depression and cognitive impairment. In our study, a pretreatment Structured Clinical Interview DSM-IV (SCID) was administered and four patients were evaluated weekly using the Beck Depression Inventory (BDI). The first three patients had a diagnosis of hepatitis C. A 47-year-old man had an IFN pretreatment BDI of 0. By week 17 after starting IFN, the BDI increased to 21. A SSRI was prescribed and BDI subsequently decreased to 5. The second patient was a 48-year-old female with a baseline BDI of 5 and no current psychopathology. IFN was started and four weeks later she developed depression with a BDI of 25. A SSRI was prescribed and a BDI of 8 was recorded two weeks later. The third patient, a 42-year-old female with a single past episode of major depression secondary to IFN therapy had a pretreatment BDI of 1. Eleven weeks after beginning IFN the BDI was 27. A SSRI was prescribed and the BDI subsequently decreased to 11. The fourth case was of a 67-year-old man with melanoma in remission. Pretreatment BDI was 1. Six weeks after commencing IFN therapy, the BDI rose to 20 and his depressive symptoms necessitated hospitalization. IFN was discontinued and the BDI decreased to 3. IFN was restarted and by week 5, depressive symptomatology reappeared with a BDI of 16. IFN was again stopped. A SSRI was prescribed and IFN restarted two weeks later with no further complaints of depression. Prophylaxis with anti-depressants may have a future role in susceptible patients on IFN. These case reports emphasize the importance of monitoring depression in such patients and treating them with SSRIs thus allowing completion of IFN therapy.

TARGET AUDIENCE:

Psychopharmacologists and mental health care professionals.

REFERENCES:

1. Valentine AD, Kling M, Richelson E, Hauser P, Meyers C: Mood and Cognitive Side Effects of Alpha Interferon Therapy.
2. Mchutchison JG, Gordon SC, Schiff ER, et al: Interferon Alpha-2b alone or in combination with ribarvarin as initial treatment for chronic hepatitis C. New England Journal of Medicine 1998; 339:1485–92.

Poster 77 **Sunday, October 31**
10:00 a.m.-11:30 a.m.

IMPROVING EFFECTIVENESS OF PRACTICE GUIDELINES

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SUMMARY:

Background: The American Psychiatric Association (APA) started publishing practice guidelines in 1993 with the ultimate goal of improving patient care. Ten guidelines have been published: eating disorders, substance use disorders, delirium, bipolar disorder, major depression, panic disorder, nicotine dependence, Alzheimer's disease, and schizophrenia.

Objectives: One, to determine the estimated effectiveness of the APA practice guidelines in improving patient care, and, two, strategies to improve effective clinical application of the guidelines.

Methods: The probability of the APA practice guidelines to change clinical practice was assessed using factors (guideline development, dissemination, and implementation strategies) developed in a systematic review of controlled practice guideline evaluations.

Results: The probability of effectiveness of the APA practice guidelines based on the development and dissemination strategies is low. Implementation and some aspects of dissemination are modifiable by those applying the practice guidelines. Effectiveness can be improved by using highly effective implementation and local dissemination methods, such as continuing medical education sessions for dissemination and patient-specific reminder systems for implementation.

REFERENCES:

1. Grimshaw J, Russell I: Effect of clinical guidelines on clinical practice: a systemic review of rigorous evaluations. Lancet 1993; 342:1317–1322.
2. Zarin DA, Pincus HA, McIntyre JS. Practice Guidelines. Am J Psychiatry 1993; 105:2.

Poster 78 **Sunday, October 31**
10:00 a.m.-11:30 a.m.

BEST PRACTICE IN SCHIZOPHRENIA AT A PUBLIC INSTITUTION

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SUMMARY:

Last year, the psychiatry service at the University Health System (UHS) began a continuous improvement process (CIP) for best practice in schizophrenia. Through this presentation we will: (1) discuss the process of implementing a best practice guidelines for patients with schizophrenia at our institution, and (2) present specific products of this process.

Establishing the guidelines: A multidisciplinary task group with representatives of all the clinical sites (outpatient/inpatient/emergency) was established. The group developed a treatment grid describing the best practice through the continuum of care (presentation, maintenance, acute, and post-acute). Needs, obstacles, and resources were identified within each area of the continuum. Work groups established included: documentation, pharmacological treatment, comorbid disease states, patient & family education. Each work group identified a problem and devised a solution that could be implemented within six to 12 months. Once implemented, work groups revisited the solution to modify it, adopt it, or disregard it.

Products of this process include: The Schizophrenia Rating Scale, The Thought Disorder Progress Note (Documentation); the antipsychotic treatment algorithm (pharmacological treatment); the weight management group (comorbid states); the "Interacting with the Pharmacy" videotape (Patient & Family Education).

Conclusions: Implementing the guidelines is an arduous, but rewarding process. It requires collaboration and commitment of all the parties involved as well as flexibility to adapt to the ever-changing realities of clinical practice.

TARGET AUDIENCE:

Clinicians and administrators.

REFERENCES:

1. Lehman AF, Steinwachs DM, et al: At issue: translating research into practice: the Schizophrenia Patient Outcomes Research Team (PORT) treatment recommendations. Schizophrenia Bulletin 1998; 24:1–10.
2. Chiles JA, Miller AL, Crison ML, et. al: Development and implementation of the schizophrenia algorithm. Psychiatric Services 1999; 50:69–74.

Poster 79 **Sunday, October 31**
10:00 a.m.-11:30 a.m.

INTEGRATING PRIMARY CARE WITH MENTAL HEALTH TREATMENT: FIRST-YEAR EXPERIENCES OF A CLUBHOUSE-BASED CLINIC

Gail L. Patrick, M.P.P., *Research Associate, Thresholds, 4101 North Ravenswood, Chicago, IL 60613;* Eva Martinez, M.S.W., J.C.A.D.C., *Team Leader, Thresholds, 734 West 47th Street, Chicago, IL 60609;* Marion L. McCoy, Ph.D.; Angela Falco, M.P.H.

SUMMARY:

Background: Physical and mental illness are intertwined, with one causing or exacerbating the other. Screening for physical illness should be central to treatment plans. People with mental illnesses, however, often have limited access to physical health care due to poverty, symptomotology, and cognitive deficits (Karasu, et al, 1980). Navigation of the health care system itself is also problematic (Schwab, et al, 1988).

An innovative response: In March 1998, family nurse practitioners from a local university began delivering primary care services to clients through an on-site arrangement with a large psychiatric rehabilitation center in Chicago, Illinois. The FNPs provide care for a range of acute and chronic conditions including physicals, immunizations, and preventive screenings. The clinic is part of the agency's Well-Being Program, which includes health education, guest speakers, and fitness activities. Clinic users are surveyed at six and 12 months from the first visit date about satisfaction with clinic services and self-perception of health status, barriers to health care, and provider preferences.

Outcomes: In 1998, the FNPs saw 111 members and provided 73 physical exams, 51 TB tests, and 104 flu shots. The most prevalent chronic conditions included hypertension (17.1%), diabetes (9.9%), and asthma (9.9%). Clients identified convenience and personal attention as benefits of the program.

Future Plans: Plans include expanding the health services to more clients, monitoring physical health status, and developing clinical practice guidelines for people on psychoactive medications.

TARGET AUDIENCE:

Psychiatrists, physicians, nurse practitioners, social workers, case managers, and administrators.

REFERENCES:

1. Karasu TB, Waltzman SA, Lindenmayer JP, Buckley PJ: The medical care of patients with psychiatric illness. Hospital and Community Psychiatry 1980; 31(7): 463–471.
2. Schwab B, Drake RE, Burghardt EM: Health care of the chronically mentally ill: the culture broker model. Community Mental Health Journal 1988; 24(3): 174–184.

Poster 80 **Sunday, October 31**
10:00 a.m.-11:30 a.m.

STIGMA AND PERCEIVED NEED FOR TREATMENT AS PREDICTORS OF TREATMENT DISCONTINUATION

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fessor of Psychiatry, Weill Medical College, 6 Algonquin Drive, Chappaqua, NY 10514-2806

SUMMARY:

Aim: Patients' perceptions of treatment (psychological barriers) may influence the course of care for depression. This study was designed to compare perceived stigma and attitudes toward care as predictors of treatment participation among young and older outpatients with major depression.

Method: A two-stage sampling design was used to identify and follow 63 outpatients aged 25–64 and 29 patients aged ≥65 with SCID-diagnosed major depressive disorder seeking outpatient mental health treatment. Instruments were administered to assess perceived stigma and need for treatment at admission. At three months, patients were reinterviewed about their treatment and service use.

Results: Although older patients reported lower levels of stigma ($p = .05$), higher stigma predicted discontinuing treatment among older and not younger outpatients even after controlling for depression severity (OR = .26, $p = .047$). Despite lower stigma, older adults reported less need for treatment ($t = 2.36$, $df = 90$, $p < .05$) and less concern about the impact of the depression ($t = 3.52$, $df = 90$, $p < .001$).

Conclusions: Patients' perceptions of care at the initiation of treatment are predictive of treatment outcome. Early detection of age-related psychological barriers to care and active interventions to overcome them may maximize the likelihood of adequate antidepressant treatment.

REFERENCES:

1. Link BG, Cullen FT, Struening E, Shrout PE, Dohrenwend BP: A modified labeling theory approach to mental disorders: an empirical assessment. Am Sociological Rev 1989; 54:400–423.
2. Carsky M, Selzer MA, Terkelsen K, Hurt SW: A questionnaire to assess acknowledgment of psychiatric illness. J Nerv Ment Dis 1992; 180:458–464.

Poster 81 **Sunday, October 31**
10:00 a.m.-11:30 a.m.

WORK STRESS AND MENTAL ILLNESS IN THE UNITED STATES MILITARY

Steven E. Pflanz, M.D., *Chief, Mental Health Services, F.E. Warren AFB, United States Air Force, 408 West First Avenue, Cheyenne, WY 82001*

SUMMARY:

Objective: The primary goal of this study was to gather preliminary data on the relationship between occupational stress and mental illness amongst military personnel.

Methods: Eighty-five military mental health patients answered a 65-item survey that included items on the perception of occupational stress and reported life changes. It incorporated the 43-item Schedule of Recent Experiences (SRE). By adding the weighted values assigned to the 43 items, each respondent was given an SRE score, which is a measure of overall stress and has been shown to be predictive of future illnesses.

Results: Sixty percent reported suffering from significant work stress, 52% reported that work stress was causing them significant emotional distress, and 42.5% reported that work stress was a significant contributor to the onset of their mental illness. The average SRE score for all respondents was 266, reflecting increased risk for future illnesses. Generic work stressors were endorsed more frequently than military-specific stressors.

Conclusions: The results suggest that work stress may be a significant occupational health hazard in the U.S. military that warrants further investigation. By gathering these data, interventions can be planned to mitigate the impact of stress caused by the military work environment on the mental health of military personnel. No funding source.

REFERENCES:

1. Pflanz SE: Psychiatric illness and the workplace: perspectives for occupational medicine in the military. Military Medicine 1999; 164(6):401–406.
2. McCarroll JE, Lundy AC, Orman DT: Clients, problems and diagnoses in a military mental health clinic: a 20-month study. Military Medicine 1993; 158:701–705.

Poster 82 **Sunday, October 31**
10:00 a.m.-11:30 a.m.

REIMBURSEMENT FOR MENTAL HEALTH SERVICES

Mantosh J. Dewan, M.D., *Professor and Interim Chair, Department of Psychiatry, State University of New York Health Science Center at Syracuse, 5310 Aquarius Drive, Syracuse, NY 13224-2146*

SUMMARY:

There is universal agreement that reimbursement for mental health services have been declining over the past few years but this has not been carefully studied. It is not known by how much these rates have dropped, for which procedures, and if the different specialties have been differentially affected. We therefore collected fee schedules for five large managed care organizations (MCOs) and Medicare for 1995 and 1998. In 1996, these

MCOs were nationally ranked first (Value Behavioral Health), third (Merit Behavioral Health Corp), fourth (Green Spring Health Services), sixth (US Behavioral Health), and fifteenth (CMG Health). Together they owned 48% of the market and covered 59.9 million lives. Medicare covered an additional 36.9 million people. Therefore, these fee schedules were applicable to 97.8 million people.

I calculated the median fee for an initial evaluation and a 50–60 minute psychotherapy session paid to a psychiatrist, psychologist, and social worker in 1995 and 1998. Fees paid to a psychiatrist for medication management were also calculated. Reimbursement decreased an average 12% for psychiatrists, 15% for psychologists, and 19% for social workers. Respective decreases for initial evaluation were 7% ($113 to $105), 15% ($98 to $73), and 20% ($75 to $60). Psychotherapy dropped by 18% ($98 to $80), 15% ($86 to $65), and 17% ($66 to $55), respectively. Medication management decreased by 12%, from $49 to $43. The effect of these decreased rates on annual income and practice patterns of mental health professionals is discussed.

REFERENCES:

1. Dewan M: Are psychiatrists cost-effective? An analysis of integrated versus split treatment. American Journal of Psychiatry 1999; 156:2.
2. Private Practice. Practice strategies 1996; 2:1–10.

Poster 83 **Sunday, October 31 10:00 a.m.-11:30 a.m.**

LOCUS: RELIABILITY AND VALIDITY MEASUREMENT

Wesley E. Sowers, M.D., *Chief Clinical Officer, The Center for Addiction Services, St. Francis Medical Center, and Former APA/Bristol-Myers Squibb Fellow, 400 45th Street, Pittsburgh, PA 15201;* Kenneth S. Thompson, M.D., *Director, Institute for Public Health and Psychiatry, Western Psychiatric Institute and Clinic, and Former APA/Bristol Myers-Squibb Fellow, 3811 O'Hara Street, Pittsburgh, PA 15213*

SUMMARY:

The American Association of Community Psychiatrists developed the Level of Care Utilization System for Psychiatric and Addiction Services (LOCUS) in 1995. This is an instrument designed to guide decisions regarding the level of intensity of treatment and support services relative to an assessment of service needs of consumers. LOCUS uses a quantifiable dimensional assessment format to arrive at placement recommendations in one of six defined levels of service intensity or "levels of care." To determine the degree to which clinicians could consistently make level of care recommendations using LOCUS, and the utility of the recommendations they make using this instrument, some simple reliability and validity studies were developed. This poster session will present the results of these studies in the context of the research design and data analysis.

REFERENCES:

1. Sowers W: Level of care determinations in psychiatry. Harvard Rev Psychiatry 1998, 5:286–90.
2. Sowers W: LOCUS: an aid for service need placement determinations. Clinical Psychiatry Quarterly 1997; 20(2) 9.

Poster 84 **Sunday, October 31 10:00 a.m.-11:30 a.m.**

HEALTH STATUS AND NEEDS ASSESSMENT: A FOCUS ON THE HISPANIC COMMUNITY

Samuel O. Okpaku, M.D., Ph.D., *Department of Psychiatry, Vanderbilt University, 1916 Patterson Street, Suite 604, Nashville, TN 37203-2118;* Celia Larson, Ph.D., *Evaluation Department, Metropolitan Health Department, 311 23rd Avenue North, Nashville, TN 37203*

SUMMARY:

There is an increasing interest in cultural diversity as it relates to health definitions, perceptions of illness, service delivery, and acceptance. In various parts of the country, the Hispanic population is projected to grow substantially in future years. In Nashville, this population group doubles every three years. In preparing for preventive psychiatric and physical health services, it is timely to begin to examine attitudes toward health care, spiritual needs, and social support as they relate to health needs and access to services. The purpose of the present study was to examine self-perceived health status, health care needs, health practices, social support, and spirituality among a sample of Hispanics in Davidson County. Preliminary results based on interviews with a sample of Hispanic adults indicated a need for preventative education including mammograms, hormone treatment for women, and PSA for males, in addition to cholesterol tests and bowel cancer tests. Limitations and risks for this sample were found to be inadequate social support and physical activity. The data suggest that a specific concern for this group is domestic violence and abuse. Religiosity and level of spirituality were found to be very high. Implications for policy, practice, and service delivery will be discussed.

REFERENCES:

1. David RA, Rhee M: The impact of language as a barrier to effective health care in an underserved

urban Hispanic community. Mt. Sinai Journal of Medicine 1998; 65(5–6): 393–7.
2. Zoucha RD: The experiences of Mexican Americans receiving professional nursing: an ethnonursing study. Journal of Transcultural Nursing 1998; (2) 34–44.

Poster 85 **Sunday, October 31 10:00 a.m.-11:30 a.m.**

PSYCHOLOGICAL AND PHYSICAL IMPAIRMENT IN MUNICIPAL WORKERS

Samuel O. Okpaku, M.D., Ph.D., *Department of Psychiatry, Vanderbilt University, 1916 Patterson Street, Suite 604, Nashville, TN 37203-2118;* Celia Larson, Ph.D., *Evaluation Department, Metropolitan Health Department, 311 23rd Avenue North, Nashville, TN 37203*

SUMMARY:

Background: Two major challenges in the field of disability management are the search for cost-effective strategies and the determination of benefits for psychological stress/strain claims. Although greater public attention has been focused on the escalating health care and medical costs, employers are becoming increasingly concerned about disability related expenses. Meanwhile trial lawyers are pushing for more liberal viewpoints on psychological stress claims. On the other hand, insurance companies are opposed to a more liberal interpretation because of their perception of mental illness and its chronicity.

Objective: This study explores these issues by an examination of records obtained from a metropolitan government board of benefits.

Method: The data on workers filing for job-related injuries or absence from work for the period of 1992–1996 were examined. Variables obtained included demographic information, job-related injuries, stress-related claims, work days lost, number of cardiovascular cases including hypertension, and workers compensation costs. The data were analyzed for interdepartmental, age, and gender differences.

Results and Observations: There are significant interdepartmental differences in work days lost, stress-related claims, and costs of workmens compensation. The uniform officers score higher than non-uniform employers. The firefighters score higher on the above variables than police officers. The implications for policy and practice are discussed.

REFERENCES:

1. Hudgens RW: Personal catastrophe and depression, in Stressful Life Events: Their Nature and Effects. Edited by Dohrenwend BS, Dohrenwend BP. New York, John Wiley and Sons, 1974.
2. Perry S, Diffede JA, Musngi G, Francis AJ, et al: Predictors of postraumatic stress disorder after burn injury. Am J psychiatry 1992; 149:931–35.

Poster 86 **Sunday, October 31 10:00 a.m.-11:30 a.m.**

SCHIZOPHRENIA TREATMENT AND ITS ASSOCIATED SIDE EFFECTS: THE ATTITUDES AND PERCEPTIONS OF HEALTH CARE PROFESSIONALS, PATIENTS AND THEIR CAREERS

Jonathan S.E. Hellewell, M.D., *Department of Psychiatry, Trafford General Hospital Manchester, United Kingdom;* Jamie A. Mullen, M.D., *Associate Medical Director, AstraZeneca Pharmaceuticals, 1800 Concord Pike, Wilmington, DE 19850*

SUMMARY:

Treatment with conventional antipsychotics is associated with a high level of noncompliance; this may be due largely to side effects, in particular extrapyramidal symptoms (EPS). Reported here are the results of a multinational survey undertaken to investigate attitudes toward treatment and side effects. Interviewees included psychiatrists and other health care workers, patients, and carers. The survey was carried out in six countries (Canada, France, Germany, Italy, UK, and USA) and focused particularly on EPS and sexual dysfunction. A total of 1380 participants expressed their views, 615 of whom were patients with a clinical diagnosis of schizophrenia, all of whom were living in the community. The patients' views were contrasted with those of the health care professionals. Over half (56%) of the patients questioned admitted to not taking medication as agreed; side effects were recognized by both patients and health care professionals as a major contributor to noncompliance, psychiatrists identifying EPS as the main contributor. Despite this, the survey suggested that a proportion of psychiatrists do not normally discuss side effects, such as EPS and sexual dysfunction, with their patients. Furthermore, many patients appeared not to report these symptoms to their doctors, for example 74% of patients with sexual dysfunction said they had not communicated this to their doctor. Moreover, both psychiatrists and nurses appeared to underestimate the prevalence of EPS and sexual and hormonal side effects among patients, when compared with the experiences of the patients themselves (psychiatrists estimated EPS affects 63% of patients, nurses estimated 22%, whereas 87% of patients clearly described having experienced EPS). Clear differences were seen between psychiatrists and patients in their perceptions of the response to both EPS and sexual dysfunction. These findings suggest a need for a more

proactive and open approach to the recognition and management of the side effects of antipsychotic treatment.

REFERENCES:

1. Goren JL, Levin GM: Quetiapine, an atypical antipsychotic. Pharmacotherapy 1998; 18(6):1183–1194.
2. Arvanitis LA, Miller BG, and the Seroquel Trial 13 Study Group: Multiple fixed doses of "Seroquel" (quetiapine) in patients with acute exacerbation of schizophrenia: a comparison with haloperidol and placebo. Biol Psychiatry 1997; 42:233–246.

Poster 87 **Sunday, October 31**
10:00 a.m.-11:30 a.m.

PREDICTORS OF RECOVERY FOLLOWING INVOLUNTARY HOSPITALIZATION FOR VIOLENT SUBSTANCE ABUSE PATIENTS

Charles Andre, M.D., Ph.D., *Assistant Professor of Neurology Services, Venancio Flores 305-602 Leblon, Rio de Janeiro, Brazil 22441-090;* Jorge A. Jaber-Filho, M.B.A., *Department of Psychiatry, Clinica Jorge Jaber, Venancio Flores 305-602 Leblon, Rio de Janeiro, Brazil 22441-090;* Marcelo C.L. Carvalho, Ph.D.; Angela V. Hoffmann, Ph.D.

SUMMARY:

Objectives: To evaluate involuntary hospitalization in substance abuse patients.

Methods: Twenty patients (16 male, aged 13 to 53 years [mean ± s.d. = 32.9 ± 10.2]), were admitted in 1997 - median hospital time: 73.5 days (20 to 455)- following loss of self-control and violent behaviour. They were treated with psychiatric medications, 12-step program (Minnesota), psychotherapy and family therapy, and, following hospitalization, counseling, psychotherapy, and participation in self-help groups. Follow up varied from three to 24 months (17.8 ± 4.9). We studied the chances to maintain complete abstinence and socially adapt (professional-educational, family, and legal parameters) with T and Fisher tests (significance level $p \leq 0.05$).

Results: Thirteen patients (65%) reached excellent social reintegration; 12 of them maintained total abstinence. Two patients died (AIDS, hepatic cirrhosis). The chances for total abstinence and social reintegration were increased by any kind of treatment following hospitalization ($p = 0.007$), adherence to the entire period of treatment ($p = 0.05$), regular attendance at self-help groups ($p = 0.05$). No influence could be detected by any demographic parameters, drugs used (number or class), previous hospital admissions, or length of hospitalisation.

Conclusions: Sixty percent of the patients may exhibit excellent outcome for 18 months. Factors increasing adherence to prolonged treatment also increase abstinence and social reintegration.

TARGET AUDIENCE:

Psychiatrists, psychologists, and drug counselors.

REFERENCES:

1. Tardiff K: Assessment and management of violent patients. 2nd Edition. Washington D.C., American Psychiatric Press, 1996.
2. Beck JC: The therapist's legal duty when the patient may be violent. Psychiatr Clin North Amer 1988; 11:665–679.

Poster 88 **Sunday, October 31**
10:00 a.m.-11:30 a.m.

HOMELESSNESS IN PUBLIC PSYCHIATRY PATIENTS: FIFTEEN YEARS LATER

Lawrence Appleby, Ph.D., J.D., *Department of Psychiatry, University of Illinois at Chicago, 1601 West Taylor, Chicago, IL 60612;* Daniel J. Luchins, M.D., *Associate Professor of Psychiatry, University of Chicago, 100 West Randolph Street, Room 6-400, Chicago, IL 60601;* Nancy B. Slagg, Ph.D.; Douglas Burman, Ph.D.

SUMMARY:

Objective: This study compared patterns of homelessness in public psychiatric patients over a 15-year period.

Method: Admission flow data were retrieved from statewide reports and public documents. Patient information was collected from hospital records and central patient computer files for undomiciled admissions ($n = 265$) to a Chicago area state facility during FY '96.

Results: Paralleling national trends, the number of psychiatric beds and admissions, including undomiciled, markedly declined in Chicago area state hospitals between 1980 and 1995. Undomiciled admissions, however, were relatively stable the last few years, constituting a greater percent of fewer total admissions, 6.3% in 1990 and 12.9% in 1995. The homeless comprised 15% of the admissions to the largest state facility in 1980 and nearly 20% in 1996. First admission homeless were more frequently immigrants or born out-of-state than previously hospitalized homeless. Furthermore, in sharp contrast with significant referral pattern variations in 1980, about 80% of all admission presentations were prescreened in 1996.

Conclusions: Community prescreening is effectively redirecting domiciled patients to private hospitals. Thus,

current state hospital admissions are composed of more isolated individuals with fewer social supports and no housing resources. In addition, homeless immigrants add special financial/discharge planning issues and multicultural problems to be addressed.

REFERENCES:

1. Appleby L, Desai PN: Documenting the relationship between homelessness and psychiatric hospitalization. Hosp Comm Psychiatry 1985; 36:732–737.
2. Grab GN: Mad, homeless and unwanted: a history of the case of the chronically mentally ill in America. Psychiatric Clin N Am 1994; 17:541–558.

Poster 89 **Sunday, October 31**
10:00 a.m.-11:30 a.m.

REPRESENTATIVE PAYEE PROGRAM FOR THE MENTALLY ILL

Patricia Hanrahan, Ph.D., *Associate Professor of Psychiatry, University of Chicago, 5841 Maryland Avenue, MC-3077, Chicago, IL 60637;* Daniel J. Luchins, M.D., *Associate Professor of Psychiatry, University of Chicago, 5841 Maryland Avenue, MC-3077, Chicago, IL 60637;* Gail L. Patrick, M.P.P.; Courtenay Savage, M.A.

SUMMARY:

Purpose: Representative payee (RP) programs can increase the community tenure of mentally ill persons by assuring that basic needs such as housing are met (Luchins, et al., 1998). Because of this important role, a survey was conducted to determine the extent to which RP programs are provided and the criteria used to enable clients to access this service.

Methods: All community mental health centers (CMHCs) that contract with the Illinois Department of Human Services were surveyed; 159 CMHCs provided services primarily for mentally ill persons. Respondents numbered 114 CMHCs for a response rate of 72%. Questions concerned provision of RP, service characteristics, and criteria for enrollment in RP.

Results: RP programs were directly provided by 62% of the CMHCs; 33% of clients receiving intensive services were in RP. Frequent criteria for RP enrollment included the lack of financial skills (90%), lacking rent money (55%), substance abuse (46%), being homeless (35%), and frequent (33%) or long-term hospitalization (28%).

Discussion: About two-thirds of the CMHCs provided RP, only a moderately high proportion. Moreover, the proportion of clients receiving intensive services who had RP seemed rather low, at 33%, given the likely severity of their impairments. Referral criteria from our respondents may provide useful guidelines for assessing clients for RP services.

TARGET AUDIENCE:

Psychiatrists, social workers, case managers, and administrators.

REFERENCES:

1. Luchins DJ, Hanrahan P, Conrad KJ, Savage C, et al: An agency-based representative payee program and improved community tenure of persons with severe mental illness. Psychiatric Services 1998; 49(9):1218–1225.
2. Conrad KJ, Matters MD, Hanrahan P, Luchins DJ, et al: Characteristics of persons with mental illness in a representative payee program. Psychiatric Services 1998; 49(9):1223–1225.

Poster 90 **Sunday, October 31**
10:00 a.m.-11:30 a.m.

ATYPICAL ANTIPSYCHOTICS: DIFFERENCES IN LENGTH OF STAY, LENGTH OF REMISSION AND TOTAL DAILY COST

Stephen R. Saklad, Pharm.D., *Clinical Associate Professor, Pharmacotherapy Department, University of Texas Health Sciences Center at San Antonio, 7703 Floyd Curl Drive, San Antonio, TX 78284-6220;* Larry Ereshefsky, Pharm.D.; Daniel J. Still, Pharm.D.; Dennis J. Pabbis, Pharm.D.; Julia E. Vertrees, Pharm.D.

SUMMARY:

Aims: Outcomes and effectiveness of atypical antipsychotics were analyzed using data combining a pharmacy distribution system and an administrative database.

Methods: Data (1994–1998) from the San Antonio State Hospital (SASH) pharmacy and the Texas Department of Mental Health and Mental Retardation were analyzed. Inclusion criteria: a single atypical antipsychotic prescribed on discharge from SASH and the patient was subsequently readmitted.

Results: Of the 377 patients (546 admissions) 59% were male; 48% Hispanic, 40% Caucasian, 11% African American, 1% other. Age at discharge was 35 ± 12 years. Primary DSM diagnoses were schizophrenia (59%) and bipolar (32%). Mean period between discharge and readmission were clozapine 205 days (N = 59); olanzapine 136 days (N = 178); quetiapine 36 days (N = 7); and risperidone 226 days (N = 303) (olanzapine vs risperidone $p = 0.001$). Mean length of stay were clozapine 442 days; olanzapine 101 days: quetiapine 71 days; and risperidone 110 days (clozapine vs olanzapine $p < 0.0001$; clozapine vs risperidone $p < 0.0001$). Mean total daily costs of drug therapy were clozapine $11.88; olanzapine $9.94; quetiapine $7.87; and risperidone

$6.08 (clozapine vs risperidone $p < 0.0001$; olanzapine vs risperidone $p < 0.0001$)

Conclusions: Length of stay was greater for patients discharged on clozapine than either olanzapine or risperidone. Length of remission was greater for patients discharged on risperidone than for olanzapine. Total daily cost of pharmacotherapy was less for patients discharged on risperidone than for clozapine or olanzapine.

REFERENCES:

1. Procyshyn RM, Zerjav S: Drug utilization patterns and outcomes associated with in-hospital treatment of risperidone or olanzapine. Clinical Therapeutics 1998; 20:1203–1217.
2. Conley RR, Love RC, Kelly DL, Bartko JJ: Rehospitalization rates of patients recently discharged on a regimen of risperidone or clozapine. Am J Psychiatry 1999; 156:863–868.

POSTER SESSION 4

Posters 91-120

CULTURAL ISSUES, GERIATRIC PSYCHIATRY, ADVERSE DRUG EFFECTS AND PHARMACOECONOMIC PSYCHOPHARMACOLOGY

Poster 91 **Sunday, October 31 3:30 p.m.-5:00 p.m.**

AN EPIDEMIOLOGICAL STUDY OF PERSONALITY DYSFUNCTION IN ADOLESCENTS IN URBAN BEIJING

Yueqin Huang, M.D., M.P.H., *Associate Professor and Chair, Department of Preventive Medicine, Beijing Medical University, 38 Xue Yuan Road, Beijing, China 100083;* Hong Ma, M.D., *Associate Professor, Institute of Mental Health, Beijing Medical University, Beijing, China 100083;* Lihong Shi, M.D., Shumei Yun, M.D.

SUMMARY:

Objective: To explore the prevalence of personality dysfunction and its distribution among high school students in urban Beijing, and to explore the effect of parental rearing behavior and related factors on adolescent personality dysfunction.

Method: In this cross-secertional study, 1148 students in four key and non-key high schools selected by cluster sampling in urban Beijing were investigated with Personality Diagnostic Questionnaire-Revised (FDQ-R), the EMBU scale, and the General Information Questionnaire.

Results: The mean of total PDQ-R was 23.94. The rate of positive score was 14.3%. Among the 11–14 age group, the males had significantly higher scores than the females. The girls in the 15–17 age group had significantly higher scores than the girls in the 11–14 age group. It showed that age and sex had interaction to the PDQ-R score. Three clusters of personality disorders had positive correlation with parental rejection and overprotection, negative correlation with parental emotional warmth. Multiple stepwise regression exhibited that parental rejection, overprotection, educational level, and single-parent family influenced occurrence of personality dysfunction in adolescents.

Conclusion: Certain parental rearing behavior is risk factor of PD.

TARGET AUDIENCE:

Clinical psychiatrists and social workers.

REFERENCES:

1. Hyler SE, Skodol AE, Kellman HD, et al: Validity of the personality diagnostic questionnaire-revised: comparison with two structured interviews. Am J Psychiatry 1990; 147:1043–1048.
2. Bernstein DP, Cohen P, Velez N, et al: Prevalence and stability of the DSM-III-R personality disorders in a community-based survey of adolescents. Am J Psychiatry 1993; 150:1237–1243.

Poster 92 **Sunday, October 31 3:30 p.m.-5:00 p.m.**

THE LINK BETWEEN DRUG ATTITUDES, COMPLIANCE BEHAVIORS AND RESOURCE USE AMONG INDIVIDUALS WITH SCHIZOPHRENIA

George A. Awad, M.D., *Department of Psychiatry, Clarke Institute, 250 College Street, Toronto, ON Canada M5T 1R8;* Vera Mastey, M.S.

SUMMARY:

Objective: This study assesses the link between compliance attitudes, behaviors, and resource use.

Method: This study uses cross-sectional data from a June 1998 survey of 357 individuals with schizophrenia. Using the Drug Attitude Inventory, compliant attitudes are categorized as "noncompliant" (–10 to 0), "somewhat compliant" (1 to 6), and "very compliant" (7 to 10). Behaviors include medication switching (yes/no) and skipping (a 5-point scale).

Results: More respondents with noncompliant attitudes switched their antipsychotic medication in the past year (43%) than those who are somewhat (24) or very

(22) compliant (P = 0.02). They are also more likely to report skipping medication (P = 0.06 ANOVA).

Respondents who switched their medications in the past year are more likely to have been hospitalized in the past six months (34%) than those who did not switch (11%) (P < 0.001). More switchers (32%) than non-switchers (17%) also report ER visits (P < 0.001). Those who skip their medications are more likely to have used the ER (27%) than those who did not skip (20%).

Conclusion: Clinicians need to assess and address patients' subjective feelings on medication and their attitudes toward them. These attitudes have significant implications for resource utilization and, for those who are noncompliant, this in turn is related to higher costs.

REFERENCES:

1. Gaebel W: Critical issues in the treatment of schizophrenia. Int Clin Psychopharmacol 1998; 13(Suppl 3):S1–S6.
2. Fleischhacker WW, Meise U, Gunther V, Kurz M: Compliance with antipsychotic drug treatment: influence of side effects. Acta Psychiatrica Scandinavica 1994; 89(832):11–15.

Poster 93 **Sunday, October 31 3:30 p.m.-5:00 p.m.**

THE IMPACT OF WEIGHT GAIN ON QUALITY OF LIFE AMONG INDIVIDUALS WITH SCHIZOPHRENIA

David B. Allison, Ph.D., *Obesity Research Department, St. Lukes/Roosevelt Hospital Center, 1090 Amsterdam Avenue, 14th Floor, New York, NY 10025;* Joan Mackell, Ph.D.

SUMMARY:

Objectives: Substantial weight gains have been linked to treatment with antipsychotic medications. This research examines the impact of weight gain on life quality and psychological well-being as self-reported by individuals with schizophrenia.

*Methods:*Two national mental health organizations were surveyed in June 1998, yielding 303 individuals who provided relevant information. The respondents currently taking antipsychotic medication ($n = 280$) were classified into four weight gain groups. Quality of life was measured using a one-item global evaluation and a 10-item scale, assessing satisfaction within life domains such as money, housing, and social activities. Psychological status was assessed with a standardized scale, the Psychological Well-Being index.

Results: The results of these surveys showed that, within the previous year, 100 respondents (36%) reported no weight gain, 64 (23%) gained 1–10 lb, 59 (21%) gained 11–20 lb, and 57 (20%) gained more than 20 lb. Analysis of covariance controlling for gender demonstrated that higher weight gain was related to lower psychological well-being ($P = 0.04$) and lower life quality using single-item ($P = 0.05$) and scale ($P = 0.06$) measures.

Conclusions: Because weight gain can have a negative impact on psychological well-being and quality of life, clinicians should consider the potential for weight gain when prescribing antipsychotic medications and assist patients in adopting wellness behaviors to maintain desirable weight.

REFERENCES:

1. Wirshing DA, Spellberg BJ, Erhart SM, Marder SR, Wirshing WC: Novel antipsychotics and new onset diabetes. Biol Psychiatry 1998; 44(8):778–83.
2. Fleischhacker WW, Meise U, Gunther V, Kurz M: Compliance with antipsychotic drug treatment: influence of side effects. Acta Psychiatrica Scand 1994; 89(832):11–15.

Poster 94 **Sunday, October 31 3:30 p.m.-5:00 p.m.**

AN ASSESSMENT OF TARDIVE DYSKINESIA IN ELDERLY PATIENTS TREATED WITH HALOPERIDOL, RISPERIDONE AND OLANZAPINE

Jacquelyn G. Wilson, Pharm.D., *Assistant Professor of Pharmacy Practice and Psychiatry, Wayne State University, Shapero Hall, Room 328, Detroit, MI 48202;* Cynthia L. Arfken, Ph.D., *Assistant Professor of Psychiatry, Wayne State University, 4201 St. Antoine, 9-B VHB, Detroit, MI 48202;* Anita C. Pinkerton, B.S.; Martha J. Miller, Pharm.D.; Stephen M. Aronson, M.D.; Vehkata R. Lingham, M.D.; Norma C. Josef, M.D.

SUMMARY:

Objective: The objective of this study was to compare the incidence and prevalence of tardive dyskinesia (TD) in elderly patients treated with risperidone, olanzapine or haloperidol.

Method: To attain 90 patients (30 per medication group), a retrospective review of 165 records of elderly in-patients (age range 60-75 years old), who had been systematically screened with the Abnormal Involuntary Movement Scale. Excluded were patients receiving the medications for less than six months, no baseline TD examination or who had a medical condition or received medications that produce involuntary movements.

Results: The prevalence rate of TD at baseline for the 90 patients (30 per medication group) was 23%. There were no significant differences between the three treat-

ment groups at baseline on mean ± SD for age, sex, gender, race, and length of prior exposure to any antipsychotics [mean 30 years (range 1-38)]. There were no new cases of progression of TD in risperidone or olanzapine groups. There were four new cases of TD (incidence = 13.3%) and 1 case of worsening TD (prevalence rate = 16.7% for all cases) in the haloperidol group (p = 0.0097).

Conclusion: The results of this pilot study suggest that chronic treatment with atypical antipsychotics do not produce or worsen TD in patients treated for six months to one year. However, large scale prospective studies are needed to validate these findings.

REFERENCES:

1. Labbate LA, Landa RG, Jones F, Olerahanky MA: Tardive dyskinesia in older outpatients: a follow-up study. Acta Psychiatrica Scandinavia 1997; 96(3):195–5.
2. Casey DE: The relationship of pharmacology to side effects. J Clin Psychiatry 1997; 10(8):55–62.

Poster 95 **Sunday, October 31 3:30 p.m.-5:00 p.m.**

COMPLIANCE AND COSTS IN A CASE MANAGEMENT MODEL

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SUMMARY:

The widespread use of case management (CM) models of service delivery to individuals with serious and persistent mental illness has inspired a broad research literature. Early investigations focused on definitions and the effectiveness of CM models, but more recent studies examine the cost-effectiveness of different models (Berren, Hill, Zent, Carbone, Eblen, & Eck, 1999). While consumer engagement can be enhanced by model characteristics (Ryan, Ford, Beadsmore, & Muijen, 1999), compliance has not been a specific focus of CM research. However, many CM models still require consumers to attend scheduled outpatient appointments with the psychiatrist. This study examined the relationship between compliance to psychiatric outpatient appointments and costs in a flexible CM model for seriously and persistently mentally ill individuals. Two groups of participants were randomly selected based on a single compliance data point and examined using cross-sectional and longitudinal methods. Results revealed relatively-high compliance rates that were significantly different between groups over time. Yet, no differences in costs for services over time, and no demographic variables (i.e., age, miles from residence to site, ethnicity, diagnostic group, level of functioning) predictive of noncompliance were identified.

REFERENCES:

1. Berren MR, Hill K, Zent M, Carbone C, et al: Two models of managed care and assertive community treatment: impact on cost of services. (submitted for publication.)
2. Ryan P, Ford R, Beadsmore A, Muijen M: The enduring relevance of case management. British Journal of Social Work 1999; 29:97–125.

Poster 96 **Sunday, October 31 3:30 p.m.-5:00 p.m.**

ANTIPSYCHOTIC TREATMENT OF BEHAVIORS IN DEMENTIA

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SUMMARY:

This study examined improvement in maladaptive behaviors of geriatric psychiatric inpatients with a primary discharge diagnosis of dementia (n = 2747). Data were obtained from CQI+^{SM} Outcomes Measurement System of Mental Health Outcomes, Lewisville, TX. Maladaptive behaviors were defined by the Psychogeriatric Dependency Rating Scale. Improvement from admission to discharge was compared with respect to three antipsychotic treatment groups; haloperidol, olanzapine, and risperidone. Groups were equivalent on the vast majority of pretreatment patient characteristics examined (e.g., illness severity, comorbid illnesses, prior medical resource utilization, alcohol/substance use, life stressors, suicide attempts). However, patients subsequently treated with olanzapine had been rated by collaterals as more depressed at admission. Patients treated with olanzapine displayed significantly greater improvement in total maladaptive behaviors than did patients taking haloperidol or risperidone ($p < .001$). Olanzapine was significantly superior to both haloperidol and risperidone for improving active aggression ($p < .05$ and $p < .001$ respectively), verbal aggression ($p < .001$), and delusions/hallucinations ($p < .01$, $p < .001$). Olanzapine also led to significantly greater improvement compared with risperidone for manipulative ($p < .05$) and for noisy ($p < .02$) behaviors. Results indicate that olanzapine is

effective for improving several maladaptive behaviors common for dementia patients. Additional, highly-controlled studies are indicated to corroborate these findings.

TARGET AUDIENCES:

Psychiatrists, psychologists, nurse clinicians, social workers, and health services researchers.

REFERENCES:

1. Wilkinson IM, Graham-White J: Psychogeriatric dependency rating scale (PGDRS): a method of assessment for use by nurses. Brit J Psychiatry 1980; 137:558–565.
2. Cohen-Mansfield J, Werner P, Watson V, Pasis S: Agitation among elderly persons at adult day care centers: the experiences of relatives and staff members. International Psychogeriatrics 1995; 7(3):447–458.

Poster 97 **Sunday, October 31 3:30 p.m.-5:00 p.m.**

AFRICAN-AMERICAN RESPONSE TO TWO ATYPICAL DRUGS

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SUMMARY:

African Americans are more frequently diagnosed with schizophrenia than other ethnic groups and are more likely to receive unnecessarily higher doses of antipsychotics. It may be that African Americans are perceived as being more dangerous or they may have a fear of hospitalization and involuntary commitment; eliminating the opportunity for earlier intervention and faster improvement in psychopathology. Multi-center studies have shown that African Americans tend to respond more quickly to antipsychotics than some other ethnic groups. We hypothesize that African Americans diagnosed with schizophrenia will respond as well, if not better, at lower doses, stabilize faster, and maintain a lower rate of relapse when treated with new generation antipsychotics. This study will use a state-wide epidemiological database. The study sample will be derived from a database of 3000 cases, admitted from Jan 1997-July 1998, of which approximately 50% are diagnosed with schizophrenia or schizoaffective disorder; two new generation antipsychotics: risperidone and olanzapine will be investigated. Independent variables are age, diagnosis (schizophrenia), gender, ethnicity, drug dosage, admission and discharge data, and relapse time. Dependent variables are: discharge dose, number of inpatient days, and rate of relapse. Data will be analyzed through survival analysis and logistic regression. Outcomes have direct implications when new generation antipsychotics are the primary drug intervention.

TARGET AUDIENCE:

Psychiatrist, psychologist, social workers, and psychiatric nurses.

REFERENCES:

1. Lawson WB: Clinical issues in the pharmacology of African-Americans. Psychopharmacology Bulletin 1996; 32:275–281.
2. Strakowski SM, Lonczak HS, Sax KW, et al: The effects of race on diagnosis and disposition from psychiatric emergency service. Journal of Clinical Psychiatry 1995; 56:101–107.

Poster 98 **Sunday, October 31 3:30 p.m.-5:00 p.m.**

FACTORS INFLUENCING WEIGHT CHANGE IN PATIENTS WITH SCHIZOPHRENIA TREATED WITH OLANZAPINE VERSUS HALOPERIDOL OR RISPERIDONE

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SUMMARY:

Objective: Factors that influenced weight change in patients diagnosed with schizophrenia, schizoaffective, or schizophreniform disorders and treated with olanzapine, haloperidol, or risperidone were retrospectively determined from two large, randomized, double-blind clinical trials.

Method: Data from these trials were compared using repeated measures analysis of variance (ANOVA) models, and classification and regression trees (CART). The influence on weight change on clinically relevant covariates was analyzed.

Results: In the regression modeling, significant predictors of weight gain for all three antipsychotic drugs (APDs) included low BBMI and favorable clinical response. CART modeling suggested that with the conventional APD haloperidol and the novel APD olanzapine choice of drug (therapy) and appetite disturbance were the most important predictors of weight change following six weeks of therapy. However, following 28 weeks of therapy with olanzapine or risperidone (both novel agents), clinical response, BBMI, and age were more important than therapy in influencing weight change.

Conclusions: Weight change associated with APD treatment may be affected by a multitude of factors. Patients' experience with all three APDs investigated runs from losing to gaining weight over relatively short periods of time. Factors that may differentially affect weight gain during treatment with olanzapine, haloperidol, or risperidone include better clinical response, less body mass at initiation of treatment, younger age, and appetite stimulation while on therapy.

REFERENCES:

1. Tollefson GD, Beasley CM, Tran P, Street JS: Olanzapine versus haloperidol in the treatment of schizophrenia and schizoaffective and schizophreniform disorders: results of an international collaborative trial. Am J Psychiatry 1997; 154:457–465.
2. Tran P, Hamilton SH, Kuntz AJ, Potvin JH, Andersen SW: Double-blind comparison of olanzapine versus risperidone in the treatment of schizophrenia and other psychotic disorders. J Clin Psychiatry 1997; 17:407–418.

Poster 99 **Sunday, October 31 3:30 p.m.-5:00 p.m.**

TIAGABINE AS AN ADJUNCTIVE MOOD STABILIZING AGENT: INITIAL ASSESSMENT OF TOLERABILITY AND EFFICACY

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SUMMARY:

Tiagabine is an antiepileptic agent that may have mood stabilizing properties. We report preliminary findings regarding the tolerability and efficacy of this agent as an adjunct to other psychopharmacologic medications in patients participating in an assertive community treatment program. These patients had previously received multiple trials of both single and combination psychopharmacological agents yet remained psychiatrically unstable. We performed a baseline PANSS to help identify prominent psychiatric symptoms before initiating tiagabine therapy. Six patients (three with schizoaffective disorder, bipolar type; one with bipolar disorder, mixed; one with bipolar II, hypomanic; and one with schizophrenia, chronic undifferentiated type) agreed to a trial of tiagabine. Two patients, both with mild preexisting gait abnormalities, fell during early titration (four and eight mg daily). The four remaining patients have tolerated tiagabine for at least eight weeks. Two patients experienced improvement of mood symptoms and two patients remained on tiagabine with no notable improvements. While our trials using tiagabine as an adjunctive mood stabilizing agent will continue to expand, our experience has made us wary of the use of tiagabine in patients with pre-existing gait disturbances.

REFERENCES:

1. Luer MS, Rhoney DH: Tiagabine: a novel antiepileptic drug. Annals of Pharmacotherapy 1998; 32:1173–80.
2. Kaufman KR. Adjunctive tiagabine treatment of psychiatric disorders: three cases. Annals of Clinical Psychiatry 1998; 10:181–84.

Poster 100 **Sunday, October 31 3:30 p.m.-5:00 p.m.**

OLANZAPINE, 25 TO 40 MILLIGRAMS PER DAY: A CASE SERIES

Rebecca R. Neal, M.D., *Assistant Professor of Psychiatry, Darmouth Medical School, 36 Clinton Street, Concord, NH 03301;* Chester P. Swett, Jr., M.D., *Chief of Psychiatry, Brockton-West Roxbury Veterans Affairs Medical Center, 124 Edgewater Drive, Needham, MA 02492;* Robert M. Vidaver, M.D.; Diane Hill, R.N.

SUMMARY:

This poster focuses on one state hospital's experience with the use of olanzapine in doses ranging from 25 to 40 mg. per day. The sample includes 26 patients of whom at least two-thirds had been chronically psychotic. They had tolerated a conventional trial of olanzapine but had not responded sufficiently to warrant discharge. Most had responded incompletely to at least one other agent. In the absence of safety and efficacy data for olanzapine doses beyond 20 mg. per day, the hospital established guidelines for monitoring that included periodic checks of CBC, serum chemistries, TSH, electrocardiograms, electroencephalograms, and neurology consultation. Additional available data include changes in weight, length of hospital stay, and in several cases, admission and discharge ratings such as GAF, BPRS, and NOSIE. For a few patients, two-year follow-up data will be included. Because the patients in this group were so profoundly impaired, there was no attempt to restrict the use of other pharmacotherapeutic agents. The findings suggest that the higher doses were well tolerated, and in many cases there was significant clinical improvement. Negative results include significant weight gain for many and question of impaired cognition for a very few.

REFERENCES:

1. Tollefson GD, Beasley CM Jr., Tran PV, Street JS, et al: Olanzapine versus haloperidol in the treatment of schizophrenia and schizoaffective and schizo-

phreniform disorders: results of an international collaborative trial. Am J Psychiatry 1997; 154:457–465.
2. Sheitman BB, Lindren JC, Early J, Sved M: High-dose olanzapine for treatment-refractory schizophrenia. Am J Psychiatry 1997; 154:1627.

Poster 101 **Sunday, October 31 3:30 p.m.-5:00 p.m.**

BUPROPION SR TREATMENT OF BEREAVEMENT

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SUMMARY:

Background and Objective: When a depressive syndrome closely follows the loss of a loved one, the syndrome is called "bereavement" rather than major depression. Although recent findings suggest "bereavement" shares many clinical characteristics with major depressive episodes, there are not yet systematically gathered data testing whether such syndromes respond to standard antidepressant treatment.

Method: Twenty recently bereaved widows and widowers experiencing a major depressive syndrome were recruited from death certificate records. At intake, they received a Structured Clinical Interview for DSM-IV (SCID) to confirm the diagnosis. They also were administered the Inventory of Complicated Grief (ICG) and the Texas Revised Inventory of Grief (TRIG) to measure grief; and the Hamilton Depression Rating Scale (HDR-16) to access depression severity/improvement. Subjects were treated with bupropion SR 150-300 mg. daily for eight weeks.

Results: Seventy-five percent of the subjects were widows and the mean age was 64 years; 25% had previous major depressive episodes. Mean HDR-16 scores decreased from 15.4 to 4.9, and 70% of subjects experienced a reduction of ≥50% on the HDR-16. The mean total score on the ICG decreased from 36-29. Similarly, mean total scores on the TRIG decreased from 55 to 51 and the correlation between changes on the HDR-16 and TRIG was .57 ($p < .05$).

Conclusions: Major depressive syndromes developing within two months of widowhood (called "bereavement" in the DSM-IV) appear to respond to treatment with bupropion-SR. This is further evidence that depressive syndromes following loss may be more appropriately conceptualized as major depressive episodes than "bereavement".

REFERENCES:

1. Reynolds CF, Miller MD, Pasternak RE, Frank E, et al: Treatment of bereavement-related major depressive episodes in later life: a controlled study of acute and continuation treatment with nortriptyline and interpersonal psychotherapy. Am J Psychiatry 1999; 156:202–208.
2. Zisook S. Paulus M, Schuchter SR, Judd LL: The many faces of depression following spousal bereavement. J Affective Disorders 1997; 46:85–95.

Poster 102 **Sunday, October 31 3:30 p.m.-5:00 p.m.**

USE OF TOPIRAMATE: A NEW ANTIEPILEPTIC DRUG AS A MOOD STABILIZER

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SUMMARY:

Several of antiepileptic drugs are effective in bipolar disorders. The objective of this study was to evaluate topiramate in mood disorders refractory to previous therapies including lithium, and other antiepileptic drugs, (valproate, carbamazepine, lamotrigine, and gabapentin). Charts of 58 consecutive outpatients were reviewed. Topiramate 25mg/BID was added to existing therapy and titrated in 50 mg increments every three to seven days to response. Average dose of topiramate was 200 mg. Improvement was rated with a global assessment of sleep, appetite, mood, and concentration. Of 58 patients treated with topiramate, 44 patients had bipolar disorders and 14 had various psychiatric disorders refractory to previous therapies. Marked or moderate improvement was observed in 36 (62%) patients. Minimal/no improvement was observed in 16 patients; six were rated as worse. Most of those rated as worse experienced symptoms known to be topiramate-related side effects. Agitation was reported in one patient with generalized anxiety disorder. Confusion and hallucinations developed when topiramate was increased from 200 to 600 mg/day in one bipolar patient who had previous and subsequent episodes of psychotic symptoms when not taking topiramate. Other adverse events were somnolence, fatigue, impaired concentration, and impaired memory. Based on these preliminary findings, topiramate may be useful in mood disorders unresponsive to traditional therapy.

TARGET AUDIENCE:

Psychiatrists with an interest in treating bipolar disorders.

REFERENCES:

1. Prien RG, Gelenberg AJ: Am J Psychiatry 1989; 146:840–48.
2. Post Rm, Frye MA, George MS, Callahan AM: Psychopharmacology 1996; 128:115–29.

Poster 103 **Sunday, October 31 3:30 p.m.-5:00 p.m.**

CONTINUOUS DURATION OF ANTIPSYCHOTIC THERAPY: ARE THERE DIFFERENCES BETWEEN SUBCLASSES OR AMONG AGENTS?

David S. Hutchins, M.B.A., M.H.S.A., *Researcher, Value Development Department, PCS Health Systems, Inc., 9501 East Shea Boulevard, MC-034, Scottsdale, AZ 85260;* William F. Signa, B.S., *Senior Data Analyst, PCS Health Systems, Inc., 9501 East Shea Boulevard, MC-034, Scottsdale, AZ 85260;* Bryan M. Johnstone, Ph.D.; Sandra L. Tunis, Ph.D.

SUMMARY:

Purpose: This retrospective study examined duration of antipsychotic therapy differences between novel and conventional agents and among chlorpromazine, clozapine, haloperidol, olanzapine, and risperidone.

Method: Patients (N = 105,960) dispensed an antipsychotic agent between October 1 and December 31, 1996, had antipsychotic prescriptions extracted for one year before and after their first antipsychotic prescription from a large U.S. prescription database. Initiators—patients with no prior antipsychotic use (n = 5,233)—were categorized into novel, conventional, chlorpromazine, clozapine, haloperidol, olanzapine, and risperidone cohorts with subsets for ages 18 to 64 and for initiators with two or more prescriptions. Continuous duration of therapy was measured by summing the days supplied for each prescription to a patient prior to a 45-day gap.

Results: Continuous duration of therapy was significantly ($p \leq 0.05$) longer across all subsets for all novel cohorts compared with conventional antipsychotics, each of the individual novel antipsychotics in comparison with haloperidol and chlorpromazine cohorts, and olanzapine cohorts in comparison with risperidone cohorts between the ages of 18 and 64.

Conclusion: Patients dispensed novel antipsychotics received significantly longer medication therapy than those dispensed conventional antipsychotics, suggesting potential treatment benefits from prescribing novel antipsychotic medications.

TARGET AUDIENCE:

Physicians prescribing antipsychotic agents.

REFERENCES:

1. Marder SR: Facilitating compliance with antipsychotic medications. Journal of Clinical Psychiatry 1998; 59(suppl 3):21–25.
2. Buckley PF: Treatment of schizophrenia: let's talk dollars and sense. American Journal of Managed Care 1998; 4(3):369–383.

Poster 104 **Sunday, October 31 3:30 p.m.-5:00 p.m.**

RACE, PSYCHIATRIC DIAGNOSIS AND MENTAL HEALTH CARE UTILIZATION IN OLDER PATIENTS

Helen C. Kales, M.D., *Department of Psychiatry, University of Michigan, 5180 Merritt Road, Ypsilanti, MI 48197-6601;* Frederic C. Blow, Ph.D.; Alan M. Mellow, M.D., Ph.D.

SUMMARY:

To evaluate the impact of race on mental health care utilization among older patients within given psychiatric diagnoses, the authors examined a retrospective sample of 23,718 elderly veterans. Significant racial differences in mental health care utilization found were related to outpatient (but not inpatient) care. These differences included: (1) African-American patients with psychotic disorders had significantly fewer outpatient psychiatric visits, and (2) African-American patients with substance abuse disorders had significantly more psychiatric visits than Caucasian patients in their respective groups. While the inpatient utilization appeared to be similar among races, outpatient findings may relate to such factors as compliance, treatment efficacy, or possible-clinician bias.

REFERENCES:

1. Segal SP, Bola JR, Watson MA: Race, quality of care, and antipsychotic prescribing practices in psychiatric emergency services. Psychiatric Services 1996; 47:282–286.
2. Chung H, Mahler JC, Kakuma T: Racial differences in treatment of psychiatric inpatients. Psychiatric Services 1995; 46:586–591.

Poster 105 **Sunday, October 31 3:30 p.m.-5:00 p.m.**

UNUSUAL BIPHASIC ONSET OF SEROTONIN SYNDROME AFTER A SERTRALINE OVERDOSE

Catherine Stayer, M.D., Ph.D., *Resident in Psychiatry, Harvard South Shore Hospital, 940 Belmont Avenue,*

Brockton, MA; James J. Levitt, M.D.; Naheed Akhtar, M.D.

SUMMARY:

Due to their broad therapeutic index, selective serotonin reuptake inhibitors (SSRIs) are rapidly becoming the mainstay of treatment for a wide array of psychiatric illnesses. Serotonin syndrome is an infrequent complication of medications that increase serotonergic neurotransmission, such as SSRIs, tricyclics, and MAO-inhibitors. It is typically caused by the addition of a second medication, but even therapeutic doses of a single agent can be causative. The syndrome is characterized by a symptom triad involving cognitive-behavioral changes, autonomic dysregulation, and neuromuscular hyperexcitability. Symptoms are easily mistaken for underlying psychiatric or medical disorders—which frequently result in delayed or inappropriate treatment. Symptoms typically resolve spontaneously within 24 hours, although a minority of patients may develop life-threatening complications.

We report the case of a patient who developed serotonin syndrome after ingesting over 6,000 mg of sertraline. His serum level attained a never previously reported high of 660ng/ml. This case was unusual in that symptoms presented in a bimodal fashion: resolving completely within the first 32 hours, then abruptly recurring approximately 50 hours post-ingestion, and eventually leading to near-fatal ARDS. The possible pathophysiological mechanisms of this course (e.g., pharmacokinetics of metabolites) as well as distinguishing diagnostic characteristics and treatment options for serotonin syndrome are discussed.

REFERENCES:

1. Bodner R Lynch T, Lewis L, et al: Serotonin syndrome. Neurology 1995; 45:219–223.
2. Greenblatt D, von Moltka L, Harmatz J, Shader R: Drug interactions with newer antidepressants: role of human cytochromes P450. J Clin Psychiatry 1998; 59(suppl 15)19–27.

Poster 106 **Sunday, October 31 3:30 p.m.-5:00 p.m.**

LESS TRANQUILIZER USE WITH RIVASTIGMINE FOR ALZHEIMER'S DISEASE

Keith R. Edwards, M.D., *Director, Neurological Research Center, 140 Hospital Drive, Suite 210, Bennington, VT 05201;* William A. Goodman, Psy.D., *Department of Geriatric Neurology, Neurological Research Center, 140 Hospital Drive, Suite 210, Bennington, VT 05201;* Judith A. Norton, R.N.

SUMMARY:

Background: Many patients with probable Alzheimer's disease (AD) are placed in nursing homes due to unmanageable behaviors that are disruptive to caregivers and often require the administration of tranquilizers.

Objective: To analyze the efficacy of rivastigmine (Exelon) at 12, 26, and 52 weeks in improving patient behavior, cognition, and tranquilizer use.

Design and Methods: Forty-two nursing home patients with probable AD were enrolled in an open-label study with rivastigmine. Seventeen of these patients were receiving tranquilizers prior to starting rivastigmine treatment. Mini-Mental Status (MMS), Neuropsychiatric Inventory (NPI), and psychotropic medication use were analyzed at 12, 26, and 52 weeks.

Results: Of the nine patients receiving tranquilizers who completed the 52-week study, over 50% terminated tranquilizer use and did not resume for the remainder of the study. In these patients, rivastigmine dosage ranged from 6 to 12mg/day.

Discussion: In this group of patients, behavior improved, consequently tranquilizer use decreased, functional status, and quality of life increased, while caregiver burden decreased. It is unknown at this time whether the improved behavior is due to cognitive improvement or if there is an independent cholinergic modification of behavior.

REFERENCES:

1. Kaufer DI, Cummings, JL: Effect of tacrine on behavioral symptoms in Alzheimer's disease: an open-label study. J Geriatr Psychiatry Neurol 1996; 9:1–6.
2. Cummings JL, Kaufer KI: Neuropsychiatric aspects of Alzheimer's disease: the cholineric hypothesis revisited. Neurology 1996; 47:876–883.

Poster 107 **Sunday, October 31 3:30 p.m.-5:00 p.m.**

ADJUNCTIVE LOXAPINE THERAPY WITH ATYPICAL AGENTS

Samuel Mowerman, M.D., *Assistant Director, Day Hospital, P.O. Box 38, Glen Oaks, NY 11004–0038*

SUMMARY:

Following the report of the successful use of loxapine in schizophrenic patients partially responding to clozapine, we evaluated a similar strategy in patients taking either risperidone or olanzapine. To be eligible for this evaluation, patients had to have a partial or poor response to high doses of either agent over at least eight weeks. The major diagnosis for the 55 consecutive patients enrolled was paranoid schizophrenia. Patients partially responsive, but intolerant to high doses and patients

refractory to the second agent received adjunctive loxapine. The main residual symptoms were delusions or hallucinations. Loxapine improved 16 and showed no change in 12 of 28 refractory patients. Loxapine improved 25 and did not change two of 27 intolerant patients. Prior to loxapine, 16 of 55 patients (13 on risperidone) required the anticholinergic, benztropine for EPS symptoms. Following loxapine augmentation, an additional 12 patients (10 on risperidone) showed EPS symptoms. The loxapine adjunct dose was between 10 and 50 mg for 75% of the patients.

Loxapine may be a viable adjunct in patients partially or unresponsive to risperidone or olanzapine. Loxapine appears to provide an effective, well-tolerated and low-cost means to augment these atypical agents.

REFERENCES:

1. Mowerman S, Siris S: Adjunctive loxapine in a clozapine-resistant cohort of schizophrenic patients. Annals of Clinical Psychiatry 1996; 8(4).
2. Kapur S. A new framework for investigating antipsychotic action in humans: lessons from PET imaging. Mol Psychiatry 1998; 3:135–140.

Poster 108 **Sunday, October 31 3:30 p.m.-5:00 p.m.**

EFFECTS OF MIRTAZAPINE ON DEPRESSION AND WEIGHT IN VERY ELDERLY PATIENTS

Ben Zimmer, M.D., *Associate Professor of Psychiatry, Allegheny General Hospital, 6506 Dalzell Place, Pittsburgh, PA 15217-1440;* Victor G. Stiebel, M.D., *Consultant, Psychiatric Associates of Western Pennsylvania, 6350 Phillips Avenue, Pittsburgh, PA 15217–1808;* Sherryl May, Ph.D.; Robert T. Rubin, M.D., Ph.D.

SUMMARY:

Objective: Few studies of the ancillary effects of antidepressants have been performed in very elderly subjects. Mirtazepine is a tetracyclic antidepressant that appears to increase central noradrenergic activity by antagonizing central presynaptic a_2 autoreceptors. It also antagonizes 5-HT_2 and 5-HT_3 receptors, H_1 receptors (accounting for its sedative and purported weight-gain properties), and a_1 receptors (occasionally producing orthostatic hypotension). This study examined the therapeutic efficacy and ancillary effects of mirtazepine, especially its influence on weight, in depressed patients ages 74–98.

Method: Nineteen depressed nursing home residents (85.6 ± 7.1 years; 14 women, 5 men) were administered mirtazepine (7.5–30 mg/day) for one to 10 months. Fifteen patients also had dementia of varying etiology and severity. Outcome variables included behavioral rating scales and weight.

Results: Mirtazepine was an effective antidepressant in these very elderly patients. The initial Montgomerysberg Depression Rating Scale score was 22.0 ± 7.8; and the final score was 6.2 ± 4.9. Seventeen patients had initial and final weights documented, and weight change (Δ) varied significantly inversely with age: Of five patients ages 74–80, four gained weight, none lost weight, and one remained the same; of six patients ages 81–90, three gained weight, two lost weight, and one remained the same; of six patients ages 91–98, one gained weight, three lost weight, and two remained the same ($r_{age:\Delta\ weight} = -0.50$; $p < 0.05$). Older patients tended to receive less mirtazepine; controlling for mirtazepine dose reduced the $r_{age:\Delta\ weight}$ to –0.43 (18% shared variance; $p < 0.10$). There was a trend for systolic blood pressure to drop (mean Δ = –5.4 mm Hg), with no consistent change in diastolic pressure (mean Δ = 0.9 mm Hg). No episodes of orthostatic hypotension were reported.

Conclusions: Mirtazepine is a relatively safe, sedating antidepressant in very elderly patients with dementia. Its weight-promoting effect diminishes with increasing age.

(Supported in part by NIMH grant MH28380 to RTR.)

TARGET AUDIENCE:

Psychiatrists, psychopharmacologists, primary care physicians, and geriatricians.

REFERENCES:

1. de Boer T: The pharmacological profile of mirtazepine. J Clin Psychiatry 1996; 57(Suppl 4):19–25.
2. Montgomery SA: Safety of mirtazepine: a review. Int Clin Psychopharmacol 1995; 10(Suppl 4):37–45.

Poster 109 **Sunday, October 31 3:30 p.m.-5:00 p.m.**

EFFICACY AND SAFETY OF CITALOPRAM IN PAROXETINE-INTOLERANT PATIENTS

Michael E. Thase, M.D., *Professor of Psychiatry, Western Psychiatric Institute and Clinic, 3811 O'Hara Street, Pittsburgh, PA 15213;* James Ferguson, M.D.; Charles Wilcox, Ph.D.

SUMMARY:

Objective: To examine the clinical response to citalopram in patients who had failed to tolerate paroxetine treatment for a major depressive episode.

Method: Patients with major depressive disorder who had discontinued paroxetine treatment due to adverse events were eligible for enrollment. The minimum inter-

val between discontinuation of paroxetine and initiation of 20 mg/day citalopram was one week. During the six-week, open-label treatment period, titration was permitted up to 40 mg/day or down to 10 mg/day.

Results: Sixty-one patients enrolled in this study. The most common reasons for discontinuation of paroxetine treatment were libido decreased (49%), somnolence (31%), ejaculation disorder and impotence in males (21% and 17%, respectively), and anorgasmia in females (16%). Median time between discontinuation of paroxetine and initiation of citalopram was 15 days, and the mean citalopram dose was 23.8 mg/day. Citalopram produced a significant ($p < 0.001$) improvement in depressive symptoms on the Hamilton Depression Rating Scale, the Clinical Global Impressions scale, and the Beck Depression Inventory. Adverse events reported during paroxetine treatment were unlikely to recur during citalopram treatment. Six patients (10%) discontinued citalopram due to adverse events, and the adverse event most often associated with discontinuation of citalopram was headache (3%).

Conclusion: Depressed patients who are unable to tolerate paroxetine can be successfully switched to and will benefit from treatment with citalopram.

TARGET AUDIENCE:

Physicians, pharmacists, psychologists, and nurses.

REFERENCES:

1. Noble S, Benfield P: Citalopram: a review of its pharmacology, clinical efficacy, and tolerability in the treatment of depression. CNS Drugs 1997; 8:410–431.
2. Mendels J, Kiev A, Fabre LF: Double-blind comparison of citalopram with placebo in depressed outpatients with melancholia. Depression and Anxiety 1999; 9:54–60.

Poster 110 **Sunday, October 31 3:30 p.m.-5:00 p.m.**

INHIBITION OF CYP2D6 ACTIVITY BY NEWER ANTIDEPRESSANTS: IN VITRO AND IN VIVO CORRELATIONS

David J. Greenblatt, M.D., *Professor and Chair, Department of Pharmacology, Tufts University, 171 Harrison Avenue, Box 1007, Boston, MA 02111-1854;* Lisa L. von Moltke, M.D.; Richard I. Shader, M.D.

SUMMARY:

Objective: Using *in vitro* metabolic systems and human liver microsomal preparations, forecast clinical drug interactions involving inhibition of cytochrome P450 (CYP)-mediated drug metabolism by newer antidepressants and their metabolites.

Methods: O-demethylation of dextromethorphan to form dextrorphan by human liver microsomes was used as an index of CYP2D6 activity. This system was used to evaluate the inhibiting potency of a number of newer antidepressants.

Results: At a fixed concentration of dextromethorphan (25 μM), the mean 50% inhibitory concentration (IC_{50}) of quinidine (the index inhibitor for this reaction) was 0.4 μM. Antidepressants (and metabolites) classified as "strong" CYP2D6 inhibitors, and corresponding IC_{50} values, were fluoxetine (2.0 μM), norfluoxetine (2.7 μM), and paroxetine (2.6 μM). "Weak" CYP2D6 inhibitors were sertraline (29.9 μM), desmethylsertraline (81 μM), citalopram (80 μM), and desmethylcitalopram (39.5 μM). Venlafaxine, mirtazapine, and reboxetine also were "weak" inhibitors. The relative *in vitro* inhibitory potencies closely correspond to clinical findings, in which very large inhibition of clearances of CYP2D6 substrate drugs (such as desipramine or dextromethorphan) is produced by cotreatments with fluoxetine or paroxetine, whereas sertraline, citalopram, or venlafaxine produce small or negligible inhibition.

Conclusion: This *in vitro* system can rapidly provide predictive information on clinical drug interactions with newer antidepressants.

TARGET AUDIENCE:

Physicians, pharmacists, psychologists, and nurses.

REFERENCES:

1. Greenblatt DJ, von Moltke LL, Harmatz JS, Shader RI: Drug interactions with newer antidepressants: role of human cytochromes P450. Clin Psych 1998; 59(suppl 15):19–27.
2. Alfaro CL, Lam YW, Simpson J, Ereshefsky L: CYP2D6 status of extensive metabolizers after multiple-dose fluoxetine, fluvoxamine, paroxetine, or sertraline. J Clin Psychopharmacol 1999; 19:155–163.

Poster 111 **Sunday, October 31 3:30 p.m.-5:00 p.m.**

QUETIAPINE IMPROVES PSYCHOTIC SYMPTOMS ASSOCIATED WITH PARKINSON'S DISEASE

Jeffrey M. Goldstein, Ph.D., *Medical Research and Communications Group, AstraZeneca Pharmaceuticals, 1800 Concorde Pike, Wilmington, DE 19850;* Jorge L. Juncos, M.D.; Paul P. Yeung, M.D., M.P.H.

SUMMARY:

The incidence of psychotic symptoms in patients with advanced Parkinson's disease (PD) is ≤40%. These symptoms are frequently precipitated by treatment with anticholinergic and dopaminergic agents, but withdrawal of these agents or treatment with conventional antipsychotics can lead to intolerable motor disability. Quetiapine fumarate (quetiapine), a recently approved antipsychotic, is effective in treating the positive and negative symptoms of psychosis, is well tolerated, and does not differ from placebo in the incidence of extrapyramidal symptoms or elevations of plasma prolactin. In addition, quetiapine has been shown to be safe and effective in elderly patients with psychotic disorders. We present results from an exploratory analysis of the effects of quetiapine on the symptoms of PD. We include in the analysis 40 patients (mean age 72.6 years) with advanced PD (mean Hoehn and Yahr Stage 3, or bilateral disease with balance impairment), who were part of a larger (n = 184), one-year trial of quetiapine in elderly psychotic patients. Patients could receive from 25 to 800 mg/day of quetiapine, dosed according to clinical response and tolerability, for up to one year. Assessments included the Brief Psychiatric Rating Scale (BPRS), Clinical Global Impression Severity of Illness Score (CGI-S), the Unified Parkinson's Disease Rating Scale (UPDRS), and the Modified Schwab and England Activities of Daily Living Scale (MSEADLS). The BPRS and CGI improved by 30% to 40% by Week 12 and remained significantly improved throughout the 52-week trial. The improvement from baseline in mean UPDRS score was statistically significant through Week 12; at Week 12, patients who improved outnumbered those who worsened by about 4 to 1. At baseline, 60% of the patients had a MSEADLS score of ≤40, but by Week 12, disability scores improved and only 37.9% had a score of ≤40; by Week 52, MSEADLS scores had returned to baseline and 60.6% of patients had a score of ≤40. The results of this exploratory analysis show that quetiapine is an effective and well tolerated antipsychotic in patients with PD. The short-term improvement in PD motor performance remains unexplained but underscores quetiapine's lack of extrapyramidal side effects.

REFERENCES:

1. McManus DQ, Arvanitis LA, Kowalcyk BB: Quetiapine, a novel antipsychotic: experience in elderly patients with psychotic disorders. J Clin Psychiatry 1999; 60:292–298.
2. Arvanitis LA, Miller BG, The Seroquel Trial 13 Study Group: Multiple fixed doses of "Seroquel" (quetiapine) in patients with acute exacerbation of schizophrenia: a comparison with haloperidol and placebo. Biol Psychiatry 1997; 42:233–246.

Poster 112 **Sunday, October 31**
3:30 p.m.-5:00 p.m.

QUETIAPINE AND RISPERIDONE IN OUTPATIENTS WITH PSYCHOTIC DISORDERS: RESULTS OF THE QUEST TRIAL

Jamie A. Mullen, M.D., *Associate Medical Director, AstraZeneca Pharmaceuticals, 1800 Concord Pike, Wilmington, DE 19850;* Michael J. Reinstein, M.D.; Mohammad M. Bari, M.D.

SUMMARY:

In a four-month, multicenter, open-label trial, the tolerability and efficacy of quetiapine fumarate (quetiapine) and risperidone were compared in 751 adult outpatients with psychotic disorders. Patients were randomized in a 3:1 ratio (quetiapine: risperidone) and were flexibly dosed. Assessments included the Extrapyramidal Symptoms (EPS) Checklist, the Hamilton Rating Scale for Depression (HAMD), the Clinical Global Impression (CGI), the Positive and Negative Syndrome Scale (PANSS), and the Drug Attitude Inventory (DAI-10). At the completion of the trial, the mean quetiapine dose was 317 mg and the mean risperidone dose was 4.5 mg. EPS events in both treatment groups declined over the four-month treatment period, with no significant differences between groups in the overall occurrence of EPS. Patients in the risperidone group were more likely to have an EPS event and more likely ($p < 0.001$) to have EPS that required adjustment of study medication or adjunctive medication than were patients in the quetiapine group. EPS symptoms rated as "at least moderate" occurred more frequently at each visit in risperidone patients. The quetiapine and risperidone groups had improvements in all efficacy measures. The quetiapine group had significantly ($p = 0.028$) greater improvement in the HAMD than the risperidone group. A higher percentage of patients in the quetiapine group relative to the risperidone group had improvement in the CGI at each visit. No statistically significant differences between groups were evident in the PANSS positive scale, negative scale, general psychopathology score, or total score, nor was there a statistically significant difference between groups in the DAI-10. In summary, quetiapine was less likely than risperidone to require dose adjustment for EPS or concurrent anti-EPS medication, was more effective than risperidone in treating depressive symptoms, and was as effective as risperidone in treating the positive and negative symptoms of outpatients with psychosis.

REFERENCES:

1. Goren JL, Levin GM: Quetiapine, an atypical antipsychotic. Pharmacotherapy 1998; 18(6):1183–1194.

2. Arvanitis LA, Miller BG, the Seroquel Trial 13 Study Group: Multiple fixed doses of "Seroquel" (quetiapine) in patients with acute exacerbation of schizophrenia: A comparison with haloperidol and placebo. Biol Psychiatry 1997; 42:233–246.

Poster 113 **Sunday, October 31 3:30 p.m.-5:00 p.m.**

QUETIAPINE IN NEUROLEPTIC DEPENDENT MOOD DISORDERS

Martha Sajatovic, M.D., *Department of Psychiatry, Cleveland VAMC, 345 Timberidge Trail, Gates Mills, OH 44040-9319;* Debra W. Brescan, M.D.; Dalia Perez, M.D.

SUMMARY:

Objective: Quetiapine is an effective novel antipsychotic with mixed serolonergic and dopaminergic activity. Clinically, it is generally readily tolerated, with a low extrapyramidal adverse effect profile. This is a prospective, open-label trial of quetiapine therapy in patients with neuroleptic-dependent mood disorders.

Methods: Individuals with bipolar or schizoaffective disorder who, based upon clinical history, required both mood stabilizing and neuroleptic medication for at least six months, were given add-on quetiapine therapy to existing medication regimen. Other antipsychotic medication was gradually discontinued. Psychopathology was evaluated with the Brief Psychiatric Rating Scale (BPRS), the Young Rating Scale (YMRS), and the Hamilton Depression Scale (HAM-D). Abnormal movements were assessed with the Simpson Angus Neurological Rating Scale (SA).

Results: Sixteen individuals (9 with bipolar disorder and 7 with schizoaffective disorder) received quetiapine therapy for a mean of 10.8 weeks at a mean maintenance dosage of 155 mg/day. Mean age of the group was 49.9 years. Overall, patients did very well on queliapine therapy with significant improvement in BPRS score ($p = .0001$), YMRS score ($p = .008$), and HAM-D score ($p = .0003$) compared with previous antipsychotic medication therapy. SA score decreased from a baseline of 5.5 to an endpoint score of 2.5 but failed to reach statistical significant ($p = .075$).

Conclusion: Quetiapine is an effective antipsychotic medication in neuroleptic dependent patients with serious mood disorders. These preliminary findings should be explored in larger, controlled trials. This study was supported by a grant from Zeneca Pharmaceuticals.

REFERENCES:

1. Sachs GS: Adjuncts and alternatives to lithium therapy in bipolar affective disorder. Journal of Clinical Psychiatry 1989; 51(12, Suppl):31.
2. Saller CF, Salama AL: Seroquel: biochemical profile of a potential atypical antipsychotic. Psychopharmacology 1993; 112:285–292.

Poster 114 **Sunday, October 31 3:30 p.m.-5:00 p.m.**

CHANGES IN COGNITIVE FUNCTION WITH QUETIAPINE VERSUS HALOPERIDOL

Dawn I. Velligan, Ph.D., *Associate Professor, Department of Psychiatry, University of Texas Health Sciences Center, 7703 Floyd Curl Drive, San Antonio, TX 78284;* John W. Newcomer, M.D.; Joseph Pultz, Ph.D.

SUMMARY:

Objective: Recent evidence suggests that schizophrenia patients taking novel antipsychotic medications may perform better on some tests of neurocognitive ability than those treated with older neuroleptics. Furthermore, the cognitive advantages of these newer agents may differ from one another. The current study compared the effects of quetiapine fumarate (quetiapine) and haloperidol on measures of executive function, memory, and attention.

Method: Subjects were 40 stable outpatients with schizophrenia (DSM-III-R) who received a battery of cognitive tests as part of a randomized, double-blind, multisite clinical efficacy study. Neuropsychological assessments were conducted prior to randomization to treatment when patients were on 30 mg/day or less of haloperidol or equivalent, and again after 24 weeks of fixed-dose treatment with either 600 mg/day of quetiapine or 12 mg/day of haloperidol.

Results: Analyses of covariance were used to compare change in scores on neurocognitive measures by treatment group with baseline cognitive function scores used as covariates. Patients on quetiapine improved to a greater extent than patients on haloperidol on tests of both executive function (verbal fluency) and verbal memory (paragraph recall) ($F(1,37) = 5.59$; $p < 0.03$ and $F(1,37) = 7.61$; $p < 0.01$, respectively).

Conclusions: Treatment with quetiapine appears to have a positive impact on important domains of cognitive performance that have been found to predict role function and community outcomes in patients with schizophrenia.

REFERENCES:

1. Goren JL, Levin GM: Quetiapine, an atypical antipsychotic. Pharmacotherapy 1998; 18(6):1183–1194.
2. Arvanitis LA, Miller BG, the Seroquel Trial 13 Study Group: Multiple fixed doses of "Seroquel" (quetiapine) in patients with acute exacerbation of schizo-

phrenia: a comparison with haloperidol and placebo. Biol Psychiatry 1997; 42:233–246.

Poster 115 **Sunday, October 31 3:30 p.m.-5:00 p.m.**

SSRI USE IN A VETERANS HEALTH CARE SYSTEM

Raymond A. Faber, M.D., *Professor of Psychiatry and Neurology, University of Texas Health Sciences Center at San Antonio, and Chief of Neuropsychiatry, Audie Murphy VA Hospital, 7400 Merton Minter (116A), San Antonio, TX 78284*

SUMMARY:

Selective serotonin reuptake inhibitor (SSRI) usage and acquisition costs in the South Texas Veterans Health Care System were analyzed for the one-year period from October 1, 1996 through September 30, 1997.

Results: A total of 3,934 patients (90% [3,547] males and 10% [387] females) received a total of 17,292 prescription fills (new and refills) written by 580 providers. Sertraline accounted for 7,289 fills, fluoxetine 7,010 fills, and paroxetine 2,993 fills. Total SSRI acquisition costs were $832,543. The average daily doses and per-day costs were: fluoxetine 28 mg costing $1.74, paroxetine 32 mg costing $1.32, and sertraline 93 mg costing $1.15. While 36% of treated patients received fluoxetine, it accounted for 49% of the SSRI budget; 44% of treated patients received sertraline for 36% of the budget, and 20% received paroxetine for 15% of the budget.

Switch rates among SSRIs were 6.8% of fluoxetine patients to another SSRI, 16.9% of paroxetine patients, and 5.9% of sertraline patients. Interestingly, there were no differences in SSRI prescribing practices between psychiatrists and other providers.

Conclusions: Acquisition costs of SSRIs were a substantial expenditure in the South Texas Veterans Health Care System during the one-year study period. Sertraline was the most cost-effective SSRI, while fluoxetine was the least cost-effective. The average daily SSRI dose and the option to split scored tablets accounted for these cost differences.

TARGET AUDIENCE:

Psychiatrists and health care administrators.

REFERENCES:

1. Depression Guideline Panel: Depression in Primary Care; Vol 2. Treatment of Major Depression. Rockville, Md: U.S. Dept of Health and Human Services; 1993. Agency for Health Care Policy and Research Publication 93–0551.
2. Simon GE, VonKorff M, Heiligenstein JH, et al: Initial antidepressant choice in primary care; effectiveness and cost of fluoxetine vs. tricyclic antidepressants. JAMA 1996; 275:1897–1902.

Poster 116 **Sunday, October 31 3:30 p.m.-5:00 p.m.**

DIABETOGENESIS AND KETOACIDOSIS WITH ATYPICAL ANTIPSYCHOTICS

Daniel R. Wilson, M.D., *Medical Director, The Lewis Center, 1101 Summit Road, Cincinnati, OH 45237-2621;* Lee D'Souza, M.D.; Nibar Sarka, M.D.

SUMMARY:

Objective: With the advent of novel antipsychotic compounds that are relatively free of extrapyramidal symptoms, clinicians have shown increased interest in side effects, which have previously not been the focus of attention. However, recent case reports have suggested some atypical antipsychotics may induce clinically significant alterations in glucose metabolism. The authors evaluated the risk of diabetogenesis in a large state hospital cohort.

Method: The computerized records of all adult patients in an academically affiliated state hospital were retrospectively reviewed over a 48-month period (May 1995- May 1999). Persons treated with novel antipsychotics were identified as were persons evaluated for diabetes management. The rosters were collated and full charts of persons on both lists were reviewed intensively with respect to age, sex, psychiatric diagnosis, drug treatment history, diabetic risk factors, and clinical association between glucose intolerance and treatment with atypical antipsychotics.

Results: Results of preliminary data analysis reveal acute and marked glucose intolerance in 11 patients. Changes were not related to significant weight gain and typically occurred in the first six weeks. Six patients were treated with insulin at least transiently and four patients experienced diabetic ketoacidosis with referral to a tertiary care facility for intensive and life-saving medical care. It is of considerable concern that at least some antipsychotics may be dangerously diabetogenic. A more extensive analysis of the larger statewide Ohio Department of Mental Health database is now underway to ascertain if (1) this is a class risk of if only as subset medications may be diabetogenic, (2) more assertive treatment monitoring is warranted, and (3) atypical antipsychotics may be contraindicated in a subset of patients due to risk of new-onset diabetes.

REFERENCES:

1. Wirshing DA, Spellberg RJ, Erhart SM, Marder SR, Wirshing WC: Novel antipsychotics and new onset diabetes. Biological Psychiatry 1998; 8:778–83.

2. Fertig MK, Shelton VG, English CW: Hyperglycemia associated with olanzapine. J Clin Psychiatry 1998; 12:59:687–9.

Poster 117 **Sunday, October 31 3:30 p.m.-5:00 p.m.**

PREVALENCE OF DUAL DIAGNOSIS IN SAO PAULO, BRAZIL

Paulo R. Menezes, Ph.D., *Professor, Department of Preventive Medicine, Sao Paulo University, Av. Dr. Arnaldo 455, Sao Paulo, Brazil 01246-903;* Lillian R.C. Ratto, M.D.

SUMMARY:

In order to investigate the prevalence of substance use disorder among patients with severe mental illnesses in São Paulo, Brazil, a coss-sectonal study was carried out. Twenty mental health services (emergency, inpatient, and outpatient services) were scrutinized to identify all patients aged 18 to 65, with a clinical diagnosis of functional psychosis, who were resident in one of seven administrative districts chosen for the study, and who had at least one contact with such services between September 1 and November 30, 1997. Out of 620 patients identified, 404 were randomly selected to be directly interviewed. Patterns of use of substances and symptoms of dependence were assessed using the appropriate sections of the scan. One hundred ninety three patients (47.8%) were directly interviewed, of whom 102 (52.8%) were male. Fifteen (7.8%) fulfilled criteria for substance use disorder, according to ICD-10 criteria. Male patients were almost 2.5 times more likely to present with such comorbidity than females. The low prevalence of dual diagnosis in the present study suggests that, in São Paulo, such patients may be more frequently seen in specific settings, such as emergency services or inpatient units.

REFERENCES:

1. Bartels SJ, et al: Substance abuse in schizophremia: service utilization and coste. J Nerv Ment Dis 1993; 181:227–232
2. Menezes PR, et al: Drug and alcohol problems among individuals with severe mental illnesses in South London. Br J Psychiatry 1996; 168:612–619.

Poster 118 **Sunday, October 31 3:30 p.m.-5:00 p.m.**

RELIGIOUS AND SPIRITUAL EXPECTATIONS OF PSYCHIATRIC INPATIENTS

Hetal K. Brahmbhatt, M.D., *Resident, Department of Psychiatry, East Tennessee State University, 1007 Oracle Court, Johnson City, TN 37604;* Brent R. Coyle, M.D.; Barney Miller, Ph.D.; Tim Lacy, M.D.; Ali A. Garatli, M.D.; Safia M. Sabri, M.D.

SUMMARY:

Introduction: Sheehan found that 23% of psychiatric inpatients consider religious/spiritual conflict to be a primary reason for their hospitalization. Anderson found that approximately 59% of psychiatric inpatients chose to have a spiritual component to their care. APA advises psychiatrists' not to impose their own religious beliefs on patients for therapeutic practice. Larson found that the general population is significantly more religious than psychiatric providers. This religiosity gap suggests that patients have high interest in incorporating a spiritual component into their care.

Method: Survey of 100 psychiatric inpatients and 50 controls was done to study expectations for spiritual component to health care.

Results: It was found that 50% of patients wished to have their religious beliefs explored during their hospital stay. Fifty percent felt their current emotional problems were due to religious conflict; 78% felt "prayers changes things"; 46% wanted their provider to pray with them; and 71% felt spirituality helped in coping with illness.

Conclusion: A large number of psychiatric patients expect a spiritual component to their care. Other findings support highly beneficial psychological outcome of spirituality. Our wisdom as psychiatrists comes in acknowledging this aspect of health care.

REFERENCES:

1. Sheehan W, Kroll J: Psychiatric patients' belief in general health factors and sin as causes of illness. American Journal of Psychiatry. 1990; 147. pages 112-113.
2. Anderson RG, Young JL: The religious component of hospital treatment. Hospital and Community Psychiatrists. May 1998, vol. 39, no. 5:528-533.

Poster 119 **Sunday, October 31 3:30 p.m.-5:00 p.m.**

COGNITIVE VARIABLES INFLUENCING COMPLIANCE IN A POST-DISCHARGE POPULATION

Geetha Jayaram, M.D., *Department of Psychiatry, Johns Hopkins University, 600 N. Wolfe Street, Meyer 101, Baltimore, MD 21287-7101*

SUMMARY:

Studies of patient relapses do not include a critical analysis of cognitive requisites for adherence to medication regimens. The role of attention, memory, and infor-

mation processing affecting compliance in chronic patients is not demonstrated.

Ninety consented, severely mentally ill patients meeting study inclusion criteria completed a neuropsychological battery of tests. Four to six months after discharge, we reached and interviewed 55 of 90 patients using a compliance questionnaire. The questionnaire included demographic data, compliance outcome measures such as knowledge of and adhesion to to medications, appointments, and recidivism.

Outcome measures were correlated with measures of verbal learning, recall, reading, comprehension, full-scale IQ, psychopathology, and functional ability. Both parametric and non-parametric tests were used to analyze data.

Among significant cognitive variables influencing outcome were gender, full-scale IQ, type of instructional material provided, employment status, attention and cognitive flexibility, visual learning, and recall.

REFERENCES:

1. Way BB, Evans ME, Banks, SM: Factors predicting referral to inpatient or outpatient treatment from psychiatric emergency services. Hospital and Community Psychiatry 1992; 43(7), 703–8.
2. Ellison JM, Blum N, Barsky AJ: Repeat visitors in the psychiatric emergency service: a critical review of the data. Hospital and Community Psychiatry 1986; 37(1):37–41.

Poster 120 **Sunday, October 31**
3:30 p.m.-5:00 p.m.

QUETIAPINE TREATMENT OF DRUG-INDUCED PSYCHOSIS IN PARKINSON'S DISEASE

Hubert H. Fernandez, M.D., *Brown University School of Medicine, Division of Neurology, Memorial Hospital of Rhode Island, 111 Brewster Street, Pawtucket, RI 02860;* Joseph H. Friedman, M.D., Carol Jacques, N.P.

SUMMARY:

Quetiapine is an atypical antipsychotic with clozapine-like pharmacology but without associated agranulocytosis. We report our complete experience with quetiapine in the treatment of drug-induced psychosis (DIP) in Parkinson's disease (PD).

Fifty-nine patients with DIP between 49 and 91 years old, with a mean PD duration of nine years and on an average of 460 mg levodopa per day received 44.6 mg of quetiapine daily.

Twenty-eight of 34 neuroleptic-naive patients had marked improvement of psychosis. Seven of the 34 had increased parkinsonism. The mild worsening in the Unified Parkinson's Disease Rating Scale (UPDRS-motor) was statistically significant (45.6 vs 50.6 $p = 0.006$). Twelve patients had baseline and four-week follow-up assessment using the Mini-Mental Status Examination (MMSE) and Brief Psychiatric Rating Scale (BPRS). The improvement in BPRS score (31.4 vs 23.2) was clinically and statistically significant, $p = 0.024$. Six of 34 were unable to tolerate quetiapine due to orthostatic hypotension, headache, nausea, confusion, agitation, and persistence of hallucinations.

We also tried to switch 25 psychiatrically stable patients on clozapine (22) and olanzapine (3). Seventeen patients made this transition without a loss of effect as measured on BPRS and MMSE. Eight did not (seven on clozapine, one on olanzapine) because of increased parkinsonism (5), recurrence of hallucinations (4), anxiety and agitation (3), and dyskinesia (1).

Low dose quetiapine is useful and well-tolerated as a first drug to treat DIP in most PD patients. It is also an option for psychiatrically-stable PD patients who need a change in their antipsychotic agent.

TARGET AUDIENCE:

Psychiatrists, neurologists and health care providers.

REFERENCES:

1. Friedman JH: The management of levodopa psychoses. Clin Neuropharmacol 1991; 14:283–295.
2. Juncos JL, Evatt ML, Jewart D: Long-term effect of quetiapine furmate in parkinsonism complicated by psychosis. Neurology 1998; 50 (suppl 4):A70–71.

POSTER SESSION 5

Posters 121–153

NEUROPSYCHIATRY, PSYCHOTHERAPY, SUBSTANCE ABUSE AND COMMUNITY PSYCHIATRY

Poster 121 **Monday, November 1**
10:00 a.m.-11:30 a.m.

QUALITY END-OF-LIFE CARE FOR SERIOUS MENTAL ILLNESS

Mary Ellen Foti, M.D., *Area Medical Director, Massachusetts Department of Mental Health, 45 Hospital Road, Medfield, MA 02052;* Meredith Hanrahan-Boshes, *Project Director, Medfield State Hospital, 45 Hospital Road, Medfield, MA 02052*

SUMMARY:

The Robert Wood Johnson Foundation is supporting a grant based in the Massachusettes Department of Mental

Health entitled: "End of Life Care for Persons With Serious Mental Illness." The grant interventions include the development of two new tools. One, the MacCAT-P, assesses the capacities of persons with serious mental illness to participate in the selection of a health care proxy. This tool is a modification of the MacCAT-T, an instrument used to assess capacities related to the acceptance or deferral of medical treatment(s). The poster session will provide an example of this tool and its early pilot results.

A second instrument has been developed to gain knowledge about the attitudes and values of persons with severe mental illness regarding the kinds of interventions they would prefer at the end of their life. This questionnaire is based on work done by the American Health Decisions regarding the wishes of the general public. The questionnaire covers areas, including general health status, doctor-patient relationship, and possible end-of-life interventions (physician-assisted suicide, discontinuation of mechanical life support systems). The poster session will include an example of the questionnaire along with early pilot results.

REFERENCES:

1. Grisso T, Appelbaum PS, Hill-Fotouhi C: The MacCAT-T: a clinical tool to assess patients' capacities to make treatment decisions. Psychiatric Services 1995; 48:1415–1419.
2. The Quest to Die with Dignity, An Analysis of American's Values, Opinions, and Attitudes Concerning End-of-Life Care. A Report by American Health Decisions, 1997.

Poster 122 **Monday, November 1**
10:00 a.m.-11:30 a.m.

PREVALENCE AND CORRELATES OF ALCOHOL DEPENDENCE IN A NATIONWIDE SAMPLE OF KOREAN ADULTS

Maeng J. Cho, M.D., Ph.D., *Associate Professor of Psychiatry, College of Medicine, Seoul National University, Hospital, 28 Yongun-Dong, Chongno-Gu, Seoul, Korea 110-744;* Seong-Jin Cho, M.D., *Research Fellow, Department of Psychiatry, Seoul National University, 28 Yongun-Dong, Chongno-Gu, Seoul, Korea 110-744;* Tongwoo Suh, M.D., Ph.D.; Jung J. Nam, Ph.D.

SUMMARY:

We estimated the prevalence rate of alcohol dependence(AD), and tried to find out correlates of sociodemographic variables, drinking patterns, and risk factors of AD in Korea.

Among the nationwide probability sample of 5,717 adults aged 20 years and over, 1,926 were drinkers (33.7%: male 54.8%, female 14.2%). CAGE, CES-D, and a 20-item questionnaire of drinking pattern were administered during the interview. Drinkers with CAGE scores 2 and over were defined as the AD group. With weighting, chi-square test and logistic regression analysis were done for the correlates and risk factors, respectively. Analyses were done for each gender separately. Prevalence of AD was 10.9% (males 20.8%, females 1.8%). In both genders, the AD group was older, less educated, had less income, were more depressive, and more likely to have jobs in the service section than drinkers without dependence. Both of the AD groups drank more frequently, had more drinks, tried to quit drinking on more occasions, and preferred high concentrated alcohol. Less than six years of education and depressive symptoms proved risks of AD in both genders. These results suggest that early detection and treatment of depression and social support systems for the lower education group are strongly needed for prevention of alcohol dependence.

REFERENCES:

1. Lynn PL, Cynthia RL, Robert BW, Thomas KW: Epidemiology of alcohol use in a group of older American Indians. Ann Epidemiol 1997; 7(4):241–248.
2. Hamlett K, Eaker ED, Stoke J: Psychosocial correlates of alcohol intake among women aged 45 to 64 years: the Framingham study. Behav Med 1989; 12(6):525–542.

Poster 123 **Monday, November 1**
10:00 a.m.-11:30 a.m.

INVOLVING CONSUMERS/FAMILIES IN THE DESIGN OF AN EVIDENCE-BASED, STRUCTURED EDUCATIONAL PROGRAM FOR FAMILIES OF PERSONS WITH SERIOUS MENTAL ILLNESS

Jennie F. Hall, M.D., *Director, Psychosocial Rehabilitation Program, VA Medical Center, 2002 Holcombe Boulevard, Houston, TX 77030;* Travis J. Courville, M.S.W., *Coordinator, Community Support Program, Department of Psychiatry, VA Medical Center, 2002 Holcombe Boulevard, Houston, TX 77030;* Joseph D. Hamilton, M.D.; Bruce R. Graunke, Ph.D.

SUMMARY:

Research has demonstrated the effectiveness of structured psychoeducational programs for families of the seriously mentally ill. However, little information exists on how to involve families in designing these programs,

though family collaboration is crucial for successful treatment and JCAHO requires assessment for families' learning needs as part of treatment planning. In 1996 Houston VA Medical Center developed a family education program based on published research and involving families from design through implementation. The program included (1) surveying needs and learning preferences using a locally constructed Family Education Needs Questionaire; (2) involving staff, families, and patients to design educational content; (3) training staff; (4) publicizing the program to families; (5) providing education sessions; (6) establishing an ongoing family support group; and (7) collecting outcome data. On self-report instruments (the Information Test and the Attitude Checklist), families showed significantly increased knowledge and changes in attitude about mental illness after this education. It has also resulted in a psychiatric resident seminar on "Educating Families of Persons with Serious Mental Illness," co-led by program staff and a family member. Our evidence-based program empowered and educated families and future mental health workers about serious mental illness, addressed JCAHO standards, and improved customer satisfaction.

TARGET AUDIENCE:

Mental health professionals and members of consumer advocacy groups.

REFERENCES:

1. Ascher H, et al: Educational needs of families of mentally ill adults. Psychiatric Services 1997; 48:1072–1075.
2. Solomon P, et al: Effectiveness of two models of brief family education: retention gains by family members of adults with serious mental illness. American Journal of Orthopsychiatry 1997; 67(2):177–186.

Poster 124 **Monday, November 1**
10:00 a.m.-11:30 a.m.

CASE MANAGEMENT FOR RECIDIVISTIC PATIENTS

Jean G. Shelor, R.N., C.S., *Associate Chief for Nursing, Mental Health Service Line, Veterans Affairs Medical Center, 1970 Roanoke Boulevard, Salem, VA 24153*

SUMMARY:

A southwestern Virginia Veterans Administration Medical Center has been experiencing a high rate of inpatient bed days of care and admissions in the mental health service line (MHSL). Staff felt an assessment of individual use of the facility as well as individual needs for a select group of veterans would be beneficial. This chronically recidivistic population has shown to have high use of the medical center services as well as limited stability in their personal settings and lives. These individuals have a primary Axis I diagnosis other than substance abuse in nature.

An intensive outpatient program, which is an abbreviated case management initiative, was developed. Services provided include case management with an emphasis on education regarding other individualized needs. Three groups of patients are currently being managed. Staff for the program consists of a masters-prepared social worker and a registered nurse. The two case managers coordinate and consult with other disciplines as necessary. Home visits are made to all individuals residing in a 50-mile radius of the medical center. Home visits are made at intervals of six weeks or greater. Monitors for the program include examination of bed days of care as well as testing on BPRS and provision of GAF scores. Preliminary data suggest over $140,000 saved within the past year due in part to the intensive outpatient program.

REFERENCES:

1. Flynn A, Kilgallan M: Case management: A multidisciplinary approach to the evaluation of cost and quality standards. Journal of Nursing Quality Care 1993; 8(1):58–66.
2. Lyon J: Models of nursing care delivery and case management: Clarification of terms. Nursing Economics 1993; 11(3):163–169.

Poster 125 **Monday, November 1**
10:00 a.m.-11:30 a.m.

CLOZAPINE ACCESS PROJECT (CAP)

Jeffery J. Grace, M.D., *Clinical Director, Buffalo Psychiatric Center, 400 Forest Avenue, Buffalo, NY 14213;* Renee Szarowicz, R.N., M.S., *Registered Nurse, Research Department, Buffalo Psychiatric Center, 400 Forest Avenue, Buffalo, NY 14213*

SUMMARY:

Objective: Provide refractory schizophrenic recipients not taking clozapine with an opportunity to share their concerns or fears about clozapine with recipients who have experience and success with it.

Method: 1995 survey assessed the use of clozapine at a 415-bed state psychiatric hospital. It found that 24% of the patient population who were appropriate for clozapine therapy were not receiving it. Patient fear and refusal was identified as the primary cause. Peer counseling and education groups co-facilitated by clinicians was provided to research participants. Clozapine Access Project (CAP).

Results: Of ten participants, nine consented to a trial of clozapine. Seven recipients ultimately initiated clozapine treatment, while two refused. Thirty months later

five of the seven recipients remained on clozapine. Two of the seven who initiated clozapine therapy developed severe leukopenia and were discontinued.

Conclusion: Informing and educating recipients about clozapine's favorable risk-benefit ratio is necessary and important. Medication education groups involving peers who have had experience and success with clozapine therapy may increase patients' willingness to begin therapy by allowing them to teach each other and to share their own experiences.

REFERENCES:

1. Conley RR: Optimizing treatment with clozapine. Journal of Clinical Psychiatry 1998; 59(3):44–8.
2. Walker A, Lanza L, et al: Mortality in current and former uses of clozapine. Epidemiology Resources, Inc. Harvard School of Public Health, MA., 1977.

Poster 126 **Monday, November 1 10:00 a.m.-11:30 a.m.**

PATTERN REVERSAL VISUAL EVOKED POTENTIALS IDENTIFY PSYCHIATRIC PATIENTS WITH ONE TYPE OF BIOLOGICALLY-BASED EXPLOSIVE BEHAVIOR

F. La Marr Heyrend, M.D., *Medical Director, Intermountain CRC, 411 North Allumbaugh Street, Boise, ID 83704–9210;* Donald R. Bars, Ph.D., *Vice President for Research and Development, Behavioral Management Center, 411 North Allumbaugh Street, Boise, ID 83704-9210;* C. Dene Simpson, Ph.D.; James C. Munger

SUMMARY:

Visual evoked potentials (VEP) were statistically analyzed to assess their effectiveness in predicting explosive behaviors in children and adolescents regardless of their diagnosis. The data set (N = 326) consisted of a clinical population heavily weighted with intermittent explosive disorder type behaviors, which Pierre Tarriot (1997) defined as; "inappropriate verbal, vocal, or motor activity not explained by apparent needs, confusion, medical condition, or social/environmental disturbances." The presence of explosive behaviors was defined by reports from the legal system, schools, parents, health care workers, and during individual intake interviews.

Logistic regression indicated that explosive individuals were significantly more likely to produce high amplitude P100 wave forms ($p < .0001$) and 46% of the individuals with explosive behaviors and the effects of medication will be discussed. The use of pattern/reversal visual evoked potential (PREP) studies empirically identifies a large subset of individuals who exhibit out-of-control explosive behaviors, permitting more accurate intervention and appropriate treatment strategies to be implemented.

TARGET AUDIENCE:

Adult and child psychiatrists, neuropsychiatrists and health care providers.

REFERENCES:

1. Tariot P: Better management of violence and agitation. Paper presented at Recent Advances in Neuropsychiatry, San Diego, CA December 1997.
2. McElroy SL, Soutullo CA, Beckman DA, Taylor Jr P, Keck PE: DSM-IV intermittent explosive disorder: a report of 27 cases. J of Clin Psychiatry 1998; 59:203–210.

Poster 127 **Monday, November 1 10:00 a.m.-11:30 a.m.**

NICOTINE DEPENDENCE IN THE CHRONICALLY MENTALLY ILL

Cherise Rosen-Chase, M.A., *Clinical Specialist, Department of Psychiatry, University of Illinois, 1601 West Taylor Street, Chicago, IL 60601;* Vida B. Dyson, Ph.D., *Assistant Professor of Psychology, Department of Psychiatry, University of Illinois at Chicago, 1601 West Taylor Street, Chicago, IL 60603*

SUMMARY:

Since rates of smoking cessation in psychiatric patients are low, the manner in which information on the importance of abstinence is presented and the scope of the treatment provided to psychiatric patients who have decided not to smoke are very important. This poster presentation will describe the development and implementation of a smoking cessation group for chronic mentally ill patients. Components of the program are described and a detailed case example is provided. The smoking behavior of patients who participated in the first year of programming was reviewed along with patient evaluation of program effectiveness. Our experience demonstrates the importance of psychoeducation for chronic psychiatric patients who tend to have not received formal education on the dangers of smoking and the possibility of addiction. Our findings indicate that patients are willing to learn more about smoking and the consequences of this behavior even though many of them were not able to set quit dates. The provision of information through education groups increases the possibility of moving patients to the precontemplation stage.

REFERENCES:

1. American Psychiatric Association: Practice Guidelines for the Treatment of Patients with Nicotine De-

pendence. The American Journal of Psychiatry 1996; 53, October Supplement.
2. Hughes JR, Frances RJ: How to help psychiatric patients stop smoking. Psychiatric Services 1995; 46.

Poster 128 **Monday, November 1**
10:00 a.m.-11:30 a.m.

IF WE BUILD IT, WILL THEY COME? ASSESSMENT OF QUALITY IN RURAL TELEPSYCHIATRY

Barbara M. Rohland, M.D., *Assistant Professor of Psychiatry, University of Iowa College of Medicine, Psychiatry Research, 1-400 MEB, Iowa City, IA 52242-1000*

SUMMARY:

Objective: To compare the quality of psychiatric care provided at a rural outreach clinic through telemedicine versus traditional face-to-face service delivery.

Methods: During a 12-month study period, psychiatric care was provided to patients at one of two rural sites. Quality of care was measured by self-report of patient satisfaction in several domains in addition to physician assessment of functional status.

Results: A total of 47 patient contacts in 12 patients occurred at the telemedicine clinic compared with 29 patient contacts in 13 patients at the face-to-face site. Diagnostic categories were similar in both groups. A net change of +9.4 in GAF was observed over the 203-day mean duration of enrollment in telemedicine patients, compared with +4.3 over a 169-day mean enrollment in the face-to-face clinic. Overall satisfaction with care was similar in both groups (4.1 versus 4.3) but eye contact was rated lower in the telemedicine group compared with the face-to-face group (3.7 versus 4.6).

Conclusions: Telemedicine provides an acceptable and adequate alternative to face-to-face delivery of psychiatric services to patients who live in rural areas as evidenced by similar ratings of patient satisfaction and change in clinical status in both groups.

TARGET AUDIENCES:

Psychiatrists and rural mental health service providers.

REFERENCES:

1. Preston J, Brown FW, Hartley B: Using telemedicine to improve health care in distant areas. Hospital and Community Psychiatry 1992; 43:25–32.
2. Ruskin PE, Reed S, Kumar R, et al: Reliability and acceptability of psychiatric diagnosis via telecommunication and audiovisual technology. Psychiatric Services 1998; 49:1086–1088.

Poster 129 **Monday, November 1**
10:00 a.m.-11:30 a.m.

ADVERSE INVESTIGATION OF THE EFFECT OF TYPICAL VERSUS ATYPICAL ANTIPSYCHOTICS ON MOTOR FUNCTION USING FUNCTIONAL MRI

Tonmoy Sharma, M.D., *Director, Section of Cognitive Psychopharmacology, Institute of Psychiatry, Denmark Hill, London, United Kingdom SE5 8AF*

SUMMARY:

We have previously demonstrated abnormal lateralization of motor systems in schizophrenic patients treated with typical neuroleptics. This study aimed to investigate the effect of risperidone on motor function. Two groups of six male right-handed schizophrenic patients treated with typical neuroleptics were recruited. We used functional MRI and a paced, visually cued joystick task in two groups of schizophrenic patients at baseline and six weeks later. One group was treated with typical antipsychotic drugs throughout. Risperidone was substituted for typical antipsychotics after baseline assessment in the second group. A matched group of healthy volunteers were also studied on a single occasion. Control subjects activated bilateral sensorimotor cortex, inferior parietal lobe, SMA and cerebellum. Typically treated patients showed an abnormal baseline response; however, at six weeks, activation was similar to controls. Risperidone-treated patients demonstrated an abnormal lateralization of sensorimotor cortex at baseline and six weeks; however, there was increased activation of the SMA at six weeks. Risperidone did not reverse abnormal lateralization, but did improve SMA activation. This demonstrates an anatomically specific effect of risperidone, consistent with a serotonergic modulation of brain regions innervated by dopamine. The typically treated group indicate that dynamic changes in brain activation associated with motor stimulation occur with practice.

REFERENCES:

1. Weinberger DR, Berman KF, Zeck RF: Physiologic dysfunction of dorsolateral prefontal cortex in schizophrenia. I. Regional cerebral blood flow evidence. Arch Gen Psychiatry 1986; 43:114–24.
2. Honey GD, Bullmore ET, Soni W, Varatheesan M, Williams SCR, Sharma T: Investigation of Prefrontal Activation of Working Memory in Schizophrenic Patients Following Substitution of Risperidone for Typical Antipsychotic Drugs. PNAS, in press 1999.

Poster 130 **Monday, November 1**
10:00 a.m.-11:30 a.m.

FROM NON-COMPLIANCE TO COMPLIANCE: A BRIDGE PROGRAM

Neil Pessin, Ph.D., *Director, Community Mental Health Services, Visiting Nurse Service of New York, 1250 Broadway, 3rd Floor, New York, NY 10001;* Stephanie L. Moeller, M.A., *Administrative Coordinator, Community Mental Health Services, Visiting Nurse Service of New York, 1250 Broadway, 3rd Floor, New York, NY 10001*

SUMMARY:

It has been well described in the psychiatric literature that patients discharged from psychiatric hospitals have high rates of noncompliance with aftercare. Seriously mentally ill individuals who do not follow an aftercare regime are at risk for rehospitalization. One goal of discharge planning is to ensure that the patient is linked with outpatient mental health services. In collaboration with a local health management organization (HMO) experiencing high rates of aftercare noncompliance, the Visiting Nurse Service of New York's Community Mental Health Services (VNS) has developed a home-based "bridge program" to achieve successful linkage for atrisk patients upon hospital discharge. Preliminary data with the first 50 patients show a rate of 95% aftercare compliance, with an average of <2 home visits/patient. Examining our current population (N = 125), this poster session presents risk factors for aftercare non-compliance, bridge program intervention strategies, and outcome data measured in terms of kept clinic appointments and rehospitalization rates. We also describe aspects of the relationship that has developed between the HMO and VNS, a community-based organization, that bear on bridge program management.

TARGET AUDIENCE:

Mental health administrators, practitioners and consumers involved in the mental health system.

REFERENCES:

1. Zang SM, Bailey NC: Home Care Manual, Making the Transition. New York, Lippincott, 1997.
2. Geller JL: Clinical guidelines for the use of involuntary outpatient treatment. Hospital and Community Psychiatry 1990; 41:749–755.

Poster 131 **Monday, November 1**
10:00 a.m.-11:30 a.m.

SIGNIFICANCE OF CARDIAC RISK FACTORS IN PATIENTS WITH SEVERE AND PERSISTENT MENTAL ILLNESS

Varsha Vaidya-Kunnirickal, M.D., *Director, Consultation Psychiatry, Johns Hopkins Bayview Medical Center, 4940 Eastern Avenue, A-4 Center, Baltimore, MD 21224;* Gerard Gallucci, M.D., M.H.S., *Director of Community Psychiatry, Johns Hopkins Bayview Medical Center, 4940 Eastern Avenue, D-2 East, Baltimore, MD 21224*

SUMMARY:

Creative Alternatives, a component of the Johns Hopkins Bayview Medical Center Community Psychiatry Program, is a capitated mental health program that provides intensive, community-based case management services for patients with severe and persistent mental illness. The program was developed as part of a five-year demonstration project insisted by the Baltimore Mental Health Systems. There are currently 110 patients enrolled in the program. We have noted a high rate of cardiac and other medical problems in this population.

We have examined the cardiac risk factors that are contributatory to multiple medical problems encountered in these patients. Prevelance rates of cardiac risk factors such has hypertension, hypercholesteromia, smoking, diabetes, obesity, and family history for cardiac disease are presented. Suggestions for interventions that acknowledge the unique psychosocial and demographic characteristics of this population are presented.

REFERENCES:

1. Depression, psychotropic medication, and risk of myocardial infarction: prospective data from the Baltimore ECA follow up. Circulation. 1995; 94(12):3123–9.
2. Psychological profiles as predictors of success in a cardiovascular risk factors life style intervention program. Southern Medical Journal 1996; 89(10):971–6.

Poster 132 **Monday, November 1**
10:00 a.m.-11:30 a.m.

CORRELATES OF COMORBID SUBSTANCE USE IN PERSONS WITH SCHIZOPHRENIA

Janine C. Delahanty, M.A., *Data Analyst, Department of Psychiatry, University of Maryland at Baltimore, 685 West Baltimore Street, MSTF Building, #300, Baltimore, MD 21201;* Leticia T. Postrado, Ph.D.; Lisa B. Dixon, M.D., M.P.H.

SUMMARY:

Introduction: The purpose of this study was to determine whether demographic and clinical factors are associated with comorbid substance use disorder among persons with schizophrenia.

Methods: The Schizophrenia PORT Project surveyed a stratified, random sample of 719 persons (63% male,

54% white) with schizophrenia. The survey assessed the presence of depressive and psychotic symptoms and the comorbid diagnosis of substance abuse disorder.

Results: The odds of being diagnosed with a substance use disorder were three times greater in men than in women, and those who had had a recent hospitalization were twice as likely to have been diagnosed with a substance use disorder. Not surprisingly, substance abusers had significantly higher scores on both alcohol CAGE and drug CAGE. Older individuals and those with a substance use disorder reported significantly more symptoms on the SCL-90 Depression Scale, SCL-90 Psychoticism Scale, and the SCL-90 Total Scale.

Conclusion: This study suggests the importance of both gender and depression as predictors of a diagnosis of substance use disorder in persons with schizophrenia.

REFERENCES:

1. Greenfield SF, Weiss RD, Tohen M: Substance abuse and the chronically mentally ill: A description of dual diagnosis treatment services in a psychiatric hospital. Community Mental Health Journal 1995; 31(3), 265–277.
2. Brunette M, Drake RE: Gender differences in homeless persons with schizophrenia and substance abuse. Community Mental Health Journal 1998; 34(6), 627–642.

Poster 133 **Monday, November 1 10:00 a.m.-11:30 a.m.**

UTILITY OF ACETYLCHOLINESTERASE INHIBITOR DONEPEZIL HYDROCHLORIDE IN HUNTINGTON'S DISEASE

Mahmoud A. Parsa, M.D., *Director, Neuropsychiatry and Geropsychiatry Program, University Hospital of Cleveland, 11100 Euclid Avenue, Cleveland, OH 44106;* Heather M. Greenaway, R.N.

SUMMARY:

Introduction: Huntington's disease (HD) is an autosomal-dominant neurodegenerative disorder. It is distinguished by caudate atrophy, choraoathetosis, psychiatric symptoms, and dementia. Impaired memory and concentration, lack of initiative and spontaneity, diminished ability to communicate, decline in frontal-executive functioning and work performance are characteristics of HD-associated dementia. Postmortem examinations of brain tissue have demonstrated decreased levels of gamma-aminobutyric acid (GABA) and acetylcholine (ACh) in HD. Donepezil is an acetylcholinesterase inhibitor, shown to enhance cholinergic transmission in Alzheimer's disease.

Objective: This study was intended to evaluate the efficacy of donepezil in the treatment of HD-associated dementia.

Method: Three patients with HD (genetically confirmed) and dementia were treated with open-label donepezil (dose range 5-10 mg a day) over a six-month period. Cognitive status was measured by the Mini-Mental-State Examination (MMSE) on a monthly basis throughout the study period. Functional capacity was assessed by the Shoulson and Fahn Functional Disability Scale at baseline and endpoint.

Results: All three patients well tolerated the treatments and showed significant improvement in memory, cognition, and functional capacity.

Conclusion: Our data suggest that donepezil is a promising cognitive enhancer in the treatment of HD-associated dementia.

REFERENCES:

1. Martin JB: Huntington's Disease: New Approaches to an Old Problem. Neurology 1984; 34:1059–1072.
2. Doraiswamy PM: Current cholinergic therapy for symptoms of Alzheimer's disease. Primary Psychiatry 1996; 56–68.

Poster 134 **Monday, November 1 10:00 a.m.-11:30 a.m.**

COMORBIDITY AS A FUNCTION OF AGE AND GENDER

Sanjay M. Vaswani, M.D., *Resident, Department of Psychiatry, University of Kansas Medical Center, 7622 Halsey Street, Apartment 305, Lenexa, KS 66216-3451;* Elizabeth C. Penick, Ph.D., *Professor of Psychiatry, University of Kansas Medical Center, 3901 Rainbow Boulevard, Kansas City, KS 66160;* Elizabeth J. Nickel, M.A.; William F. Gabrielli, M.D., Ph.D.; Marsha R. Read, Ph.D.; Cherilyn M. De Souza, M.D.; Barry I. Liskow, M.D.; Ekkehard Othmer, M.D.; Vishal K. Adma, M.D.

SUMMARY:

Objective: To investigate the influence of age and gender on lifetime psychiatric comorbidity in a clinic population.

Method: Consecutive admissions to a psychiatric outpatient clinic (N = 1458) were administered a criterion-referenced, diagnostic interview before being seen by the treating physician. The mean age was 37.4 years; range = 17 to 92. Hierarchy-free, inclusive, Feighner/DSM-III criteria were used to determine the lifetime prevalence of 15 disorders for male (N = 531) and female (N = 927) patients representing five decades of life.

Results: The average number of lifetime disorders was roughly the same for men and women (X = 2.1 and

2.0). A significant decline in lifetime comorbidity was found for both sexes as age increased, a finding consistent with the ECA study. Examination of the individual psychiatric disorders by age and sex showed considerable variations which will be detailed in the presentation, for substance abuse, mood disorder, schizophrenia, antisocial personality, somatization disorder, anorexia nervosa, anxiety disorder, mental retardation, and OBS.

Conclusion: Overall, the average number of lifetime psychiatric disorders declined among this large patient group as a function of age for both men and women. This age-related decline was not uniform across the different disorders or uniform across the males and females. Clinicians should be alert to the fact that both age and gender significantly influence psychiatric comorbidity in different ways.

REFERENCES:

1. Robins LN, Helzer JE, Weissman MM, Orvaschel H, Gruenberg E, Burke JD: Lifetime prevalence of specific psychiatric disorders in three sites. Archives of General Psychiatry 1984; 41:949–958.
2. Alastair JF. Epidemiology and Comorbidity of Anxiety Disorders in the Elderly. American Journal of Psychiatry 1994; 51:640–649.

Poster 135 **Monday, November 1 10:00 a.m.-11:30 a.m.**

CONSUMER SATISFACTION WITH SCHIZOPHRENIA SERVICES

Louis Covington, Ph.D., *Research Fellow, Outpatient Research, Maryland Psychiatric Research Center, P.O. Box 21247, Baltimore, MD 21228*

SUMMARY:

Schizophrenia is the most debilitating, most severe form of mental illness. Positive and negative symptoms interfere with social function and interpersonal relationships. Chronic mental health disabilities require ongoing management as well as intervention for acute episodes. Medication is more effective in combination with psychosocial and rehabilitation services. This study examines client satisfaction with overall agency, primary clinical caregiver, center support staff, and four kinds of psychosocial therapeutic support as they relate to family and community coping in schizophrenia patients treated with clozapine. Following treatment with clozapine in combination with therapeutic supports of individual, group, family, and multifamily group therapy, a self-report evaluation of satisfaction with agency and therapy was administered to 36 respondents. The primary clinical caregiver variable provided the largest explained variance when regressed on family and community coping. Multifamily group therapy was the only other significant predictor of the coping outcome. Clozapine therapy and contact with professional clinical caregiver—e.g., social workers, case managers, primary therapists—extends length of stay in the community. Multifamily therapy may be the best therapeutic intervention. Agencies and service providers receiving block grants and decreased funding may do well to invest more dollars in primary clinical caregiver and multifamily therapy.

TARGET AUDIENCE:

Case managers, therapist, social workers and psychiatric nurses.

REFERENCES:

1. Sullivan G, Spritzer SL: Consumer satisfaction with community mental health centers. Community Mental Health Journal 1997; 33(2):123–131.
2. Buchanan R, Breier A, Kirkpatrick B, Ball P, Carpenter Jr WT: Positive and negative symptom response to clozapine in schizophrenic patients with and without the deficit syndrome. American Journal of Psychiatry 1998; 155(6):751–760.

Poster 136 **Monday, November 1 10:00 a.m.-11:30 a.m.**

AWARENESS OF COMMUNITY SERVICES AMONG MENTAL HEALTH PROFESSIONALS

Babak Mirin-Babazadeghan, M.D., *Resident in Psychiatry, State University of New York Health Science Center, 7623 Narrows Avenue, Brooklyn, NY 11209;* Felix Barroso, Ph.D., *Clinical Associate Professor of Psychiatry, State University of New York Health Science Center, 450 Clarkson Avenue, Box 1203, Brooklyn, NY 11203;* Stephen M. Goldfinger, M.D.

SUMMARY:

Psychiatric training has not adequately adjusted to the shift of psychiatric care to the community, but has remained largely tied to its funding base in hospitals. Accreditation guidelines for psychiatric training do not require specific training in rehabilitation approaches for chronic mental illness. Consequently, most programs do not provide adequate training in psychiatric rehabilitation.

We conducted a survey of awareness of community services among mental health professionals via a questionnaire distributed to the department of psychiatry at the State University of New York at Brooklyn. Analysis of the data indicates that (1) over 30% of respondents actually could not define what is meant by community psychiatry or did not have a good understanding of what community psychiatry is and does; (2) 29% of

respondents never referred their patients to clubhouses, 26% of them never referred their patients to Clients of Self-Help Groups, and 41% of respondents never referred patients to NAMI, and (3) 54% of respondents believed that between 25% and 75% of their patients were able to reintegrate and to function in their community; 35% believed that between 50 and 75% of their patients relapse because of social/economical difficulties.

Additional findings indicate that the majority of respondents had, as their career preference, outpatient treatment and most of them were aware of factors associated with relapse. They also knew what factors improved continuity of care. These same respondents, however, were not aware of specific services outside of their narrowly defined place of work. Indeed, their awareness of community services is so poor that they often did not use these services. Most respondents believed that training in community psychiatry was important and should be done on site.

REFERENCES:

1. Santos AB, Ballenger JC. Bevilacqua JJ, et al: A community-based public-academic liason program. American Journal of Psychiatry 1994; 151:1181–1187.
2. Essentials of accredited residencies in directory of GME programs, 1992–93, Chicago, American Medical Association, 1992.
3. Barreira PJ, Dion GL: Training psychiatrists in rehabilitation principles and practice for working people with long-term mental illness. Psychological Rehabilitation Journal 1991; 14:93–96.

Poster 137 **Monday, November 1**
10:00 a.m.-11:30 a.m.

DIFFERING SIDE-EFFECT BURDENS WITH NEWER ANTIPSYCHOTICS

Peter J. Weiden, M.D., *Director, Neurobiological Disorders Service, St. Lukes-Roosevelt Hospital Center, 411 West 114th Street, Suite 3B, New York, NY 10025;* Joan Mackell, Ph.D.

SUMMARY:

Objective: This study compares side-effect profiles between patients on conventional and novel antipsychotics.

Method: A self-administered survey was mailed in June 1998 to persons with schizophrenia, identified through NAMI and NMHA chapters. Data included demographic, treatment variables, and structured side-effect variables: tremor, weight gain, sedation, and sexual dysfunction.

Results: Most of the 256 respondents (71%) were receiving a novel antipsychotic—clozapine, risperidone, olanzapine, quetiapine. The group on conventional monotherapy reported more problems with tremors than the group on novel antipsychotics, both in frequency (8% *versus* 7%, $P = 0.74$) and distress (30% *versus* 13%, $P = 0.11$). In contrast, patients on novel monotherapy were more likely to report weight gain (32% *versus* 16%, $P = 0.02$), sedation (26% *versus* 7%, $P = 0.001$), and sexual dysfunction (19% *versus* 11%, $P = 0.16$). These differences could not be accounted for by covarying baseline differences. Women reported a significantly higher frequency of weight gain than men (36% *versus* 22%, $P < 0.05$) along with greater distress (62% *versus* 36%, $P < 0.01$), whereas men were more concerned about sexual dysfunction, reporting both a higher frequency (22% *versus* 11% $P = 0.05$) and greater distress (42% *versus* 25%, $P = 0.15$) than women.

Conclusion: Self-reported side-effect profiles diverge between older and newer antipsychotics. Based on patient report, clinicians should shift emphasis from extrapyramidal side effects, focusing more on weight gain, sedation, and sexual dysfunction.

REFERENCES:

1. Weiden P, Aquila R, Standard J: Atypical antipsychotic drugs and long-term outcome in schizophrenia. J Clin Psychiatry 1996; 57 (Suppl 11):53–60.
2. Casey DE: Side effect profiles of new antipsychotic agents. J Clin Psychiatry 1996; 57 (Suppl 11):40–5; discussion 46–52.

Poster 138 **Monday, November 1**
10:00 a.m.-11:30 a.m.

EFFECTIVENESS OF OLANZAPINE UPON PSYCHIATRIC AND VOCATIONAL REHABILITATION

Peter J. Weiden, M.D., *Director, Neurobiological Disorders Service, St. Lukes-Roosevelt Hospital Center, 411 West 114th Street, Suite 3B, New York, NY 10025;* Ralph Aquila, M.D., *Director, Residential Community Services, Project Renewal, and Department of Psychiatry, St. Luke's-Roosevelt Hospital Center, 448 West 48th Street, New York, NY 10036;* Bruce J. Kinon, M.D.; Denai R. Milton, M.S.

SUMMARY:

Objective: The objective of this study was to determine whether patients treated with olanzapine (OLZ) as compared with currently marketed oral antipsychotics performed better in their psychiatric rehabilitation programs as measured by the total cummulative days worked up to one year and medication compliance.

Methods: In this single-site study, 100 patients with a diagnosis of schizophrenia or schizoaffective disorder, clinically stable, and attending a rehabilitation program, were randomized to receive open-label treatment with either OLZ 5 mg to 20 mg per day or a currently available oral antipsychotic medication dosed within the package labeling for a total of 58 weeks. Rehabilitation outcome was measured by the Employment Summary Form (ESF) and compliance attitudes by the Rating of Medication Influence Scale (ROMI). Other measures included standard symptom and adverse event scales.

Results and Conclusions: Preliminary results to be presented will compare the effects of each treatment on performance in psychiatric rehabilitation programs as well as overall medication compliance. It is extremely important to understand how the newer atypical antipsychotics may affect psychiatric rehabilitation to better help patients reintegrate into the community.

TARGET AUDIENCE:

Psychiatrists and psychiatric nurses.

REFERENCES:

1. Lehman AF: Vocational rehabilitation in schizophrenia. Schizophrenia Bulletin 1995; 21:645–655.
2. Rosenheck R, Tekell J, Peters J, Cramer J: Does participation in psychosocial treatment augment the benefit of clozapine? Arch Gen Psychiatry 1998; 55:618–625.

Poster 139 **Monday, November 1 10:00 a.m.-11:30 a.m.**

RAPID REDUCTION HYPERPROLACTINEMIA UPON SWITCHING TREATMENT TO OLANZAPINE FROM CONVENTIONAL ANTIPSYCHOTIC DRUGS OR RISPERIDONE

Bruce J. Kinon, M.D., *Senior Clinical Research Physician, Eli Lilly and Company, Lilly Corporate Center, Indianapolis, IN 46285;* Bruce R. Basson, M.S., Jeff Wang, M.S.

SUMMARY:

Objective: To determine whether serum prolactin (PRL) levels were reduced in patients switched to treatment with olanzapine (OLZ) during a three week clinical trial which studied the medication switching phenomenon.

Method: This multi-site study was designed to compare the efficacy and safety of strategies for switching patients from previous APDs to OLZ. Outpatients with a diagnosis of schizophrenia or schizoaffective disorder and with documented clinical stability while being treated with a conventional APD (n=152) or with RIS (n= 57) were randomized to one of four medication switching paradigms. Patients completing the study had been on OLZ 10 mg/day as monotherapy for at least one week. PRL data was collapsed across all four switching groups.

Results: Baseline and endpoint serum PRL were obtained in 176 out of 209. The prevalence of hyperprolactinemia among patients previously taking conventional APDs dropped from 51% to 22% after three weeks of the study ($p < 0.001$). For those previously on RIS, the prevalence dropped from 87% to 36% after three weeks of the study ($p < 0.001$). For patients switched from conventional APDs, mean serum PRL dropped from 1.04 ± 1.06 nmol/L to 0.59 ± 0.64 nmol/L; for those switched from RIS, levels decreased from 2.12 ± 1.66 nmol/L to 0.72 ± 0.76 nmol/L.

Conclusions: Stable outpatients who switch to OLZ from conventional APDs or RIS may demonstrate a significant reduction in prevalence of hyperprolactinemia and a reduction in mean serum PRL within three weeks.

TARGET AUDIENCE:

Psychiatrists and psychiatric nurses.

REFERENCES:

1. Green AI, Faraone SV, Brown WA: Prolactin shifts after neuroleptic withdrawal. Psychiatry Research 1990; 32:213-219.
2. Dickson RA, Glazer WM: Neuroleptic-induced hyperprolactinemia. Schizophrenia Research 1999; 35:575-586.

Poster 140 **Monday, November 1 10:00 a.m.-11:30 a.m.**

TOKEN ECONOMY AS ADJUNCT PSYCHIATRIC TREATMENT

Bethany A. Marcus, Ph.D., *Department of Psychology, Eastern State Hospital, 4908 Whitby Mews, Williamsburg, VA 23188;* Joselito B. Morales, M.D., *Department of Psychiatry, Eastern State Hospital, 100 Carnoustie, Yorktown, VA 23693;* Janet L. Colazzi, Ph.D.

SUMMARY:

Objective: To assess the effect of an individualized, token economy-based behavior program as an adjunct to the usual psychiatric treatment of patients with severe behavior problems, e.g., self-injury, aggression.

Method: A 24-hour contingency-based token economy behavior program was implemented on two patients following a three to five months initial observation period. The behavior program was run for a period of five months. The comprehensive program consisted of

intensive psychopharmacologic treatment psychosocial rehabilitation and a structured reinforcement program, which incorporated response cost and brief time-out.

Results: Use of restraints and emergency psychiatric medication was reduced by at least 75%. Adaptive behaviors and compliance to daily schedules were observed between 60% to 80% across the five months after the added behavioral treatment.

Conclusion: A highly structured behavioral program provided increased management techniques for the treatment team providers while significantly reducing severe behavior problems.

TARGET AUDIENCE:

Psychiatrists, psychologists and mental health care providers.

REFERENCES:

1. Morisse D, Batra L, Hess L, Silverman R, Corrigan P: A demonstration of a token economy for the real world. Applied & Preventive Psychology 1996; 5:41–46.
2. Dickerson F, Ringel N, Parente F, Boronow J: Seclusion and restraint, assaultiveness, and patient performance in a token economy. Hospital and Community Psychiatry 1994; 45:168–170.

Poster 141 **Monday, November 1 10:00 a.m.-11:30 a.m.**

BEHAVIOR AND PSYCHIATRIC TREATMENT FOR SELF-INJURY

Joselito B. Morales, M.D., *Department of Psychiatry, Eastern State Hospital, 100 Carnoustie, Yorktown, VA 23693;* Bethany A. Marcus, Ph.D., *Department of Psychology, Eastern State Hospital, 4908 Whitby Mews, Williamsburg, VA 23188;* Janet L. Colazzi, Ph.D.

SUMMARY:

Objective: To determine the effectiveness of behavior therapy as an adjunct to traditional inpatient treatment in managing severe self-injurious behavior.

Method: A highly structured and individualized "Behavior Contract" was instituted upon her admission, in addition to her regular treatment. The period of analysis comparing use of emergency medications, 1:1 observation for self-injury and restraint procedure, was focused on the first ten weeks of treatment for this and her five previous admissions. The direct-care staff was given in-service training prior to the implementation and whenever changes to the program were made.

Results: We found an 80% reduction in the use of emergency interventions following initiation of a structured behavior plan. In addition, she was free of emergency interventions for a total of eight weeks during this admission as compared with 0.4 week in her five previous admissions.

Conclusion: There is a significant and dramatic improvement since implementing a behavior program in this difficult to manage patient that medication and traditional inpatient services have not effectively addressed. This program can be expanded to include several patients (as in our unit) or even include the whole unit with specific target symptoms identified for each patient.

REFERENCES:

1. Silverstain SM, Hitzel H, Schenkel L: Identifying and addressing cognitive barriers to rehabilitation readiness. Psychiatric Services 1998; 49:34–36.
2. Corrigan PW: Behavior therapy empowers persons with severe mental illness. Behavior Modification 1997; 21:45–61.

Poster 142 **Monday, November 1 10:00 a.m.-11:30 a.m.**

ADVERSE CHILDHOOD EXPERIENCES, PARENTAL ALCOHOLISM AND DEPRESSION IN ADULT CHILDREN OF ALCOHOLICS

Daniel P. Chapman, Ph.D., M.S.C., *Psychiatric Epidemiologist, Department of Health Care, Centers for Disease Control and Prevention, 4770 Buford Highway, N.E., M.S., K-45, Atlanta, GA 30341;* Robert F. Anda, M.D., *Epidemiologist, Centers for Disease Control, 4770 Buford Highway, N.E., M.S., K-47, Atlanta, GA 30341;* Vincent J. Felitti, M.D.; Wayne H. Giles, M.D.

SUMMARY:

Previous research suggests adult children of alcoholics (ACOAs) are at increased risk for alcoholism and depression and possible genetic bases for these associations have been proposed. Yet, children with alcoholic parents may be more likely to be exposed to a variety of adverse childhood experiences (ACEs), which could also elevate their risk for psychopathology in adulthood. To investigate this issue, we analyzed data from 9,346 adults (mean age = 56.7 years) who received standardized medical evaluations at Kaiser-Permanente Health Appraisal Clinic in San Diego. Participants provided information about their personal and family history of alcoholism and depression and their childhood exposure to each of nine ACEs, including various types of abuse and domestic violence. Prevalences of parental alcoholism (20%) and a personal history of depression (23%) were high; 6% reported personal alcoholism. Parental alcoholism was strongly associated with each ACE ($p < .0001$) and the number of ACEs ($p < .0001$). The prevalence of alcoholism was highest among persons with alcoholic

parentage and >3 ACEs, compared with persons with neither exposure (17.9% vs. 2.8%). In contrast, while a dose-response relationship emerged between the number of ACEs reported and a personal history of depression ($p < .0001$), there was no effect of parental alcoholism on the risk of depression.

TARGET AUDIENCE:

Psychiatrists, non-psychiatric physicians and mental health professionals.

REFERENCES:

1. Miller NS, Mahler JC, Belkin BM, et al: Psychiatric diagnosis in alcohol and drug dependence. Ann Clin Psychiatry 1991; 3:79–89.
2. Regier DA, Farmer ME, Rae DS, et al: Comorbidity of mental disorders with alcohol and other drug abuse: results from the Epidemiological Catchment Area (ECA) study. JAMA 1991; 264:2511–2518.

Poster 143 **Monday, November 1 10:00 a.m.-11:30 a.m.**

HUMOR AS A TREATMENT APPROACH FOR THE HIV-INFECTED

Kathleen J. Welch, Ph.D., M.P.H., *Epidemiologist, HIV Outpatient Unit, Department of Infectious Diseases, Louisiana State University, and Hightower and Sparks Art, 136 South Roman Street, New Orleans, LA 70112;* Alan D. McGillivray, B.S.A., B.A.rch, *Artist, Hightower and Sparks Art, 4424 Canal Street, New Orleans, LA 70119;* Janet Rice, Ph.D.

SUMMARY:

The purpose of this poster is to inform providers that humor is an acceptable treatment approach for HIV-infected individuals. "Join the Laugh Track" took place at a public HIV clinic's Christmas party. The study sample included 30 HIV-infected adults who attended the party. Art work, life-size puppets, original comics, and a skit helped to raise awareness about humor's physiological and psychological benefits. In the skit "Humor Me, Mister T", Mr. T-Cell demonstrated through rap and dance, humor's benefits. "I pity the fool who can't be a fool!" The majority approved highly of the intervention and they planned to use humor to reduce stress, "take my meds" and "not take drugs." Over half planned to use the Polaroid photo of themselves with the puppets as a way to remember to use humor. Half planned to use the "belly laugh" bracelet to remember to take their medicine. Ninety-two percent reported that they wanted to learn even more about humor and all believed that humor had helped them survive. It is recommended that this pilot study be expanded. If used appropriately, humor can be a self-help measure that improves the quality of the HIV-infected patient's life, a successful outcome in its own right.

TARGET AUDIENCE:

Health care providers of HIV-infected patients.

REFERENCES:

1. Ziegler J: Immune system may benefit from the ability to laugh. Journal of the National Cancer Institute 1995; 87:342–343.
2. Berk L: Neuroendocrine and stress hormone changes during mirthful laughter. The American Journal of the Medical Sciences 1989; 298:390–396.

Poster 144 **Monday, November 1 10:00 a.m.-11:30 a.m.**

THE THERAPEUTIC ALLIANCE IN RANDOMIZED, CONTROLLED CLINICAL TRIALS

Amy L. Kossoy, B.A., *Department of Psychiatry, Payne Whitney Clinic, 525 East 68th Street, Box 140, New York, NY 10021;* Philip J. Wilner, M.D.

SUMMARY:

The therapeutic alliance, familiar to those who treat patients and conduct clinical trials, is considered by many to be a nonspecific effect in research studies. The concept of the therapeutic alliance has its roots in the doctor-patient relationship and has been discussed extensively in the context of psychodynamic psychotherapy. Research has demonstrated that the strength of the alliance is a strong predictor of outcome in psychotherapy and has emphasized its importance in ensuring compliance in pharmacotherapy. However, little empirical research has been conducted that examines the impact of the therapeutic alliance on patient compliance and retention in randomized, controlled clinical trials. Moreover, tension and debate exist between those who see the therapeutic alliance as both a necessary and positive component of a clinical trial and those who view it as a confounding variable. Those who view it as a confounding variable argue that this alliance may serve to influence patients' participation and make difficult the assessment of treatment affects.

We report our observations from one study of adults with schizophrenia who were enrolled in a clinical trial of a new antipsychotic medication. We hypothesize that there is an association between the strength of the therapeutic alliance and subsequent compliance and retention of patients enrolled in clinical drug trials. The relationship among these constructs could be tasted empirically as could the association between the therapeutic alliance and the assessment of clinical response.

TARGET AUDIENCE:

Individuals interested in clinical research.

REFERENCES:

1. Kossoy A, Wilner PJ: The therapeutic alliance in randomized controlled clinical trials. Forschande Komplementärmedizin (Research in Complementary Medicine) 1998; 5(Suppl 1):31–36.
2. Downing R, Rickels K: Nonspecific factors and their interaction with psychological treatment in pharmacotherapy, in Psychopharmacology: A generation of progress. Edited by Lipton M, Dinascio A, Killam K, New York, Raven Press, 1978.

Poster 145 **Monday, November 1 10:00 a.m.-11:30 a.m.**

PSYCHIATRISTS KNOWLEDGE OF THE COST OF TREATMENT

David P. Bellian, M.D., *Resident in Psychiatry, Medical College of Ohio, 2090 Kenton Trail, Perrysburg, OH 43552;* Jeffrey W. Wahl, M.D.

SUMMARY:

A survey was conducted to assess psychiatrists' knowledge of the costs of various psychiatric treatments. Psychiatrists were randomly selected from a mailing list of members of the Ohio Psychiatric Association. The survey explored several aspects of psychiatrists' knowledge of coats including estimated prices of 24 specific psychiatric treatments (frequently used psychotropic drugs, laboratory tests, and inpatient and outpatient procedures) as well as level of confidence in those estimates. The survey also included a series of attitude/opinion questions and asked for specific demographic information. The return rate for the survey was 59%. Descriptive analysis of the data is presented in graphical format.

REFERENCES:

1. Kuiken T, Prather H, et al: Physician awareness of rehab costs. Am J Rehab 1996; 75:416–421.
2. Hoffman J, Barefield F, et al: A survey of physician knowledge of drug costs. Journal of pain and symptom management 1995; 10:432–35.

Poster 146 **Monday, November 1 10:00 a.m.-11:30 a.m.**

CLINICAL IMPROVEMENT AND TOLERABILITY IS MAINTAINED LONG-TERM WITH QUETIAPINE TREATMENT OF ELDERLY PATIENTS WITH PSYCHOTIC DISORDERS

Paul P. Yeung, M.D., M.P.H., *Medical Research and Communications Group, AstraZeneca Pharmaceuticals, 1800 Concord Pike, Wilmington, DE 19850;* Pierre N. Tariot, M.D.; Carl Salzman, M.D.

SUMMARY:

Physiologic changes can make elderly patients more vulnerable than younger patients to the side effects of standard antipsychotic medications, especially extrapyramidal symptoms (EPS). Quetiapine fumarate (quetiapine), an antipsychotic with no treatment-emergent or dose-related EPS or elevations of plasma prolactin, has demonstrated advantages to suggest that it may be potentially a very attractive therapeutic option in an EPS sensitive patient population such as the elderly. To explore the therapeutic utility and tolerability of quetiapine in this EPS sensitive patient population, a 52-week, multicenter, open-label trial in men and women at least 65 years of age (50 years or older for patients with Parkinson's disease) with psychotic disorders was conducted. This report provides preliminary data in 184 patients regarding the clinical therapeutic utility and tolerability of quetiapine in elderly patients with psychotic disorders. Patients received 25 to 800 mg/day of quetiapine, dosed according to clinical response and tolerability for up to one year. Clinical benefit was assessed using the BPRS and the CGI. Patients were also evaluated using the Simpson-Angus Scale (SAS) and AIMS in addition to physical examination, vital signs, weights, clinical laboratory tests, ECGs, and reports of adverse events. In this patient population with a mean age of 76 years, the median total daily dose was 100 mg and the median duration of exposure was 350 days. Significant improvement from baseline in BPRS Total ($p < 0.0001$) and CGI Severity of Illness ($p < 0.01$) scores was noted at all time points measured (from weeks 2 onward). BPRS positive and negative symptom cluster scores also showed improvement at all time points. Clinically significant improvement, defined as a decrease of at least 20% from baseline scores on the BPRS, was achieved by 49% of the patients at end point. Mean SAS total score decreased from 19.0 at baseline to 17.2 at end point and the mean AIMS score decreased from 4.9 at baseline to 4.3 at end point. No clinically important effects on mean hematology or clinical chemistry values, ECGs, or vital signs were observed. The results from this open-label trial suggest that quetiapine may be a potential alternative to standard antipsychotic agents for long-term use in the elderly.

REFERENCES:

1. McManus DQ, Arvanitis LA, Kowalcyk BB et al: Quetiapine, a novel antipsychotic: experience in elderly patients with psychotic disorders. J Clin Psychiatry 1999; 60:292–298.
2. Arvanitis LA, Miller BG, and the Seroquel Trial 13 Study Group: Multiple fixed doses of "Seroquel" (quetiapine) in patients with acute exacerbation of

schizophrenia: a comparison with haloperidol and placebo. Biol Psychiatry 1997; 42:233–246.

Poster 147 **Monday, November 1 10:00 a.m.-11:30 a.m.**

ROLE OF HIPPOCAMPUS AMYGDALA COMPLEX IN SCHIZOPHRENIA: AN MRI STUDY

Rajaprabhakaran Rajarethinam, M.D., *Research Fellow, Department of Psychiatry, University of Michigan, 3855 Green Brier Drive, Apartment 341-C, Ann Arbor, MI 48105-2679;* John Dequardo, *Department of Psychiatry, University of Michigan, Ann Arbor, MI 48109;* John Miedler; Ravi S. Kirbat, M.D.; Rajiv Tandon, M.D.

SUMMARY:

Introduction: Patients with schizophrenia have been reported to have volume reductions of the hippocampus and amygdala that may be associated with specific symptoms. The hippocampus and amygdala play a role in attention and working memory and are integrally connected to other areas of the brain, especially to the superior temporal region, prefrontal cortex, and thalamus, all of which are implicated in the pathophysiology of schizophrenia and for impairment of associative memory often seen in the disease.

Methods: In this study, we measured the volume of the hippocampus-amygdala complex in 20 male normal controls and 20 age-matched patients with schizophrenia using 3 mm contiguous coronal T1 MRI images. The structures were manually traced on a 1 mm thick ACPC resampled image using the software 'BRAINS'.

Results: The left and right hippocampus amygdala complex were smaller in patients than controls, covarying for the total brain volume, the right side significantly and the left at a trend level. (P values 0.029 and 0.069, respectively).

Discussion: About 25% of the studies in the literature show no significant volume difference between patients and controls. This may be in part due to methodological differences or the heterogeneity of the illness.

REFERENCES:

1. Shenton ME, Wible CG, McCarley RW: A review of magnetic resonance imaging studies of brain abnormalities in schizophrenia. Brain Imaging in Clinical Psychiatry. Edited by Krishnan RR, Doraiswamy M, Marcel Decker, Inc., New York, 1997.

Poster 148 **Monday, November 1 10:00 a.m.-11:30 a.m.**

A NEW GROWTH STRATEGY FOR A PSYCHIATRY CLINIC: WILL IT WORK?

Claudio Winitskowski, M.B.A., *Administrator, Clinica Jorge Jaber, Venancio Flores 305-602 Leblon, Rio de Janeiro, Brazil 22441-090;* Charles Andre, M.D., Ph.D., *Assistant Professor, Neurology Services, Venancio Flores 305-602 Leblon, Rio de Janeiro, Brazil 22441-090;* Jorge A. Jaber-Filho, M.B.A.

SUMMARY:

Objectives: The Jorge Jaber Clinic is a mental-health facility for inpatient and outpatient treatment of substance abuse disorders. We evaluated the efficiency of a strategic growth plan along a two-year period.

Methods: From April '97 to April '99, we developed a new strategy for increasing professional efficiency (training and increase in inpatient-therapist ratio) and preferential admission of patients covered by health insurance companies. Also, some 20 new beds were created—a 50% increase in our inpatient unit—and other structural changes made (e.g., a new industrial kitchen). We studied financial and administrative variables with Pearson correlation coefficients and linear regression analysis (p values ≤ 0.05 considered significant) to evaluate the appropriateness of this new strategy.

Results: Growth was reflected in increases in the number of new hospital admissions ($p = 0.04$), admissions of insured patients ($p = 0.01$), expenses ($p = 0.0001$) and expenses ($p = 0.0001$). Increasing numbers of new admissions were not explained by a parallel increase in hiked professionals ($r = 0.27$, $p = 0.18$) but correlated with incomes ($r = 0.55$, $p = 0.004$). Profits did not change ($p = 0.22$).

Conclusions: We demonstrated the efficiency of a strategy privileging cost effectiveness in a scenario of marked growth of the health insurance coverage in Brazil. Profits did not drop despite huge investments on physical structure.

REFERENCES:

1. Kotler P, Armstrong G: Principles of Marketing. Prentice-Hall, Inc. 1980.
2. Porter ME: Competitive Strategy. New York, Free Press, 1980.

Poster 149 **Monday, November 1 10:00 a.m.-11:30 a.m.**

AMBULATORY CURRICULUM INNOVATIONS FOR CLERKSHIPS

Tamara L. Gay, M.D., *Clinical Assistant Professor of Psychiatry, University of Michigan, 1500 East Medical*

Center Drive Box 0840, Ann Arbor, MI 48109; Michelle B. Riba, M.D., *Vice Chair, APA Institute Scientific Program Committee, Secretary APA Board of Trustees, and Associate Chair for Education and Academic Affairs, Department of Psychiatry, University of Michigan Medical Center, 1500 East Medical Center Drive, Ann Arbor, MI 48109-0704;* Joseph A. Himle, Ph.D.; Rachel L. Glick, M.D.

SUMMARY:

Previously, each University of Michigan based medical student spent one-half day/week as a passive observer on an outpatient diagnostic team. A new program was developed to increase ambulatory time to one day/week and enhance the quality of the educational experience. The new ambulatory experience consists of:

1. Videotape: Students observe and discuss a patient interview with a faculty facilitator.
2. Simulated patient interviews: Allow the student increased interview experience with faculty and "patient" feedback.
3. New patient evaluation interviews: Conducted jointly by a medical student and his/her mentor (faculty member or fourth-year resident). Student participation and control of the interviews increases as the four-week clerkship progresses.
4. Medical student team meetings: These occur following the live patient evaluations and involve the medical students, the faculty member, and fourth-year resident mentors. The medical students present the cases.
5. Return visits: The medical student/mentor pairs schedule some patients for return visits, to aid the student in getting more longitudinal follow-up of patients.

The preliminary data indicate increased student confidence conducting psychiatric interviews. The greater availability of active ambulatory teaching experiences are critically needed, and require a significant commitment of departmental resources and time, as demonstrated by this program.

TARGET AUDIENCE:

Medical student educators.

REFERENCES:

1. Irby, DM.: Teaching and learning in ambulatory care settings: a thematic review of the literature. Academic Medicine 1995; 70:898–931.
2. Stimmel B, (ed.): Utilizing standardized patient protocols. Josiah Macy, Jr., Foundation, New York, 1998.

Poster 150 **Monday, November 1**
10:00 a.m.-11:30 a.m.

SHIFT FROM PER DIEM TO CASE-RATE REIMBURSEMENT

Jeffrey A. Borenstein, M.D., *Chief Executive Officer and Medical Director, The Holliswood Hospital, 87-37 Palermo Street, Holliswood, NY 11423;* Regina Colombo, R.N., *Utilization Review Coordinator, The Holliswood Hospital, 87-37 Palermo Street, Holliswood, NY 11423;* Michael Haber, M.S.W., C.S.W., Gay Hartigan, C.S.W.

SUMMARY:

This poster presents the methodology employed by a free-standing psychiatric hospital to implement the shift from per diem to case rate reimbursement. The covered population includes adults and adolescents and commercial as well as managed Medicaid patients, and both adults and adolescents. New clinical systems were developed and implemented, including the tracking of key target symptoms and treatment interventions, prompting of clinical team with practice guidelines, and integration of inpatient and outpatient case management. In-service training for physicians, social workers, and nursing staff was key to acceptance of the role of "manager of care" as well as provider of care.

The results of the initial period of implementation are compared with a similar period prior to case rate. The findings include a decrease in length of stay for both adults and adolescents as well as commercial and Medicaid populations. Patient satisfaction and aftercare compliance were not negatively affected by the decreased length of stay. The recidivism rate showed a slight improvement. Most importantly, the new clinical systems, which were implemented in response to this change in reimbursement, have allowed the interdisciplinary treatment team to both manage and provide effective care.

REFERENCES:

1. Wetzler S, Schwarts BJ, Sanderson, W, Karasu TB: Academic psychiatry and managed care: a case study. Psychiatry Serv 1997; 48(8):1019–1026.
2. Zieman GL: The Complete Capitation Handbook: How to Design and Implement At Risk Contracts for Behavioral Healthcare. Tiburon, California, CentraLink Publications, 1995.

Poster 151 **Monday, November 1**
10:00 a.m.-11:30 a.m.

BUPROPION SR WITH PHENTERMINE FOR WEIGHT REDUCTION

Paul S. Bradley, M.D., *Primary Investigator, St. Joseph's/Candler Health System, 5353 Reynolds Street,*

Savannah, GA 31405; Ray R. Maddox, Pharm.D.; Wanda Kay North, R.N.

SUMMARY:

Objectives: To evaluate the efficacy and safety of phentermine with bupropion for weight reduction and to evaluate changes in mood and/or subclinical depression as assessed by the Beck Depression Inventory (BDI) in treated obese patients.

Methods: Forty-four (44) outpatients with an adjusted BMI >30 kg/m^2 were enrolled in a physician-managed weight reduction program. Each was randomly assigned to receive either phentermine 30mg plus placebo (21 patients) or phentermine 30mg plus bupropion SR 150mg twice a day (23 patients) in a double-blind fashion. Patients were followed for six months on a 1200 calorie ADA diet with office visits every three weeks. BDI scores, side effects, and weight loss were evaluated.

Results: There were no differences between the groups in demographic or laboratory parameters measured in the study. Weight loss exceeded 12% and was not different between the groups. BDI scores showed a greater improvement among those taking bupropion. No serious complications or side effects were seen in either group.

Conclusions: Bupropion may be a useful and well-tolerated adjuvant to phentermine in obese patients who exhibit mood changes and/or subclinical depression. However, it did not enhance weight loss in patients receiving phentermine and on a 1200 calorie diet.

REFERENCES:

1. Weintraub M, Sundaresan PR, Madan M, et al: Long-term weight control study I (weeks 0 to 34). Clin Pharmacol Ther 1992; 51:586–94.
2. Weintraub M: Long-term weight control study I conclusions. Clin Pharmacol Ther 1992; 51:542–46.

Poster 152 **Monday, November 1**
10:00 a.m.-11:30 a.m.

PTSD AFTER A PROLONGED ICU STAY

Frank G. Pajonk, M.D., *Department of Psychiatry, University of Hamburg, Martinistr. 52, Hamburg, Germany 20246;* Jens C. Richter, M.D.; Christian Waydhas, M.D.

SUMMARY:

Objective: Aim of the study was to investigate whether prolonged intensive care unit (ICU) treatment could be a risk factor for developing posttraumatic stress disorder (PTSD). Trauma victims were analyzed separately.

Methods: Data from patients treated in the ICU of the Department of Surgery, University of Munich, for 30 days or longer were collected. The surviving patients were invited for a psychological follow-up examination after 35 ± 14 months after discharge from the ICU. They were specifically asked for the DSM IV criteria of PTSD, and completed a questionnaire including the SCL-90-R.

Results: 101 patients were treated for 30 consecutive days or longer in the ICU. 55 deceased primarily or in the interval. 37 patients (m/f: 28/9, mean age: 45 ± 17 years, length of stay on the ICU: 52 ± 20 days) were able to come to the clinic, the SCL-90-R could be performed in 33 patients. According to DSM IV criteria, 7 patients (19%) developed PTSD but 2 of them had other severe psychiatric disorders. All of them had survived severe multiple trauma. Psychiatric disorders were common (n = 22, 59%), dominantly substance abuse (n = 14). Patients who fulfilled the criteria for PTSD had a significantly increased score in the PTSD-subscale of the SCL-90-R (1.7 ± 1.0 vs. 0.6 ± 0.5, $p < 0.01$); trauma patients had a higher score than others.

Conclusions: PTSD occurs with a considerable frequency but its attribution to either the trauma or the subsequent treatment is difficult, although only trauma victims developed PTSD. However, prolonged ICU-treatment is undoubtedly a severe stressor to any individual.

REFERENCES:

1. Blanchard EB, Hickling EJ, Taylor AE, Loos WR, Forneris CA, Jaccard J (1996): Who develops PTSD from motor vehicle accidents? Behav Res Ther 34:1–10.
2. Schelling G, Stoll C, Haller M, Briegel J, Manert W, Hummel T, et al. (1998): Health-related quality of life and post-traumatic stress disorder in survivors of the acute respiratory distress syndrome. Crit Care Med 26:651–659.

Poster 153 **Monday, November 1**
10:00 a.m.-11:30 a.m.

OLANZAPINE IN THE MANAGEMENT OF BEHAVIORAL DISTURBANCES AND/OR PSYCHOSIS IN DEMENTED NURSING HOME PATIENTS

Bruce J. Kinon, M.D., *Senior Clinical Research Physician, Eli Lilly and Company, Lilly Corporate Center, Indianapolis, IN 46285;* Steven D. Targum, M.D.; Bruce R. Basson, M.S.

SUMMARY:

Objective: To determine the efficacy and safety of the novel antipsychotic olanzapine (OLZ) in elderly demented nursing home patients who required antipsychotic drug intervention for the management of behavioral disturbances and/or psychosis.

Methods: Eighty-two patients (aged 60 or older) who met DSM-IV criteria for dementia with agitation and/or psychosis received open-label OLZ in a dose-ranging, eight week multi-site study. After a three to seven day washout period, eligible patients initially received OLZ 2.5 mg/day which could be titrated by 2.5 mg/day every 3 days as needed up to 10 mg/day. After two weeks on 10 mg/day, non-responsive patients were titrated up to 20 mg/day if needed. Efficacy was assessed weekly with the CGI-Severity Scale for Psychosis and/or Agitation (CGI), BPRS, CMAI, and NOSGER II. Safety measures included the MMSE, UKU, the Modified Simpson-Angus, Barnes Akathisia, and Abnormal Involuntary Movement scales, vital signs, and lab analytes.

Results: Sigificant improvement was noted in the CGI, BPRS-Total, CMAI, and NOSGER II-Negative subscale. There was no evidence of either cognitive impairment or development of EPS compared to baseline. No clinically significant changes in vital signs or lab analytes were observed. OLZ 5 mg was the mean daily dose.

Conclusion: In this single arm study, OLZ demonstrated efficacy and safety for the treatment of psychosis and agitation in elderly demented nursing home patients.

TARGET AUDIENCE:

Psychiatrists and psychiatric nurses.

REFERENCES:

1. Yeager BF, Farnett LE, Zicka SA: Management of the behavioral manifestations of dementia. Arch Intern Med 1995; 155:250-260.
2. Fleming KC, Evans JM: Pharmcologic therapies in dementia. Mayo Clin Proc 1995; 70:1116-1123.

Award Workshop 1 **Saturday, October 30**
8:30 a.m.-11:30 a.m.

REDUCING VIOLENCE IN A FORENSIC STATE HOSPITAL

Certificate of Significant Achievement

Colleen Carney Love, D.N.Sc., R.N., *Clinical Safety Project, Atascadero State hospital, 10333 El Camino Real, Atascadero, CA 93423;* Mark Becker, Ph.D.; Mel Hunter, J.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to identify eight key components of a comprehensive violence-prevention program, including development of data-driven performance improvement initiatives and augmented behavioral treatment programming for habitually violent inpatients.

SUMMARY:

This APA Achievement Award workshop will provide interested participants with an overview of the successful inpatient violence-prevention initiatives at Atascadero State Hospital, a large, all male, forensic state hospital located on the central coast of California. The workshop will include a didactic presentation as well as dialogue with the audience.

REFERENCES:

1. Love CC, Hunter M: Creating an Inpatient Violence Prevention and Monitoring Program: the Atascadero State Hospital Clinical Safety Project. Maintaining Your Quality Edge. Update 2 Joint Commission on Accreditation of Healthcare Organizations, Oakbrook Terrace, IL, 1998, pp. 45-68.
2. Becker M., Love CC, Hunter M: Intractability is relative: behavior therapy in the elimination of violence in psychotic forensic patients. Legal and Criminological Psychology 1997; 2:89-101.

Award Workshop 2 **Saturday, October 30**
8:30 a.m.-11:30 a.m.

ACCOMPLISHMENTS OF A CHILD MEDICAL PSYCHIATRY UNIT

Certificate of Significant Achievement

James D. Lock, M.D., Ph.D., *Assistant Professor of Child Psychiatry, Packard Children's Hospital, 401 Quarry Road, Palo Alto, CA 94305*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should recognize the benefits of a specialized treatment service for children and adolescents with medical and psychiatric problems.

SUMMARY:

The purpose of the presentation is to discuss the clinical, research, and administrative contributions of the Comprehensive Pediatric Care Unit (CPCU) at Lucile Salter Packard Children's Hospital, an affiliated hospital of the University of California at San Francisco and Stanford University Hospitals' Children's Services. The CPCU is a child and adolescent medical psychiatry service. Children treated in this setting over the past 20 years have the following types of diagnoses: anorexia nervosa, somatoform disorders, severe medical nonadherence due to psychiatric problems, factitious disorder by proxy, depression, psychotic disorders, and anxiety disorders. Clinical contributions of the CPCU are in the treatment of psychosomatic disorders and eating disorders, especially in the development of innovative strategies for treatment of these disorders. Academic contributions include more than 30 peer-reviewed publications and numerous book chapters as well as the development of an integrated teaching program for residents in pediatrics and child and adolescent psychiatry. An important administrative contribution of the CPCU is the development of a clinical pathway for treating adolescent anorexia nervosa.

We conclude that a combined program of child psychiatry and pediatrics provides an important opportunity to treat, conduct research, and teach about combined medical and psychiatric illnesses in children and adolescents. Participants will be invited to ask questions and discuss key points throughout.

REFERENCES:

1. Lock J: Pediatric psychiatry at Lucile Packard Children's Hospital at Stanford. Clinical Child Psychology and Psychiatry 1999; 4:325-330.
2. Lock J: How clinical pathways can be useful: an example of a clinical pathway for anorexia nervosa. Clin Child Psychol 1999; 4:331-340.

Award Workshop 3 **Saturday, October 30**
8:30 a.m.-11:30 a.m.

HAMILTON-WENTWORTH HEALTH SERVICES ORGANIZATION MENTAL HEALTH PROGRAM

Certificate of Significant Achievement

Nick S. Kates, M.B., *Associate Professor of Psychiatry, McMaster University, 43 Charleton Avenue East, Hamilton, Ontario, Canada L8N 1Y3;* Anne Marie Crustolo, B.S., C.N.; Lambrina Nikolaou, B.S.; Sheryl Farrar, M.S.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be familiar with one model for integrating mental health services in primary care.

SUMMARY:

The Hamilton-Wentworth HSO Mental Health Program, established in 1995, integrates counselors and psychiatrists within the offices of 90 family physicians serving 170,000 people in Southern Ontario. Counselors are permanently attached to each practice (one per 8,000 patients), while psychiatrists visit for half a day every one to four weeks and are available by phone between visits. Services offered include consultation, ongoing care, crisis assessments, case discussions with the family physician, educational presentations to primary care staff, and maintaining linkages between primary care and the mental health system. The program has led to a 12-fold increase in the number of individuals being referred for mental health assessment by each family physician, with a reduction of 2/3 the number of referrals to outpatient clinics. Satisfaction ratings of consumers are consistently above 90% as are satisfaction ratings of family physicians and participants in the program.

Lessons learned about primary mental health care include: (1) it requires different skills from outpatient or private office practice, (2) it complements but does not replace physician outpatient services, (3) it offers new opportunities for education of consumers and family physicians, (4) it opens new opportunities for preventive and early interventions, (5) it has the potential to significantly reduce other health care costs, (6) it can meet the needs of underserved populations such as the homeless or those in isolated communities. The components of the program are transposable to any community.

REFERENCES:

1. Kates N, Craven M, Crustolo A, et al: Integrating mental health services into primary care. Gen Hosp Psych 1997; 19:324-337.
2. Kates N, Craven M, Crustolo A, et al: Sharing care: the psychiatrist in the family physician's office. Can J Psychiatry 1997; vol. 4, 960-965.

Gold Award **Saturday, October 30**
Workshop 1 **8:30 a.m.-11:30 a.m.**

THE FOUNTAIN HOUSE CLUBHOUSE MODEL

Kenneth J. Dudek, M.S.W., *Executive Director, Fountain House, 425 West 47th Street, New York, NY 10036*

SUMMARY:

The Fountain House Clubhouse model is one of the most widely replicated approaches to comprehensive community support in this country and the least understood. It is a partnership model involving people with mental illness and a professional mental health staff. It is not a consumer-run model.

The goal of the clubhouse model (the generic name) is to assist people with major mental illness to achieve their full potential and be respected as workers, neighbors, and friends. It seeks to achieve these goals by providing community support (case management), transitional, supported, and independent employment; transitional and permanent housing; supported education; active outreach teams; cultural programs; and an evening/weekend cultural program. While it provides jobs, education, and housing opportunities in the larger community, it also provides a strong base of support in its clubhouse workday setting.

The model promotes a partnership with psychiatrists who provide quality psychopharmacology and medical case management. A complete support system for a person with major mental illness involves a clubhouse program, an active outreach team, and a psychiatric group with a hospital affiliation. Fountain House is also actively involved in research, advocacy, and training.

Quality implementation of this approach suffered greatly in the 1980s and the early 1990s because of partial implementation and underfunding. The introduction of a common set of standards, along with a certification process, is improving the overall quality of the replication of the clubhouse approach.

Gold Award **Saturday, October 30**
Workshop 2 **8:30 a.m.-11:30 a.m.**

THE MENTALLY ILL IN JAILS AND PRISONS: A COMMUNITY-BASED MODEL OF PREVENTION

J. Steven Lamberti, M.D., *Associate Professor of Psychiatry, University of Rochester, 1650 Elmwood Avenue, Rochester, NY 14620;* Robert L. Weisman, D.O.; Rudo Mundondo-Ashton, M.S., R.N.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to understand factors contributing to overrepresentation of persons with severe mental illness in jails and prisons, to describe the importance of service integration in preventing jail recidivism, to understand the importance of cultural diversity in promoting effective outreach and engagement, and to discuss the five components of Project Link and their role in promoting community reintegration.

SUMMARY:

Jails and prisons have become a final destination for the severely mentally ill in America. Addiction, homelessness, and cultural barriers have contributed to the problem and have underscored the need for new service delivery approaches. Project Link is a university-led community consortium that spans health care, social services, and criminal justice systems. It features a mobile treatment team with a forensic psychiatrist, a dual-diagnosis treatment residence, multicultural staff, and integration with the criminal justice system. Project Link is effective at reducing jail recidivism and hospitalization among consumers with substantial criminal histories and provides a model for urban communities.

This workshop will discuss the over-representation of persons with severe mental illness in jails and prisons and will present Project Link as a community-based model of prevention. The development, design, and operation of Project Link will be discussed. This workshop will emphasize the importance of service integration and will present findings from a recent program evaluation. Discussion and audience participation will be encouraged.

REFERENCES:

1. Lamberti JS, Weisman RW, Schwarzkopf SB, et al: Prevention of jail recidivism among outpatients with schizophrenia. Schizophrenia Research 1999; 36:344.
2. Torrey EF: Out of the Shadows: Confronting America's Mental Illness Crisis. New York, John Wiley and Sons, Inc., 1997.

Symposium 1 **Friday, October 29**
8:30 a.m.-11:30 a.m.

MENTAL ILLNESS RESEARCH, EDUCATION AND CLINICAL CARE CENTERS: BRIDGING CLINICAL AND SERVICES RESEARCH

APA Committee on Health Services Research

Harold Alan Pincus, M.D., *Psychiatric Research Consultant, 5409 Center Street, Chevy Chase, MD 20815-7123;* Grayson S. Norquist, M.D.; G. Richard Smith, Jr., M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to describe unique research opportunities offered by MIRECC programs.

SUMMARY:

The symposium describes the opportunities for psychiatrists to work with clinicians, administrators, researchers, and patients to improve care for persons with mental illness through a unique initiative funded by the Veterans Administration's Mental Illness Research, Education, and Clinical Care Centers (MIRECCs). MIRECCs have the integrative mission of improving care for persons with mental illness through education, improved service delivery, and research, including research that spans basic science, treatment research, and health services research. Each of the six funded MIRECCs covers all three areas of activity, but with a different focus and balance of emphasis. Funding of additional MIRECCs have been proposed. The overarching structure provides excellent opportunities for psychiatrist health services researchers to bridge with scientists in other areas (e.g., brain imaging, generics, clinical trials), to develop new insights into mechanisms to improve care and outcomes. The diversity of service delivery programs within and across VA programs, as well as existence of large, Integrated data sets, provides opportunities to track variations in services delivery, quality of care, and costs of care for this vulnerable population. The MIRECC structure, combined with other VA funding opportunities, permits an excellent infrastructure for fielding quality improvement programs that are broadly informed by the education, research, and practice components of the MIRECCs. Opportunities for psychiatrists and researchers, as well as the field of health services research will be emphasized.

No. 1A

SERVICES RESEARCH IN THE VETERANS AFFAIRS MENTAL ILLNESS, RESEARCH, EDUCATION AND CLINICAL CARE CENTER PROGRAM

J. Greer Sullivan, M.D., *Director, Mental Illness, Research, Education and Clinical Centers Program, Little Rock Veterans Affairs Medical Center, 2200 Fort Roots Drive, Building 58, North Little Rock, AR 72114;* Thomas B. Horvath, M.D.

SUMMARY:

The Veterans Administration is now supporting six Mental Illness Research, Education, and Clinical Centers (MIRECCs) nationally. Funding for additional MIRECCs is being requested. Because MIRECCs are required to have clinical, research, and education components, and to include a portfolio that encompasses basic science and clinical and services research, they present unique opportunities for collaborative work across research disciplines. This presentation will give a brief overview of the six MIRECCs, each thematically unique. Approaches to integrating services research will be compared and contrasted across the MIRECC programs.

No. 1B

THE VETERANS AFFAIRS HEALTHCARE NETWORK OF SOUTHERN CALIFORNIA AND NEVADA MENTAL ILLNESS RESEARCH, EDUCATION AND CLINICAL CARE CENTER: IMPROVING OUTCOMES OF PSYCHOSIS

Alexander S. Young, M.D., *Associate Director of Health Services West Los Angeles Veterans Affairs Medical Center, 11301 Wilshire Boulevard, 210-A, Los Angeles, CA 90073;* Stephen R. Marder, M.D.

SUMMARY:

The Veterans Healthcare Network of Southern California and Nevada (VISN 22) has been awarded a Mental Illness Research, Education, and Clinical Center (MIRECC) funded by the Department of Veterans Affairs. The goal of the VISN 22 MIRECC is to improve long-term functional outcomes of individuals with chronic psychotic disorders through innovative research, clinical care, and education. The MIRECC focuses on barriers that limit functioning in schizophrenia and psychotic mood disorders, and includes three scientific units. A neuroscience unit focuses on understanding neurochemical and neurophysiological impairments. A treatment unit focuses on developing improved pharmacologic and psychosocial treatments. A health services research and development unit focuses on enhancing the effectiveness

and efficiency of routine care by improving provider behavior and organizational structure. These units are supported by data management and neuroimaging cores, and information is communicated by an education and dissemination unit. This MIRECC includes a remarkable breadth of research from neurophysiological studies in rodents to interventions to improve the mean level of treatment quality for schizophrenia. The opportunities presented by this center structure will be discussed, with consideration of the extent to which health services research can inform basic and clinical science, and, in turn, be shaped by these fields of study.

No. 1C
TARGETING APPROPRIATE TREATMENT IN PSYCHIATRY

Jerome A. Yesavage, M.D., *Director, Veterans Affairs Health Sciences Center of Palo Alto, and Department of Psychiatry, Stanford University, 401 Quarry Road, C-305, Stanford, CA 94305-5550;* Helena C. Kraemer, Ph.D.; John W. Finney, Ph.D.

SUMMARY:

The Sierra-Pacific Network has chosen as its overall theme for the MIRECC the matching of treatments for mental illnesses to the personal characteristics of the individual veteran patient. Given the extensive array of behavioral and biological treatments now available for mental illness, the VISN will emphasize how matching specific treatments to individual veterans can improve the quality of care afforded our veteran patients with mental illness.

Focusing first on patients with post-traumatic stress disorder (PTSD) and behavioral problems associated with Alzheimer's disease and related dementias, MIRECC investigators will build a wide network across Hawaii, Northern California, and Nevada to conduct studies matching patients to the best treatment. The characteristics of patients will be assessed using a broad range of neurochemical, neuroimaging, and psychosocial measures.

We will use signal detection methods to identify characteristics of treatment responders. Modifications of signal detection methods (Kraemer, 1988; 1992) have been developed to optimize diagnostic and prognostic procedures. In standard diagnostic applications, these methods are based on assessing criteria of various kinds (''tests'') against a ''gold standard,'' describing the performance of each criterion graphically by its sensitivity and specificity or by chance-corrected sensitivity and specificity. Identifying the outer boundary of the locations of such ''tests'' determined by their sensitivity and specificity yields the ROC (receiver operating characteristic), as determined by chance-corrected values the QROC (quality ROC), and if considerations of test costs are included as well, the QCROC (quality and cost ROC). In predictions of treatment outcome, treatment response (e.g., improvement versus no improvement or deterioration) is the ''gold standard.''

No. 1D
THE CONNECTICUT-MASSACHUSETTS VETERANS AFFAIRS MENTAL ILLNESS, RESEARCH, EDUCATION AND CLINICAL CARE CENTERS

Robert A. Rosenheck, M.D., *Co-Director, Veterans Affairs Connecticut Health Care System, 950 Campbell Avenue, West Haven, CT 06516;* Rani Hoff, Ph.D.; Douglas Leslie, Ph.D.

SUMMARY:

The Connecticut-Massachusetts VA MIRECC has conducted a series of services research studies to identify patterns of cross-system service use among VA patients (i.e., use of non-VA services). These studies conducted in Philadelphia, PA; Colorado; Massachusetts; New York; and Connecticut examine the use of non-VA services by VA system users. A second series of studies has compared changes in VA and private sector mental health care during the 1990s and compared developments in quality of care in both systems.

REFERENCES:

1. Lehman AF, Carpenter WT, Goldman HH, Steinwachs DM: Treatment outcomes in schizophrenia: implications for practice, policy, and research. Schizophrenia Bulletin 1995; 21:669-5.
2. Young AS, Sullivan G, Burnam MA, Brook RH: Measuring the quality of outpatient treatment for schizophrenia. Archives of General Psychiatry 1998; 55:611-617.
3. Kraemar HC: Assessment of 2 x 2 association: generalization of signal detection methods. Americal Statistician 1998; 42:37-49.
4. Kraemar HC: Evaluating medical tests: objective and quantitative guidelines. Newbury Park, CA, Sage, 1992.
5. Hosenhack RA, Stolar M: Access to public mental health services: determinants of population coverage, Medical Care 1998; 36:503-512.
6. Hoff RA, Rosenheck RA: The use of VA and non-VA mental health services by female veterans. Medical Care 1998; 16:1524-1533.

Symposium 2 **Friday, October 29**
2:00 p.m.-5:00 p.m.

EMERGING CONCEPTS IN THERAPEUTIC FAMILY EDUCATION

Therapeutic Education Association

Cynthia C. Bisbee, Ph.D., *Clinical Director, Montgomery Area Mental Health Authority, 101 Coliseum Boulevard, P.O. Box 3223, Montgomery, AL 36109*

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, participant should be able to describe several emerging concepts in therapeutic family education and understand the relationship between provider training and effectiveness in family education.

SUMMARY:

Educational interventions for families of persons with mental illness clearly provide benefit for both the consumer and the family involved. These interventions have been in use for over 20 years and are becoming commonplace as a vital part of the treatment and rehabilitation plan. This presentation will address some of the new directions, issues, and concepts that are arising in the practice of family education in response to need to increase effectiveness of educational interventions and meet the needs of more diverse groups of family members. The symposium will focus on some of these new efforts including education of specific subgroups of families (siblings, spouses, parents), how education can be provided in informal settings such as advocacy and support groups, and how we can assist aging caregivers in making plans for their disabled relatives. Two of the sessions will focus on training of professionals: an interactive session relating professionals' pre-service education to their roles in helping prevent family stress, and description of a statewide effort to change clinicians' perceptions of persons with psychotic disorders and their families, and thus help to reduce stigma for family members. The symposium will allow ample time for discussion and comment.

TARGET AUDIENCE:

Providers of psychiatric/psychosocial and educational interventions, family members, and consumers.

No. 2A
FOCUS ON PARENTS, SPOUSES, SIBLINGS AND OFFSPRING

Diane T. Marsh, Ph.D., *Professor of Psychology, University of Pittsburgh at Greensburg, 1150 Mount Pleasant Road, Greensburg, PA 15650*

SUMMARY:

The impact of mental illness on family members depends partly on its timing in their life span and on their roles within the family. As a result, parents, spouses, siblings, or offspring have unique experiences and needs. This presentation explores each of these family roles as well as effective interventions.

Parents generally experience intense losses and often assume responsibilities as primary caregivers or informal case managers. They are prone to feelings of guilt and responsibility, which may be intensified by social and professional assumptions of parental accountability.

Spouses typically endure emotional, social, and financial losses similar to those that accompany spousal bereavement. Faced with increased responsibility for family life, they often struggle to meet their own needs and experience substantial conflict if they consider separation or divorce.

Siblings may undergo the dual losses of their brother or sister and of their parents, whose energy may be consumed by the mental illness. Often, they feel neglected and ignored.

Offspring may become enveloped in the psychotic system or move into a "parentified" role. Growing up too quickly, they may feel they have lost their childhood. Both siblings and offspring are likely to carry a legacy of "unfinished business" into their adulthood.

No. 2B
HELPING AGING CAREGIVERS MAKE PLANS FOR A DISABLED RELATIVE

Agnes B. Hatfield, Ph.D., *Professor Emeritus, Department of Human Development, University of Maryland, 8351 Canning Terrace, Greenbelt, MD 20770*

SUMMARY:

As caregivers age, their concerns for the well-being of their relative with mental illness when they are gone takes on increased urgency. This paper presents data on the special concerns and needs of older caregivers and describes a model program for helping them meet these needs.

No. 2C
THERAPEUTIC FAMILY EDUCATION IN INFORMAL SETTINGS

Harriet P. Lefley, Ph.D., *Professor, Department of Psychiatry, University of Miami School of Medicine, D-29, P.O. Box 016960, Miami, FL 33101*

SUMMARY:

The literature on therapeutic education for families has focused primarily on research-based psychoeducational interventions. Although they vary in duration and format, all share the common elements of education, support, behavior management techniques, and problem-solving strategies. These elements are delivered in a structured format, primarily through didactic, social learning (role modeling/playing), and homework techniques. Although they have been powerfully effective in reducing or deterring relapse, most of the research models have been too lengthy and intensive to meet the needs of the multiple families who would benefit from them.

This presentation deals with therapeutic education administered in informal settings, with a focus on application to existential problems presented in advocacy and support groups. An analysis is presented of models of therapeutic education administered during a 10-year period of a weekly support group for families of persons with severe and persistent mental illness. A 3 × 3 schema describes transmission channels of information—mental health professionals, legal or resource specialists, and experienced family members—in relation to content areas, implementation, and outcome. Case materials are presented on the utilization of therapeutic education when applied to specific problems and their resolutions.

No. 2D
EDUCATION AND SUPPORT FOR FAMILIES: A PREVENTION MODEL

Victoria A. Conn, M.D., *2430 Germantown Avenue, Philadelphia, PA 19118*

SUMMARY:

This interactive session addresses the important roles of professionals in providing education and support to patients' parents, children, siblings, or spouses as a buffer against the occupational hazard of caregiving. The presenter contends that psychiatrists and mental health professionals often overlook the families of persons with serious mental illness as a population at risk for stress-related disorders and traces this oversight to deficits (omissions) in their preservice education about families and mental illness. Members of the audience will be cast as professionals and family members in a vignette contrasting the outcomes of interactions that stem from contrasting conceptual frameworks about families.

No. 2E
CHANGING CLINICIANS PERCEPTIONS OF PERSONS WITH MENTAL ILLNESS

Claire Griffin-Francell, A.P.R.N., *President, Southeast Nurse Consultants, Inc., 5424 Saffron Drive, Dunwoody, GA 30338*

SUMMARY:

Destigmatizing families of persons with psychotic disorders will be the focus of this presentation. The presenter will describe a statewide, systematic initiative in continuing education for public sector mental health clinicians that was delivered at eight geographically diverse sites. Three-day conferences over an eight-month time span targeted multidisciplinary audiences. Strategies used to gain cooperation of administrators will be outlined. The core components of the curriculum will be described, including new best-practice findings in psychiatry, psychiatric rehabilitation, and family research.

REFERENCES:

1. Marsh DT: Serious Mental Illness and the Family: The Practitioner's Guide. New York, Wiley, 1998.
2. Marsh DT, Dickens RM: Troubled Journey: Coming to Terms with the Mental Illness of a Sibling or Parent. New York, Tarcher/Putnam, 1997.
3. Lefley HP, Hatfield AB: Helping consumers cope with parental aging and loss. Psychiatric Services (in press).
4. Lefley HP: Aging parents as caregivers of mentally ill adult children: an emerging social issue. Hospital & Community Psychiatry 1987; 38:1063-1070.
5. Solomon P: Moving from psychoeducation to family education for families of adults with serious mental illness. Psychiatric Services 1996; 47:1364-1370.
6. Pickett SA, Heller T, Cook JA: Professional-led versus family-led support groups: exploring the differences. Journal of Behavioral Health Services & Research 1998; 25:437-445.
7. Conn VS, Marsh DT: Working with families, in Advanced Practice Nursing in Psychiatric & Mental Health Care. Edited by O'Shea LA, Pelletier E, et al. Boston; American Psychiatric Nurses Association, in press.
8. Conn VS: Are psychiatric nurses overlooking an important population at risk? Dan Weisburg (ed.) Journal of the California Alliance for the Mentally Ill, in press.
9. Griffin-Francell C: What families of people with mental illness want physicians to know. Relapse: Issues in The Management of Chronic Psychosis 1993; Vol. 13.
10. Griffin-Francell C: Training mental illness professionals in curricular issues. National Forum Phi Kappa Journal 1993; Winter.

Symposium 3 **Saturday, October 30**
8:30 a.m.-11:30 a.m.

PATIENT AND FAMILY EDUCATION AS A STANDARD OF CARE

Garry M. Vickar, M.D., *Chief of Psychiatry, Christian Hospital Northwest, Northeast, Vickar, Tilzer and Associates, 1245 Graham Road, Suite 506, Florissant, MO 63031*

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to identify practice guidelines and clarify what works best for which persons and within which psychiatric setting.

SUMMARY:

Patient and family education has become a prevalent form of psychosocial intervention and an integral component of psychiatric treatment. The goal of patient and family education is to improve patient health outcomes by promoting better skills in illness management and involving the patient and family members in the treatment process. These goals can be met only when mental health providers perform well specific educational processes. The nature of these processes and their practical applications are the core contents of this symposium. Presenters will describe innovative programs designed to improve implementation of this standard of care, along with ways to monitor their performance. The presenters, each working with a different type of psychiatric population at various settings, will describe their practical applications and identify ways to tackle obstacles in implementing this standard of care.

TARGET AUDIENCE:

Professionals and consumers involved in patient and family education.

No. 3A
PLANNING, DELIVERING AND MONITORING MULTIDISCIPLINARY PATIENT EDUCATION

Kay McCrary, Ed.D., *Director, Patient and Family Education, Bryan Psychiatric Hospital, 220 Faison Drive, Columbia, SC 29203*

SUMMARY:

In this portion of the symposium, the director of patient and family education at a psychiatric hospital in Columbia, South Carolina, will discuss the following, also asking audience input:

- *Options:* Types of patient education that are warranted in a psychiatric hospital.
- *Assessment:* Screening patients according to classes/instruction needed.
- *Delivery:* At the point of readiness to learn, patients benefit from multiple formats, addressing different learning styles—brochures, computers, videotapes, demonstration aids, classes, and one-to-one instruction—and interactive learning.
- *Monitoring:* The multidisciplinary team that plans delivery of patient education also plans the way to check that delivery occurred and monitors trends that indicate improvement of patient education is needed.

No. 3B
STRATEGIES IN IMPLEMENTING A PATIENT AND FAMILY EDUCATION PROGRAM

Deanne Gilmur, M.S., *Director, Patient Education, Pierce College, Administration Building R-125, Fort Steilacoon, WA 98494*

SUMMARY:

For many years the practice of offering patient education to persons with serious and persistent mental illness was offered on a minimal basis, with few guidelines or recommendations for standards of practice by which the quality of education was measured. Patient and family education at present has evolved into a clinical specialty and an integral component of a service recipient's treatment program. However, providers remain uncertain about the essentials of a patient and family education program and what best practices are. This presentation will include a discussion of a model patient and family education program, strategies for implementation, guidelines for meeting standards of care, and the future issues and problems for those providing patient and family education.

No. 3C
EDUCATING PATIENTS ABOUT ILLNESS SELF-MANAGEMENT: WHAT HAVE WE LEARNED?

Haya Ascher-Svanum, Ph.D., *Department of Psychiatry, Roudebush VA Medical Center, 116-A, 1481 West 10th Street, Indianapolis, IN 462022*

SUMMARY:

Along with the proliferation of patient education programs, we are seeing growing diversity in intervention models and lack of consensus as to what marks a best practice. In an attempt to bridge the gap between practice and research in this field, this presentation will clarify practice implications that are pertinent for mental health

professionals who are involved in patient education. This segment of the symposium will present implications and clinical guidelines that were generated from a body of published, controlled, outcome studies, with a focus on illness self-management for persons with schizophrenia.

REFERENCES:

1. Lefley HP: Family care giving in mental illness. Thousand Oaks, California, Sage, 1996.
2. Family intervention in mental illness. Edited by Hatfield AB. New Directions for Mental Health Services No. 62. San Francisco, Josssey-Bass, 1994.
3. Kemp R, Hayward P, Applewhaite G, et al: Compliance therapy in psychotic patients: randomised controlled tiral, American Journal of Psychiatry 1996; 312:345-349.
4. Eckman TA, Wirshing WC, Marder SR, et al: Technique for training schizophrenia patients in illness self-management: a controlled study. Am J Psychiatry 1992; 149:1549-1555.

Symposium 4 **Saturday, October 30**
8:30 a.m.-11:30 a.m.

CULTURAL COMPETENCE IN CLINICAL CARE

World Psychiatric Association and the Group for the Advancement of Psychiatry

Juan E. Mezzich, M.D., *World Psychiatric Association Secretary General, and Professor of Psychiatry, Mt. Sinai School of Medicine, Fifth Avenue and 100th Streets, Box 1093, New York, NY 10029;* Allan Tasman, M.D., *President, American Psychiatric Association, and Professor and Chair, Department of Psychiatry and Behavioral Sciences, University of Louisville School of Medicine, 500 South Preston Street, Building A, #210, Louisville, KY 40292-0001;* Edward F. Foulks, M.D., Ph.D.; Renato D. Alarcon, M.D., M.P.H.; Francis G. Lu, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to recognize key anthropological, clinical service, standardized and international perspectives on cultural competence.

SUMMARY:

Cultural competence, in the increasingly multicultural nation and world in which we live, is becoming a critical ingredient for effective diagnosis and treatment of people presenting with psychiatric problems. The growing presence of African Americans, Latinos, Asian Americans and American Indians in the general population, particularly in large cities, makes compelling for clinicians of all ethnic backgrounds to be aware and skillful in the key principles and perspective of cultural competence for clinical care. This symposium examines the topic of cultural competence at the light of four fundamental viewpoints. First, the anthropological understanding of culture and ethnicity as it applies to the topic at hand is presented. Second, the complexity and challenges of clinical services, and multidisciplinary teams, are outlined as settings and requirements for cultural competence efforts. Discussed in third place are standardized approaches to achieving cultural competence recently developed by agencies such as the Substance Abuse and Mental Health Services Administration. The fourth paper, reviews recent international developments spearheaded by the World Psychiatric Association and the World Health Organization to enhance clinical diagnosis and care across the world.

No. 4A
ANTHROPOLIGICAL PERSPECTIVES AND CULTURAL COMPETENCE

Edward F. Foulks, M.D., Ph.D., *Consultant, Institute Scientific Program Committee, and Sellars-Polchow Professor of Psychiatry and Associate Dean for Graduate Medical Education, Tulane University Medical Center, 1430 Tulane Avenue, SL77, New Orleans, LA 70112-2699*

SUMMARY:

The increasing cultural diversity in this country has resulted in more clinical situations in which cultural differences exist between patients, medical students, and residents. Cultural diversity includes ethnicity, race, gender, religion-spirituality, sexual orientation, and other important social factors that influence diagnosis, management, and treatment of illnesses. It is essential that all clinicians develop knowledge, attitudes, and skills that will help them care for patients and families from culturally diverse populations. Psychiatric practice should be informed regarding epidemiological, anthropological, and sociological factors in America's subcultures, particularly those found in the patient community served by the clinical practice.

No. 4B
CLINICAL PERSPECTIVES ON CULTURAL COMPETENCE

Renato D. Alarcon, M.D., *Professor and Vice Chair, Department of Psychiatry, Emory University School of Medicine, and Chief, Psychiatry Service, VA Medical Center, 1570 Clairmont Road, Atlanta, GA 30033*

SUMMARY:

An indispensable component of culturally competent health operations, the clinical perspective goes beyond the theoretical framework of anthropology and the necessary sanction of sound bureaucratic regulations. This clinical perspective has to deal simultaneously with the need of globally applicable service options, and the unique cultural characteristics of each human community in which those services are provided. On the basis of the multidimensional interrelationships between culture and clinical psychiatry, this presentation deals with the following areas: (1) Interpretive/explanatory: to prevent harmful pathologization of culturally based behaviors; (2) Pathogenic/pathoplastic: to assist in the appropriate analysis of abnormal behaviors; (3) Diagnostic/nosological: to foster a clinically adequate use of DSM-IV's Cultural Formulation and other interviewing resources; (4) Therapeutic/protective: to delineate culturally sound approaches to the clinician-patient relationship, psychotherapy, and ethnopsychopharmacological approaches; and (5) Service/management: perhaps the most relevant as it deals with issues of mental health care delivery from scheduling and personnel assignment to physical plant and actual structure of programs. Examples of these interactions will be provided to emphasize the strong role of culture at both the conception and the actual delivery of clinical services to all kinds of communities.

No. 4C
CULTURAL COMPETENCE: STANDARDIZED PERSPECTIVES

Francis G. Lu, M.D., *Clinical Professor of Psychiatry, University of California at San Francisco, and Director, Cultural Competence and Diversity Program, San Francisco General Hospital, 1001 Potrero Avenue, San Francisco, CA 94110-3518*

SUMMARY:

Over the past four years, the Substance Abuse and Mental Health Services Administration Center for Mental Health Services (CMHS) has convened several work groups to produce important consensus documents on cultural competence. This presentation reports on these efforts focusing on Cultural Competence Standards in Managed Care Mental Health Services for Four Underserved/Underrepresented Racial/Ethnic Groups and Cultural Competence Performance Measures for Managed Behavioral Healthcare Programs. These work groups consisted of multidisciplinary mental health experts in cultural competence, consumers, and family members. The Cultural Competence Standards document resulted from work done first by four separate panels focusing on blacks, Hispanics, Native-Americans, and Asian and Pacific Islanders and secondly by a consensus panel that met in June 1997. It was prepared through the Western Interstate Commission for Higher Education (WICHE) Mental Health Program, Harriet G. McCombs, Ph.D., served as CMHS Project Officer. Standards applied to three levels of care: overall system, clinical service or agency level, and for individual providers. For each standard, implementation guidelines, recommended performance indicators, and recommended outcome measures were included. The Cultural Competence Performance Measures document utilized an extensive literature review and focus groups of ethnic/minority consumers in addition to the expert panel. It enunciated six domains across the three levels of care: needs assessment, information exchange, services, human resources, policies/plans, outcomes.

No. 4D
INTERNATIONAL PERSPECTIVES ON CULTURAL COMPETENCE

Juan E. Mezzich, M.D., *World Psychiatric Association Secretary General, and Professor of Psychiatry, Mt. Sinai School of Medicine, Fifth Avenue and 100th Street, Box 1093, New York, NY 10029*

SUMMARY:

The ongoing globalization process in all spheres of human activity, and the growing presence of immigrants and ethnic minorities across the general population, particularly in large cities, point out the need to be aware of and participate in international developments concerning culturally competent clinical care.

The following topics will be specifically reviewed:

1. International participation in the design of a cultural presence in DSM-IV and prospects for future editions.
2. The preparation by the World Psychiatric Association of International Guidelines for Diagnostic Assessment, including a new diagnostic model articulation a standardized diagnostic statement with a personalized or idiographic formulation, jointly promoting scientifically, humanistically, and ethically based clinical care.
3. The ongoing evaluation, by the World Health Organization of the Mental health component of ICD-10, which may lead to updates and revisions, for which more effective international collaboration will be essential.

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Competence Standards in Managed Care Mental Health Services for Four Underserved/Underrepresented Racial/Ethnic Groups. Washington, D.C., Author, 1991.
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Symposium 5 **Saturday, October 30**
8:30 a.m.-11:30 a.m.

COMMUNITY PSYCHIATRY: EUROPEAN VERSUS UNITED STATES APPROACH

World Association for Psychosocial Rehabilitation

Francois Petitjean, M.D., *Department SM 24, Hospital Sainte Anne, 1 Rue Cabanis, Paris, France 75674;* William R. Breakey, M.D.; Jacques Dubuis, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to describe the recent development concerning community psychiatry and to describe the various services established for the provision of mental health care in Europe and the United States.

SUMMARY:

In Europe and America, the last 50 years have seen a shift from psychiatric care delivered in large mental institutions to smaller facilities within the community and in general hospitals. This process of deinstitutionalization was carried out at a different pace in each country, leading to systems of care commonly known as Community Psychiatry in Britain and the U.S. Sectorization Policy in France.

This symposium sponsored by the World Association For Psychosocial Rehabilitation (WAPR), to include speakers from the U.S. and Europe, will examine the present situation characterized by the development of integrated networks for the delivery of psychiatric care in the context of strong concern with the cost of health care, and reduction of hospital capacities. Presentations will address questions such as:

- What are the best ways to provide mental health services for groups with special needs (homeless people, dual-diagnosis patients)?
- What should be the role of emergency services at the interface between the hospital and the community, between medical and psychiatric care?
- How can services be effectively accredited to ensure they meet appropriate standards?
- What is the impact of financing mechanisms on the provision of care for the mentally ill?

TARGET AUDIENCE:

Psychiatrists and other mental health professionals service planners and policy makers, health service researchers and epidemiologists.

No. 5A
ADDRESSING THE NEEDS OF A SPECIAL GROUP: HOMELESS PEOPLE

William R. Breakey, M.D., *Professor and Deputy Director, Department of Psychiatry and Behavioral Sciences, Johns Hopkins University School of Medicine, 600 North Wolfe Street, Baltimore, MD 21205*

SUMMARY:

Within any system for delivery of mental health services, special provision must be made for groups with special needs. Homeless people are one such group, with high rates of psychiatric disorders, significant comorbidity, special needs for access to services, and particularly complex needs for case management. The provision of mental health services to homeless people has four stages: engagement, basic services, transition, and integration. The presenter will discuss each of these stages and review the methods for treating this group that are currently considered state of the art.

No. 5B
EMERGENCY SERVICES IN THE COMMUNITY PSYCHIATRY NETWORK

Francois Petitjean, M.D., *Department SM 24, Hospital Sainte Anne, 1 Rue Cabanis, Paris, France 75674;* Bernard Seletti, M.D.; Alain Mercuel, M.D.; Francois Caroli, M.D.

SUMMARY:

Reports published in France in the early 1990s have shown that emergency units thoughout the country treat an increasing number of patients. A survey carried out in 1992 showed that during one year 13% of the whole population was admitted to an emergency room. (7.68 million admissions in one year). Various hypotheses have been put forward to explain this phenomenon: search for a fast answer to any stressful situation, loss of the traditional role of the GP, increasing turnover of patients in hospital beds. However, studies have shown that 10% to 30% of patients examined in general emergency services should be referred to a psychiatrist for

evaluation. Placed at the interface between the hospital and the community, these services thus play an important role in terms of prevention and access to psychiatric care.

Various solutions have been developed to improve evaluation and treatment of emergencies. Crisis intervention centers were developed in some big cities in the eighties. Their lack of integration within the general network of emergency structures has been criticized. Mobile crisis teams are still at an experimental level. Recommandations by public health authorities have led to the integration of general emergency services within the community psychiatry network. The recent development of such a program in two catchment areas in Paris (totalizing 250,000 inhabitants) will be described. Conclusions drawn from the experience of similar networks in other big cities will be highlighted.

No. 5C
CULTURAL COMPETENCE IN COMMUNITY MENTAL HEALTH CARE

Annelle B. Primm, M.D., M.P.H., *Assistant Professor and Director, Community Psychiatry Program, Johns Hopkins University School of Medicine, 600 North Wolfe Street, Meyer 144, Baltimore, MD 21287-7180*

SUMMARY:

The ability to recognize and treat psychiatric disorders in patients from diverse cultural and ethnic backgrounds is a critical skill in the provision of mental health care. Culture and ethnicity influence a number of areas including: conceptions of mental illness, expression of psychopathology, acceptance of psychiatric diagnoses, effects of psychopharmacologic agents, and compliance with treatment. This presentation will illustrate how cultural and ethnic factors mediate the presentation, course, and outcome of treatment of psychiatric disorders. This presentation will also describe the attitudes, knowledge, skills, and behaviors necessary for providing culturally competent mental health care. The audience will be invited to share their experiences in working with patients of different ethnic and cultural backgrounds.

No. 5D
DUAL DIAGNOSIS: A CHALLENGE FOR COMMUNITY CARE

Sonia J. Johnson, M.D., *Department of Psychiatry, University College of London, Wolfson Building, 48 Riding House, London, United Kingdom W1N 8AA*

SUMMARY:

Dual diagnosis of severe mental illness and substance abuse has been a much less prominent focus for research and service development in Europe in the last decade than in the U.S. However, as I will show in a brief overview of research from Europe on this theme, there is a dawning awareness that the prevalence of dual diagnosis is probably high, and that conventional generic community mental health services such as those now established in the U.K. encounter significant difficulties in engaging and managing this group.

Clinicians, researchers, and policymakers in the U.K. and elsewhere are thus now seeking better strategies for managing the dually diagnosed. I will discuss several significant questions that arise in considering whether it is appropriate to transplant to Europe service models developed in the U.S. These include: (1) Is development of specialist teams the best strategy in a service currently based on generic teams serving small geographical sectors?; (2) Does "dual diagnosis" really define a subgroup with a sufficiently homogeneous set of needs to constitute a basis for service planning?; and (3) How should dual diagnosis interventions fit into the development of assertive outreach teams, now becoming a central element in U.K. service planning?

No. 5E
CARE IN THE COMMUNITY HAS FAILED: CHANGES IN APPROACH IN THE UNITED KINGDOM

David G. Kingdon, M.D., *University of Southampton, Royal South Hants Hospital, Southampton, United Kingdom*

SUMMARY:

Health ministers in the U.K. have recently announced that "Care in the community has failed"; there are "widespread and unacceptable variations in standards and quality of care" with "families ... overburdened" and "vulnerable patients ... abandoned". There is a commitment to greater security for patients and public with specialist secure units, 24-hour nursed accommodation, assertive outreach teams, and changes in mental health legislation. But this does not mean that a return to custodial institutional care should occur; they envisage a "third way." A new National Service Framework for Mental Health, drawn up by an External Reference Group, will cover both health and social care and provide guidance on the level and balance of services needed in each locality. This was to be published in March 1999 and its structure and components, and the quality standards set, will be described in this presentation. A Commission for Health Improvement is to monitor its implementation. Finally, there is to be substantial extra funding to produce safe, sound, and supportive mental health services for the millennium. Progress toward achieving these objectives will be reported.

No. 5F
IMPACT OF FINANCING MECHANISMS ON CARE OF PEOPLE WITH SEVERE MENTAL ILLNESS

Gerard Gallucci, M.D., M.H.S., *Director of Community Psychiatry, Johns Hopkins Bayview Medical Center, 4940 Eastern Avenue, D-2 East, Baltimore, MD 21224;* Thomas Marshall, L.C.S.W.; Wayne Swartz, M.S.W.

SUMMARY:

New financing mechanisms have impacted on the provision of services for people with severe and persistent mental illness. Compared with traditional fee-for-service delivery systems, capitated funding models have allowed for more individualized and creative mental health services.

Creative Alternatives is a component of the Community Psychiatry Program of the Johns Hopkins Bayview Medical Center. It is part of a five-year demonstration project, initiated by the Baltimore Mental Health Systems, and uses a capitated model of funding to provide comprehensive services for people with severe and persistent mental illness. Individuals with a history of long-term hospitalization or who have had frequent inpatient or emergency room visits are eligible for the program.

A preliminary review of various outcome measures has shown that the program has been successful as well as financially feasible.

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7. Okpaku S: Clinical Methods in Transcultural Psychiatry. Washington, D.C., American Psychiatric Press Inc., 1998.
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10. Commissioning Mental Health Services. Edited by Thornicroft G, Strathdee G. HMSO, London, 1996.
11. Shern DL, Donahue SA, Felton C., et al: Partial capitation versus fee-for service in mental health care. Health Affairs 1995; 14:208-219.

Symposium 6 **Saturday, October 30**
8:30 a.m.-11:30 a.m.

WHAT IS REALLY GOING ON IN PSYCHIATRY TODAY? UPDATE FROM THE AMERICAN PSYCHIATRIC ASSOCIATION PRACTICE RESEARCH NETWORK

Harold Alan Pincus, M.D., *Psychiatric Research Consultant, 5409 Center Street, Chevy Chase, MD 20815-7123;* John S. McIntyre, M.D.; Iván Montoya, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to understand the research aims of the APA's Practice Research Network and understand major trends related to psychiatry and psychiatric clinical practice patterns; to be aware of recent clinical and services findings from PRN studies, including findings related to the impact of managed care on clinical practice.

SUMMARY:

This symposium will review findings from the APA's Practice Research Network (PRN), a research initiative that aims to gather information on what's happening in the "real world" of psychiatry. PRN members (n=750) work in the full range of practice settings (e.g., public hospitals, private practice, correctional facilities) and treat patients of all ages with diverse psychiatric profiles. This symposium will present data from a number of network studies. The National Survey of Psychiatric Practice (NSPP), a large national probability sample survey of APA members, provides data on critical clinical, financial, and other issues of importance to psychiatry. It collects nationally representative data on psychiatrists' professional activities, work settings, and patient caseloads. The Study of Psychiatric Patients and Treatments (SPPT) generates data to systematically characterize PRN members, their practices, patient caseloads, and clinical treatment patterns. In addition, it provides detailed clinical and diagnostic data on PRN patients and the specific types and combinations of treatments provided. The Study of Outpatient Referral Patterns collected data to characterize the nature and frequency of

communication between nonpsychiatric physicians and psychiatrists with regard to outpatient referrals.

The first presentation will highlight findings from the NSPP on the characteristics of psychiatrists and trends in psychiatric practice over the past 10 years. The second presentation will review findings from the SPPT, including data on the types and combinations of treatments provided to geriatric patients. The third presentation will present data to characterize the referral interface between psychiatry and primary care.

No. 6A
CURRENT TRENDS IN PSYCHIATRIC PRACTICE

Ana P. Suarez, M.P.H., *Practice Research Network Project Manager, Office of Research, American Psychiatric Association, 1400 K Street, N.W., Washington, DC 20005;* Harold Alan Pincus, M.D.; Deborah A. Zarin, M.D.; Max Sederer, B.A.

SUMMARY:

Findings from the 1998 National Survey of Psychiatric Practice will be presented. This study is conducted every other year to study critical clinical, financial, and other issues of importance in the field of psychiatry and to track changes in psychiatric practice over time. The principal objective of this study, which gathers data on a large, randomly selected sample of APA members, is to collect nationally representative data on psychiatrists' professional activities, work settings, and patient caseloads to create a scientific baseline for current and future research in the rapidly changing field of psychiatry. Approximately 1,500 APA members are randomly selected for study participation each year. To date, 67% of psychiatrists have returned valid surveys. Preliminary results indicate that 8% of respondents are fully retired and 69% of respondents spend more than 15 hours in direct patient care per week.

Key findings and trends related to psychiatrists' professional activities, practice settings, patient caseloads, and referrals as well as data on psychiatrists' participation in managed care plans and the financing and economics of psychiatric practice will be presented. In addition, trends in psychiatric practice patterns over the past 10 years will be presented.

No. 6B
CHARACTERISTICS AND TREATMENT OF GERIATRIC PSYCHIATRIC PATIENTS

Christopher C. Colenda, M.D., M.P.H., *Professor and Chair, Department of Psychiatry, Michigan State University, East Lansing, MI 48824-1316;* Harold Alan Pincus, M.D.; Maureen Mikus, Ph.D.

SUMMARY:

Data will be presented from the 1997 Study of Psychiatric Patients and Treatments with regard to the characteristics and treatments of psychiatric patients over the age of 65. The mean age of patients in the study population is 42, 12% of patients (n=150) were over the age of 65, and 55.7% (n=693) were between ages 35 and 64. The most common primary diagnosis was mood disorders (53.7% of patients), followed by anxiety disorders (9.3% of all patients). Elderly patients were least likely to be seen as outpatients (7.0% of elderly patients were seen as outpatients compared with 27.4% as inpatients and 42.7% in a partial/intermediate setting). More specifically, these analyses (currently underway) will compare the clinical and treatment characteristics of patients over age 65 with patients between the ages of 35 and 64. The presentation will focus on findings related to substance abuse history, psychiatric hospitalizations, psychiatric comorbidity, treatment settings, and treatment services. The presentation will also examine the differences in the clinical severity and the financial and reimbursement characteristics of the patients.

No. 6C
REFERRAL INTERFACE BETWEEN PRIMARY CARE AND PSYCHIATRY

Terri L. Tanielian, M.A., *Practice Research Network Manager, Office of Research American Psychiatric Association, 1400 K Street, N.W., Washington, DC 20005;* Harold Alan Pincus, M.D.; Aulen Dietrich, M.D.; John Williams, M.D.; Thomas E. Oxman, M.D.; Eve Kupersanin, B.A.; Heather Cohen, B.A.

SUMMARY:

Purpose: To better understand the nature of the mental health referral process through characterizing the current communication and referral interface between psychiatry and primary care.

Methods: The American Psychiatric Association Practice Research Network (PRN) is developing a two-phase study to examine the current referral and communication process between primary care and psychiatry. Using a 10-item mail survey, Phase 1 gathered data from psychiatrists regarding the frequency of referrals from primary care and the nature and frequency of and satisfaction with their communication between primary care physicians. Phase II will gather detailed patient-level data on four new outpatients per psychiatrist to examine the mechanics of the referral process and assess the types, frequency, and satisfaction with communication with primary care physicians. This 30-item paper/pencil

survey also collects psychiatrist-reported data regarding the patient's demographic, clinical, treatment, and system/setting characteristics.

Results: Over 80% of PRN members have completed the Phase I survey, and 76% of PRN members completed Phase II. Preliminary analysis of the Phase I data (n= 213 psychiatrists) shows that 46% of psychiatrists indicated that the overall quality of their interactions with nonpsychiatric physicians was fair or poor 35% indicated that they actively seek referrals from nonpsychiatric physicians. With regard to the type of information communicated to psychiatrists by nonpsychiatric physicians, 48.3% indicated that they often or always receive the information regarding the reason for the referral. However, 38.6% of psychiatrists indicated they almost never or never receive the patient's treatment history. In addition, 78% of psychiatrists reported that they often or always provide diagnostic information and treatment information regarding the patient back to the referring nonpsychiatric physician, but 26% of psychiatrists report confidentiality concerns often or sometimes limit them from sharing this information. Preliminary data from Phase II (n=167 patients) will also be presented and compared with similar data being collected through the Ambulatory Sentinel Practice Network (ASPN) Referral Study in family medicine and other studies.

Conclusions: Results from these surveys will be used to help build a conceptual framework of the various domains and aspects of the referrals for mental health patients. Through collaboration with primary care and psychiatric researchers, this initiative will develop a multidisciplinary project to implement and evaluate an intervention based on this framework and aimed at improving the referral process and enhancing the communication between psychiatry and primary care.

REFERENCES:

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Symposium 7 **Saturday, October 30**
2:00 p.m.-5:00 p.m.

PATHWAYS: ENHANCING CLINICAL EFFECTIVENESS IN AN AGE OF MANAGED CARE

Frank Ghinassi, Ph.D., *Chief, Adult Services, Director, Outcomes and Pathways Division, and Assistant Professor of Psychiatry, University of Pittsburgh School of Medicine, 3811 O'Hara Street, Room E, Pittsburgh, PA 15213*

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to understand the function of clinical pathways; review the pathway development process; understand outcomes implications; improve feedback loops to clinicians and patients.

SUMMARY:

Over the past decade, managed care companies have increasingly dominated the mental health care market, creating substantial changes in the delivery and cost of mental health services. These changes have become the subject of political debate, legislative action, and public concern. Administrators and clinicians are placed in the uneasy position of negotiating between seemingly incompatible interests while market forces encourage the provision of inexpensive care, ethical obligations require the provision of high quality care that promotes the clients' best interests. Clinical pathways may aid in addressing this dilemma. Pathways are treatment plans developed by multidisciplinary teams based upon empirical data and expert models of clinical decision making. Pathways describe the timing and delivery of treatment interventions and focus on targeted measures of client outcome. These features allow clinical excellence to coexist more comfortably with resource efficiency.

This symposium will: (1) provide tools and instruction for developing, implementing, evaluating, and revising pathways, and for maximizing the likelihood of their success in existing organizations; (2) review two pathways focused on different levels of care that are in use at WPIC and affiliated sites; and (3) provide data on the complex relationships among pathway use, clinician performance, client outcome and satisfaction, and program efficiency.

TARGET AUDIENCE:

Clinicians, administrators and policy developers.

No. 7A
DEVELOPING PATHWAYS FOR EXISTING MENTAL HEALTH CARE SYSTEMS

Frank Ghinassi, Ph.D., *Chief, Adult Services, Director, Outcomes and Pathways Division, and Assistant Professor of Psychiatry, University Pittsburgh School of Medicine, 3811 O'Hara Street, Room E, Pittsburgh, PA 15213*

SUMMARY:

In this era of managed care, clinical pathways may represent the best solution to the need to combine clinical excellence with resource efficiency. Pathways distill expert models of decision making and the benchmarks of care into concrete descriptions of multidisciplinary treatment interventions laid out along a real-world time line. Pathways are best developed through the combined efforts of seasoned research-practitioners from a variety of disciplines, information analysts, and clinical administrators skilled in system management and include measures of client outcome and clinician performance. The pathway development process is iterative and collaborative: after implementation trials, clinicians receive feedback *and* provide suggestions for pathway improvement. Pathways developed in this way enable clinicians to increase the consistency, timeliness, and quality of their treatment efforts.

This presentation will examine relevant experiences gleaned from a recent, ongoing, and extensive Pathway development project at WPIC. The presentation will (a) disseminate and describe pathway and outcome development templates, (b) examine the development and use of decision-making algorithms in planning levels of care, (c) discuss the challenges involved in introducing clinical pathways into complex care delivery organizations including hospitals, community mental health centers, and teaching institutions, and (d) review the steps involved in providing feedback to clinicians and improving pathways.

No. 7B
PATHWAY DEVELOPMENT FOR AN EARLY INTERVENTION PROGRAM

Jennifer Skeem, M.S., *Doctoral Candidate, Department of Psychology, University of Utah, 390 South 1530 East, Room 502, Salt Lake City, UT 84112*

SUMMARY:

As they develop infants and toddlers undergo constant, multifaceted changes and are uniquely susceptible to environmental influences. Although this makes developing a pathway for early intervention programs a challenging enterprise, there are compelling economic, practical, and scientific reasons for doing so. First, patterns of funding for early intervention programs are highly complex. Pathways explicitly describe the timing and nature of services rendered to conveniently provide accountability to third-party payers. Second, most early intervention programs are staffed primarily by paraprofessionals. When they apply the standards of care distilled in a pathway, paraprofessionals obtain focused training and guidance. Third, there are few clinically focused investigations of the effectiveness of early intervention programs. Pathways build in mechanisms for strong but convenient program evaluation. In this presentation, we will describe the development and implementation of a pathway for a therapeutic nursery for 0-3-year-old children with prenatal exposure to controlled substances and/or caretakers with major psychiatric disorders. This pathway is unusual in that it is (a) community-based, (b) developmentally inclusive, (c) built around an established early intervention curriculum, (d) relatively long term, and (e) includes a flexible time course that provides for the impingement of environmental forces. Pilot outcome data will also be provided.

No. 7C
PATHWAY IMPLEMENTATION ON AN INPATIENT SCHIZOPHRENIA UNIT

Rohan Ganguli, M.D., *Professor of Psychiatry and Pathology, Western Psychiatric Institute and Clinic, 3811 O'Hara Street, Pittsburgh, PA 15213-2593*

SUMMARY:

The deinstitutionalization movement and the more recent advent and domination of managed care have dramatically changed the nature and duration of treatment provided to patients with chronic mental illnesses. Patients with psychotic disorders are typically managed and treated in the community: inpatient care is reserved for acute, critical illness-related events. Inpatient care has become short term, intensive, streamlined, and focused on efficiency. To balance efficiency with high-quality care, a multidisciplinary team at WPIC developed a clinical pathway for the inpatient schizophrenia unit approximately two years ago. This pathway was designed in several iterations based on the input and feedback of the unit's staff with full representation from each of the involved professions. The pathway was initiated approximately one year ago, and since that time, eligible patients have been placed on the pathway. This presentation describes the development, revision, implementation, and evaluation process for this pathway. The presentation will include data on variances from the

pathway by the treatment team, functional status outcomes on the patients, and satisfaction ratings by patients.

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No. 7D
PATHWAY VARIANCE, CLIENT OUTCOME AND RESOURCE EFFICIENCY

Frank Ghinassi, Ph.D., *Chief, Adult Services, Director, Outcomes and Pathways Division, and Assistant Professor of Psychiatry, University of Pittsburgh School of Medicine, 3811 O'Hara Street, Room E, Pittsburgh, PA 15213*

SUMMARY:

To ensure the successful implementation of effective clinical pathways, information on clinical performance and client outcome must be analyzed. This information is used to provide feedback to clinical teams, develop better clinical practices, and educate patients. This presentation will present data from an ongoing, extensive pathway-development project at WPIC. Information on the relationships among pathway use and (a) clinician performance, (b) client outcome and satisfaction, and (c) resource efficiency will be provided. Methods for comparing competing interpretations of data on clinician performance with different implications for either improving pathway implementation or revising pathway content will be analyzed. The complex relationships among clinical status and client satisfaction will be explored, focusing on the inverse relationship between clients' satisfaction and baseline level of clinical functioning. Finally, concrete information on pathway-related increases in resource efficiency will be presented.

The implications of these data for improving normative clinical practice will be emphasized. These include (a) enhancing clinical pathways by devising a feedback loop between pathways and outcome data, and (b) improving implementation of revised clinical pathways by devising a useful feedback process between clinicians and outcome data.

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2. Lee S, Kahn J: Measures of child progress and program effectiveness in early intervention. Infant-Toddler Intervention 1997; 7:215-233.
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Symposium 8 **Saturday, October 30**
2:00 p.m.-5:00 p.m.

BPD TREATMENT: DIALECTICAL BEHAVIORAL THERAPY AND PSYCHOPHARMACOLOGY

Daniel P. Potenza, M.D., *Clinical Director, Community Support Program, The Mental Health Center of Greater Manchester, 401 Cypress Street, Manchester, NH 03101;* Patricia C. Auciello, M.S.

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to understand the functioning of an integrated system of care for borderline personality disorder, as well as for those with special challenges, and for adolescents, who present with para-suicidal and/or self-destructive behaviors at a community mental health setting.

SUMMARY:

At the conclusion of this symposium the participants should be able to recognize the diagnosis of borderline personality disorder, recognize specific psychopharmacologically sensitive targets to help improve outcomes in borderline personality disorder, and recognize the efficacy of dialectical behavioral therapy (DBT) within the overall scope of the treatment of borderline personality disorder within a community mental health setting. This presentation will center on a system of care utilizing formal DBT, a modified version of DBT with special applications to populations that tend to utilize a mental health center setting, special application to adolescents, and a detailed treatment of the application of psychopharmacologic techniques to borderline personality disorder.

TARGET AUDIENCE:

Mental health clinicians who work with clients with borderline personality disorder.

No. 8A
INTEGRATED CARE OF BPD

Patricia C. Auciello, M.S., *Senior Director, Community Support Services, Mental Health Center of Greater Manchester, 401 Cypress Street, Manchester, NH 03101*

SUMMARY:

Extensive literature exists discussing the efficacy of dialectical behavioral therapy for the treatment of borderline personality disorder, but little is written about its ability to be fully utilized within a community mental health setting. This symposium centers on the utilization of dialectical behavioral therapy in the treatment of borderline personality disorder within a community mental health setting. More specifically, this symposium will discuss how dialectical behavioral therapy identifies target behaviors and helps to replace them with skill-building techniques allowing a patient suffering from borderline personality disorder greater ability to reconstruct his/her approach, thus altering what was previously experienced as a nonvalidating environment. This allows for improved interpersonal effectiveness better regulation of emotional changes, and greater ability to alleviate stress.

This presentation will also concentrate on the utilization of a screening tool that allows for the proper understanding and organization of borderline personality disorder, which then focuses treatment options in a way that provides a cohesive framework for the overall successful reduction and restructuring of symptomatology.

TARGET AUDIENCE:

Mental health center clinicians who work with clients with borderline personality disorder.

No. 8B
PSYCHOPHARMACOLOGIC TREATMENT OF BPD

Daniel P. Potenza, M.D., *Clinical Director, Community Support Program, The Mental Health Center of Greater Manchester, 401 Cypress Street, Manchester, NH 03101*

SUMMARY:

The effective pharmacologic treatment of borderline personality disorder has been difficult to accomplish. However, the evolution of the diagnosis of this pervasive disturbance yields clues to the appropriate selection of certain signs and symptoms that provide targets for specific pharmacologic trials.

This presentation traces the biologic and diagnostic origins of borderline personality disorder, which when summarized yield overlapping areas that categorize symptomatology into more manifest *positive symptoms* (affective instability and impulsivity), and somewhat more subtle more *negative symptoms* (dissociation, psychosis, and inability to concentrate). This system allows better recognition of pharmacologically sensitive targets, so they can be more successfully treated. The more specific amelioration of behaviors that were the cause of patient's referral into treatment but frequently caused their ability to utilize this treatment can then be more successfully accomplished.

This paper will also present how this treatment fits into overall treatment of patients with borderline personality disorder and the use of dialectical behavioral therapy within the community mental health system.

TARGET AUDIENCE:

Mental health clinicians and psychiatrists who work with clients with borderline personality disorder.

No. 8C
INTEGRATION OF DIALECTICAL BEHAVIORAL THERAPY FOR ADOLESCENTS IN A COMMUNITY MENTAL HEALTH CENTER

Toni Paul, R.N.C., *Mental Health Center of Greater Manchester, 401 Cypress Street, Manchester, NH 03101*

SUMMARY:

This presentation will center on demonstrating utilization of dialectical behavioral therapy (DBT) techniques for the adolescent population in a community mental health center setting. This successful integration of a DBT program into an adolescent population has resulted in the decrease of suicidal behaviors in this targeted group. Patients who were involved in this pilot program were previously high utilizers of services and poor responders to more traditional forms of psychotherapy.

This program was developed through the collaborative efforts of staff within the community mental health center, community mental center's existing adult DBT program, and psychotherapists who treat adolescents interested in DBT-type skills-building techniques. This was done in multifamily schools training group setting, which will be described during this presentation. The results showed a significant decrease in para-suicidal behavior, hospital admissions, and emergency contacts. Complete program description and graphs showing these results will be discussed.

TARGET AUDIENCE:

Mental health clinicians who work with clients with borderline personality disorder.

No. 8D
DIALECTAL BEHAVIORAL THERAPY ENHANCEMENT STRATEGIES IN A COMMUNITY MENTAL HEALTH CENTER

Diane R. Distaso, M.Ed., *Clinical Coordinator, North End Counseling, Community Support Services, Mental*

Health Center of Greater Manchester, 401 Cypress Street, Manchester, NH 03101

SUMMARY:

Extensive literature exists on the efficacy of DBT for those with borderline personality disorder. Through extensive practice, however, its original design requires its participants to be motivated, literate, have several hours per week, and an average intelligence level. This presentation centers around the application of DBT techniques to persons who may or may not have a primary diagnosis of borderline personality disorder, who may be cognitively challenged, unable to read, or who don't have the motivation or time to spend several hours per week in a treatment modality, and yet present with potential DBT-sensitive symptoms, in a community mental health setting. These "enhancement statagies" function alongside more traditional DBT and consist of DBT "lite" group as well as seperately functioning brief individual enhancement applications.

REFERENCES:

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2. Marcus HR: Integrating dialectical behavioral therapy into a community mental health program. Psychiatric Services 1998; 49:1336-1340.
3. Gabbard G: Treatment of Psychiatric Disorders, Washington, DC, American Psychiatric Press, Inc. 2nd Ed, 1995.
4. Millen, et al: Dialectical behavior therapy adapted for suicidal adolescents. Sound of Practical Psychiatry and Behavioral Health 1997; 3:76-86.

Symposium 9 **Saturday, October 30**
2:00 p.m.-5:00 p.m.

INCARCERATION OF MENTALLY ILL YOUTH IN AMERICA

American Association of Community Psychiatrists and National Mental Health Association

Andrés J. Pumariega, M.D., *Professor and Chair, Department of Psychiatry and Behavioral Sciences, James H. Quillen College of Medicine, East Tennessee State University, P.O. Box 70567, Hillrise Hall, Johnson City, TN 37614-9567*

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to learn that the increasing rates of incarceration of youth in the U.S. and the mental health and sociocultural factors leading to this alarming trend; learn of the roles, issues, and challenges facing psychiatrists wroking with encarcerated youth; exposed to possible solutions to this crisis.

SUMMARY:

The United States is facing increasing rates of incarceration amongst its youth, with over 100,000 youth being incarcerated currently. This population has already been demonstrated to be at high risk for psychopathology at levels equal or exceeding those found in clinical treatment settings. The problems of these youth from primarily underserved minority backgrounds have been allowed to persist without significant intervention, leading to significant chronicity and persistent inability to function, as often reflected by their high rates of recidivism. Psychiatrists are increasingly asked to provide consultative and treatment services for youth in the juvenile justice system. If they are to develop effective clinical interventions and programs, they must familiarize themselves with the characteristics of these very high risk youth and learn to address their multiple complex needs. This symposium first presents data on the mental health status of incarcerated youth in the United States from available studies, as well as in-depth data from an intensive study of incarcerated youth using epidemiological methods. Data from another study are also presented that focus on the factors that lead to referral versus non-referral for mental health services. A presentation will review the unique mental health needs of youth in the juvenile justice system and how many states are currently failing to provide these services, leading to many class action lawsuits. Finally, the advocacy efforts on behalf of this population by the National Mental Health Association are highlighted, along with recommendations for addressing what is rapidly becoming a crisis in American child mental health services.

No. 9A
PSYCHOPATHOLOGY AND SERVICE USE IN JAILED YOUTH

Andrés J. Pumariega, M.D., *Professor and Chair, Department of Psychiatry and Behavioral Sciences, James H. Quillen College of Medicine, East Tennessee State University, P.O. Box 70567, Hillrise Hall, Johnson City, TN 37614-9567*

SUMMARY:

A number of studies of incarcerated youth have reported rates of psychopathology ranging from 20% to 80%. In a study of the prevalence of psychopathology in a juvenile correctional setting in South Carolina, we studied the mental health, socioeconomic, criminal, and services utilization status of a random sample of 75 incarcerated youth. We compared their psychiatric and service utilization status with that of 50 hospitalized

youth and 60 youth treated in community mental health centers from the same region. The DISC 2.3 and the CBCL were used to determine prevalence of psychiatric disorders and behavioral symptomatology, and a service-utilization instrument was used to determine prior service use, including mental health services. We also reviewed their criminal and clinical charts. Among the incarcerated youth, 71% met criteria for at least one diagnosis on the DISC, 53% met criteria for both one DISC diagnosis and met the clinical cut-off (T = 60) on the CBCL; the mean number of DISC diagnoses per youth was 2.40, and the mean number of symptoms was 30.5. These rates were comparable to those of the other groups. The incarcerated youth used significantly fewer mental health services but more nonhospital residential services than the other groups.

We will also report on socioeconomic and history of criminality in the incarcerated youth. Additionally, we will review initial data from a residential treatment program initiated in response to the South Carolina juvenile justice class action lawsuit. Our data suggest that incarcerated youth have significant mental health needs that are not being met either prior to or during incarceration, which indicates a critical failure of our child mental health system of care.

No. 9B
MENTAL HEALTH AND RECIDIVISM IN JAILED YOUTH

Kenneth M. Rogers, M.D., M.S.H.S., *Assistant Professor, Department of Psychiatry, University of South Carolina, 1800 Colonial Drive, P.O. Box 202, Columbia, SC 29202*

SUMMARY:

This presentation will review the results of a study that examined factors associated with recidivism in 244 youth referred for mental health treatment at a juvenile corrections facility in Los Angeles County, California. These were all youth referred between January 1 and June 30, 1995. There were 100 youth who were repeat offenders and 144 youth who were first-time offenders. The data for this study were abstracted from the youths' mental health and juvenile corrections charts. Data were classified into three types: demographic, clinical, and delinquency history. Differences between first-time offenders and repeat offenders were analyzed using logistic and linear regression models.

Minority youth were twice as likely to be repeat offenders (odds ratio = 2.00, p = 0.03). Youth who had more internalizing behavior were twice as likely to be repeat offenders (odds ratio = 1.97, p = 0.046). Youth with long criminal records were more likely to be repeat offenders (odds ratio = 1.69, p < 0.000), but were less likely to be those with a violent offense (odds ratio = 0.53, p = 0.048). Gender, age, drug use, number of mental health visits, and current DSM-IV diagnosis were not significantly associated with repeat offenses. Juvenile justice history has a greater impact on recidivism in mentally ill youth than do clinical and demographic factors. This may reflect the fact that once a youth is identified as being delinquent, it is less likely that psychopathology and the need for mental health treatment will be recognized. This may be especially true for mentally ill youth who tend to be nonviolent offenders with a history of multiple arrests.

No. 9C
STATUS OF MENTAL HEALTH SERVICES FOR JAILED YOUTH

Pamela K. McPherson, M.D., *Assistant Professor, Department of Psychiatry, Louisiana State University, 4107 Beau Chene Drive, Lake Charles, LA 70605-4022*

SUMMARY:

Studies suggest that an increasing number of emotionally disturbed youth are being incarcerated in the U.S.. However, many state juvenile justice system fail to provide adequate mental health services for their charges. This has led to a rising number of class action lawsuits being brought against states in federal court, with the risk of federal intervention by court masters or at least consent decrees determining the direction of such services. This presentation will inform psychiatrists about the clinical, administrative, and policy challenges related to this important issue. The presenter will first review the status of class action litigation against various states and the deficits in mental health services found in the juvenile justice systems involved. A model for an effective system of care for emotionally disturbed youthful offenders will then be presented, with a focus on both preventive and institutional services. The role of child and adolescent psychiatrists within such services will also be discussed, including clinical, administrative, and advocacy roles. Child and adolescent psychiatrists should be more involved in the development and implementation of mental health services for juvenile offenders given the serious psychopathology and services needs of this population.

No. 9D
MENTAL HEALTH ADVOCACY FOR INCARCERATED YOUTH

Michael M. Faenza, M.S.S.W., *Consultant, APA Institute Scientific Program Committee, and President and*

Chief Executive Officer, National Mental Health Association, 1021 Prince Street, Alexandria, VA 22314-2971

SUMMARY:

The crisis facing the United States due the incarceration of its youth is illustrative of the critical problems still facing us in delivering effective mental health services for children and youth. The fact that youth of color are highly over-represented among this population also illustrates how institutional racism still pervade our human service infrastructure. This trend towards increasing institutionalization could well have highly adverse consequences for the future well being of this nation. Advocacy efforts to reverse and prevent these adverse outcomes are being joined by a number of organizations, particularly the National Mental Health Association. The NMHA and its state affiliates have been at the forefront of advocacy for children's mental health in the United States, supporting the efforts of federal agencies such as the Center for Mental Health Services in developing culturally competent systems of care for children's mental health. As this crisis of youth incarceration has unfolded, NMHA has become active in the various state juvenile justice class action lawsuits and in investigating the conditions under which culturally diverse and mentally ill youth are detained and in bringing them to the attention of policymakers who can work on solutions to this crisis. This presentation will review the advocacy efforts of the NMHA and the goals of such efforts over the next few years.

REFERENCES:

1. Cohen R, Parmelee, D, Irwin L, et al: Characteristics of children and adolescents in psychiatric hospital and a correctional facility. J Am Acad Child Adolesc Psychiatry 1990; 29:909-913.
2. Otto RK, Greenstein JJ, Johnson MK, Friedman RM: Prevalence of mental disorders among youth in the juvenile justice system, in J.J. Cocozza (Ed.). Responding to the Mental Health Needs of Youth in the Juvenile Justice System. Seattle, Washington, The National Coalition for the Mentally Ill in the Criminal Justice System 1992, pp. 7-48.
3. Hollender H, Turner F: Characteristics of incarcerated delinquents: relationship between developmental disorders, environmental and family factors, and patterns of offense and recidivism J Am Acad Child Adolesc Psychiatry 1985; 24:221-226.
4. Barnum R, Famularo R, Bunshaft I, et al: Clinical evaluation of juvenile delinquents: who gets court referred? Bull Am Acad Psychiatry Law 1989; 17:335-344.
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7. Kaplan SL, Busner J: A note on racial bias in the admission of children and adolescents to state mental health facilities versus correctional facilities in New York. Am J Psychiatry 1992; 149:768-772.
8. Brown WK, Rhodes WA, Miller TP, Jenkins RL: The negative effect of racial discrimination on minority youth in the juvenile justice system. International Journal of Offender Therapy and Comparative Criminology 1990; 34:87-93.

Symposium 10 **Sunday, October 31**
8:30 a.m.-11:30 a.m.

E-MAIL IN PSYCHOTHERAPY

Paul Jay Fink, M.D., *Professor of Psychiatry, Temple University, and Past President, American Psychiatric Association, One Belmont Avenue, Suite 523, Bala Cynwyd, PA 19004-1608;* Yehuda Nir, M.D.; Ian E. Algen, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to understand how computer technology will affect psychiatry, recognize the problems related to having e-mail in psychotherapy, and expand psychotherapy to include new technologies.

SUMMARY:

E-mail has become a powerful force in the lives of Americans and it is beginning to touch both the way therapists conduct therapy as well as the content within the therapy. The value of e-mail as a therapeutic tool needs to be explored and how it will affect the practice of psychotherapy will be described. In addition, many of the activities that go on in the world of the Internet become part of the content of the therapeutic hour, whether it has to do with meeting people, fulfilling fantasies, and developing chat rooms or web sites. All of these things are of critical importance in the life of some patients who may use the e-mail for defensive purposes, pleasure purposes, or to deal with and possibly overcome inhibitions. As the technological world expands, e-mail will have a greater role to play in the daily lives of people who have made computers an integral part of

their routine. In some cases, people become computer-bound, computer excited, or computer dependent.

No. 10A
PATIENT USE OF E-MAIL TO ENHANCE PSYCHOTHERAPY

Paul Jay Fink, M.D., *Professor of Psychiatry, Temple University, and Past President, American Psychiatric Association, One Belmont Avenue, Suite 523, Bala Cynwyd, PA 19004-1608*

SUMMARY:

A case presentation will be given that describes the difference between face-to-face encounters and exchange of e-mails. In this case, the patient was much better able to free associate on the computer than he was in the face-to-face interview. Utilizing the material from the e-mail became a regular part of the treatment and allowed the patient to open up hidden areas more easily and helped him handle the confrontations about those areas when they were brought into the sessions. These kinds of therapeutic activities take place with specific plans, or if they are serendipitous when they occur, may be an important element in the utilization of e-mail as part of an overall therapeutic process. Many of the questions regarding ethics, confidentiality, and payment will be discussed.

No. 10B
LOVE AT FIRST BITE

Yehuda Nir, M.D., *1050 Park Avenue, New York, NY 10028-1031*

SUMMARY:

This paper will address some aspects of the impact of the Internet on psychotherapy. It will stress the importance of including Internet e-mail communications of patients in understanding the lifestyle in the 90s and its impact on our lives, our patients' lives, and the psychotherapist relationship. Three cases will be discussed. Case 1: Internet, love and deception made possible only because of the mailings. Case 2: A long-lasting Internet affair of a married man who can stay married and be in love and emotionally intimate on a daily basis with the long-distance lover. Case 3: Promiscuity via the Internet, a married woman who meets a new man every week after finding him on the Internet. An anonymous encounter. Anonymous sex. My attempt in this paper is to acknowledge what Marshall McLuhn described as "the medium is the message." It refers to interpersonal relationships these days, psychotherapy, and the tragedy of Littleton.

No. 10C
MEDIA IN THERAPY

Ian E. Alger, M.D., *Multimedia Consultant, APA Institute Scientific Program Committee, and Clinical Professor of Psychiatry, New York Presbyterian Hospital-Cornell Medical Center, 500 East 77th Street, New York, NY 10162-0025*

SUMMARY:

For decades new advances in communication technologies, such as the telephone, audio and video recordings, computers, e-mail, and the Internet have fostered the inclusion of these modalities into the practice of psychotherapy. In the sixties the use of video recording played back to patients, was first introduced in an inpatient hospital situation. The idea of video recording and playback, sometimes including the therapist(s) was a later innovation.

Technology has always been a part of medicine's therapeutic approaches, so it is not surprising that as the computer age advances, more and more applications are being found for computerized adjuncts to therapy. The Internet has, of course, made it possible for distance to be erased as a major factor in interchange, and therapy on the net is growing reality.

This presentation will review some of the earlier introduction of electronic communication modalities into therapy, and will consider some of the social, moral, therapeutic, and professional issues that are raised by this ever expanding communication revolution.

REFERENCES:

1. Alger I: Telemedicine: a personal journey, in Medicine Meets Virtual Reality:6—Technology and Informatics. Edited by Westwood JD, Hoffman HM, Stredney D, Weghorst SJ, Washington, D.C., IOS Press, 1998, pp.161-167.
2. Sander FM, Couples group therapy conducted by a computer-mediated communicator: a preliminary case study. Computers and Human Behavior 1996; 12(2)301-212.
3. Stolberg S Gay: Ideas and trends: from M.D. to I.P.O., chasing virtual fortunes, The New York Times, July 4, 1999,
4. Cook B: Down and dirty. Modern Physician 1999; 30-42.

Symposium 11 — Sunday, October 31 8:30 a.m.-11:30 a.m.

CURRENT TRENDS IN PUBLIC SECTOR MANAGED CARE

American Association of Community Psychiatrists

Michael A. Hoge, Ph.D., *Associate Professor of Psychiatry, Yale University, 25 Park Street, Sixth Floor, New Haven, CT 06519;* Kenneth Minkoff, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to recognize key dimensions and national trends regarding public sector managed care; discuss models in which providers receive government contracts to function as a managed care organization; and identify methods, such as performance-based contracting and utilization management strategies, for enhancing the quality of care delivered.

SUMMARY:

Managed care has emerged as a major force in the public sector, reshaping the financing and delivery of mental health and substance abuse services. All but four states now have implemented some form of managed behavioral health care. This symposium is designed to provide a broad overview of current trends and key issues in this area. The first of five presentations is designed to provide participants with a model for assessing and better understanding public sector managed care initiatives. The second outlines the findings from the recent SAMHSA-funded national survey of trends in public sector managed behavioral health care as conducted by the Lewin Group. One key finding from the Lewin study is that provider organizations are frequently involved in managing behavioral health care. This will be the focus of the third presentation, a case study of a joint venture to manage care that involves a public sector mental health center and an academic department of psychiatry. The fourth presentation focuses on strategies being pursued by states, in their role as purchasers, to ensure the quality of care delivered through carveouts. The final presentation will provide models to aid in the process of managing utilization of services in the public sector.

No. 11A
TEN DIMENSIONS OF PUBLIC SECTOR MANAGED CARE

Michael A. Hoge, Ph.D., *Associate Professor of Psychiatry, Yale University, 25 Park Street, Sixth Floor, New Haven, CT 06519;* Selby C. Jacobs, M.D.; Neil Thakur, Ph.D.

SUMMARY:

Managed care in public-sector mental health remains a poorly defined concept. It is currently understood largely through case examples, an approach of limited usefulness since each managed care initiative is shaped by local forces and is constantly changing. From a review of current public sector managed care initiatives, 10 key dimensions on which such initiatives vary have been identified. In this segment of the symposium an assessment model focusing on these dimensions is proposed as a useful approach to establishing the essential characteristics and core differences of efforts to implement public sector managed care. Each of the 10 dimensions will be reviewed, and the common ways in which initiatives vary on these dimensions will be discussed. A case example will be used to demonstrate the utility of this approach to better understanding public sector managed care. It will be suggested that the application of this assessment approach to a broad range of managed care projects yields the finding that most have focused on one principal dimension to the exclusion of other critical dimensions.

No. 11B
STATE PROFILES ON PUBLIC MANAGED BEHAVIORAL HEALTH

Gail K. Robinson, Ph.D., *Senior Manager, The Ledin Group, 9302 Lee Highway, Suite 500, Fairfax, VA 22031;* Traci S. Tunkelrott, M.P.P.

SUMMARY:

A persistent policy question facing the health care community is whether behavioral health should be integrated or carved out. This paper explores the differences between programs that integrate behavioral health services with physical care and those that carve out such services. The study had two goals: to determine if differences exist and if the differences observed could be attributed to the inherent characteristics or to other factors.

The Lewin Group collected information on these public programs between January and July 1998 on 97 programs. Overall, 45% of the programs identified are integrated. The remaining 55% are carved out. Comparisons of these two approaches found:

- Integrated programs are more often managed by private MCOs, whereas carveout plans are more often managed by public MCOs;
- Among programs that offer both mental health and substance abuse services, integrated programs are significantly more likely to receive Medicaid funding, whereas carveout programs receive county and block grant funding;
- Integrated programs are significantly more likely to reimburse MCOs through capitation, whereas carveout programs are significantly more likely to use fixed fees to reimburse managed care entities;
- Carveout programs are significantly more likely to offer mental health "specialty" services.

No. 11C
PROVIDERS AS MANAGERS OF CARE IN THE PUBLIC SECTOR

Allan Tasman, M.D., *President, American Psychiatric Association, and Professor and Chair, Department of*

Psychiatry and Behavioral Science, University of Louisville School of Medicine, 500 South Preston Street, Building A, #210, Louisville, KY 40292-0001

SUMMARY:

The staff of behavioral health provider organizations, including academic departments of psychiatry delivering services in the public sector, have often felt helpless when faced with state initiatives to introduce managed care. States frequently contract with private, for-profit, managed behavioral health care organizations, leaving providers with little influence or control over the delivery system and utilization management decisions. However, numerous provider organizations and academic departments of psychiatry involved in the public sector have pursued a more aggressive and competitive course. These providers have formed joint ventures or new provider-sponsored organizations in order to compete for contracts to manage publicly funded behavioral health care. In this segment of the symposium such a collaboration will be described, involving a partnership between a public mental health center and the department of psychiatry and behavioral sciences at the University of Louisville School of Medicine. The discussion will focus on the challenges of forming provider joint ventures, competing successfully for contracts, building networks, and implementing management systems. The presentation will include discussion of the strategic advantages and disadvantages of competing to manage care and the pros and cons of partnering with private, for-profit, managed care organizations.

No. 11D
CONTRACTING FOR QUALITY OF CARE

Paul J. Barreira, M.D., *Deputy Commissioner, Massachusetts Department of Mental Health, 25 Staniford Street, Boston, MA 02114-2503*

SUMMARY:

In an effort to ensure that quality services are provided by the MCO that manages behavioral health and substance abuse services, each year the state negotiates performance standards that reflect the issues of particular concern to Medicaid, DMH, consumers, families, and providers. The process includes input from all key stakeholders. The standards carry bonuses tied to their achievement or penalties for failure to meet the standard. Examples of standards include primary medical care linkage, cultural competency, substance abuse capacity, and continuity of care. The symposium will discuss in detail the process of defining standards and assuring their effectiveness.

No. 11E
UTILIZATION MANAGEMENT IN PUBLIC SECTOR MANAGED CARE

Kenneth Minkoff, M.D., *Medical Director, Choate Health Management, and Medical Director, Arbour-Fuller Hospital, 200 May Street, South Attleboro, MA 02703-5515*

SUMMARY:

For public managed care to be successful, clinicians, programs, and agencies must approach care management as a scientific pursuit, not as a political issue. The science of utilization management has been neglected in our training. This presentation describes the concept of multidimensional service intensity and relates it to "levels of care" in public managed systems. Then it will identify current methodology for multidimensional service intensity assessment (ASAM, LOCUS) and describe the utilization of these instruments in managed systems for clinical decision making, training, and research. Finally, there will be discussion of a comprehensive service array for psychiatric and addictive disorders, with utilization management criteria presented for each.

REFERENCES:

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2. Hoge MA, Davidson L, Griffith EEH, et al: Defining managed care in public-sector psychiatry. Hospital and Community Psychiatry 1994; 1994; 45:1085-1089.
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Symposium 12 **Sunday, October 31**
8:30 a.m.-11:30 a.m.

FROM BACH TO THE BLUES: MUSIC THERAPY IN PSYCHIATRY

John S. McIntyre, M.D., *Chair, APA Steering Committee on Practice Guidelines, Chair, Department of Psychiatry and Behavioral Health, Unity Health System, and Past President American Psychiatric Association, 81 Lake*

Avenue, Third Floor, Administration, Rochester, NY 14608; Bryan C. Hunter, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to: (1) describe the development of music therapy in the United States. (2) Identify illnesses that respond to music therapy. (3) Describe some of the outcome data from music therapy research.

SUMMARY:

Since before the inception of the profession in 1950, music therapy as a discipline has been used as an ancillary service in the treatment of persons with psychiatric disorders. In recent years the scientific basis for music therapy practice has been greatly expanded, allowing for new and exciting applications of music therapy from neonatal units to programs in geriatric medicine, from psychiatric units to oncology units, from neurology units to obstetrics, and in programs throughout the rest of medicine. Its longstanding history and current research base has positioned the discipline to be an important part of the current developments in integrative medicine. This symposium will present a history and overview of music therapy, and include specific presentations on music therapy in the treatment of a wide range of psychiatric diagnoses including those related to aging, and in the treatment of persons with neurological deficits. A review of related past and current research will also be presented. Presenters will include two past presidents from the American Music Therapy Association and other expert music therapy clinicians.

TARGET AUDIENCE:

Psychiatrists, psychologists, social workers and nurses.

No. 12A
MUSIC THERAPY: SOUND HEALTH IN INTEGRATIVE MEDICINE

Bryan C. Hunter, Ph.D., *Associate Professor, Music Department, Nazareth College, 4245 East Avenue, Rochester, NY 14618*

SUMMARY:

Music has been part of the healers' armamentarium for many centuries. Music therapy, one of the creative arts therapies, has developed dramatically in this country since the end of World War II. The unique post-war collaboration between musicians and physicians, often psychiatrists who were musicians, gave birth to the 20th century music therapy profession in 1950. Beginning first in mental health care, the discipline has rapidly expanded, allowing the powerful influence of music to effect positive results in psychosocial intervention, physical rehabilitation, and pain management. Scientific studies reported in the Journal of Music Therapy and other numerous periodicals provide an empirical foundation for the practice of music therapy with patients ranging in age from birth to the elderly. The ability of music therapy to help decrease depression, pain perception, and medication demands; and increase adaptive behavior skills, muscle relaxation, and positive attitude has benefited patients across a broad spectrum of diagnoses. This presentation will provide an overview of the music therapy profession, whose historical foundations, clinical practice, and research base have positioned it to be a part of the current rapid developments in integrative medicine.

No. 12B
MUSIC THERAPY: A PARTNER IN PSYCHIATRIC TREATMENT

Darlene M. Brooks, Ph.D., *Associate Professor of Music Therapy, Loyola University, 6363 Saint Charles Avenue, New Orleans, LA 70118*

SUMMARY:

The goals of music therapy include the expression of suppressed emotions, increased self-esteem, improved communication, the development of insight, increased interpersonal skills, and return to healthy functioning. In music therapy, as in psychiatry, the transference relationship is important to successful treatment. Music therapy uses a variety of methodologies designed to foster transference, including (1) improvisation-an extemporaneous activity where the client uses music to develop spontaneity, express emotions, and problem solve; (2) songs, where singing, creating, and listening to songs can be an integral part of psychotherapy because songs are ways that human beings explore emotions; (3) music imaging, which involves listening to music and allowing oneself to respond imaginally through free associations, projective stories, images, feeling body sensations, memories, and so forth (Bruscia, 1998).

"Music itself is often used to elicit emotional and/or cognitive reactions, which are essential for therapy (Wheeler, 1987, p. 40)." In order for insight to develop, a transference is necessary. Music therapy offers several configurations for developing and working through the transference. The music therapist uses transference in working through emotional conflicts and increasing problem solving and decision-making abilities. This presentation will describe the partnership between music therapy and psychiatry.

No. 12C
MUSIC THERAPY WITH PERSONS WHO ARE ELDERLY

Paul D. Cotten, Ph.D., *Professor, Music Department, William Carey College, 402 East Ivy Street, Ellisville, MS 39437*

SUMMARY:

The music therapy literature is replete with the therapeutic use of music, in assisting older persons in meeting their needs, with the music therapist serving as a member of the individual's interdisciplinary team. Studies have presented data supporting the therapeutic value of music in increasing both the degree of physiological as well as psychological relaxation. The use of music in reminiscence with persons experiencing dementia has been shown to be of value not in eliminating the dementia but in contributing to an improved quality of life for that individual by increasing their degree of engagement in the environment in which they reside.

Three of the primary groups of older persons benefitting from music therapy are (1) persons experiencing one of the dementias, (2) recipients hospice services, and (3) those experiencing psychiatric conditions, which may or may not be associated with the normal aging process. This portion of the presentation will consist of a literature review including examples of activities utilized and the reason for such.

No. 12D
MUSIC THERAPY WITH NEUROLOGICALLY-IMPAIRED PERSONS

Victoria P. Vega, M.M.T., *Music Therapist, Therapeutic Recreation, Touro Infirmary, 1401 Foucher Street, New Orleans, LA 70115*

SUMMARY:

In all populations groups under 40 years of age, trauma is the leading cause of prolonged disability and death. In conjunction with the interdisciplinary team, the music therapist is a valuable component in the rehabilitative process of the neurologically impaired person.

A more comprehensive treatment program is ensured when the music therapist, working along with the interdisciplinary team, provides integrative treatment that addresses the following: cognition, communication, motor, social/emotional, and visual rehabilitation. The physiological effects of music are motivating to the neuroloiclly impaired person. "Psychological and physiological research points to the fact that perceptual processes can have emotional accompaniments that may lead to the perception enhancing experiences of pleasure, reward, and positive feedback." (Thaut, 1990).

One of the unique qualities of music therapy is the wide variety of methods and tools available to the music therapist, for example, song writing. This method addresses a variety of targeted areas and can be a medium for self-expression, increasing self-esteem, enhancing socialization, promoting family communication, and can be an integral part of the client's physical well being (Robb, 1996). By utilizing the media of music, therapists do not only address the functional skills of clients, but also encourage growth in coping strategies, sustained attention, cognition, and socialization skills.

No. 12E
MUSIC THERAPY RESEARCH IN PSYCHIATRIC TREATMENT

Anthony A. Decuir, Ph.D., *Professor of Music Therapy, Music Department, Loyola University College of Music, 6363 Saint Charles Avenue, New Orleans, LA 70118*

SUMMARY:

This report will document and chronicle the modern use of music as therapy in the treatment of children, adolescents, and adults in psychiatric treatment. The history of the influence of music on human emotions is well documented; that history dates from the Middle Ages to the present. However, the modern history of music as therapy in the treatment of individuals with emotional problems is more recent. During the early decades of the twentieth century, several writers described the influence of music on physical and mental behaviors. It was not until the 1940s that "music in the treatment of psychiatric disorders became more widespread." Karl Menninger was a chief proponent of the use of music in holistic treatment. Earlier attempts at systematic research in music therapy were conducted at the University of Kansas with patients at the Winter VA Hospital in Topeka, Kansas (1992). Topics included the influences of sedative music on acutely disturbed patients, music's effect on insulin coma therapy, and a comparison of rhythm responses of normal and neuropsychiatric subjects. Presently, music therapy research in psychiatry ranges from the effect of music on the treatment of AIDS-related depression to music's effect on the interactions between caregivers and care receivers in late-stage dementia patients.

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Symposium 13 **Sunday, October 31**
8:30 a.m.-11:30 a.m.

TECHNOLOGY MEETS PSYCHOTHERAPY: FRIEND OR FOE

APA Commission on Psychotherapy by Psychiatrists

Jesse H. Wright, M.D., *Professor of Psychiatry, University of Louisville, Norton Psychiatric Clinic, P.O. Box 35070, Louisville, KY 40232-5070;* Marcia K. Goin, M.D., Ph.D.; Jerald Kay, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to (1) identify new technologies that can be used in psychotherapy, (2) discuss clinical issues in using technology in psychotherapy, (3) project an "office of the future" for the psychotherapist.

SUMMARY:

New technologies are providing exciting opportunities for expanding the reach of psychotherapy and altering methods of service delivery. Over half of American households now have a personal computer, and Internet communication is becoming a standard part of daily life. How will psychotherapists use computers and other communication technologies in the future to enhance their ability to serve patients? This symposium explores the potentials and challenges of using information technology in the practice of psychotherapy.

Technology could be a friend of the therapist by helping to deliver innovative, time saving, and useful services to patients. But, many clinicians are wary of using technology in psychotherapy. Typical concerns include possible adverse effects on the therapeutic relationship and problems with confidentiality. However, recent advances in computer-assisted therapy and teleconferencing suggest that these tools can be used to promote good working relationships and to augment the therapy process. The most controversial use of technology in psychotherapy is electronic communication with patients via the Internet. The current status of provision of psychiatric services on the Internet is reviewed, and possible future developments are outlined. It is concluded that the "office of the future" may include a broad array of technological advances that could transform the practice of psychotherapy.

No. 13A
COMPUTER TOOLS FOR PSYCHOTHERAPY

Jesse H. Wright, M.D., *Professor of Psychiatry, University of Louisville, Norton Psychiatric Clinic, P.O. Box 35070, Louisville, KY 40232-5070;* Andrew S. Wright, M.D.

SUMMARY:

Newly developed computer tools for psychotherapy emphasize the unique strengths of computers instead of attempting to simulate the dialogue between therapist and patient. A variety of innovative technologies have been used including multimedia, palm top computers, and interactive voice response. These computer programs have been found to be clinically useful and to have high levels of patient acceptance.

This presentation focuses on the use of computer-assisted therapy in clinical practice. After examining the pros and cons of computer-assisted therapy, guidelines are offered for incorporating computer tools in the practice of psychotherapy. A multimedia therapy program for cognitive therapy of depression and anxiety is used to illustrate clinical applications of computer-assisted therapy. This computer program is typically used to teach patients basic concepts of cognitive therapy and to help them master cognitive therapy skills. Computerized reports of progress in using the therapeutic software are used to integrate the work of clinician and computer.

Research studies with this multimedia computer program for cognitive therapy and other forms of computer-assisted therapy are reviewed. Although research is still in an early stage, preliminary evidence suggests that computer-assisted psychotherapy offers significant opportunities for advancing the delivery of psychotherapy services.

No. 13B
PSYCHOTHERAPY OVER THE INTERNET: ISSUES AND DILEMMAS

Mark Wiederhold, M.D., *Scripps Clinic, 1200 Prospect Street, Suite 400, La Jolla, CA 92307*

SUMMARY:

A recent Nielsen survey estimated that over 70 million Americans are now using the Internet to search the World Wide Web from both home and the office. This continually growing number of people has stimulated the offering of a variety of new services such as on-line shopping, banking, and stock and bond purchase. The use of the Internet for access to health care information and services is already well established. This highlights one major concern with Internet content, namely that it is not regulated, and significant information is available that is false or potentially dangerous. With the growing problem of access to mental health care services, particularly in the managed care setting, significant attention has been drawn to utilization of the Internet as a platform for increasing access to these services. Many self-help groups and psychotherapy services are now available, some of which are achieving wide acceptance and popularity. Regulation of these clinical activities is only now being addressed, with the majority of states having only general guidelines for telemedicine and telehealth. Issues of reimbursement, patient confidentiality, and information security remain open.

No. 13C
TELEPSYCHOTHERAPY: WHAT THE PSYCHOTHERAPIST MUST KNOW

Marcia K. Goin, M.D., Ph.D., *APA Board of Trustees Member, and Clinical Professor, Department of Psychiatry, University of Southern California, 1127 Wilshire Boulevard, Suite 1115, Los Angeles, CA 90017-4002*

SUMMARY:

In the world of cyberspace any number of doors are opening to enhance the availability of psychiatric treatment, including psychotherapy. This has many advantages but there are also potential pitfalls for the unwary psychotherapist. This paper will discuss issues of transference and countertransference and how they are enhanced and disguised by the blank screen and the absence of the real person. As one psychiatrist told me, "There is something about a patient's smell that provides a clue as to their state of psychological organization. I know I am limited when that reality check is not available". How to organize treatment in order to diminish the occurrence of related problems is discussed as well as issues of confidentiality, reimbursement, setting limits, suicidal patients, and dealing with families.

No. 13D
TELECONFERENCING FOR PSYCHOTHERAPY SUPERVISION

William R. McFarlane, M.D., *Chair, Department of Psychiatry, Maine Medical Center, 22 Bramhall Street, Portland, ME 04102-3134*

SUMMARY:

Although several new psychosocial treatments for severe mental disorders have been developed over the past two decades, their use has not become routine. Recently, the Center for Mental Health Services has embarked on a large-scale effort to expand the use of these new treatments. Over 40 programs to deliberately influence practice patterns and encourage the adoption of empirically tested approaches are under way nationally. One of those is the Maine Family Support Action Initiative, which is training staff and supporting implementation of psychoeducational multifamily groups on a state-wide basis in Maine. A key barrier to that effort is physical distance: the trainers and supervisors are in some cases more than a six-hour drive from their supervisees. There is little accessibility even by air. In that context the initiative has been using videoconferencing to bring the experts and the new practitioners together on a regular basis. Experience has shown that this new technology carries most of the interpersonal qualities of traditional face-to-face clinical supervision, while allowing the supervisors to see videotaped excerpts of actual sessions and discuss them with the supervisees. It deals with one of the key barriers to adoption of new treatments: trialability. This presentation will describe this new application in detail and present results of this remote version of clinical supervision. Barriers and complexities will also be discussed.

REFERENCES:

1. Wright JH, Wright AS: Computer-assisted psychotherapy. J Psychotherapy Practice and Research 1997; 6:(4)315-329.
2. Huang MP, Alessi NE: The Internet and the future of psychiatry. Am J Psychiatry 1996; 153(7): 861-869.
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Symposium 14 **Sunday, October 31**
2:00 p.m.-5:00 p.m.

TEXAS MEDICATION ALGORITHM PROJECT: UPDATE

Steven P. Shon, M.D., *Medical Director, Texas Department of Mental Health and Mental Retardation, 409 West 45th Street, Box 12668, Austin, TX 78751*

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, participants will be able to explain what psychiatric medication algorithms are and how they are developed, implemented, and their outcomes evaluated. Participants will be able to evaluate the benefits and drawbacks of utilizing medication algorithms to guide treatment in mental health systems.

SUMMARY:

With the introduction of a wide variety of medications for mental disorders, clinicians are now faced with the complex task of determining which medications to begin with, and which to try when initial treatments have failed. Efforts to develop medication algorithms have arisen as a result of this abundance of treatment options, and in response to behavioral health care's growing concern with access to, quality of, and cost of care.

The Texas Department of MHMR has entered into a unique collaboration with Texas medical schools and universities to develop, implement, and evaluate medication algorithms for schizophrenia, bipolar disorder, and major depression—the Texas Medication Algorithm Project (TMAP). TMAP has four phases: (1) development of the algorithms based on scientific evidence and clinical consensus, (2) a feasibility trial, (3) a prospective study of the clinical and economic costs and benefits of algorithms compared with treatment-as-usual, and (4) system-wide implementation.

This symposium reports on our experiences in developing, implementing, and evaluating the algorithms. The presenters will discuss rationale for and methods of developing algorithms, algorithm treatment strategies and tactics, the patient education component, and methods of assessing adherence to and outcomes of algorithm use. Results from the feasibility trial will be presented and a physician's experience with using algorithms will be discussed.

TARGET AUDIENCE:

Practitioners, administrators, academics, and consumers.

No. 14A
ISSUES IN GUIDELINE DEVELOPMENT

M. Lynn Crismon, Pharm.D., *Professor of Psychiatric Pharmacy, College of Pharmacy, University of Texas, 2400 University, 5110 A-1910, Austin, TX 78712;* A. John Rush, M.D.

SUMMARY:

Algorithms provide a structured framework for assisting clinicians in providing care. They are not intended to serve as a substitute for education, training, or clinical expertise, but rather as a tool to facilitate decision making. Evidence-based, consensually driven algorithms are designed to guide decisions, decrease variance in care, and lead to improved outcomes.

Algorithms are composed of strategies (What to do?) and tactics (How to do it?). Strategies progress from relatively simple, easy to implement interventions with extensive evidence toward more complex, perhaps higher risk, interventions based primarily on clinical consensus. Actual implementation of algorithms requires the creation of a treatment environment to facilitate their use. This may require support systems for the clinician, technical assistance, workflow redesign, and patient/family education.

Algorithms are not without potential dangers. Administrators may erroneously consider algorithms as a substitute for clinical judgment or qualified clinicians. In some instances, insufficient evidence exists for evidence-based decisions, and thus clinical consensus may lead to less than optimal outcomes. Thus, algorithms must be evaluated for their validity and ability to produce cost-effective, positive clinical outcomes. Finally, algorithms must be periodically reviewed and updated as new medications and research evidence indicates a need for change.

No. 14B
A SURVEY OF ALGORITHMS FOR THREE MENTAL DISORDERS

Madhukar H. Trivedi, M.D., *Associate Professor of Psychiatry, University of Texas Southwestern Medical Center, 5959 Harry Hines Boulevard, Suite 520, Dallas, TX 75236;* Brandi O'Neal, R.N.

SUMMARY:

In the past, psychiatric research has focused on producing a measurable response to treatment, often defined as a 50% reduction in symptom severity or partial response. While this is a significant improvement, this level of response is clearly not returning the patient to a premorbid state. Additionally, functional outcome is often not assessed in defining response. Therefore, the

goal of treatment should be not only a full remission of symptoms, but also a return to premorbid level of functioning.

The TMAP algorithms have been developed with this objective in mind. Each algorithm is multi-staged, with each stage describing a treatment strategy. Strategies of treatment include decisions regarding which medication to use, when to discontinue a medication, and when to augment. Once a strategy has been selected, the algorithms employ the use of critical decision points in time to determine tactical changes, such as at what dose, at what blood level, and for how long. The earlier treatment stages in each algorithm involve simpler, more routine medications in terms of safety, ease of use, and side-effect profiles, while the later stages utilize more complicated single or combined regimens. Each of the algorithms is accompanied by an implementation manual that describes the rationale for each strategic step and critical decision points that enhance close adherence to the medication algorithms.

No. 14C
PATIENT AND FAMILY EDUCATION

Marcia G. Toprac, Ph.D., *Special Assistant to the Medical Director, Texas Department of Mental Health and Mental Retardation, 909 West 45th Street, Box 12668, Austin, TX 78751*

SUMMARY:

Medications can not achieve their desired effects if the patient does not adhere to the prescribed treatment regimen. Thus, creating a means of enhancing patient adherence was considered critical to the success of algorithm-based treatment. Development of the patient/family education (PFE) component of TMAP was undertaken primarily to address this need. TMAP derives from the philosophy that patients (and families) should be partners with the clinician in treatment planning and implementation. Education about one's illness and about treatment options provides the knowledge that empowers the patient and family to function as true partners in treatment. PFE should not only lead to enhanced partnership/alliance and adherence, but should also improve patient/clinician communication and thereby better clinical decision making.

TMAP PFE was developed by a committee composed of consumers, advocates, and professionals who aimed to create a package that would meet consumer-defined educational needs and preferences. The package includes written materials, illustrations, videotapes, and group activities. The program is phased from basic to more in-depth information. Trained consumers are involved as facilitators of the group activities.

This presentation will describe the rationale and development process for the TMAP PFE and will also describe each of the components of the package and how they are used in the project.

No. 14D
CLINICAL ADHERENCE TO MEDICATION GUIDELINES

A. John Rush, M.D., *Betty Jo Hay Distinguished Chair in Men's Health, and Rosewood Corporation Chair in Biomedical Science, Department of Psychiatry, University of Texas Southwestern Medical Center, 5323 Harry Hines Boulevard, MC 9086, Dallas, TX 75235-9086*

SUMMARY:

Medication and other disease management guidelines have been used in general medicine for some years. Much has been learned about how to help clinicians implement these guidelines, and how to measure (gauge) the degree of adherence.

This presentation will review lessons learned from studies in general medicine relevant to developing clinician adherence to medication guidelines. We will report on the methods used and results obtained in TMAP to help clinicians to learn and to implement medication guidelines. Further, we will review the methods that we have used to determine the degree of adherence and the types of deviations from these guidelines in our feasibility trial conducted with medication guidelines for schizophrenic, major depressive, and bipolar disorders.

Implications for a unified clinical charting system and for the consistent measurement of clinical benefits and side effects in routine care will be discussed.

No. 14E
ASSESSING PATIENT OUTCOMES

Alexander L. Miller, M.D., *Professor of Psychiatry, University of Texas Health Sciences Center, 7703 Floyd Curl Drive, San Antonio, TX 78284-6200*

SUMMARY:

Patient outcomes can be characterized along a number of dimensions, such as symptoms, functionality, resource utilization, and burden of illness on caregivers. In TMAP, measurement of patient outcomes is used in two ways: (1) to quantify the effects of algorithm implementation on clinical diagnostic groups (major depression, schizophrenia, bipolar disorder); and (2) to provide clinicians with data on patient progress that can be used to optimize treatment.

The first part of this presentation will discuss the measures that have been chosen to assess the effects

of algorithm implementation. These outcomes are the independent variables in TMAP. They assess the costs and benefits of using medication algorithms within a system, from clinical, social, and fiscal perspectives. Data on patient outcomes from the pilot phase of TMAP will be presented, illustrating substantial improvements in symptomatology in all patient groups.

The second part of the presentation will focus on the use of clinical outcome measures to guide treatment. The assessment instruments for each disorder will be discussed and examples will be shown of how they are integrated into the clinical decision-making process.

No. 14F
USING ALGORITHMS: A PHYSICIAN'S PERSPECTIVE

Margaret J. Weidow, M.D., *Instructor of Psychiatry, Texas Technical Health Sciences Center, 3601 4th Street, Lubbock, TX 79430*

SUMMARY:

The Texas Medication Algorithm Project has provided a unique opportunity for physicians to experience a new method of planning treatment for persistent mental illness. Although the portion we have been involved with at Texas Tech University Health Science Center is for schizophrenia and this seems to have been the simplest algorithm to apply, the algorithms for major depressive disorders and bipolar disorders are being refined at this time. Our experience has been that the algorithms, far from being restrictive or preventing our use of clinical skills, have freed us to become more involved and to increase the frequency of visits for our patients. The resistance that initially was expressed by many physicians to a "cookbook" approach to treatment was overcome quickly by the improvements noted in our patients and the ease with which we were able to change or add medications during this study. Additionally, the assistance of the clinical coordinator was invaluable in keeping the project on track and the patients participating willingly and for the most part, enthusiastically. We feel that the model, after modifications for major depression and bipolar disorder, can be a new tool for physicians on the cutting edge of psychiatry.

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Symposium 15 — Sunday, October 31 2:00 p.m.-5:00 p.m.

HOW TO WORK WITH WHITE PATIENTS

Ronald J. Diamond, M.D., *Professor of Psychiatry, Mental Health Center of Dane County, 625 West Washington Avenue, Madison, WI 53703*

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium participants will understand that cultural competence is part of all clinical competence, and be better able to work with people from diverse cultures.

SUMMARY:

Cultural competence is often believed to be something that applies only when working with ethnic minorities. The reality is that white people also have a culture that needs to be taken seriously. We all have a sense of values about what kinds of things are most important and what is less. Is it more important to be successful, or be connected with family? We have different beliefs about the causes of illness, and the nature of healing. Does taking medication indicate that one is "really sick" or is medication something that can be useful in a broader range of situations? We have different ways of communicating about feelings, of connecting to other people, of sharing intimacy. Are we direct, or engage in more circumlocution when we disagree with someone? We bring our own experience of traditions and families into the room whatever our skin color or accent. It may be more difficult for two white men to recognize that they have very different cultures than it would be if they looked more different. This symposium will discuss issues of working with culture no matter what the person's ethnicity or skin color. We will point out some special

situations, including the special issues of working with white people in a majority white society.

TARGET AUDIENCE:

Clinicians interested in working with patients different from themselves.

No. 15A
CULTURAL COMPETENCE AS A PART OF CLINICAL COMPETENCE

Ronald J. Diamond, M.D., *Professor of Psychiatry, Mental Health Center of Dane County, 625 West Washington Avenue, Madison, WI 53703*

SUMMARY:

Cultural issues are sometimes believed to be something that can be dealt with by a few questions at the end of an assessment. The reality is that understanding and working with culture is a core part of all clinical competence. For example, many of us are from cultures that value direct communication, "good" eye contact, and independence. We may be working with a patient (or staff person) whose culturally supported way of disagreeing is to be indirect, or where staring is provocative, or where living in family groups and being interdependent is considered a good thing. We may come from a culture and training that teaches us to be "efficient" and "getting right down to business." Our patients may need more time to develop a relationship first. We may come from a culture where conversations are marked by a very brief pause before one person begins talking after another person has stopped, and become frustrated by the extraordinary time it takes a patient to respond to even a simple question. We tend to label such differences as evidence of pathology rather than differences of culture. This paper will discuss what is meant by cultural competence as it applies to normal clinical work. We will discuss the elements of culture that are assessed by chart audits at the Mental Health Center of Dane County, and practical examples using cultural thinking in clinical work.

No. 15B
LIKE WHITE ON RICE: PSYCHIATRY AND WHITE PEOPLE

Kenneth S. Thompson, M.D., *Director, Institute for Public Health and Psychiatry, Western Psychiatric Institute and Clinic, and Former APA/Bristol-Myers Squibb Fellow, 3811 O'Hara Street, Pittsburgh, PA 15213*

SUMMARY:

This paper will examine the concept of "whiteness," the social and personal identity of being "white," and their impact on psychiatric practice. Building on ideas about the dynamics of identity formation in our culture, the process of becoming "white" will be explored. White patients and clinicians are obviously both impacted upon and carry their "whiteness" into the clinical encounter. How do the notions of privilege, power, racism transcendent connection, "tribalism," "rightness"—all historical attributes of "whiteness"—carry themselves into therapy? Can the recognition of the identity of being "white" offer anything to people who are "not of color?" Is it useful in therapy?

After considering these questions the paper will suggest an approach to psychiatric practice that attempts to recognize culture, and "whiteness" in particular, that is both grounded in lived experience and at the same time transcends imposed oppressive social categories and stereotypes.

No. 15C
CLINICAL REALITIES OF WORKING WITHIN A RACIST SOCIETY

Annelle B. Primm, M.D., M.P.H., *Assistant Professor and Director, Community Psychiatry Program, Johns Hopkins University School of Medicine, 600 North Wolfe Street, Meyer 144, Baltimore, MD 21287-7180*

SUMMARY:

This presentation will provide historical perspectives on the subject of racism in psychiatry. The speaker will describe the evolution of racism in psychiatry up to the present. Examples will be presented of clinical manifestations of racism, including racial stereotypes as a basis of transference and countertransference. In addition, the impact of racism and racial bias on engagement in, retention, and satisfaction with psychiatric services will also be discussed. The presentation will conclude with recommendations on how individuals and systems providing mental health care can learn to discontinue practices of racist behavior.

No. 15D
CULTURAL COMPETENCE TRAINING: ACADEMIC AND CLINICAL

Russell F. Lim, M.D., *Clinical Assistant Professor, Department of Psychiatry, University of California at Davis, 601 W. North Market Boulevard, #100, Sacramento, CA 95834*

SUMMARY:

Cultural competence has recently become mandated by two states, California and New York, and WICHE (Western Interstate Commission for Higher Education) has published a set of standards for cultural competence. The RRC (Residency Requirements Committee) guidelines for resident education include a requirement that residents see ethnically diverse clients. Therefore, academic departments of psychiatry and training sites have a mandate to provide culturally competent training and clinical service. At the University of California, Davis (UCD), department of psychiatry, training occurs at many levels, including medical school, psychiatric residency, and mental health service agency. Components of training include demographic information, instruction in the DSM-IV Outline for Cultural Formulation, ethnopsychopharmacology, and presentations on the various ethnic minority groups that would include a brief historical survey, characteristic communication styles, expectations of mental health professionals, ethnic healing beliefs, as well as religious beliefs, and family hierarchies and values.

No. 15E
RECRUITING AND RETAINING CULTURALLY DIVERSE STAFF

Donald A. Coleman, M.S.W., *Program Manager, Mental Health Center Compass Unit, 625 West Washington Avenue, Madison, WI 53703*

SUMMARY:

All individuals represent dimensions of cultural diversity. Cultural diversity by definition includes, but is not limited to, race, gender, sexual orientation, age, religious/spiritual orientation, and partnership status. With that as our foundation, the following questions seem essential regarding recruiting and retaining culturally diverse staff: What makes an organization attractive to culturally diverse workers and once they are on board what kind of organizational culture is conducive to retention of those workers? The obvious answer is that the organization has to value cultural diversity and have that be demonstrated behaviorally and concretely throughout the organization. This is far easier said than done. Truly valuing diversity requires for most organizations and programs significant cultural change. True organizational change is a doting affair at best so that organizations are often open to adding a program here and reorganizing a service there while avoiding significant cultural change. If we are sincerely interested in creating an inclusive work environment, then change of culture is a fundamental requirement. This paper will discuss recruiting and retaining of culturally diverse staff, at the program level and its connection to larger organizational cultural change.

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Symposium 16 **Sunday, October 31**
2:00 p.m.-5:00 p.m.

INNOVATIVE PHARMACY SERVICES IN COMMUNITY MENTAL HEALTH CENTERS

Peter L. Forster, M.D., *Associate Clinical Professor of Psychiatry, University of California at San Francisco, 211 Gough Street, Suite 211, San Francisco, CA 94102*

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to identify strategies for developing a regional psychopharmacology newsletter for local community mental health agencies, define the new patient care roles of clinical psychopharmacology pharmacists, identify the benefits of developing a review process and guidelines for long-term care medication monitoring, recognize how a pharmacy-based drug information service for community psychiatrists can promote the rational and safe use of medication across a system of care, and apply the principles of academic detailing to effectively implement treatment guidelines for community psychiatrists.

SUMMARY:

The delivery of community mental health services has always been based on a team approach, including

psychiatrists, psychologists, social workers, and community workers. The last two decades have witnessed the development of a clinical pharmacy specialty in psychopharmacology. Medication monitoring, consultation, clinical care, supervision of pharmacy students, and administration of medication-related programs are some of the primary roles that clinical pharmacists in mental health fill. This symposium highlights some innovative approaches to improving pharmacy service delivery in community mental health systems.

—We will describe the benefits of a pharmacy-based drug information service that responds to telephone drug information questions regarding mental health drug therapy.

—We will present the review process, guidelines, and database for a long-term care medication monitoring program.

—We will discuss patient care roles of psychiatric pharmacists.

—We will describe the benefits of developing a regional psychopharmacology newsletter that is provided to community mental health center psychiatrists in a large region in Northern California.

—We will discuss "academic detailing," or educational outreach, by pharmacists to community psychiatrists to improve clinical decision-making.

TARGET AUDIENCE:

Psychiatrists, medical directors and clinic administrators.

No. 16A
DEVELOPMENT OF A DRUG INFORMATION SERVICE FOR COMMUNITY PSYCHIATRISTS

Renee Williard, Ph.D., R.Ph., *Drug Information Clinical Coordinator, Community Mental Health Center, San Francisco Department of Public Health, 1380 Howard Street, 2nd Floor, San Francisco, CA 94103*

SUMMARY:

The following describes the benefits of a pharmacy-based drug information service that responds to telephone drug information questions regarding mental health drug therapy. The service (1) provides clinical psychopharmacology consultation for psychiatrists and staff, (2) develops and supports evidence-based drug use policy through comprehensive literature analysis and reviews, and (3) provides pharmacy and therapeutics support through writing drug monographs for evaluation by the formulary committee. Consultations have included dosing and designing drug regimens, evaluation of drug interactions, assessment of adverse drug effects, information on drug stability, drug use in pregnancy and lactation, practice guidelines and treatment algorithms, requests for primary literature, and literature analysis and evaluation. Drug information consultations promote the rational and safe use of medication by analyzing and summarizing recent, relevant, primary drug literature. The drug information service has access to several databases including Medline and PsychInfo for performing literature searches and is available to all prescribers and staff in the San Francisco City and County Community Mental Health Services (CMHS) system. Details of the drug information service, including technical and staff resources and scope of questions received, will be presented.

No. 16B
LONG-TERM CARE MEDICATION MONITORING REVIEW PROGRAM

Sandra H. Suzaki, Pharm.D., *Clinical Pharmacist, Pharmacy Department, San Francisco Community Mental Health Service, 1380 Howard Street, 2nd Floor, San Francisco, CA 94103*

SUMMARY:

The goal of this session is to present the San Francisco Community Mental Health System (CMHS) Long-Term Care Medication Monitoring Program. This review process is part of the Quality Improvement Program, which is designed to ensure that treatment throughout the system meets CMHS standards of care. Chart reviews are performed by a registered clinical pharmacist according to practice guidelines set by CMHS. The review focuses on checking dosages of psychotropic medications and other medications, which relate to the care and outcome of the patient's stay at the facility. Also included in the review is a brief medical and psychiatric history, potential drug-drug interactions, laboratory test results, side effects of medications, and target behaviors. In addition to the conducting of reviews of patients at these facilities, the data collected are entered into a database, which can be accessed by other clinicians in the system. This central database serves to ensure that pertinent medical and psychiatric histories are available to other providers and ensures a smoother transition of care as patients are transferred to other programs or facilities. Details of the review process, guidelines, and database will be presented at the meeting.

No. 16C
PATIENT CARE ROLES OF PSYCHIATRIC PHARMACISTS

Stephen R. Saklad, Pharm.D., *Clinical Associate Professor, Pharmacotherapy Department, University of Texas*

Health Sciences Center at San Antonio, 7703 Floyd Curl Drive, San Antonio, TX 78284-6220

SUMMARY:

Psychiatric pharmacy practice has developed to fill a variety of roles in public and private sector mental health care. In the past few years, psychiatric pharmacy has become a recognized specialty area in pharmacy, and there are now hundreds of board-certified practitioners. Psychiatric pharmacists provide services at many levels in mental health agencies. These services range from the traditional pharmacy role of drug use control and formulary management, to providing direct patient care under the supervision of a psychiatrist. The patient care roles of psychiatric pharmacists that are part of the University of Texas Psychiatric Pharmacy Program will be reviewed and evaluation data presented showing the impact of these services.

No. 16D
DEVELOPMENT AND INITIATION OF A PSYCHOPHARMACOLOGICAL NEWSLETTER

Gary L. Viale, Pharm.D., B.C.P.P., *Assistant Director of Pharmacy, Santa Clara Valley Health and Hospital System, 2221 Enborg Lane, San Jose, CA 95128*

SUMMARY:

The following describes the benefit of the development and initiation of a psychopharmacology newsletter by community mental health agencies and the importance of creating such newsletters in other areas of the United States. In 1996 it was determined by the San Francisco Bay Area's medical directors and pharmacy directors that there was not a structured way for the mental health community to collaborate. As a result of meetings between four counties (Alameda, San Francisco, San Mateo, and Santa Clara County) The Bay Area Psychopharmacology Newsletter was created. The newsletter is published quarterly with four pages of general articles relevant to all four counties, and a two-page insert written by each individual county with material specifically relevant to that county. Other national community mental health centers could also benefit from forming their own collaborative newsletter, enabling them to bridge the gap between the research literature available in journal articles and the local clinical world that each practitioner works in. Articles could range from collaborative naturalistic outcome results of the new atypical antipsychotic medications in the specific counties to formulary issues specific to each county. Other articles might include new medications and indications and psychopharmacology and psychotropic therapeutic questions for the editor.

No. 16E
ACADEMIC DETAILING OF COMMUNITY PSYCHIATRISTS

Peter L. Forster, M.D., *Associate Clinical Professor of Psychiatry, University of California at San Francisco, 211 Gough Street, Suite 211, San Francisco, CA 94102*

SUMMARY:

Increasing costs of medications and disparities in psychiatrists' prescribing practices underscore the importance of ensuring that drugs be prescribed in a way that maximizes effectiveness, minimizes risks and costs, and respects patient choices. There is a broad degree of support in the literature for the idea that the pharmaceutical industry's marketing strategies, also known as detailing, can serve as a practical model for implementing the most effective treatment guidelines. While there are significant differences between pharmaceutical marketing and medical education, many "drug rep" techniques are adaptable to such aims.

This presentation discusses the principles of academic detailing, or educational outreach, by pharmacists to educate community psychiatrists in the implementation of treatment guidelines. Academic detailing by pharmacists entails (1) understanding the rationale and motivation behind psychiatrists' current prescribing patterns, (2) delineating concise educational and behavioral goals, (3) eliciting active psychiatrist participation in instructional meetings, (4) emphasizing and repeating the essential messages, and (5) affirming improved practices at follow-up visits.

The San Francisco Community Mental Health Services Pharmacy has established guidelines for the utilization of atypical antipsychotics, antidepressants, and mood stabilizers. In the context of our discussion on academic detailing, this presentation will highlight how these recommendations have been put into practice for psychiatrists in San Francisco's community mental health centers.

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Symposium 17 **Monday, November 1**
8:30 a.m.-11:30 a.m.

THE PRACTICE OF NON-URBAN ADDICTION PSYCHIATRY

Carl R. Sullivan III, M.D., *Associate Professor, Departments of Behavioral Medicine and Psychiatry, West Virginia University School of Medicine, 930 Chestnut Ridge Road, Morgantown, WV 26505*

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to: 1) identify relevant psychological, social, and physiological signs and symptoms of alcohol and other drug abuse and dependence through utilization of appropriate screens and consideration of comorbidity possibilities; 2) identify several approaches to dealing with resistance, denial, and other defense mechanisms that inhibit successful treatment referral; 3) identify several treatment options for alcohol and drug dependence (including nicotine dependence) and assist patients in considering the most appropriate choice; 4) identify strategies to assist family members in dealing with the impact of addiction, relapse, and recovery in their own lives.

SUMMARY:

Many patients have either primary addictive disorders or associated comorbidity. Treating these patients in a non-urban setting where resources may be limited can be difficult and frustrating. The presentations will overview areas of practical application including: (1) identifying the hidden alcoholic, (2) common problems of comorbidities e.g., depression, anxiety, chronic pain, thought disorders, (3) usefulness of disulfuram and naltrexone, (4) screening instruments in addiction treatment, (5) motivating patients to treatment, (6) dealing with resistance and denial, and (7) treating the nicotine-dependent patient.

No. 17A
SCREENING AND MOTIVATING TO TREATMENT

Marilyn Byrne, A.C.S.W., *Associate Professor, West Virginia University School of Medicine, 930 Chestnut Ridge Road, Morgantown, WV 26505;* Robert Edmundson, M.S.W.; Eric Rankin, Ph.D.; Carl R. Sullivan III, M.D.

SUMMARY:

The speaker will review existing screening instruments and consider pros and cons for each. Motivating to treatment or self-help can happen rapidly or be a lengthy individualized process. A variety of motivation techniques will be presented. In addition involvement of family which can help, hinder, or actually constitute at least a part of the treatment will be considered.

No. 17B
DEALING WITH DENIAL AND RESISTANCE

Robert Edmundson, L.C.S.W., *Assistant Professor, West Virginia University School of Medicine, 930 Chestnut Ridge Road, Morgantown, WV 26505;* Marilyn Byrne, A.C.S.W.; Eric Rankin, Ph.D.

SUMMARY:

Denial/resistance is a defense mechanism familiar in all of psychiatry. Denial is common among the addicted population for several reasons. Thus, referral for treatment often is difficult and unsuccessful until severe consequences have occurred. A non-urban population can present different challenges to a treating professional. This presentation will focus on the issues of denial/resistance in the non-urban addicted population. Topics covered include defense mechanisms, specific to addiction, non-urban cultural factors, gender considerations and guidelines for dealing with denial/resistance.

No. 17C
TREATING THE NICOTINE-DEPENDENT PATIENT

Elbert D. Glover, Ph.D., *Professor, West Virginia University School of Medicine, 930 Chestnut Ridge Road, Morgantown, WV 26505;* Penny Glover, M.Ed.

SUMMARY:

This presentation with accompanying question and answer period will review the biology of addiction, the addictive potential of nicotine, and discuss the latest management options for treating the nicotine dependent

patient. The Food and Drug Administration's (FDA) approved nicotine replacement therapies will be reviewed, i.e., nicotine polacrilex (2 mg and 4 mg), nicotine transdermal patches (16 and 24-hr), the nicotine nasal spray, and the nicotine oral inhaler. In addition, the only non-nicotine smoking management option approved by the FDA will be discussed in detail, i.e., bupropion SR (an antidepressant). Moreover, a quick review of the investigational drugs currently being reviewed by the FDA and other tobacco cessation researchers for smoking cessation will be noted. Finally, effective brief counseling strategies suggested by the Agency for Health Care Policy and Research will be reviewed.

REFERENCES:

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Symposium 18 **Monday, November 1**
8:30 a.m.-11:30 a.m.

MEDICATION ADHERENCE: CONSUMER AND FAMILY PERSPECTIVE

Christopher S. Amenson, Ph.D., *Director of Training Institute, Pacific Clinics, 909 South Fair Oaks Avenue, Pasadena, CA 91105;* Alex J. Kopelowicz, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to recognize 40 factors related to medication nonadherence and implement some of the 40 consumer and family interventions that promote adherence.

SUMMARY:

Nonadherence to medication regimes is the most frequent cause of relapse and rehospitalization for psychotic disorders. This symposium presents the perspectives of consumers and families on antipsychotic medication, recent research on adherence, and interventions to promote cooperation with medication regimes.

A consumer and a family member will describe the views of consumers and families on medications and methods for engaging consumers and families as collaborators. Drs. Amenson and Kopelowicz will integrate this phenomenology with recent research findings on adherence to medication regimes. The audience will engage in structured role plays that frame medication as a means toward a consumer's goals and explore the options that families have if their consumer is nonadherent. Case examples will be used to illuminate the criteria used to match the intervention strategy to the situation.

Psychiatrists will leave the symposium with (a) a conceptual integration of consumer/family perspectives and recent research findings on medication adherence, and (b) a list of 40 interventions that engage consumers and families as partners in implementing medication regimes.

TARGET AUDIENCE:

Psychiatrists and other professionals.

No. 18A
CONSUMER PERSPECTIVES ON ANTIPSYCHOTIC MEDICATIONS

Jason West, A.A., *Teaching Assistant, Training Institute, Pacific Clinics, 909 South Fair Oaks Avenue, Pasadena, CA 91105*

SUMMARY:

Mr. West will bring a variety of consumer perspectives to illuminate the factors and interventions that promote adherence to medication regimes. He will present a broad range of consumer views of medication from his experiences of recovering from schizophrenia, establishing a clubhouse program, teaching consumers about their illness, and training professionals to engage and collaborate with consumers. He will use vivid examples to promote a deep understanding of consumers' experience of antipsychotic medications and their reasons for adhering or not adhering to medication regimes. He will help psychiatrists to ally with consumers' life goals of work, friendship, intimacy, mutual interdependence with others, and contribution to society Medication and symptom reduction are not viewed by consumers as life goals; rather, they are seen as methods of reducing barriers to achieving the life goals that all people share.

A recent controlled study demonstrated that "compliance therapy" could improve clinical and functional outcomes. Finally, Mr. West will present the results of this study from a consumer's prospective. This understanding will enhance the relationship factors that increase the acceptance and effectiveness of research-based interventions.

No. 18B
COLLABORATION WITH CONSUMERS TO PROMOTE ADHERENCE

Alex J. Kopelowicz, M.D., *Assistant Professor of Psychiatry, University of California at Los Angeles School*

of Medicine, 15535 San Fernando Mission Boulevard, Mission Hills, CA 91345

SUMMARY:

Dr. Kopelowicz will draw from his research, the published literature, and his clinical experience to discuss the specific interventions that psychiatrists and other mental health professionals can use to foster a therapeutic alliance with consumers of mental health services. He will present a list of 20 best-practice techniques to promote adherence to medication regimes and the research that supports each intervention. Building on the phenomenological information presented by Mr. West, Dr. Kopelowicz will integrate technical interventions with therapeutic alliance factors that promote the effectiveness of the interventions. He will describe the selection, timing, and interpersonal process of implementing interventions. These factors enhance the consumer's acceptance of, and collaboration with interventions. Over time, informed consumers, families, and psychiatrists can become an interdependent team that discovers, implements, and modifies medication regimes to reduce the symptom barriers to the consumer's goals. At the conclusion of his presentation, Dr. Kopelowicz will lead the audience in a discussion and a structed role play to help them integrate and practice the consumer interventions that promote adherence to medication regimes.

No. 18C
FAMILY CONTRIBUTIONS TO MEDICATION ADHERENCE

Rita Murray, B.A., *Teaching Assistant, Training Institute, Pacific Clinics, 909 South Fair Oaks Avenue, Pasadena, CA 91105*

SUMMARY:

Ms. Murray will present family factors that promote or interfere with adherence to medication regimes. She will describe a broad range of family views from her experiences having several relatives with psychotic mood disorders, teaching families in the NAMI Family to Family program, and training professionals to engage and collaborate with families. She will use vivid examples to promote a deep understanding of family attitudes toward, and experience with, antipsychotic medications. She will help psychiatrists to ally with both the consumer's and the family's goals and to help families and consumers identify and work toward shared goals. Psychiatrists will learn psychoeducational methods for teaching families about mental illness so families can educate and influence consumers to accept their illness and cooperate with treatment. Ms. Murray will present ways that psychiatrists and families can cooperate to persuade or coerce consumers to take prescribed medication. The emphasis of these interventions are on a long-term plan that coordinates inpatient, outpatient, legal, and family interventions to restore consumers to states from which they can make truly informed choices.

No. 18D
COLLABORATION WITH FAMILIES TO PROMOTE ADHERENCE

Christopher S. Amenson, Ph.D., *Director of Training Institute, Pacific Clinics, 909 South Fair Oaks Avenue, Pasadena, CA 91105*

SUMMARY:

Dr. Amenson will draw from the published literature and his clinical experience and writings to describe family interventions that psychiatrists can use to develop a consumer-family-psychiatrist collaboration to promote medication as a means to achieve consumer goals. Building on Ms. Murray's presentation, he will first describe methods for increasing families' understanding of mental illness and of the perspectives of professionals and consumers on medication and other treatments. He will present 14 family interventions that promote the family's acceptance of medication, enhance their ability to join with and influence their loved one to adhere to medication regimes, and understand their roles in facilitating communication between the consumer and psychiatrist.

For situations in which joining interventions fail and the consumers reject needed medication, Dr. Amenson will describe family interventions that psychiatrists can use to persuade or coerce the consumer to take prescribed medication. Emphasis will be placed on assisting families in joining with the newly stabilized consumers to promote long-term adherence. Dr. Amenson will lead the audience in a discussion and a structured role play to help them integrate and practice family interventions that promote adherence to medication regimes.

REFERENCES:

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Symposium 19 **Monday, November 1**
2:00 p.m.-5:00 p.m.

CULTURAL COMPETENCE IN COMMUNITY PSYCHIATRY

American Association of Community Psychiatrists
Andrés J. Pumariega, M.D., *Professor and Chair, Department of Psychiatry and Behavioral Sciences, James H. Quillen College of Medicine, East Tennessee State University, P.O. Box 70567, Hillrise Hall, Johnson City, TN 37614-9567;* Annelle B. Primm, M.D., M.P.H.

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant will have (1) learned the conceptual and empirical basis for cultural competence, (2) cultural aspects of illness expression, beliefs, and behaviors of different minority populations in different illnesses, (3) how to treat diverse populations and the basics of organizing culturally competent services.

SUMMARY:

Community psychiatry, by its very basis on work in public settings with undeserved populations, involves extensive contact with culturally diverse populations. In previous years, generic approaches were developed by leaders in the field to address the needs for community-based services for the seriously mentally ill. However, in recent years, specialized approaches have been developed to address the special mental health needs of culturally diverse populations. The needs of culturally diverse populations have become acute given their significant growth all across the nation, especially in large states such as New York, California, and Texas but also across the South and Midwest. The conceptual basis for the development of specialized services approaches has been well established through the principles of culturally competent services. These include increased knowledge about diagnostic factors, specialized therapeutic techniques, and service models which incorporate diverse cultural values and beliefs. This symposium will present various examples of advances toward culturally competent, community-based mental health services. It will begin with a conceptual overview of the principles of cultural competence in mental health services and selected research examples of culturally based diagnostic and treatment differences which illustrate these principles. Three presentations will focus on special diagnostic issues among African Americans, Hispanics, and Arab Americans. The organization and successes of a model multicultural community mental health service will also be presented.

No. 19A
CULTURAL COMPETENCE: CONCEPTUAL AND RESEARCH BASIS

Andrés J. Pumariega, M.D., *Professor and Chair, Department of Psychiatry and Behavioral Sciences, James H. Quillen College of Medicine, East Tennessee State University, P.O. Box 70567, Hillrise Hall, Johnson City, TN 37614-9567*

SUMMARY:

The principles of cultural competence in mental health services were first proposed by Cross, Bazron, Dennis, and Isaacs (1989). They proposed that the knowledge base, skills, and attitudes needed to effectively serve culturally diverse populations could be identified and developed. This began to move the field beyond cultural sensitivity and toward concrete steps and actions to effectively serve culturally diverse populations. This presentation reviews the conceptual basis for the principles of cultural competence as well as specific areas of clinical knowledge, skills, and competencies, and attitudes needed by practitioners. The organizational and policy adaptations needed in order to achieve cultural competence in community-based systems of care are also reviewed. The presenter will also review research on risk factors, diagnostic bias, and service utilization conducted with Hispanic and African-American adolescent populations to illustrate many of the principles of cultural competence.

No. 19B
TREATMENT OF DEPRESSION IN AFRICAN AMERICANS

Annelle B. Primm, M.D., M.P.H., *Assistant Professor and Director, Community Psychiatry Program, Johns Hopkins University School of Medicine, 600 North Wolfe Street, Meyer 144, Baltimore, MD 21287-7180*

SUMMARY:

Mental health providers who work with African Americans in community mental health settings must be able to recognize and treat depression in this population.

There is considerable evidence that depressive disorders are often missed in African Americans, particularly in young people resulting in inappropriate or inadequate care. African-American cultural beliefs and attitudes influence a number of areas, including conceptions of mental illness, expression of psychopathology, acceptance of mood disorder diagnoses, and compliance with treatment. This presentation is designed to educate health care professionals about how cultural factors mediate the presentation and course of mood disorders in African Americans and how culturally competent care can produce beneficial outcomes of treatment. It will also define parameters for skills, knowledge, and attitudes needed for non-African-American practitioners to effectively serve African Americans dealing with depressive illness.

No. 19C
ANXIETY AND SOMATIZATION IN HISPANIC AMERICANS

César E. Muñoz-Carbone, M.D., *Assistant Professor of Psychiatry, University of Alabama at Birmingham, 908 20th Street South, Birmingham, AL 35294*

SUMMARY:

Hispanics are the fastest rising minority group in the United States, with current projections for their becoming the largest minority group in the United States in the next 20 years. Many communities in California, Texas, the Southwest, and the Northeast already have Hispanic majorities. In spite of this, little attention is paid to the special mental health needs of Hispanics. Although anxiety disorders have been identified as the most prevalent psychiatric disorders among Americans, little attention has been given to their even higher prevalence and special presentation among Hispanics. Somatization is a hallmark symptom for the presentation of anxiety disorders in Hispanics. Additionally, there are a number of culture-bound syndromes in different Hispanic populations, which are anxiety disorder variants, such as susto and ataque de nervios. This presentation will review the epidemiological data available about anxiety disorders in Hispanics. It will also review the presentation of anxiety disorders in Hispanics through somatization or cultural-bound variants, and effective biological, psychological, and folk treatment modalities for anxiety disorder treatment with this population.

No. 19D
CULTURAL FACTORS IN ARAB-AMERICAN MENTAL HEALTH

Nael Kilzieh, M.D., *Clinical Instructor, University of Washington, and Staff Psychiatrist, Veterans Affairs Puget Sound Health Care System, 116-MHC, Tacoma, WA 98493*

SUMMARY:

Arab Americans are one of the least visible but fastest rising minority groups in the United States. There has been very limited study of Arab Americans in our health care system. Information regarding cultural background, illness behavior, and attitudes toward seeking health care is important to understand in order to provide appropriate and effective services to this rising population. This presentation will review such information. For example, close family ties are predominant in this community. The extended family provides most of the needed social support network. Care should be taken in order not to interpret this closeness as pathological "poor boundaries." Privacy regarding personal information is highly guarded, so detailed clinical interviews are viewed as intrusive. Establishing trust over time is crucial to obtaining such information. In Middle Eastern culture, patients delegate decision making to providers, and this is important when making recommendations. Mental health care is less frequently sought, and highly prevalent stigma is a major deterrent. Furthermore, the prospect of losing privacy by revealing private information required for such treatment compounds this problem. Prevalent mental health concerns in these communities will be discussed, with recommendations on how to interact with this population.

No. 19E
CULTURALLY COMPETENT SERVICE AND TRAINING IN A COMMUNITY MENTAL HEALTH CENTER

Russell F. Lim, M.D., *Clinical Assistant Professor, Department of Psychiatry, University of California at Davis, 601 W. North Market Boulevard, #100, Sacramento, CA 95834*

SUMMARY:

Northgate Point RST (Regional Support Team), a community mental health center (CMHC) represents a model for the development of culturally competent clinical services. It is a cooperative venture between the University of California, Davis (UCD), Turning Point RTP (Residential Treatment Programs), the Division of Mental Health, Sacramento County, SAAC (Southeast Asian Assistance Center), and APCC (Asian Pacific Counseling Center). Northgate's catchment area has unique ethnic diversity, which requires translation for over 12 languages. Four half-time personal service coordinators (PSCs) from both APCC and SAAC provide culturally appropriate care in the following languages: Cambodian, Cantonese, Hmong, Korean, Japanese, Lao-

tian, Mandarin, Mien, Russian, Spanish, Tongan, Ukranian, and Vietnamese. The UCD collaboration allows UCD trainees to work directly with culturally diverse patients complementing their lectures on culture and psychiatry with clinical experiences. The PSCs themselves are excellent resources, being cultural consultants for clinicians whose clients have similar backgrounds to the coordinator. Collaboration with UCD provides research opportunities in outcome studies. The National Research Center for Asian American Mental Health at UCD, a National Institutes of Mental Health-funded research center, provides consultants, such as statisticians and psychologists. Thus, the collaboration of five agencies creates a multidisciplinary, culturally competent CMHC for indigent mentally ill that also serves as a site for training and research. The presenter will focus on the developmental process for this collaborative program and its current work in new programs and knowledge.

REFERENCES:

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Symposium 20 **Monday, November 1**
2:00 p.m.-5:00 p.m.

THE 1999 SURVIVAL GUIDE FOR MENTAL HEALTH SYSTEMS

David C. Lindy, M.D., *Clinical Director and Chief Psychiatrist, Community Mental Health Services, Visiting Nurse Service of New York, and Associate Clinical Professor of Psychiatry, College of Physicians and Surgeons, Columbia University, 1250 Broadway, Third Floor, New York, NY 10001;* Neil Pessin, Ph.D.; Ronald J. Diamond, M.D.; Alan Rosen, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be knowledgeable about the survival of mental health organizations in various locations and know how to build upon the strengths of their own organizations and how to address concerns. Participants will have the opportunity to ask questions about their own organizations.

SUMMARY:

Every mental health system faces many challenges over the course of its life span. Program inception, growing pains, and maturity present issues specific to each developmental phase. The creation of a new program is often driven by the vision and will of a charismatic leader. However, if that program is to become successfully institutionalized as an ongoing service, clinical and administrative structures must replace charismatic vision. The survival of the mature mental health system requires the continuous negotiation of evolving relationships between service providers, parent agencies, universities, government, and, more recently, managed care organizations. Systems that thrive, as well as survive, employ a dynamic interplay between vision, pragmatics, and openness to new approaches and opportunities. These qualities are uniquely important in our current age of tumultuous change within health care.

In this symposium, three directors whose vision has shaped their very different mental health systems will discuss the clinical mission and administrative structures of their systems, and current systemic problems and challenges confronting them. In "Becoming Real: From Model Programs to Implemented Services," Rosen, Diamond, et al provide a framework for assessing the organi-

zational well-being of mental health systems. We expand the usual role of symposium discussant here so that Drs. Rosen and Diamond function as a team of system consultants to address the questions of the service directors. At the conclusion, audience members will be invited to discuss their systems with the consultants and presenters.

TARGET AUDIENCE:

Mental health administrators and any practitioner or consumer involved in the mental health system.

No. 20A
CAN MENTAL HEALTH COEXIST WITH HOME CARE?

Neil Pessin, Ph.D., *Director, Community Mental Health Services, Visiting Nurse Service of New York, 1250 Broadway, Third Floor, New York, NY 10001;* David C. Lindy, M.D.

SUMMARY:

The Visiting Nurse Service of New York (VNS) is the largest certified home health care agency in the United States. For over 100 years. VNS has delivered care in the homes of New Yorkers, regardless of ability to pay. From the beginning, its deep commitment to New York's neediest has been central to its public health mission. In 1986, VNS Community Mental Health Services (CMHS) was started with two mobile crisis teams. Today, CMHS has grown to a series of 22 community-based mental health outreach programs operating throughout New York City, all krut together by the VNS tradition of home care and public health. These programs have been successful in furthering the VNS public health mission by delivering mental health services to New York's most disenfranchised seriously and persistently mentally ill.

However, changes in the reimbursement environment for both home care and psychiatric care present pressing new challenges. Managed care and shrinking federal dollars for home health care have created pressures within VNS such that its relatively small mental health "business" has become less of a priority within the agency. At the same time, New York State is introducing Medicaid managed care for public sector mentally ill clients. This sea change in funding for CMHS's clients provides a potential crucial new opportunity for VNS. We would like to discuss with the consultants how best to navigate this important clinical, administrative, and political challenge.

No. 20B
CRISIS IN THE MOBILE CRISIS PROGRAM IN CHARLESTON, SOUTH CAROLINA

Joseph J. Zealberg, M.D., *President of the American Association for Emergency Psychiatry, and Associate Professor of Psychiatry, Medical University of South Carolina, 171 Ashley Avenue, Charleston, SC 29425-0001*

SUMMARY:

The Charleston EPS/Mobile Crisis Program was a collaboration of the mental health center and the Medical University in Charleston, South Carolina. This public-academic organization was started in 1987, and was the only mobile crisis unit in the state. Since its inception, it has evaluated over 23,000 patients and fielded over 200,000 telephone crisis calls. Close ties were formed with hospitals, schools, police, EMS, political leaders, businesses, and police chaplains. Due to funding and other changes, the emergency service was merged with the mental health center's intake service. However, due to differences in programmatic and clinical philosophy, the new model encountered grave difficulties, and the new service was terminated within several months. This presentation will focus on the response of the community, the medical university, and medical center residents, and how the future growth and direction of mental health crisis services in the Charleston area has since progressed.

No. 20C
SURVIVING WITHIN A STATE MENTAL HEALTH SYSTEM

Francine Cournos, M.D., *Professor of Clinical Psychiatry, Columbia University, 722 West 168th Street, Unit 12, New York, NY 10032;* Richard Herman, M.A.

SUMMARY:

The Washington Heights Community Service (WHCS) provides psychiatric care to residents of a largely poor, ethnically diverse neighborhood located at the northern tip of Manhattan. Operating for 27 years, WHCS serves 950 patients annually who receive care from two satellite outpatient clinics and a 22-bed inpatient unit located in the New York State Psychiatric Institute (PI). WHCS is administratively part of both the New York State Office of Mental Health (OMH) and Columbia University's Department of Psychiatry. Like many state mental health systems in recent years. OMH has been divesting itself of direct clinical services. Working within the state system. WHCS has been able to

successfully demonstrate the importance of its clinical service to state authorities looking to cut services.

Elements of this success have included a particular leadership team. WHCS's association with PI and Columbia, and adapting clinical interventions to a new immigrant Latino population. WHCS's most important challenge for the future involves the near inevitable loss of OMH funding. The question for the consultants is how to create new viable funding streams while preserving WHCS's clinical vision and surviving what will most probably be a profound cultural shock for the system's identity.

REFERENCES:

1. Rosen A, Diamond RJ, Miller V, Stein LI: Becoming real: from model programs to implemented services. New Directions for Mental Health Services 1997; 74:27-41.
2. Zang SM, Bailey NC: Home Care Manual, Making the Transition. New York, Lippincott, 1997.
3. Zealberg JJ, Santos A: Comprehensive Emergency Mental Health Care. New York, Norton and Co., Inc., 1996.
4. Breakey WR: Integrated Mental Health Services. New York, Oxford University Press, 1996.

Symposium 21 **Monday, November 1**
2:00 p.m.-5:00 p.m.

ABUSE, ATTACHMENT AND TRAUMA IN PRESCHOOLERS

Michael S. Scheeringa, M.D., *Assistant Professor of Psychiatry, Tulane University, 1440 Canal Street, TB-52, New Orleans, LA 70112*

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to demonstrate knowledge of current methods of assessment of infants and toddlers, diagnose PTSD and attachment disorders in young children, and learn the treatment fundamentals.

SUMMARY:

The field of infant psychiatry has made substantial advances in the last five years with data-based, empirical group studies of clinical samples and creation of assessment and treatment models that can inform office practice with confidence. This symposium presents several leading edges of research and clinical practice from a group of researcher-clinicians who have collaborated together in a series of projects with infants and toddlers. First, Dr. Larrieu presents the model of an infant team that systematically assesses, makes recommendations to the court, and treats maltreated young children in foster care. Second, Dr. Zeanah presents the latest outcome data on this team's intervention efforts with maltreated young children and their families. Third, Dr. Boris reviews the research on childhood attachment disorders and discusses treatment. Fourth, Dr. Scheeringa reviews the research on posttraumatic stress disorder in infants and toddlers and discusses treatment. The presentation is aimed at general psychiatry practitioners who occasionally see young children and at trainees who are being introduced to infant psychiatry. This information is also useful for clinicians who see adults who have children with problems that may impact on their own well-being.

TARGET AUDIENCE:

General practitioners who have young children as patients.

No. 21A
ASSESSMENT AND INTERVENTION FOR MALTREATMENT

Julie A. Larrieu, Ph.D., *Associate Professor of Psychiatry, Tulane University Medical Center, 1440 Canal Street, TB-52, New Orlenas, LA 70112*

SUMMARY:

Intensive intervention is imperative in cases of severe abuse and neglect. The timeline for permanency planning is particularly important for very young victims of maltreatment, whose development is greatly impacted by the caregiving environment. This presentation describes an intervention program for maltreated infants (from birth to 47 months) and their parents. Division of child psychiatry faculty members and trainees staff the program. Comprehensive evaluation of the maltreated children with their biological and foster parents is conducted. The assessment includes a caregiver perception interview, which measures memories and representations of the relationship, a caregiver-child interaction procedure, clinical interviews, and a variety of paper and pencil measures. A determination of family strengths as well as risk factors that predict maltreatment recidivism is made. The team then develops specific recommendations regarding what would be required to return the child to the biological parents. This information is presented to child protection personnel and the juvenile court judge. A variety of psychotherapeutic interventions are instituted to assist the family in achieving treatment goals. The ultimate goals of the team are to expedite permanency planning, increase continuity in high-quality foster placements, and increase court satisfaction with mental health consultation. This approach integrates delivery of services to the youngest victims of maltreatment.

No. 21B
OUTCOME OF INTERVENTION FOR MALTREATED INFANTS

Charles H. Zeanah, Jr., M.D., *Professor of Psychiatry and Pediatrics, and Director of Child and Adolescent Psychiatry, Tulane University School of Medicine, 1440 Canal Street, TB-52, New Orleans, LA 70112*

SUMMARY:

For very young children the effects of serious maltreatment are compounded by disruptions of attachment and placement in foster care. For this reason quick resolution of foster care either by return of children to their parents or by freeing them for adoption is developmentally advantageous.

This presentation describes outcome data regarding efficacy of a comprehensive psychiatric services program designed to reduce time that infants and toddlers (less than 48 months old) are in care and to reduce recidivism (subsequent maltreatment). The program is staffed by medical school faculty, based in a community mental health center, and funded by state and private funds. Program staff evaluate and treat all children less than 48 months old who are adjudicated as "in need of care" in a specific geographic area (population about 500,000).

The effectiveness of this program is being assessed by comparing lengths of time in care and rates of recidivism from 1991 to 1994 (before the program began), and from 1995 to 1998 (since the program began). In addition, the proportion of the children who were returned versus those freed for adoption will be examined. Results will be discussed with regard to the need for effective services for the youngest and most vulnerable children experiencing maltreatment.

No. 21C
INFANT PSYCHOPATHOLOGY? CAPTURING ATTACHMENT DISORDERS

Neil W. Boris, M.D., *Assistant Professor of Psychiatry, Tulane University, 1440 Canal Street, TB-52, New Orleans, LA 70112*

SUMMARY:

Reactive attachment disorder of infancy or early childhood (RAD) was introduced in DSM-III (1980). There have been no controlled studies of this disorder, despite considerable descriptive research on maltreated and institutionalized children from which the revised criteria of DSM-IV evolved. This presentation will use videotaped segments of evaluations of high-risk young children to bring RAD alive for the audience. These segments will serve to introduce the diagnostic criteria for the disorder and introduce some of the controversies regarding the criteria. A model for assessment of RAD will be presented and selected issues in treatment will be reviewed. Discussion will include the relevance of this disorder for psychotherapy of adult patients who may have a history of early disruption of attachment.

No. 21D
PTSD IN INFANTS AND TODDLERS

Michael S. Scheeringa, M.D., *Assistant Professor of Psychiatry, Tulane University, 1440 Canal Street, TB-52, New Orleans, LA 70112*

SUMMARY:

Advances in diagnostic assessment and current concepts in the treatment of infants and toddlers with posttraumatic stress disorder (PTSD) will be presented. A series of studies by the author and his colleagues have examined the diagnostic validity of PTSD in very young children. The types of events that can be traumatic to very young children will be discussed, including the evidence that has shown that the type of event that is most traumatic to young children is witnessing a threat to their caregivers. Variables of traumatic events (such as acute versus repeated, or direct versus vicarious exposure) lead to differential expression of symptoms. A set of alternative criteria has shown greater validity for making the diagnosis compared with the DSM-IV criteria. The procedural validity of a standardized assessment paradigm, including a semistructured interview and five observational/interaction sequences, has been examined for the optimal office- and research-based assessment procedure. A model for treatment will be presented in practical, useful detail. Relevant, emerging concepts of memory and psychobiological dysregulation following trauma in young children will be highlighted. The data will be supplemented and illustrated with brief clinical case descriptions.

REFERENCES:

1. Larrieu JA, Zeanah CH: Intensive intervention for maltreated infants and toddlers in foster care. Child and Adolescent Psychiatric Clinics of North America 1998; 7:357-371.
2. Zeanah CH, Larrieu JA, Valliere J, Heller SS: Relationship assessment, in Handbook of Infant Mental Health, 2nd Edition. Edited by Zeanah C. New York, NY, Guilford Press, in Press.
3. Larrieu JA, Zeanah CH: Intensive intervention for maltreated infants and toddlers in foster care. Child and Adolescent Psychiatric Clinics of North America 1998; 7:357-371.
4. Boris NW, Zeanah CH, Larrieu JA, Scheeringa MS, Heller SS: Reactive attachment disorder of infancy

and early childhood: a preliminary investigation of diagnostic criteria. American Journal of Psychiatry 1998; 155:295-297.
5. Boris NW, Zeanah CH: Reactive attachment disorder of infancy and early childhood, in Comprehensive Textbook of Psychiatry/VII. Edited by Kaplan HI, Saddock BJ. New York, Williams and Wilkins, in press.
6. Scheeringa MS, Zeanah CH, Drell MJ, Larrieu JA: Two approaches to the diagnosis of posttraumatic stress disorder in infancy and early childhood. Journal of the American Academy of Child & Adolescent Psychiatry 1995; 34(2):191-200.
7. Scheeringa MS, Zeanah CH: Symptom expression and trauma variables in children under 48 months of age. Infant Mental Health Journal 1995; 16(4):259-270.

Symposium 22 **Tuesday, November 2**
8:30 a.m.-11:30 a.m.

WORK AND OUTCOME FOR PEOPLE WITH SEVERE MENTAL ILLNESS

Peter J. Huxley, Ph.D., *Professor of Psychiatry, University of Manchester, Maths Building, Oxford Road, Manchester, England M13 9PL;* Sherrill H. Evans; Tom Sorensen, M.D., Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to understand the range and types of work scheme available and understand the research evidence for their effectiveness; and recognize the nature of positive outcomes of work for severely mentally ill people in different schemes.

SUMMARY:

Work schemes for people with severe mental illness can have a profound effect on their lives. There is a growing base of research evidence, much of which will be reviewed in this symposium, that suggests some forms of work schemes are more beneficial than others.

International experts in this field, from the U.S. and Europe, will present papers that review the nature of current provisions and the range of types of schemes. The research evidence in relation to the outcome of different types of work schemes will be considered, and the latest evidence from systematic reviews will be presented.

No. 22A
CRITICAL INGREDIENTS OF SUPPORTED EMPLOYMENT

Gary R. Bond, Ph.D., *Professor of Psychology, Indiana University, 402 North Blackford Street, Indianapolis, IN 46202;* Jeffrey B. Picone, M.Ed.; Beth A. Mauer, M.S.

SUMMARY:

Recent randomized controlled trials suggest that supported employment (SE) is more effective than traditional vocational approaches in helping people with severe mental illness achieve competitive employment. Competitive employment rates for SE exceed 50% in these studies, compared with about 20% for controls, although these rates vary according to the severity of disability of the target group. While these findings are promising, the published literature does not adequately document the critical ingredients of successful SE programs. Nor does the literature indicate how widespread these critical ingredients have been adopted outside the specific programs evaluated in the controlled studies. To fill this gap, we have developed a protocol to assess degree of implementation of critical SE program components. Pilot work completed on 75 programs in five states suggests adequate interrater reliability and internal consistency, and scale items differentiate between SE and other vocational approaches. In its current form, the scale consists of a 33-item checklist called the Quality of Supported Employment Implementation Scale (QSEIS), completed in a 1.5-hour telephone interview with vocational program staff. Our next step is to determine if better-implemented programs, as measured by the QSEIS, have better employment outcomes, as measured by a companion client outcome survey.

No. 22B
THE INDIVIDUAL PLACEMENT AND SUPPORT MODEL OF SUPPORTED EMPLOYMENT FOR SEVERE MENTAL ILLNESS: A REVIEW OF RESEARCH

Kim T. Mueser, Ph.D., *Professor of Psychiatry, Dartmouth College, 105 Pleasant Street, Main Building, Concord, NH 03301;* Vaughn Stagg, Ph.D.; Robert E. Drake, Jr., M.D.; Marianne Eppinger, M.D.; Deborah R. Becker, M.Ed.

SUMMARY:

The New Hampshire-Dartmouth Psychiatric Research Center has been engaged in a series of studies on a specific model of supported employment for persons with severe mental illness, the Individual Placement and Support (IPS) model, over the past several years. In this presentation we will begin with a review of the

components of the IPS model. Then, research from completed studies of the IPS model will be reviewed, including the results from two quasi-experimental studies conducted in New Hampshire and two randomized, controlled trials completed in New Hampshire and Washington, D.C. Future directions for research on the IPS model will be considered, including the role of other rehabilitation strategies in the broader context of vocational rehabilitation.

No. 22C
WORK DISINCENTIVES FOR THE MENTALLY DISABLED

Richard Warner, M.B., D.P.M., *Medical Director, Mental Health Center of Boulder County, 1333 Iris Avenue, Boulder, CO 80304;* Susan L. Averett, Ph.D.

SUMMARY:

Employment rates for people with schizophrenia differ between countries, partly because of differences in economic disincentives to work inherent in national disability pension programs. To establish how Supplemental Security Income (SSI) could be modified to reduce disincentives, the authors applied an econometric labor-supply model to a sample of over 200 randomly selected people with psychotic disorders in Boulder, Colorado. The most prominent findings were that unearned income was a significant disincentive to working, and that the provision of a wage subsidy was one of the most effective ways to boost working hours. Offering a wage subsidy of $2 an hour led to an increase of more than 5% in weekly work hours. Doubling the amount of money that a beginning worker could earn before losing money from the SSI check improved work hours by 3%. By contrast, changes in SSI regulations to reduce the rate at which the pension was decreased as earned income increased were surprisingly ineffective in boosting work hours.

No. 22D
RANGE OF EMPLOYMENT PROVISIONS IN NORTHWEST UNITED KINGDOM

Joseph Oliver, Ph.D., *Senior Lecturer, Department of Psychiatry, University of Manchester, Mental Health Service of Salford, Prestwich, United Kingdom;* Jennifer E. Crook

SUMMARY:

Landmark reorganization of U.K. public services is targeting modernization. All departments will be judged by how they contribute to an improvement in the "quality of life" of the general population. In partnership, health authorities and local government share responsibility for improving mental health while tackling health inequalities. One key focus is widening access to suitable employment.

A survey of the quality of life of 422 people with severe mental illnesses, in northwest England, found 80% were unemployed (Oliver, et al., 1997). To redress this inequity, a regional initiative assembled stakeholder agencies, including providers and commissioners, spanning both public and independent sectors, to ensure access to and provision of a range of meaningful daytime activities.

Health authorities were surveyed to establish the variety of employment services being purchased currently. Along with other measures (e.g., symptoms, social disability), the Lancashire Quality of Life Profile (Oliver, et al., 1997) is being introduced to measure outcomes in both existing and newly commissioned services. The workshop will describe policy and provisions and explore the evaluation results. To date, the general trend is for services to improve material circumstances and life satisfaction. Participants will have opportunities to discuss findings and to relate these to their own local services.

No. 22E
VOCATIONAL REHABILITATION SERVICES: REVIEW AND SYNTHESIS

Ruth Crowther, M.Sc., *Research Fellow, Department of Psychiatry, University of Manchester, Royal Preston, Sharoe Green Lane, Preston, United Kingdom PR2 9HT;* Peter J. Huxley, Ph.D.; Max Marshall, M.D.

SUMMARY:

There have been a number of reviews of the effectiveness of vocational programs (Bond, et al., 1998; Ridgway & Rapp, 1998). This newly completed (1999) systematic review makes use of data from all published randomized controlled trials of the outcomes of vocational programs. It reviews the results of these trials and produces a new synthesis.

The review classifies types of study by setting, and examines the outcomes of different types of vocational programs, using the Cochrane Review methodology. Cochrane reviews integrate the results of randomized controlled research investigations, and assess the validity, applicability, and implications of aggregated study results. The findings produced by these means show which programs provide the most benefit for consumers in different settings.

No. 22F
DETERMINANTS OF WELL BEING AMONG LONG-TERM PSYCHIATRIC PATIENTS IN OSLO

Tom Sorensen, M.D., Ph.D., *Department of Psychiatry, University of Oslo, Ulleval Hospital, Oslo, Norway 0407;* Inger Sandanger, M.D.

SUMMARY:

Long-term psychiatric patients in Oslo have been interviewed about their quality of life at three points of time; 1981 (N=111), 1991 (N=166), 1999 (N=200). The patients represented different systems of housing: single apartments and shared apartments in the ordinary dwelling areas, concentration of apartments for psychiatric patients, and patients living at the hospital. Quality of life is defined in terms of subjective well-being. Well-being is analyzed in relation to different housing programs and to the three points in time. The shared apartment situation showed highest well-being in 1981. In 1991 the concentrated living situation had even higher scores. The groups showed fewer differences in 1991 than in 1981. The contribution of various life domains, for instance work and social network, to general well-being are analyzed for each housing situation and in time perspective. The patients are also compared with the general population.

REFERENCES:

1. Bond GR, Becken DR, Drake RE, Vogler KM: A fidelity scale for the individual placement and support model of supported employment. Rehabilitation Counseling Bulletin 1997; 40:265-284.
2. Moffit R: The econometrics of kinked budget constraints. Journal of Economic Perspectives 1990; 4:119-139.
3. Polak P, Warner R: The economic life of seriously mentally people in the community. Psychiatric Services 1996; 47:270-274.
4. Oliver JPJ, Huxley P, Bridges K, Mohamad H: Quality of Life and Mental Health Services. London, Routledge Pubs, 1997.
5. Ridgway P, Rapp C: The Active Ingredients in Achieving Competitive Employment for People with Psychiatric Disabilities: A Research Synthesis. University of Kansas, School of Social Welfare, Lawrence, 1998.
6. Bond G, Drake RE, Mueser T, Becker DR: An update on supported employment for people with severe mental illness. Psychiatric Services 1998; 48:335-346.
7. Sorensen T: Freedom and social support: dimensions of quality of life in the rehabilitation of long-term psychiatric patients. Psychiatry and Social Science 1981; 1:197-205.
8. Sorensen T: The intricacy of the ordinary. British Journal of Psychiatry. 1994; 164 (suppl. 23), 108-114.

Symposium 23 **Tuesday, November 2**
8:30 a.m.-11:30 a.m.

VIOLENCE AND PSYCHOSIS: CONTEMPORARY PERSPECTIVES

Peter F. Buckley, M.D., *Associate Professor, Department of Psychiatry, Case Western Reserve University, University Hospitals of Cleveland, and Medical Director, Northcoast Behavioral Healthcare System, 11100 Euclid Avenue, Cleveland, OH 44106*

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to appreciate the risk factors for violence in psychosis and the emerging treatment strategies for this patient subgroup.

SUMMARY:

An understanding of the relationship between violence and serious mental illness has evolved from earlier (mis)-conceptions of a lack of a relationship to more recent formulations of a complex association. This relationship is confined to a small subgroup of patients: active psychosis, active substance abuse, and (consequently) poorly controlled illness emerge as major risk factors. This symposium, drawing from several complementary vantage points, will discuss current dilemmas in the management of aggression and psychosis across differing treatment settings and clinical interventions. Dr. Resnick will highlight the key elements of violence risk assessment, incorporating recent information of some selectivity in symptom pattern in risk analysis. Dr. Thompson will describe the clinical characteristics and current management options for persons with mental illness who reside in the correctional services. Dr. Chengappa will present data on the emerging role of novel antipsychotics in treating aggression in psychotic patients. Dr. Buckley will examine the pharmacologic management of aggression within the broader context of evolving treatment guidelines for clinical practice.

TARGET AUDIENCE:

Psychiatrists, psychologists, and allied clinical disciplines.

No. 23A
RISK ASSESSMENT FOR VIOLENCE

Phillip J. Resnick, M.D., *Department of Psychiatry, University Hospitals of Cleveland, 11100 Euclid Avenue, Cleveland, OH 44106*

SUMMARY:

This paper will provide a practical map through the marshy minefield of uncertainty in risk assessment for violence in psychotic patients. The demographics of violence and the specific incidence of violence among people with different psychotic diagnoses will be reviewed. Dangerousness will be discussed in persons with schizophrenia, mania, and depression. Special attention will be given to specific delusions that are more likely to lead to violence. These include threat control override delusions, persecutory delusions, and erotomanic delusions. The factors that predispose persons to obey command hallucinations will be reviewed. Advice will be given on taking a history from dangerous patients. Instruction will be given in the elucidation of violent threats, stalking, and "perceived intentionality." Finally, countertransference toward patients expressing violent threats will be explored.

No. 23B
VIOLENCE AND PSYCHOSIS: CONUNDRA IN THE CORRECTIONAL SETTING

John W. Thompson, Jr., M.D., *Director of Forensic Psychiatry, Tulane University, 1440 Canal Street, New Orleans, LA 70112*

SUMMARY:

With increasing focus on the issue of violence in persons with serious mental illness, the clinical characteristics and management of persons with serious mental illness who are incarcerated within the correctional system have become a growing concern. Moreover, a variety of sources suggest that this is an increasing proportion of the inmate population. While in a broad sense the current clinical and diagnostic composition of this patient group is consistent with expectations and with the available literature, the treatment issues for this group are unique. Moreover, management approaches are complicated by concerns over access, therapeutic alliances (the conflict of containment versus treatment), continuity of care, and planning sustained community tenure. With competing administrative and fiscal resources in this setting, the advent of novel antipsychotics brings those clinical issues in correctional services into sharper relief.

No. 23C
TREATMENT ALGORITHMS FOR AGGRESSION

Peter F. Buckley, M.D., *Associate Professor, Department of Psychiatry, Case Western Reserve University, University Hospitals of Cleveland, and Medical Director, Northcoast Behavioral Healthcare System, 11100 Euclid Avenue, Cleveland, OH 44106*

SUMMARY:

More effective management strategies for aggression in patients with major mental illness could have a broader impact beyond that of symptom control and result in cost containment and, most importantly, less public stigma. Currently, the management of aggression is not clearly delineated, and medication practices are diverse and often used on a trial-and-error basis. A variety of psychotropics of different classes have been tried. More recently, the use of novel antipsychotics has produced clinical and research evidence of efficacy in treating aggression, with some studies suggesting that these agents may possess a selective effect on aggression. At the same time, however, typical antipsychotics continue to have a major role in acute management of aggression. With the increasing use of treatment algorithms in clinical psychiatry, it is opportune to consider the relative merits of current treatment strategies for aggression. This presentation will discuss from a clinical perspective how research advances and clinical wisdom may be combined toward the promulgation of a treatment algorithm for aggression in psychosis.

REFERENCES:

1. Steadman HJ, Mulvey EP, Monahan J, et al: Violence by people discharged from acute psychiatric inpatient facilities and by others in the same neighborhoods. Archives of General Psychiatry 1998; 55:393-401.
2. Swanson JW, Holzer CE, Ganju VK, Jono RT: Violence and psychiatric disorder in the community: evidence from the epidemiologic Catchment Area Surveys. Hospital and Community Psychiatry, 1990; 41:761-770.
3. Buckley PF: Management of aggression in patients with schizophrenia. Schizophrenia Monitor 1998; 8:19-22.
4. Fava M: Pharmacologic treatment of pathologic aggression. Psych Clin N America 1997; 20:427-452.

Workshop 1 **Friday, October 29**
8:00 a.m.-9:30 a.m.

CULTURAL COMPETENCE: CRITICAL ISSUES IN PSYCHIATRY

1998–2000 APA/Bristol-Myers Squibb Fellows

Warachal E. Faison, M.D., *Chief Resident, Department of Psychiatry, Dorothea Dix Hospital, University of North Carolina at Chapel Hill, and 1998-2000 APA/Bristol-Myers Squibb Fellow, 1000 Smith Level Road, #I-7, Chapel Hill, NC 27510*; Samantha E. Meltzer-Brody, M.D.; Todd D. Mitchell, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to recognize the importance of cross-cultural issues in the doctor-patient relationship and apply the concept of cultural competence in clinical practice.

SUMMARY:

As psychiatrists, we work with patients from a variety of cultural backgrounds. It is therefore necessary for mental health providers to understand the potential biases that affect the doctor-patient relationship. These biases may hinder patients' access to mental health are well before a therapeutic relationship is established. Prior discrimination against minority groups can catalyze distrust of the majority culture and deter potential patients from seeking care from representatives of the "majority" culture. Ignorance to ethnoculturally-based transference and countertransference phenomena can lead to significant obstacles to treatment. A culturally competent approach can enhance the counseling style of the therapist. Sue's work warns "if the counseling style of the counselor does not match the communication style of the culturally-different client, many difficulties may arise: premature termination of the session, inability to establish rapport and/or cultural oppression of the client." Communicating effectively consists of verbal and nonverbal messages. It is important to recognize that communicating effectively is not easy. Workshop participants are encouraged to share vignettes from their practices for discussion.

REFERENCES:

1. Comas-Diaz L, Jacobsen FM: Ethnocultural transference and countertransference in the therapeutic dyad. Am J Orthopsychiatry 1991; 61:392–402.
2. Sue DW, Sue D: Counseling the Culturally Different: Theory & Practice, Wiley Interscience, 1990.

Workshop 2 **Friday, October 29**
10:00 a.m.-11:30 a.m.

ASSESSING QUALITY OF CARE IN A MENTAL HEALTH PROGRAM

1998–2000 APA/Bristol-Myers Squibb Fellows

Lindsey J. George, M.D., *Resident in Psychiatry, McMaster University, and 1998-2000 APA/Bristol-Myers Squibb Fellow, 29 James Street, Dundas, Ontario, Canada L9H 2J5*; Satyanarayana Chandragiri, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to identify the need to measure the quality of care in mental health programs, recognize the technical and conceptual problems inherent in most outcome measures, and the implication for practitioners of increasing attention to outcome measurements.

SUMMARY:

Measuring quality of care is of utmost importance to all groups: patients clinicians, managed care organizations, health administrators, and state and federal government. Evaluation is undertaken for two broad reasons: continuous quality improvement and to determine the efficacy and efficiency of mental health interventions. Traditionally, mental health outcome measures have focused on clinical symptomatology. In recent years there has been increased interest in other measures including measuring quality of life. However, there are inherent conflicts of interests in what is being measured, the choice of instruments, and what one does with the outcome measures.

The workshop will review some of the key theoretical and methodological issues in program evaluation and illustrate with an example from a university hospital psychiatric emergency department in Philadelphia, and a community mental health treatment and case management program in Ontario, Canada. There have been changes in mental health care delivery in recent years. The presenters will focus on the use of these measures in the light of these changes. The participants will have an opportunity to discuss the outcome measurement needs of their programs with the presenters and other participants.

TARGET AUDIENCE:

Administrators, program directors, and staff in emergency psychiatry and community and hospital settings.

REFERENCES:

1. Brook RH, Cleary PD, McGlynn EA: Measuring quality of care. N Engl J Med 1996; 335:966–970.

2. Dickerson FB: Assessing clinical outcome: the community functioning of persons with serious mental illness. Psychiatric Services 1997; 48(7):897–902.

Workshop 3 **Friday, October 29**
1:30 p.m.-3:00 p.m.

RELIGION AND PSYCHIATRY: BARRIERS AND LAND MINES

1998–2000 APA/Bristol-Myers Squibb Fellows

Jeffrey A. Berman, M.D., *Chief Resident, Department of Psychiatry, New Jersey Medical School (UMDNJ), and 1998-2000 APA/Bristol-Myers Squibb Fellow, 1296 Pennington Road, Teaneck, NJ 07666*; Tracey L. Irvin, M.D.; Victor Sierra, M.D.; John C. Webber, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to: (1) recognize potential barriers and opportunities in seeking, receiving, and providing mental health services among individuals of various faith/religious communities; and (2) communicate more easily with patients and families who practice religions other than those of the mental health provider.

SUMMARY:

Religion plays an important role in the formation of the individual and how he/she views the world around him. Religion is one of several institutions that interact to shape the character of the child. Religious teachings affect how the world is seen and therefore impact on the decisions made by the individual. These views also may significantly impact an individual's decision to seek treatment from a mental health professional as well as their expectations from treatment outcomes. Issues of transference and countertransference arise when therapist and patient have different religious beliefs and/or share the same religion but differ in how they interpret the teachings of their church. A particular affiliation may be a barrier to care. Clergy hold positions of authority and are often sought as counselors by the congregation. The individual's perception of good and evil, crime and punishment, or existence of heaven and hell may also affect access to mental health care. Furthermore, the significance attributed to the mental health professional will influence the interaction between patient and provider. Catholicism, Jehovah's Witness, Judaism, Santeria, and Southern Baptist and Methodist religions will be discussed. The audience is expected to share its experiences and help identify ways in which barriers pertaining to religion and mental health care may be overcome.

TARGET AUDIENCE:

Psychiatrists, psychologists, social workers, and clergy.

REFERENCES:

1. Gonzalez-Wippler M: Santeria The Religion. St. Paul, Minnesota: Llewellyn Publications, 1994.
2. Hathaway W, Pargament K: Intrinsic religiousness, religious coping, and psychological competence: a covariance structure analysis. J Sci Stud Religion 1990; 20(4):423–441.

Workshop 4 **Friday, October 29**
3:30 p.m.-5:00 p.m.

LEVEL OF CARE DECISION MAKING IN THE MOBILE CRISIS SETTING

Leila B. Laitman, M.D., *Team Psychiatrist, Community Mental Health Services, Visiting Nurse Service, 1601 Bronxdale Avenue, Bronx, NY 10462*; Francesca Perez, C.S.W.; Neil Pessin, Ph.D.; David C. Lindy, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to understand the issues involved in making level of care decisions in the mobile crisis setting and assess the pros and cons of using methods to standardize them.

SUMMARY:

Whenever mental health providers go into the field to evaluate a crisis situation, level of care decisions must be made. In more traditional settings such as psychiatric clinics or emergency rooms, decisions as to the need for hospitalization have typically fallen to the psychiatrist. In the outreach setting where M.D. time is at a premium, psychiatric social workers and nurses routinely make these decisions. Understandably, differences in training and experience will affect choices. Thus, providers' decisions may seem highly flexible. A wide variability of services may be provided to clients with similar needs and yet they all ultimately receive appropriate and effective care. Some studies propose the use of support tools for level of care decisions that can facilitate appropriate and equitable allocation of services based on a client's clinical needs. This presentation will examine the process of psychiatric triage in the field by different disciplines of mental health providers, particularly in the area of need for involuntary transport to an emergency room. Cases will be presented where differences of opinion between disciplines existed as to the appropriate level of care necessary to meet the client's clinical needs. Discussion will be encouraged from the audience regarding their reaction to the cases and

whether some method of standardization of decision making is desirable or even possible.

TARGET AUDIENCE:

Mental Health professionals involved/interested in the outreach of emergency setting.

REFERENCES:

1. Srebnik D, et al: Field test of a tool for level of care decisions in community mental health systems. Psychiatric Services 1998; 49:91–97.
2. Bengelsdorf H, et al: A crisis triage rating scale. Journal of Nervous and Mental Disease 1984; 172:424–430.

Workshop 5 **Saturday, October 30**
8:00 a.m.-9:30 a.m.

A PRAGMATIC APPROACH TO MEDICATION EDUCATION

Jerry Dincin, Ph.D., *Executive Director, Thresholds, 4104 North Ravenswood, Chicago, IL 66601*; Diane Herbeck, M.A.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to use a greater variety of treatment approaches to educate patients about medication in group and individual sessions.

SUMMARY:

At Thresholds, the purpose of medication education is to share essential medication information with program members, address adherence issues, and provide hope to members struggling with symptoms, side effects, and related problems. This workshop presents the contents of the Thresholds medication education curriculum, which includes the biological basis of mental illness, analogies and metaphors, first-person accounts, games, and techniques used to prevent relapse. Summary and results of a study examining changes in knowledge, attitude, and adherence with medication before and after group or individual education are presented. The groups used the Medication Management Module or the Thresholds model. Forty percent of study participants are people of color; therefore, findings include the experiences of culturally/ethnically diverse groups of participants. Understanding similarities and differences will help us identify mental health needs unique to various cultural groups and thus serve these needs more effectively. Our study found that members' knowledge about medications increased in both group approaches, as did attitude and adherence, though to a lesser extent. To address adherence, a Peer Educator component was added to the Thresholds model, which will be discussed. Audience perspectives and experience with medication education will be elicited, as will merits and limitations of various approaches.

TARGET AUDIENCE:

Service providers and consumers interested in mental health consumer education.

REFERENCES:

1. A Pragmatic Approach To Psychiatric Rehabilitation: Lessons From Chicago's Thresholds Program. Edited by Dincin, J. San Francisco, CA. Jossey-Bass Inc, Publishers, 1995.
2. Eckman TA, Wirshing WC, Marder SR, Liberman RP, Johnston-Cronk K, Zimmermann K, Mintz J: Techniques for training schizophrenic patients in illness self-management: a controlled trial. Am J Psychiatry 1992; 49:1549–1555.

Workshop 6 **Saturday, October 30**
8:00 a.m.-9:30 a.m.

DANGEROUSNESS: ASSESSMENT AND LIABILITY ISSUES

APA Council on Psychiatry and Law

Debra K. DePrato, M.D., *Division of Law and Psychiatry, Department of Psychiatry, Louisiana State University, 1542 Tulane Avenue, New Orleans, LA 70112-2822*; Jill Hayes, Ph.D.; Greg Polozola, J.D.; Richard Lippincott, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, participants will be able to (a) identify risk/protective factors for future dangerousness, (b) demonstrate an understanding of various legal criteria in risk appraisal, (c) recognize psychological tests used in risk assessment, and (d) be familiar with individual and institutional/hospital liability issues involved in dangerousness assessment.

SUMMARY:

The prediction of future dangerousness to self and/or others is difficult, flawed, and controversial. First, there are no widely accepted clinical or legal guidelines for assessment of dangerousness, and risk of dangerousness is context specific. In addition, clinicians may err in their predictions due to biases and/or cognitive heuristics. Finally, a false negative judgment about dangerousness may lead to a tragic outcome (i.e., injury or death). As a result, many clinicians are wary of becoming involved with patients who may need a risk appraisal. Accordingly, in an effort to familiarize attendees to this area, workshop presenters will (1) consider relevant legal cases and liability issues; (2) review personality, histori-

cal, and contextual factors in risk assessment; (3) discuss recent advances in detecting "dissimulation;" (4) review psychological tests that attempt to assess for dangerousness; and (5) explain the impact of risk assessment on institutional/hospital care. Various vignettes will be provided to participants, and they will be asked to identify pertinent legal standards, various risk and protective factors, and liability issues.

REFERENCES:

1. Melton GB, Petrila J, Poythress NG, Slobogin C: Psychological Evaluations for the Courts: A Handbook for Mental Health professionals and Lawyers (2nd Ed.). New York, The Guilford Press, 1997.
2. Gunn J: Let's get serious about dangerousness. Criminal Behavior and Mental Health, Supplement, 1996; 51–64.

Workshop 7 **Saturday, October 30**
8:00 a.m.-9:30 a.m.

THE VILLAGE: A MODEL PUBLIC MANAGED CARE SYSTEM

Mark Ragins, M.D., *Medical Director, Village Integrated Services Agency, 456 Elm Avenue, Long Beach, CA 90802-2426*; Martha N. Long, B.A.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to understand and describe a model managed care system for people with serious mental illness, a set of psychosocial rehabilitation principles, managed care principles, and the role of the psychiatrist.

SUMMARY:

As managed care moves into the public sector, it will have to make substantial alterations to address the large number of people with long-term serious mental illness. The Village Integrated Services Agency in Long Beach is a model program that is a complete integrated system of care for people with long-term severe mental illness within a capitated contract. We have some of the best outcomes across a range of life areas reported anywhere. In this workshop we will (1) describe the history, setup, and outcomes of our program; (2) describe the psychosocial rehabilitation philosophy and how we have used it as an umbrella under which to integrate our services; (3) describe the role of the psychiatrists within this setting; and (4) describe our approach to managed care, "designed care," in contrast with the standard approach. Our objective is for our experience to give a hopeful framework from which to approach future public managed care. Martha Long and Mark Ragins, the presenter, were the 1995 co-winners of APA's Arnold L. van Ameringen Award for their work at the Village.

REFERENCES:

1. The Journal of CAMI, Vol. 4, No. 2.
2. Hargreaves WA: A capitation model for providing mental health services in California, HCP Mar '92 43:3.

Workshop 8 **Saturday, October 30**
8:00 a.m.-9:30 a.m.

BLACK, WHITE, BROWN AND YELLOW: ISSUES IN ENGAGEMENT

David M. Band, M.D., *Clinical Director, Mobile Community Outreach Treatment Team, St. Elizabeth's Hospital, 2700 Martin Luther King Jr. Avenue, S.E, Washington, DC 20032*; Roger Peele, M.D., *Clinical Professor of Psychiatry, Department of Psychiatry, George Washington University School of Medicine, 8002 Lions Crest Way, Gaithersburg, MD 20879-5637*; Lidia R. Cohen, M.D.; Lien A. Hung, M.D.; Tedla W. Giorgis, Ph.D.; Marcella A. Macguire, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participants should be familiar with some of the common racial, ethnic, and cultural barriers in engaging severe and persistent mentally ill individuals into treatment. The workshop participants will help develop strategies for overcoming these barriers.

SUMMARY:

In light of the recent explosion of hate talk radio, TV talk shows, and hate-related crime, many of our colleagues have had cause to explore the meanings of culture, race, and ethnicity in the development and maintenance of therapeutic relationships in the context of assertive community treatment.

The workshop presenters who come from diverse backgrounds—American, Ethiopian, Latino, and Vietnamese—will each give brief case vignettes including both positive and negative experiences involving culture, race, and ethnicity issues in the context of establishing therapeutic relationships.

During the last two-thirds of the workshop, the participants will engage in a discussion of these issues in this open setting. Strategies for using culture, race, and ethnicity to enhance therapeutic, diagnostic, and treatment relationships, as well as training, will be developed.

TARGET AUDIENCE:

Mental health professionals with an interest in diverse populations.

REFERENCES:

1. Cheing F, Snauder L: Community mental health and ethnic minority populations. Community Mental Health Journal 1990; 26(3):277–291.
2. Mental Health in Black America. Edited by Neighbors HW, Jackson JS. Thousand Oaks, CAA Sage Publications Inc., 1996.

Workshop 9 **Saturday, October 30**
8:00 a.m.-9:30 a.m.

THE PARTNERSHIP PROGRAM PUBLIC EDUCATION MODEL: DESCRIPTION AND DEMONSTRATION

Fay G. Herrick, *Program Coordinator, Schizophrenia Society of Alberta, 206A 12th Avenue, S.E., Calgary, Alberta, Canada T2G 1A1*; Dean R. Kernohan, B.M.U.S.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant will be equipped to initiate and operate a Partnership program in his or her community.

SUMMARY:

The Partnership program is a unique, highly successful public education model involving medical professionals, consumers, and family members working as a team to present clinical, personal, and family perspectives on schizophrenia. Partnership presentations are given to schools, medical students, counselors, police, bus drivers, churches, etc. Partnership presentations have proven very effective in putting a human face on schizophrenia and reducing stigma. Partnership also serves a rehabilitative role, developing communication skills, self-advocacy skills, employment readiness, self-esteem, and team spirit in consumers and family members. These outcomes are associated with greater ability to maintain wellness, access care, live independently, and engage in employment or education. This workshop will cover major points from the manual, including philosophy, recruitment, training, soliciting presentations, presentation format, program organization, funding, and evaluation. One presenter will describe the Speaking Skills Course for consumers and family members developed by the Calgary Program. A Partnership Program Manual and Speaking Skills Workbook will be available to audience members. This will be followed by a demonstration Partnership presentation (omitting the professional). Remaining time will be devoted to questions and discussion. This is a "how-to" workshop for medical professionals who want to launch a Partnership program in their communities.

REFERENCES:

1. Partnership Program Manual. Schizophrenia Society of Alberta, Calgary Chapter: Calgary, Alberta, 1999.
2. Speaking Skills Workbook. Schizophrenia Society of Alberta, Calgary Chapter: Calgary, Alberta, 1998.

Workshop 10 **Saturday, October 30**
10:00 a.m.-11:30 a.m.

ROLE OF THE PSYCHIATRIST: SURVEY OF AMERICAN ASSOCIATION OF COMMUNITY PSYCHIATRISTS AND AMERICAN ASSOCIATION OF PSYCHIATRIC ADMINISTRATORS MEMBERS

American Association of Community Psychiatrists and American Association of Psychiatric Administrators

Jules M. Ranz, M.D., *Director, Public Psychiatry Fellowship, Department of Psychiatry, New York State Psychiatric Institute, 1051 Riverside Drive, Box 111, New York, NY 10032*; Hunter L. McQuistion, M.D.; Paula G. Panzer, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, participants will learn the results of parallel AACP and AAPA surveys on the role of the psychiatrist in organized service delivery systems. Participants will also have a clearer understanding of the various types of medical director positions occupied by psychiatrists in these systems.

SUMMARY:

A survey of alumni of the Public Psychiatry Fellowship of Columbia University revealed that respondents who are medical directors perform a greater variety of tasks and experience higher job satisfaction than those who are staff psychiatrists. Both medical directors and staff psychiatrists believed that job satisfaction is most dependent on performance of clinical collaboration tasks, yet it was the performance of administrative tasks that are most correlated with overall job satisfaction.

The ability to generalize from this survey was limited by the following reasons: (1) Public Psychiatry Fellowship alumni are a small, self-selected group of psychiatrists who have received highly specialized training and almost certainly do not represent the typical psychiatrist working in organized service delivery systems today; (2) Most of the medical directors had program, rather than agency, level responsibilities.

In order to address these issues we proceeded to obtain a larger and more representative sample of psychiatrists working in organizational service delivery systems by approaching the national organizations of both the Amer-

ican Association of Community Psychiatrists (AACP) and the American Association of Psychiatric Administrators (AAPA).

We also expanded our survey form to allow for collection of more demographic data and to obtain a more detailed analysis of the role of medical director. Results of these parallel AACP and AAPA surveys will be presented. Participants' input will be solicited with regard to implications of the findings and applicability to different settings.

TARGET AUDIENCE:

Psychiatrists working in organizational structures.

REFERENCES:

1. AACP Guidelines for Psychiatric Leadership in Organized Delivery Systems for Treatment of Psychiatric and Substance Disorders. Community Psychiatrist Autumn 1995; 9:6–7.
2. Ranz JM, Eilenberg J, Rosenheck S: The psychiatrists's role as medical director: task distributions and job satisfaction. Psychiatric Services 1997; 48:915–20.
3. Ranz JM, Stueve A: The role of the psychiatrist as program medical director. Psychiatric Services 1998; 49:1203–7.

Workshop 11 **Saturday, October 30 10:00 a.m.-11:30 a.m.**

CUBAN MENTAL HEALTH: A SOCIO-POLITICAL JOURNEY

Leslie M. Snider, M.D., *Assistant Professor, Department of Psychiatry, Tulane University Medical Center, 1440 Canal Street, New Orleans, LA 70112*; Guillermo Barrientos, Ph.D.; José M. Cañive, M.D.; Eugenio M. Rothe, M.D.; Andrés J. Pumariega, M.D.; Renato D. Alarcón, M.D., M.P.H.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participants should be able to demonstrate an understanding of the forces (political, theoretical, and economic) that have shaped the system of mental health care delivery in Cuba. Participants should be able to recognize the specific political, theoretical, economic, and cultural elements of mental health care reform in the Cuban system, and the current successes and challenges Cuba faces today. This knowledge can be utilized in critical examination of international systems of mental health care and in developing the potential for collaboration and consultation of U.S. psychiatrists to other systems.

SUMMARY:

In October of 1998, Cuba hosted the 20th Congress of the Psychiatric Association of Latin America (APAL) at their second international conference, PSICOHABANA '98. They were chosen for the site of this internationally recognized conference owing to the fact that Cuba was also celebrating the 40th anniversary of the reconstruction of the Psychiatric Hospital of Habana, formerly the "Madhouse of Cuba." The reorganization of the Psychiatric Hospital reflects the reform of care toward more humane treatment for the serious and persistently mentally ill.

The socio-political-historical journey of the Cuban mental health care system must be seen in the greater context of improvements in access and quality of general health care of the population. We will examine various aspects of Cuban mental health today, including successes, structure, economic hardships, biopsychosocial theoretical orientation, the new community movement, continuity of care, and future challenges. The panelists will include experts in the Cuban mental health system from both the U.S. and Cuba. Our target audience is psychiatrists, psychologists, social workers, and mental health professionals with an interest in lessons from international mental health care systems, relevant issues in crosscultural psychiatry, and in the Cuban experience.

REFERENCES:

1. Editorial: "Sanctions on Health in Cuba." The Lancet volume 348, Number 9040, 1461.
2. Ordunez-Garcia PO, Nieto FJ, Espinosa-Brito AD, Caballero B: Public health then and now: Cuban epidemic neuropathy, 1991 to 1994: history repeats itself a century after the "Amblyopia of the Blockade." American Journal of Public Health 1996; 86 (5):738–743.

Workshop 12 **Saturday, October 30 10:00 a.m.-11:30 a.m.**

PUBLIC/PRIVATE COLLABORATION FOR HOMELESS DUALLY-DIAGNOSED CLIENTS: OPERATIONALIZING THE CONTINUUM

Marilyn Seide, Ph.D., *Program Manager, Adult Services, Department of Mental Health, Riverside County, 4095 County Circle Drive, Box 7549, Riverside, CA 92503*; Ron Vervick, J.D.; Eileen Weilein, B.S.; Frances Charles

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to replicate, in his/her own setting, the kind of collaborative program presented, while avoiding

some of the pitfalls encountered in its development. Program staff and a client will share their experiences with attendees and encourage discussion and exchange of ideas, as well as suggestions for improving such a program and for the type of training needed for staff to successfully implement its objectives.

SUMMARY:

In early 1996, a grant was received from the Housing and Urban Development Agency to implement a collaborative program for the benefit of homeless dually diagnosed clients. The purpose of this program, a combined initiative of a nonprofit agency and a county department of mental health, was to locate potential clients, stabilize them in a structured residential setting, and help them to secure permanent housing and, after some vocational training, employment or further education. This workshop will present the various aspects of the program, from outreach to successful outcome or, in some cases, failure, and will include a client's experience in the program and impressions of how it has affected his/her life. Lessons learned in the course of its operations will be shared, with audience input solicited regarding their reactions to the specifics of this program and suggestions for how it might be improved/altered for greater effect on its clients. Staff will also discuss some of the pitfalls encountered and mistakes that might potentially be avoided in setting up such a collaborative effort—how it would be conceptualized and developed if we had it to do over, and how do audience participants see changing/improving it.

TARGET AUDIENCE:

Mental health professionals interested in programs for the homeless and dually diagnosed.

REFERENCES:

1. Center for Substance Abuse Treatment: Assessment & Treatment of Patients With Coexisting Mental Illness and Alcohol and Other Drug Abuse, Dept. HHS, 1994.
2. Sciacia K, Thompson CM: Program development & integrated treatment across systems for dual diagnosis: mental illness, drug addiction & alcoholism. Journal of Administration Summer 1996; Vol. 23, No 3.

Workshop 13 **Saturday, October 30**
1:30 p.m.-3:00 p.m.

DISSOCIATIVE IDENTITY DISORDER ISSUES: DIAGNOSIS AND THERAPY

Leah J. Dickstein, M.D., *Professor and Associate Chair of Academic Affairs, and Director, Division of Attitudinal and Behavioral Medicine, Department of Psychiatry and Behavioral Sciences, Louisville University, 323 East Chestnut Street, Louisville, KY 40202*; Paul Jay Fink, M.D.; Richard P. Kluft, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to recognize and diagnose patients with a history of past abuse and current dissociative and other PTSD symptoms as well as other psychiatric disorders.

SUMMARY:

This workshop will offer attendees the opportunity, after a short presentation by all presenters concerning correct diagnostic techniques, to raise important and current concerns about the validity of the diagnosis. Dr. Dickstein was a colleague of Dr. Cornelia Wilbur's in Kentucky, and was available to Sybil after Dr. Wilbur's death. Dr. Kluft has also worked in this area for decades. Dr. Fink is a national expert concerned about the issue of fake memory syndrome.

Following initial discussion about diagnosis, further audience participation will be encouraged after the experts outline treatment issues including different forms of psychotherapy, pharmacotherapy, and music and art therapies.

REFERENCES:

1. Schreiber FR: Sybil, Regnery, Chicago, 1973.
2. Dickstein LJ: My Distance Supervision with Cornelia Wilbur, M.D., in Clinical Perspectives on Multiple Personality Disorder. Edited by Kluft RP, Fine CCG. American Psychiatric Press, Inc., Washington, DC, 1995.

Workshop 14 **Saturday, October 30**
1:30 p.m.-3:00 p.m.

RURAL PSYCHIATRY: PROBLEMS AND SOLUTIONS

Ole J. Thienhaus, M.D., *Chair, Department of Psychiatry, University of Nevada, 401 West 2nd Street, Suite 216, Reno, NV 89503*; Elizabeth M. Tully, M.D., *Assistant Professor of Psychiatry, Department of Psychiatry, University of Nevada, 401 West 2nd Street, Room 216, Reno, NV 89503*; Grant D. Miller, M.D.; Henry K. Watanabe, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to (1) demonstrate an awareness of important issues facing psychiatrists and other clinicians in rural areas, (2) devise practical strategies for addressing these issues.

SUMMARY:

Psychiatrists who practice in rural areas face many challenges and opportunities. Treatment issues include emergencies, substance abuse, collaboration with other health care professionals, and maintaining a continuum of care. Opportunities exist for innovative programs involving telemedicine and education of residents and medical students. The faculty will discuss their experiences in a rural clinics system, which operates statewide in Nevada. This workshop is intended for clinicians and administrators who work in remote and rural community mental health programs. The panel will explore several brief clinical vignettes, and the audience will be invited to share their own experiences. Ample time will be provided at the conclusion of the presentations for the audience to contribute cases for consultation and discussion.

REFERENCES:

1. Brown FW: Rural telepsychiatry. Psychiatric Services 1998; 49:963–964.
2. Lambert D, Hartley D: Linking primary care and rural psychiatry: where have we been and where are we going? Psychiatric Services 1998; 49:965–967.

Workshop 15 **Saturday, October 30**
1:30 p.m.-3:00 p.m.

QUALITY INDICATORS FOR PSYCHIATRY

APA Task Force on Quality Indicators

John M. Oldham, M.D., *Director, New York State Psychiatric Institute, 1051 Riverside Drive, Unit 4, New York, NY 10032*; Deborah A. Zarin, M.D., *Deputy Medical Director, and Director, Office of Quality Improvement and Psychiatric Services, American Psychiatric Association, 1400 K Street, N.W., Washington, DC 20005*; Harold Alan Pincus, M.D.; Lloyd I. Sederer, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should understand performance measurement; the definition of quality indicator, measure, and standard; and the dimensions of care (access, quality, perception of care, outcomes) developed by the APA components on Quality Indicators.

SUMMARY:

There is a groundswell of interest in the development of performance measures, so that health care systems can be held accountable for the care they provide. The Joint Commission of Healthcare Organizations (JCAHO) has recently introduced an ambitious performance measurement program. Other organizations, such as the National Committee on Quality Assurance (NCQA), and the American Medical Accreditation Program (AMAP), are developing methods to evaluate health care, and JCAHO, NCQA, and AMAP have announced a collaboration on an initiative to coordinate performance measurement activities across the entire health care system. The American Psychiatric Association established a Task Force on Quality Indicators to develop a professionally-driven, clinically-based framework for performance measurement. After determining four key dimensions of care to be evaluated (access, quality, perception of care, and outcome), the task force identified priority areas of importance (population [e.g. children, the elderly] and diagnoses [e.g. schizophrenia, substance abuse]), as well as a series of clinical recommendations/goals and sample quality indicators, to be used in evaluating the provision of behavioral health care.

Participants in this workshop will receive copies of APA reports on quality indicators and will be invited to provide input and suggestions for the future development of additional quality indicators.

REFERENCES:

1. Eddy DM, Performance measurement: problems and solutions, Health Affairs 1998; 17:7–25.
2. Sederer L, Dickey B, Outcomes Assessment in Clinical Practice. Williams & Wilkins, Baltimore, 1996.

Workshop 16 **Saturday, October 30**
1:30 p.m.-3:00 p.m.

FROM THE BACK DOOR OF PRISON TO THE FRONT DOOR OF THE COMMUNITY MENTAL HEALTH CENTER

Erik J. Roskes, M.D., *Assistant Professor, Department of Psychiatry, University of Maryland, 22 South Greene Street, Box 291, Baltimore, MD 21201*; Richard Feldman, L.C.S.W.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to (1) identify barriers to treatment faced by the patient with a history of a criminal conviction and (2) determine ways in which these barriers may be overcome through collaborative relationships between the mental health and criminal justice systems.

SUMMARY:

The mentally ill are disproportionately incarcerated. There is a wealth of literature documenting the need for improved mental health services in jails and prisons. There is a large literature on "jail diversion" as a way

of moving mentally ill offenders out of the criminal justice process and into the treatment system. Similarly, there is substantial research examining mental health treatment for those unfortunates who are incarcerated. Little is known, however, of the services that the mentally ill offender receives when released from jail or prison. Frequently, obtaining treatment upon release is difficult because of mutual mistrust between the mental health and criminal justice communities. It is in this spirit that this workshop was conceived. What happens to mentally ill offenders once they are released into the community under the supervision of the probation or parole officer? This workshop will address issues specific to the treatment of the mentally ill inmate after he rejoins the community. The presenters will discuss some of the barriers to care faced by the mentally ill offender, including double stigma, lack of family/social support, comorbidity, adjustment problems, and boundary issues. They will then offer their experience with a collaborative model targeted at overcoming these barriers.

TARGET AUDIENCE:

Community mental health providers and correctional mental health providers.

REFERENCES:

1. Solomon P, Draine J, Myerson A: Jail recidivism and receipt of community mental health services. Hospital & Community Psychiatry 1994; 45(8):793–797.
2. Vaughan PJ, Badger D: Working with the Mentally Disordered Offender in the Community. London, Chapman and Hall, 1995.

Workshop 17 **Saturday, October 30**
1:30 p.m.-3:00 p.m.

MOTHER'S EMOTIONAL RESPONSES TO MURDER OF TEENAGERS

Elinor Grayer, Ph.D., *California Institute for Clinical Social Work, 2009 Hopkins Street, Berkeley, CA 94707*; Felicia Thomas, Ph.D., *California Institute for Clinical Social Work, 2009 Hopkins Street, Berkeley, CA 94707*; Robert Bennett, M.S.W.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to understand, learn to treat, and assist in the recovery process of mother's whose adolescent children have been murdered.

SUMMARY:

This presentation describes six mothers' emotional responses to the murder of their teenage children. The mothers live in South Central Los Angeles, the highest crime and most underserved area of California. The study is conducted three months after the murder. It is a phenomenological qualitative study using grounded theory methods. The findings describe the psychodynamic processes of the mothers' experiences organized in four phases. The mothers' past and present stigmatization and victimization is part of the emerging recovery process. At the conclusion of this workshop the participant should be able to identify the emotional reactions of mothers to the murder of their adolescent children as well as the four phases and processes of the emotional experience.

REFERENCES:

1. Lindemann E: Symptomology and management of acute grief. American Journal of Psychiatry 1944; 101:141–148.
2. Akhtar S: Broken structures—severe personality disorders and their treatment, Jason Aronson, Inc. Northvale, New Jersey, 1992.

Workshop 18 **Saturday, October 30**
3:30 p.m.-5:00 p.m.

CONSUMERS AS PROVIDERS: BOUNDARY ISSUES

Jaak Rakfeldt, Ph.D., *Associate Professor, School of Professional Studies, Southern Connecticut State University, Lang Social Work Center, 101 Farnham Avenue, New Haven, CT 06515*; Kenneth S. Thompson, M.D.; Deborah Fisk, M.S.W.; Dawn Johnson, B.A.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, participants should be able to identify the complex clinical, ethical, and safety issues that emerge in community treatment situations as well as to recognize the relationship between psychiatric practice, case management, and the role of consumer/providers in community support programs. Participants should also be better able to integrate these concepts into their clinical practice.

SUMMARY:

The workshop will explore the impact that more assertive community support services have had on complex boundary, ethical, clinical, and safety issues. In particular, the emerging role of consumers as colleagues and service providers will be explored. Relevant literature will be reviewed and an analysis of current practices will be provided. The workshop will feature a dialogue between a psychiatrist, a case manager from a homeless outreach program, and a consumer/provider who has previously been a client of this program. They will discuss their efforts to grapple with complex boundary issues. The lessons that consumer/providers and case

managers can teach psychiatry and vice versa will be emphasized. Workshop participants will be encouraged to join in this discussion, thus sharing their clinical experiences with complex boundary issues in assertive community support services.

TARGET AUDIENCE:

Mental health professionals, consumers, and family members.

REFERENCES:

1. Fisk D, Rakfeldt J, Heffernan K, Rowe M: Outreach workers' experiences in a homeless outreach project: issues of boundaries, ethics, and staff safety. Psychiatric Quarterly: in press.
2. Sledge WH, Astrachan B, Thompson K, Rakfeldt J, Leaf, P: Case management in psychiatry: an analysis of tasks. The American Journal of Psychiatry, 1995; 152(9):1259–1265.

Workshop 19 **Saturday, October 30**
3:30 p.m.-5:00 p.m.

DOCUMENTATION REQUIREMENTS AND CODING UPDATE

APA Committee on Codes and Reimbursements and APA Committee on Harvard Resource-Based Relative Value Scale Study

Chester W. Schmidt, Jr., M.D., *Chairman and Professor, Department of Psychiatry, Johns Hopkins Bayview Medical Center, 4940 Eastern Avenue, A-4C, Baltimore, MD 21224-2735*; Donald J. Scherl, M.D., *149 Corbett Avenue, San Francisco, CA 94114-1870*; Melodie Morgan-Minott, M.D.; Ronald A. Shellow, M.D.; Frank T. Rafferty, Jr., M.D.; Shelley Stewart

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant will be knowledgeable about (1) the 1994–1995 Documentation Guidelines for E/M services, (2) the current revisions in those guidelines, and (3) the Commission on Psychotherapy's suggestions for documenting psychotherapy.

SUMMARY:

In 1994–1995 the Health Care Financing Administration and the American Medical Association published guidelines for documenting evaluation and management services. The entire medical community raised so many concerns about these guidelines, which became requirements for documentation during subsequent audits of physician billing, that the AMA and HCFA were forced to consider major revisions of the guidelines. These revisions are now working their way through all medical societies. The goals of the combined work groups (RBRVS Study and Codes/Reimbursements) are to familiarize practitioners with the basic elements of these evolving guidelines as well as with the developments in documentation sponsored by the APA. Presentations and handouts will provide the detail of the various sets of guidelines.

REFERENCES:

1. CPT, 1999.
2. CPT Advisor, July 1997.
3. Schmidt CW, Jr: CPT Handbook for Psychiatrists, Second Edition. American Psychiatric Press, Inc., Washington, DC, September 1998.

Workshop 20 **Sunday, October 31**
8:00 a.m.-9:30 a.m.

MODELS OF PROVIDING PSYCHIATRIC TREATMENT OVER OBJECTIONS

Jagannathan Srinivasaraghavan, M.D., *Professor of Clinical Psychiatry, Department of Psychiatry, Southern Illinois University, Choate Mental Health Center, Anna, IL 62906*; Geetha Jayaram, M.D.; Paul S. Appelbaum, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to recognize the models of providing psychiatric treatment over patients' objections, principles underlying the models, and relative strengths and weaknesses of the models and variants of such models.

SUMMARY:

Criteria for civil commitment shifted from need for treatment to need for confinement based on dangerousness within the last four decades. As the doctrine of informed consent received more acceptance, the decision-making power shifted from physician to patient. With these changes, the committed person's right to decision making, including right to refuse medications, came to be recognized. This right of refusal is legally adjudicated either judicially or administratively. Placing patient's autonomy and rights greater significance than treatment considerations are models fashioned like Rogers v Commissioner of Mental Health (Mass 1983), which utilize judicial review mechanisms. Placing greater importance to treatment, not just confinement and relying on principles of Rennie v Klein (3rd Circuit Court 1983), are models that utilize administrate review panels. Dr. Srinivasaraghavan will present Illinois statute regarding administration of psychotropic medications to nonconsenting patients in nonemergency situations utilizing judicial review. Dr. Jayaram will present how Maryland handles refusal of treatment administratively

by a clinical review panel whose decision can be appealed by the patient to an administrative law judge. Dr. Appelbaum will discuss relative merits of the models and future directions in this area. Audience participation to elicit relative merits of variants of the models will be strongly encouraged.

REFERENCES:

1. Hoge SK: Treatment refusal in psychiatric practice, in Principles and Practice of Forensic Psychiatry. Edited by Rosner R. 1994, pp. 127–132.
2. Hoge SK, Appelbaum PS, Lawlor T, et al: A prospective, multi-center study of patients' refusal of antipsychotic medication. Archives of General Psychiatry 1990; 47:949–956.

Workshop 21 **WITHDRAWN**

Workshop 22 **Sunday, October 31**
8:00 a.m.-9:30 a.m.

A STATE MENTAL HEALTH SYSTEM ADDRESSES TRAUMA

Anne C. Bauer, M.D., *Clinical Director, Maine Department of Mental Health, Mental Retardation and Substance Abuse Services, 40 State House Station, Augusta, ME 04333*; Melodie J. Peet, M.P.H.; Ann Jennings, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to develop plans and initiate the implementation of effective public sector services and supports for individuals with histories of trauma, select training approaches relevant to needs of public system professionals who work with trauma survivors, and understand the implications of interpersonal violence for state and national public mental health policy.

SUMMARY:

Melodie Peet, M.P.H., will present a state commissioner's perspective on the significance and impact of interpersonal violence (sexual and physical abuse) as a priority for mental health policymakers on state and national levels. She will discuss the recent landmark decision by the National Association of State Mental Health Program Directors to issue a policy position statement on state services and supports to trauma survivors. Ann Jennings, Ph.D., will present Maine's strategic plan to address the needs of traumatized persons with psychiatric diagnoses. Action steps to accomplish the following objectives will be discussed: Changes in professional perceptions of and approach to trauma survivors; education of the workforce, creation of an integrated system of services, reduction of retraumatization, survivor/consumer empowerment, public education. Anne Bauer, M.D., will present an analysis of treatment models for persons with severe and persistant psychiatric disorders related to trauma exposure. She will highlight the emerging expert clinical consensus regarding the phases of treatment and how it has been adopted in public mental health settings in Maine and elsewhere in the country. Each presentation will be 20 minutes in length. There will be 30 minutes for audience discussion.

TARGET AUDIENCE:

Public sector clinicians, medical directors, administrators, and policy makers.

REFERENCES:

1. Women's Mental Health Services: A Public Health Perspective. Edited by Levin, Blanch & Jennings, 1998.
2. Memory, Trauma Treatment and the Law, Brown, Hammond & Scheflin, 1998.

Workshop 23 **Sunday, October 31**
8:00 a.m.-9:30 a.m.

PARTIAL HOSPITALIZATION FOR PERSONALITY DISORDERS

Association for Ambulatory Behavioral Healthcare

Lawrence L. Kennedy, M.D., *Director, Partial Hospitalization Services, The Menninger Clinic, P. O. Box 829, Topeka, KS 66601*

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to (1) recognize the special problems of treating personality disorders, (2) understand the components of a comprehensive partial hospitalization, and (3) appreciate the advantages of a partial hospital setting for treating severe personality disorders.

SUMMARY:

Axis I pathology frequently requires inpatient crisis treatment. Once the major symptoms have been treated, it is important to treat the underlying personality disorder if improvement is going to last. The treatment can be done successfully in a special comprehensive partial hospital setting. Such a program includes scheduled therapeutic activities five days weekly, group and individual psychotherapy, family treatment, medication prescription, crisis management, and psychoeducation groups.

Special problems in treating severe borderline pathology in this level of care will be examined and treatment approaches will be presented.

Case examples will be utilized. Participants will be encouraged to share their experiences. The final half hour will be devoted to open discussion.

REFERENCES:

1. Wilberg T, Karterud S, Urnes O, Pedersen G, Friis S: Outcomes of poorly functioning patients with personality disorders in a day treatment program. Psychiatric Services 1998; 49(11), 1462–1467.
2. Kennedy LL: Treatment of the borderline patient in partial hospitalization. The Psychiatric Hospital 1991; 22(2), 59–67.

Workshop 24 **Sunday, October 31**
10:00 a.m.-11:30 a.m.

EVALUATION AND TREATMENT OF PSYCHIATRIC DISORDERS IN INFANCY

Byron A. Hammer, M.D., *Department of Psychiatry, Louisiana State University School of Medicine, 1542 Tulane Avenue, New Orleans, LA 70001*; Jean Valliere, B.C.S.W.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to recognize, evaluate, briefly treat, and refer appropriately parent-infant dyads with significantly compromized function requiring psychiatric intervention.

SUMMARY:

This workshop will feature three 20–25 minute presentations by infant mental health professionals. Topics that will be introduced and discussed include an outline, description, and examples of an office-based evaluation of cases with significant parent-infant psychopathology. The etiology, treatment, and future psychiatric implications of attachment disorders will be addressed. Examples of videotaped evaluations and treatment sessions will be shown.

REFERENCES:

1. Minde L: Child and adolescent psychiatric clinics of North America-infant psychiatry.
2. Zeanah C: Handbook of Infant Mental Health.

Workshop 25 **Sunday, October 31**
10:00 a.m.-11:30 a.m.

ROLE OF PSYCHIATRY: ACTIVE LEADERSHIP, PASSIVE ACCEPTANCE

Deborah M. Moran, M.D., *President, Moran and Associates, 7 Maynard Place, Cambridge, MA 02138-4707*; Harvey Bluestone, M.D., *Member, APA Institute Scientific Program Committee, and Director of Psychiatry, Bronx-Lebanon Hospital Center, 1285 Fulton Avenue, Bronx, NY 10456-3401*; Sarah M. Owens, M.A.; Helen White

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to recognize both the process and the potential impact of the Medicaid capitated structure on the psychiatric care of mentally ill and substance abusing patient.

SUMMARY:

New York Medicaid is in the process of converting from the traditional fee-for-service payment system to a capitated reimbursement structure. Two members of the panel (Dr. Moran and Ms. White) have negotiated this major transition in MA.

Over the past year they have served as consultants to the Bronx-Lebanon Hospital Center. Their collaboration with the chairman of the department of psychiatry (Dr. H. Bluestone) and the vice president of managed care (Ms. Sarah Owens) will be presented with this transition to managed care.

This "case study" will serve as a starting point for a discussion about the major changes in mental health and substance abuse services in the managed care era.

REFERENCES:

1. Dickey B, Azeni H: Persons with dual diagnoses of substance abuse and major mental illness: their excess costs of psychiatric care. Am J Public Health 1996; 86:973–977.
2. Lazarus A: Managed competition and access to the emergency psychiatric care. Hospital and Community Psychiatry 1993; 44:1134–1136.

Workshop 26 **Sunday, October 31**
10:00 a.m.-11:30 a.m.

TOWN AND GOWN: A TALE OF A SUCCESSFUL MARRIAGE

Charles J. Chester, M.D., *Clinical Director, Department of Adult Psychiatry, DePaul-Tulane Behavioral Health Center, 1040 Calhoun Street, New Orleans, LA 70118*;

Michael J. Biunno, M.D.; Philip Griffin, Ph.D.; Sally Bates, R.N.C.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to identify key strategies in the development of academic training for psychiatric residents and medical students in an ever changing managed care environment.

SUMMARY:

In early 1997 the adult inpatient psychiatric service at Tulane University Medical Center successfully merged with DePaul Hospital, thus forming an alliance between an academic teaching service and a privately run free-standing psychiatric facility. Despite deep concerns about the future of academia in an ever changing managed care setting, the merger proved to be a positive one, providing an educational experience for all those involved.

The topic of discussion at this workshop will concern the pros and cons of the current trend of academic institutions "going corporate." The issue will be reviewed by an academic physician, a managed care physician, and a program director from the DePaul-Tulane Behavioral Health Center Department of Adult Inpatient Services. Particular areas of discussion will involve the history of academia and managed care, the development of several educational programs, and the integration of personnel "in training" in the managed care setting. The audience members will be able to discuss concerns about future changes in managed care and the effect on academic training, and also concerns about possible similar mergers of facilities of this kind. The audience will be invited to ask questions concerning the administrative process, the business practices, and the teaching activities involved in the merger. The audience will also be able to discuss the current management and evolution of this academic inpatient unit.

REFERENCES:

1. Whitman N, Schwenk T: The Physicians Teacher, Salt Lake City, Whitman Associates, 1997.
2. Grum M, Wooliscroft JO: Educating medical students in ambulatory clinics while maintaining patient flow. Acad Med 1996; 71:534–535.

Workshop 27 **Sunday, October 31**
10:00 a.m.-11:30 a.m.

MENTAL HEALTH ADVOCACY IN PROMOTING COMMUNITY SERVICES

National Mental Health Association

Mary D. Graham, B.A., *Vice President of Healthcare Reform, National Mental Health Association, 1021 Prince Street, Alexandria, VA 22314-2971*; Laura Young, Ph.D., *Senior Director, Adult Mental Health Services, National Mental Health Association, 1021 Prince Street, Alexandria, VA 22314-2971*

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to identify factors that have contributed to successful state mental health advocacy campaigns to bring about consensus for state-of-the-art community-based services for individuals with serious and persistent mental illnesses. Participants should also be aware of how all stakeholders can become active in the state and local mental health advocacy coalitions that conduct these types of campaigns.

SUMMARY:

The advances of medical technology and the newer atypical antipsychotic medications are creating new state-of-the-art service programs for people with serious and persistent mental illnesses. Consumers are experiencing levels of recovery that were not seen five to ten years ago in community settings. Consumers are developing strong advocacy roles as well, with an agenda to help create and maintain a voice in these service systems. While this change has an enormous impact on all stakeholders in the public mental health service system, our communities are still learning how to advocate effectively during the process of change.

To help accelerate that learning process, this workshop will present a model for community training to bring about consensus on local levels regarding community-based service systems and program design. The National Mental Health Association's State Healthcare Reform Advocacy Project, and the NMHA Partner's in CARE program are working in local communities with coalitions with the goal of implementing replication of model mental health programs. Presenters will examine how these campaigns were conducted and review the elements that led to achieving their goals, as well as describe the barriers that were faced. Through these case studies and an audience discussion, this symposium will also explore ways in which all stakeholders can become active in state mental health advocacy coalitions.

REFERENCES:

1. Healthcare Reform: A Consumer, Family and Advocate Perspective. Edited by Gabriele R. Alexandria, Va, National Mental Health Association, 1997.
2. Healthcare Reform: A Consumer, Family and Advocate Perspective. Vol. 2. Edited by Graham M. Alexandria, Va, National Mental Health Association, 1998.
3. Kanapaux W: Dose of NMHA-style training helps advocates prepare for reform. Mental Health Weekly 1997; (October 13) 7:39.

4. Pena A: Association trains groups to tackle managed care, forge coalitions. Mental Health News Alert August 25, 1997.

Workshop 28 **Sunday, October 31**
1:30 p.m.-3:00 p.m.

USING PRACTICE GUIDELINES TO IMPROVE QUALITY

APA Steering Committee on Practice Guidelines and APA Council on Quality Improvement

John S. McIntyre, M.D., *Chair, APA Steering Committee on Practice Guidelines, Chair, Department of Psychiatry and Behavioral Health, Unity Health System, and Past President, American Psychiatric Association, 81 Lake Avenue, 3rd Floor-Administration, Rochester, NY 14608*; Deborah A. Zarin, M.D.; Joyce C. West, M.P.P.; Philip S. Wang, M.D., D.P.H.; Sara C. Charles, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, participants should understand methods by which evidence-based practice guidelines can be used to monitor and improve quality of care provided to patients with mental disorders.

SUMMARY:

To promote evidence-based treatment and enhanced quality of care for patients with mental disorders, the APA plans to systematically abstract key recommendations from its evidence-based practice guidelines to use as the basis for quality improvement activities. Although conformance with evidence-based practice guidelines has been shown to be related to improved outcomes of treatment and provide well accepted measures of quality of care, there is substantial research indicating that dissemination of the guidelines in their current format is not effective. More succinct "user-friendly" tools are needed to facilitate more effective implementation of the guidelines and bring about improvements in the treatment of patients with mental disorders.

This workshop provides an overview of the APA's multifaceted practice guideline-based quality improvement activities, including an overview of: (1) specific practice guideline "derivative products," tools, and interventions being planned; (2) the development of guideline-based quality of care conformance measures/indicators; and (3) specific examples of research conducted to assess psychiatrist, health plan, patient, and setting factors associated with guideline conformance for patients with major depression, schizophrenia, and bipolar disorder to inform quality improvement initiatives.

REFERENCES:

1. McGlynn EA: Six challenges in measuring the quality of health care. Health Affairs May/June, 1997; 16:3.
2. Eddy DM: Performance measurement: problems and solutions, Health Affairs, July/August, 1998; 17:4.

Workshop 29 **Sunday, October 31**
1:30 p.m.-3:00 p.m.

ISSUES IN ENGAGING THE SERIOUSLY MENTALLY ILL

Daniel Yohanna, M.D., *Assistant Professor of Psychiatry, Department of Psychiatry, Northwestern University, 303 East Superior, Chicago, IL 60611*; Nancy B. Slagg, Ph.D.; Michael Maslar, Psy. D.; Katherine E. Edstrom, Ph.D.; Marcia A. Brontman, M.D.; Kenneth A. Cohen, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should learn new ideas on how to engage the homeless, severe, and persistent mentally ill patient into treatment including methods of assessing engagement; to gain knowledge on several subsets of this population based on data collected in the NWHome Project.

SUMMARY:

The NWHome Project is a HUD-funded, community-based satellite program of a psychosocial rehabilitation community mental health center in a large urban area. The program treats homeless, mentally ill patients. For the last three years, we have gathered data on patients' patterns of engagement into treatment and follow-up data on those who have stayed in the program and those who have left the program.

The workshop will present data, ideas, and outcomes on how to engage this population in treatment and will look at several subpopulations, a pathway approach, referral sources, and anecdotal case presentations. This workshop follows up on data presented at the 1998 Institution on Psychiatric Services.

REFERENCES:

1. Treatment Compliance and the Therapeutic Alliance: Chronic Mental III., Vol. 5. Edited by Blackwell B, et al. Singapore, Harwood Academic Publishers, pp. 35–60.
2. Perkins, RE, Fisher, NR: Beyond mere existence: the audition of care plans. Journal of Mental Health (UK), Vol. 5(3), July 1996, 275–286.

Workshop 30 **Sunday, October 31**
1:30 p.m.-3:00 p.m.

THE PRACTICE OF TRANSCULTURAL PSYCHIATRY IN AN INNER CITY

Nalini V. Juthani, M.D., *Director of Psychiatry Education, Bronx-Lebanon Hospital, and Associate Professor of Psychiatry, Albert Einstein College of Medicine, 1276 Fulton Avenue, 4th Floor, Bronx, NY 10456*; Ali Khadivi, Ph.D.; Mikhail Y. Ziskin, M.D.; Serina Islam, M.A.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to recognize the diagnostic, psychotherapeutic, and supervisory issues that can emerge in a transcultural dyad involving a foreign-born therapist and nonmainstream patient.

SUMMARY:

The literature on crosscultural psychotherapy has focused mainly on the mainstream therapist and minority patient dyad or on the ethnic minority therapist treating a mainstream patient. Little attention has been paid to the foreign-born therapist treating a minority patient or one from a culture other than the United States. This workshop will examine the diagnostic, psychotherapeutic, and supervisory issues that emerge in this transcultural treatment from four perspectives: director of residency training, psychotherapy supervisor, psychiatric resident, and doctoral psychology student, all of whom come from different cultural backgrounds and have varying degrees of acculturation and clinical experience. Using case vignettes, the workshop organizers will briefly outline some of the ethnocultural factors that can impact the diagnostic, psychotherapeutic, and supervisory processes. Participants will be invited to share their clinical experiences.

REFERENCES:

1. Cheng L, Lo H: On the advantages of cross-cultural psychotherapy: the minority therapist/mainstream patient dyad. Psychiatry 1991; 54:386–396.
2. Comas-Diaz L, Jacobsen FM: Ethno-cultural transference and countertransference in the therapeutic dyad. Am J Orthopsychiatry 1991; 61:392–402.

Workshop 31 **Sunday, October 31**
1:30 p.m.-3:00 p.m.

1-800-LIFENET: THREE YEARS OF ENHANCING TREATMENT ACCESS

Michael S. Lesser, M.D., *Medical Director, New York City Department of Mental Health, 93 Worth Street, Room 414, New York, NY 10013-3412*; John Draper, Ph.D.; Isaac Monserrate, C.S.W.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to understand the utility of a 24-hour, seven-day professionally staffed mental health hotline in enhancing access to treatment, crisis, and emergency services in urban areas. The participant will recognize the varied uses of the resource database and assessment software.

SUMMARY:

Now in its third year, 1-800-LIFENET, a free and confidential telephone helpline operated through a partnership between the Mental Health Association of New York City and the NYC Department of Mental Health, has been successfully enhancing access to mental health and substance abuse treatments for thousands of New Yorkers. As the city's "411 and 911 for mental health/substance abuse problems," this innovative program allows callers to speak with trained social workers via telephone, 24 hours, 7 days a week. These workers assess the severity of the caller's problem and refer the call to appropriate services from its database of over 3,000 resources. If callers are assessed to be at risk, LifeNet links callers to the city's psychiatric crisis and emergency services. LifeNet's customized software organizes the data collected from callers into dozens of reports, indicating trends in mental health/substance abuse treatment needs among NYC residents. LifeNet's success has led to 1-877-AYUDESE, a "Spanish LifeNet" recently launched to similarly address the mental health and substance abuse concerns of the city's 1.8 million Hispanics.

This highly interactive workshop will allow the audience to explore a variety of issues, including: (1) outreach and public education methods to improve access to treatments; (2) three-year trends in NYC's mental health/substance abuse service needs; (3) the effective, efficient use of software in mental health assessment and referral activities; (4) the use of a service such as this in linking the public to crisis and emergency services; and (5) multicultural treatment issues through the experience of 1-877-AYUDESE.

TARGET AUDIENCE:

All persons interested in community mental health policy, planning, and public education.

REFERENCES:

1. Sankar DV, Mintus J: An analysis of telephone referrals of a mental health association chapter. Soc. Sci Med. 1978; 12:63–66.
2. Feinstein R, Plutchik R: Violence and suicide risk assessment in the psychiatric emergency room. Comprehensive Psychiatry 1990; 31:337–343.

Workshop 32 **Sunday, October 31 3:30 p.m.-5:00 p.m.**

LESBIAN AND GAY FAMILIES: NEW SUCCESSES, NEW STRUGGLES

Association of Gay and Lesbian Psychiatrists

Mark H. Townsend, M.D., *Associate Professor of Psychiatry, Department of Psychiatry, Louisiana State University School of Medicine, 1542 Tulane Avenue, Box T4-6, New Orleans, LA 70112-2825*; Anna M. Wellman, M.S.W.; Roy Q. Sanders, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to identify common issues in the treatment of lesbian and gay couples and describe their current legal framework.

SUMMARY:

This workshop will explore the current situation of lesbian and gay families in order to develop a better understanding of the issues they bring to psychiatrists and other mental health practitioners. This workshop will be highly interactive and will rely as much on the expertise of the panel as on the experiences of the audience. The panelists will discuss the varieties of lesbian and gay families and provide an overview of both the patterns of psychological wellness and the mental health concerns that have been reported. Case studies drawn from patients treated by the panelists will be presented and relevant literature will be cited and discussed. Topics to be covered include the following: the psychological aspects of same-sex marriage and its denial; legal and psychological issues for lesbian and gay parents; and topics in the psychotherapy and counseling of same-sex couples. This workshop will place an emphasis on providing the audience with information they can put to use in their own clinical practice.

TARGET AUDIENCE:

Mental health practioners of all disciplines.

REFERENCES:

1. Townsend M: Mental health issues and same sex marriage. Edited by Cabaj RP, Purcell DW. On the Road to Same Sex Marriage. San Francisco: Jossey-Bass.
2. Patterson C: Children of the lesbian baby boom. Dev Psych 1994; v. 31.

Workshop 33 **Sunday, October 31 3:30 p.m.-5:00 p.m.**

BASIC GERIATRIC PSYCHIATRY FOR GENERAL PSYCHIATRISTS

APA Committee on Access and Effectiveness of Psychiatric Services for the Elderly and APA Committee on Long Term Care and Treatment for the Elderly

Mustafa M. Husain, M.D., *Department of Psychiatry, University of Texas Southwestern Medical Center, 5323 Harry Hines Boulevard, MC-9070, Dallas, TX 75235-7200*; Blaine S. Greenwald, M.D.; Gary J. Kennedy, M.D.; James A. Greene, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop the participants should be able to recognize, differentiate between, and provide appropriate management of depression, delirium, and dementia in the elderly. Participants will also learn special needs and assessment of patients in nursing homes.

SUMMARY:

With the number of elderly Americans increasing over the past two decades, more and more general psychiatrists are asked to take part in the care of these elderly patients. The purpose of this workshop is to assist the general psychiatrist assess and evaluate, differentiate, and provide appropriate treatment and management to this fragile population.

The leaders of the workshop will focus on different aspects for the management of late-life depression, delirium, and dementia. Special needs and management in nursing home patients will be reviewed.

The following elements will be discussed with input from workshop participants: guidelines for needs assessment, special considerations on mental status examinations, screening tests for subtle depression or dementia, indicated medical and psychological workup, and treatment options and special considerations of the geriatric patient in the nursing home.

REFERENCES:

1. Herman SE, Jordan L, Solomon G: Immediate outcomes of treating geriatric patients in a state psychiatric hospital. J Ment Health Adm 1995; 24:139–145.
2. Feighner JP: Compliance and quality of response are major contributors to cost-effective antidepressant therapy in the treatment of geriatric patients. Human Psychopharmacology 1994; 9:S26–S29.

Workshop 34 **Sunday, October 31**
3:30 p.m.-5:00 p.m.

CREATING COMMUNITY: IDENTITY AND CULTURE IN AN ASSERTIVE COMMUNITY TREATMENT PROGRAM

Alberto B. Santos, Jr., M.D., *Professor of Psychiatry, Department of Psychiatry, Medical University of South Carolina, 67 President Street, Box 250861, Charleston, SC 29425*; Israel Katz, M.D.; Manjeev K. Khush, M.D.; Julie L. Leavitt, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be familiar with how to incorporate culture, sexual orientation, and gender-specific paradigms into an ACT model.

SUMMARY:

Identity similarities and dissimilarities between client and staff, including culture, gender, and sexual orientation, are heightened in Assertive Community Treatment Programs. Because the treatment occurs in vivo, staff become familiar with various aspects of their clients' identities, and clients may have opportunities to learn about the staff's. In addition, identity issues interact with mental illness in unique ways, given the clients' sometimes fluid self and other perceptions.

Community Focus is a capitated ACT in San Francisco consisting of three teams: Adelante (the Latino and Asian Team), Crosscurrents (the women's, gay, lesbian, bisexual, and transgender team), and Kujichagulia (the African-American and Euro-American team). Our program incorporates culture, sexual orientation, and gender-specific paradigms into an ACT model. The teams are staffed by multidisciplinary providers with backgrounds, interests, and expertise in issues relevant to that team. Students of various disciplines, including medical students, nurses, residents, and social work interns, train with us. We foster with formal and informal trainings self-awareness among the staff and students of their own identity issues. We will discuss how this creative approach enhances the therapeutic interchange, improves clinical outcomes, and increases cost-containment. We will also discuss how we have used this model to enrich the training experience in our program.

TARGET AUDIENCE:

Multidisciplinary staff and trainees.

REFERENCES:

1. Manoleas P: The Cross-Cultural Practice of Clinical Case Management in Mental Health. New York, Haworth Press, 1996.
2. Stein L, Santos A: Assertive Community Treatment of Persons with Severe Mental Illness. Norton Publishers, 1998.

Workshop 35 **Sunday, October 31**
3:30 p.m.-5:00 p.m.

COMPLEMENTARY MEDICINE AND THE PSYCHIATRIST

Susan R. Downs, M.D., *Assistant Clinical Professor, Department of Psychiatry, University of California at San Francisco, 1537 Bonita Avenue, Berkeley, CA 94709*; Edward B. Gogek, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant will be able to describe the principles, supporting research, psychiatric applications, risks, drug interactions, and legal issues for the three most popular alternative medicine modalities of acupuncture, homeopathy, and herbal remedies.

SUMMARY:

A growing number of Westerners are turning to alternative medicine. This workshop will describe three of these approaches: acupuncture, homeopathy, and herbal remedies. The underlying principles and supporting clinical research will be delineated. Psychiatric applications and suggestions on combining these modalities with allopathic approaches will be presented. Issues of safety, toxicity, and interactions with psychotropic medications will be discussed. In addition, legal and liability issues will be highlighted.

REFERENCES:

1. Wong AHC, Smith M, Boon HS: Herbal remedies in psychiatric practice. Arch Gen Psychiatry 1998; 55:1033–1044.
2. Linde K, Clausius N, Ramirez G, et al: Are the clinical effects of homeopathy placebo effects? a meta-analysis of placebo-controlled trials. Lancet 1997; 350:834–843.

Workshop 36 **Monday, November 1**
8:00 a.m.-9:30 a.m.

KIDS AND MEDICATIONS: MEETING CONSUMER NEEDS

Gordon R. Hodas, M.D., *Statewide Child Psychiatrist, Pennsylvania Department of Public Welfare, 214 East Gravers Lane, Philadelphia, PA 19118-2803*

EDUCATIONAL OBJECTIVES:

At the conclusion of the workshop, participants will be able to recognize common concerns of children, adolescents, and caregivers to the use of psychotropic medication. Mental health caregivers will be able to respond constructively to such concerns.

SUMMARY:

Psychotropic medication for children and adolescents constitutes an important, often controversial, issue for children and caregivers. Parents, for example, may question if the physician's goal is to help, or control, the child. The difference between prescribed medication and "street drugs" may be unclear. There may also be cultural concerns and misconceptions regarding side effects. The child may conclude that by needing medication he/she is "bad." An adolescent may also be concerned about issues of stigma, privacy, and autonomy.

This workshop considers the issue of "kids and meds" from the perspectives of consumer and physician, highlighting the importance of meeting the needs of the consumer (child and parents/caregivers) and the physician. A key element, consistent with CASSP (Children and Adolescent Service System Program) principles, involves the creation of a respectful, collaborative process that builds on the expertise of all parties. There is also need for an appreciation of the specific concerns of child or family; consumer-friendly explanations and literature (examples will be provided); the ongoing availability of the physician; a service system supportive of integrative care.

Participants will learn the challenges and opportunities and some specific positive approaches to providing psychotropic medication, when needed, to children and adolescents.

REFERENCES:

1. Hodas G: Promoting appropriate use of psychotropic medications for children and adolescents. Sharing Newsletter, Parents Involved Network of Pennsylvania 1998; 9(6):1, 2.
2. Engler J, Goleman D: The Consumer's Guide to Psychotherapy: The Authoritative Guide to Making Informed Choices About All Types of Psychotherapy. New York, Simon & Shuster, 1992.

Workshop 37 **Monday, November 1**
8:00 a.m.-9:30 a.m.

PSYCHIATRIC ASPECTS OF OLFACTION

Alan R. Hirsch, M.D., *Neurologic Director, Smell and Taste Treatment and Research Foundation, 845 North Michigan Avenue, Suite 990-W, Chicago, IL 60611-2201*; Thomas J. Trannel, M.D.; Robert A. Baron, Ph.D.; Iris R. Bell, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to gain an understanding of the importance of olfaction and odors on behavior and psychiatric disease. To help acquire knowledge of the importance of olfaction/limbic system interaction and its effects on mood and thought processes.

SUMMARY:

This workshop will address the olfactory aspects of psychiatry. The olfactory lobe is the sensory system most intricately connected to the limbic system/emotional brain and, hence, may be a neglected key to understanding unconscious motivation. Disease states with olfactory symptoms will be addressed including depression, schizophrenia, temporal lobe epilepsy, olfactory reference syndrome, dysmorphophobia, delusional disorder, post-traumatic stress disorder, and Alzheimer's disease. Olfactory influences in normal behavior will be explored with emphasis on pheromones, food preferences, hedonics, mother-infant bonding, and emotional state. Acetylcholine, dopamine, and norepinephrine balance and their effects on the olfactory/limbic system will be presented. The potential role of olfactory stimuli in diagnosis and therapy will be discussed including effects of olfactory evoked recall on the transference relationship, use of olfactory ability as an indicator of mesolimbic dopamine receptor sensitivity, and use of odorants to modulate affective states.

TARGET AUDIENCE:

Clinical psychiatrists and neuropsychiatrists.

REFERENCES:

1. Hirsch AR, Trannel TJ: Chemosensory disorders and psychiatric diagnoses. J Neurol Orthop Med Surg 1966; 17:25–30.
2. Serby M, Larson P, Kalkstein D: Nature and course of olfactory deficits in Alzheimer's disease. Am J Psychiat 1991; 148:357.

Workshop 38 **Monday, November 1**
8:00 a.m.-9:30 a.m.

PREVENTION AND ACCESS INTERVENTION FOR SURVIVOR FAMILIES

Stevan M. Weine, M.D., *Department of Psychiatry, University of Illinois at Chicago, 1601 West Taylor Street, Room 423-S, Chicago, IL 60612*; Yasmina Kulauzovic, M.S.; Joseph A. Flaherty, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to recognize services and family-based approaches to refugee mental health and demonstrate an understanding of the use of multifamily groups.

SUMMARY:

One million refugees from ethnic cleansing in Bosnia-Herzegovina are an extreme, recent example of the global problem of torture and political violence. Despite the existence of formal mental health services offering efficacious treatments, there are still vast numbers of survivors who are suffering trauma-related mental health consequences and who do not have access to mental health care. This is in part related to the fact that refugee trauma has largely been approached from individual and psychopathological models. This presentation describes an innovative approach through a model of Prevention and Access Intervention for Survivor Families. It is currently being tested in Chicago with Bosnian refugee families who are survivors and who are not using formal mental health services. Stevan Weine will review the rationale for this preventive intervention that consists of new research data on Bosnian families as well as theory and research pertaining to help seeking, pathways to care, and families. Jasmina Kulauzovic will describe the CAFES groups (Coffee and Families Education and Support) and the training of the group leaders, including illustrative vignettes with audience participation. Joe Flaherty will discuss challenges and opportunities for prevention and access intervention projects in the areas of immigrant, refugee, and urban families. Following these three brief presentations we will facilitate an open discussion. Throughout the session the audience will be encouraged to interact with presenters.

TARGET AUDIENCE:

Clinicians, researchers, administrators, and policymakers.

REFERENCES:

1. Weine SM, Vojvoda D, Hartman S, Hyman L: A family survives genocide. Psychiatry 1997; 60:24–39.
2. Williams CL: Prevention programs for refugees: an interface for mental health and public health. J Primary Prevention 1979; 10:167–168.

Workshop 39 **Monday, November 1**
8:00 a.m.-9:30 a.m.

TREATING ECONOMICALLY DISADVANTAGED MENTALLY ILL CHEMICALLY ABUSING PATIENTS

Ali Khadivi, Ph.D., *Associate Director of Psychology, Department of Psychology, Bronx-Lebanon Hospital, 1276 Franklin Avenue, 6th Floor, Bronx, NY 10456*; Harvey Bluestone, M.D.; Ramanbhai C. Patel, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to recognize the clinical challenges and intervention strategies involved in treating disadvantaged MICA patients; to gain a better understanding of the impact of poverty on patients with severe mental illness and substance abuse.

SUMMARY:

The impact of poverty on the mentally ill can be devasting. Increased substance abuse, multiple medical problems, and chaotic and traumatic life experiences are highly prevalent in this population. This workshop will examine challenges in the diagnosis and treatment of economically disadvantaged, mentally ill, chemical abusing (MICA) patients. A major problem to be faced in treatment of disadvantaged MICA patients is that, in addition to substance abuse, the culture of poverty adds an additional complexity to their care. The aim of the workshop is to explore this problem and to offer clinical strategies to enhance diagnostic assessment and treatment adherence.

The workshop will be highly interactive. After a brief presentation outlining the clinical issues and approaches for intervention, participants will be invited to offer their views and to broaden therapeutics perspectives and discuss this challenging treatment problem.

REFERENCES:

1. Aday LA: At Risk in America. San Francisco, Jossey-Bass, 1992.
2. Herman M, Galanter M, Lifshutz H: Combined substance abuse and psychiatric disorders in homeless and domiciled patients. Am J Drug Alcohol Abuse 1991; 17:415–422.

Workshop 40 **Monday, November 1**
10:00 a.m.-11:30 a.m.

UPDATE ON PRACTICE GUIDELINES: HIV/AIDS

John S. McIntyre, M.D., *Chair, APA Steering Committee on Practice Guidelines, Chair, Department of Psychiatry and Behavioral Health, Unity Health System, and Past President, American Psychiatric Association, 81 Lake Avenue, 3rd Floor-Administration, Rochester, NY 14608*; J. Stephen McDaniel, M.D.; Deborah A. Zarin, M.D.; Sara C. Charles, M.D.; Francine Cournos, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, participants will leave the session with an understanding of the develop-

ment process of the APA practice guidelines and the content of the HIV/AIDS practice guideline with an emphasis on practical treatment strategies for persons with HIV/AIDS.

SUMMARY:

The APA practice guidelines project has moved forward according to a process designed to result in documents that are both scientifically sound and clinically useful to practicing psychiatrists. On the basis of nationally recognized standards for the development of practice guidelines (sometimes termed "practice parameters"), APA guidelines reflect: (1) comprehensive literature reviews; (2) classifications of supporting evidence and the nature of recommendations; and (3) a series of revisions based on input from the Steering Committee, Work Group, Assembly, Board of Trustees, Joint Reference Committee, related APA components, and from psychiatric consultants, nonpsychiatrist experts, and representatives from related organizations.

As increasing numbers of psychiatrists are called upon to care for patients with HIV infection, practice guidelines are needed to ensure up-to-date, comprehensive clinical care. Workshop panelists will present the latest draft of the HIV/AIDS Practice Guideline. Specific content will focus on psychiatric management of neuropsychiatric syndromes (e.g., neurocognitive disorders, mood disorders, psychotic disorders, and anxiety disorders), substance abuse, childhood disorders, somatic syndromes, and HIV risk-reduction strategies.

Copies of the latest draft of the HIV/AIDS Practice Guideline will be available for study, and members of the work group will be available to respond to questions regarding this guideline of great importance to psychiatry.

REFERENCES:

1. McDaniel JS, Purcell DW, Farber EW: Severe mental illness and HIV-related medical and neuropsychiatric sequelae. Clinical Psychology Review 1997; 17:311–325.
2. American Psychiatric Association: HIV-Related Neuropsychiatric Complications and Treatments, 1998.

Workshop 41 **Monday, November 1**
10:00 a.m.-11:30 a.m.

MEDIA SKILLS FOR MEMBERS IN TRAINING AND EARLY CAREER PSYCHIATRISTS

APA Joint Commission on Public Affairs

Nada L. Stotland, M.D., M.P.H., *Chair, Department of Psychiatry and Substance Abuse Services, Illinois Masonic Medical Center, 919 West Wellington Avenue, Chicago, IL 60657*; Lynn Schultz-Writsel; Melissa Katz

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to identify and present effective messages about psychiatric illnesses, treatments, and public policies that affect them, to the public, through the media.

SUMMARY:

The knowledge and attitudes of individuals drive personal and family decisions about mental health care, and, through the legislative and executive branches of government, determine laws and regulations concerning health care education, funding, systems, priorities, requirements, and restrictions. Ignorance about psychiatric issues is rife, as is stigma against mental illnesses, those who suffer from them, and those who treat them. Psychiatrists in training and recently out of training are in close contact with scientific developments and with the realities of providing care in a wide variety of settings. With their careers ahead of them, they have much at stake in the court of public opinion. They are perceived by the public and members of the media as less self-interested than more senior psychiatrists, and they can deliver messages with sincerity and enthusiasm. This workshop offers members in training and early career psychiatrists both didactic and hands-on experience with the skills necessary to identify newsworthy issues, craft messages about them, fit the messages to the appropriate audiences and media, and get the messages across to the public.

REFERENCES:

1. Strategic Marketing for Non Profit Organizations, 5th Edition. Philip Kotler and Alan Andreasen, 1996.
2. The GSWAE Foundation Marketing the Non Profit Association. Stephen C. Carey, Managing Editor and Publisher, 1996.

Workshop 42 **Monday, November 1**
10:00 a.m.-11:30 a.m.

ACADEMIC-COMMUNITY LIAISONS IN OUTPATIENT SETTINGS

Russell F. Lim, M.D., *Clinical Assistant Professor, Department of Psychiatry, University of California at Davis, 601 West North Market Boulevard, Suite 100, Sacramento, CA 95834*; Kathleen A. Daly, M.D.; Jacqueline M. Feldman, M.D.; John A. Talbott, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to learn (1) the advantages and disadvantages of collaborations with outpatient CMHCs (commu-

nity mental health centers), (2) the 20-year history of university-community liaisons and what makes them successful, (3) the impact of RRC (Residency Requirement Committee) requirements on residency programs, (4) three examples of successful university-community collaborations.

SUMMARY:

Over the past 20 years, three surveys have described the relationship between CMHCs and academic departments of psychiatry, one each in 1979, 1987, and 1990. All of the surveys showed that there were several models for these collaborations and that there appeared to be an increase in the number of CMHCs affiliated with academic institutions. Our group repeated the survey, but with a focus on outpatient services. We will present our results during the workshop. We believe that the CMHC provides an economically viable training site that is also culturally diverse. Many academic departments of psychiatry have increased their faculty by either contractual agreements or clinical appointments that did not increase the academic departments' budgets. In addition, many CMHCs serve the minority populations that typically have lower socioeconomic status and lack insurance or other means to be seen in fee-for-service settings.

Medical directors of public and nonprofit contract CMHCs will give presentations from Sacramento, California; Los Angeles, California; and Birmingham, Alabama. Issues discussed will be the challenges of balancing the CMHC's needs and agendas while providing quality mental health services and training experiences. The audience will participate at various points during the workshop to describe their experiences with university-community liaisons.

TARGET AUDIENCE:

Consumers, community psychiatrists, academic and county administrators.

REFERENCES:

1. Douglas EJ, Faulkner LR, Talbott JA, et al: Administrative relationships between community mental health centers and academic psychiatry departments: a 12-year update. American Journal of Psychiatry 1994; 151:722–7.
2. Talbott JA, Jeffries M, Arana JD: CMHC's: relationships with academia and the state. Community Mental Health Journal 1987; 23:271–281.
3. Faulkner LR, Eaton JS: Administrative relationships between community mental health centers and academic psychiatry departments. American Journal of Psychiatry 1979; 136:1040–4.

Workshop 43 **Monday, November 1**
10:00 a.m.-11:30 a.m.

EMPLOYING PERSONS WITH MENTAL ILLNESS

Deborah Fisk, M.S.W., *Clinical Coordinator, New Haven Access, 566 Whalley Avenue, New Haven, CT 06511*; Jaak Rakfeldt, Ph.D.; Dawn Johnson, B.A.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, participants should be able to identify issues that can emerge when consumers of mental health and/or substance abuse services are employed in non-consumer-operated projects.

SUMMARY:

In this workshop clinical and consumer staff will draw from their experiences in a federally funded homeless outreach project to explore the issues that can emerge when employing formerly homeless persons with mental illness and/or substance abuse disorders. The presenters will propose several strategies that can ease the integration of consumer staff into their work positions in non-consumer-operated clinical projects. A history of the consumer provider movement will be reviewed, along with relevant literature. The presenters will offer their insights as to why mental health agencies have resisted employing consumers of mental health services, despite research findings that consumers make valuable contributions to client care settings. Workshop participants will be encouraged to join in the discussion and share their experiences as employed consumers or employing consumers in non-consumer-operated clinical projects.

TARGET AUDIENCE:

Mental health professionals, consumers, and family members.

REFERENCES:

1. Davidson L, Weingarten R, Steiner J, et al: Integrating prosumers into clinical settings, in CT Mowbay (ed.), Consumers as Providers in Psychiatric Rehabilitation: Models, Applications and First Person Accounts. Int Assoc of Psychosocial Rehab Serv, 1997.

Workshop 44 **Monday, November 1**
1:30 p.m.-3:00 p.m.

RISK MANAGEMENT IN THE ERA OF MANAGED CARE

Helen G. Muhlbauer, M.D., *Director, Comprehensive Psychiatric Emergency Program, Bronx-Lebanon Hospital, 1276 Franklin Avenue, Bronx, NY 10456*; Ali Khadivi, Ph.D.; Sarah M. Owens, M.A.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to learn clinical strategies needed to assess and treat high-risk psychiatric patients in the current managed care environment; to become familiar with the risk-management procedures sought by managed care organizations when contracting with providers.

SUMMARY:

Managed care has greatly limited the resources and time available to assess and treat high-risk psychiatric patients. However, psychiatrists' clinical, ethical, and legal responsibilities for their patients have not changed. Most standards for evaluation of high-risk psychiatric patients are based on pre-managed care patterns of care. This raises important risk management and medicolegal problems.

This workshop will explore and expand time-sensitive clinical strategies for risk assessment and management of acutely ill psychiatric patients. Participants will benefit from the perspective of a managed care administrator who will discuss the industry's methods of assessing risk-management procedures of providers. The workshop organizers will review the current guidelines in the literature and will offer cases to initiate discussion. Participants will be encouraged to bring their own institutional and practice experiences for discussion. Finally, strategies to facilitate more effective documentation and communication of these issues with patients, managed care entities, and utilization reviewers will be discussed. Handouts and references will be provided.

REFERENCES:

1. Simon RI: Psychiatrists' duties in discharging sicker and potentially violent inpatients in the managed care era. Psychiatric Services 1998; 49:62–67.
2. Appelbaum PS: Legal liability and managed care. American Psychologist 1993; 48:251–257.

Workshop 45 **Monday, November 1**
1:30 p.m.-3:00 p.m.

CURRENT CONCEPTS IN WORKING WITH LESBIAN AND GAY PATIENTS

APA New York County District Branch's Committee on Gay and Lesbian Issues

John A. Gosling, M.D., *152 8th Avenue, #1R, New York, NY 10011-5118*; Richard O. Hire, M.D.; Alan Schwartz, M.D.; Julie K. Schulman, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participants should know many of the current concepts of the psychological development of lesbians and gay men and of frequently encountered problems of this population, and how this information can be used in clinical work with this population.

SUMMARY:

There will be three 15-minute presentations by the panal in this workshop, with a focus on clinical issues pertaining to the treatment of lesbian and gay patients with ample time for audience questions and discussion. The presentations will address: (1) a review of the recent literature on the unique factors influencing the psychological development of lesbians and gay men and how these can inform clinical work. Case vignettes will illuminate these factors; (2) a review and critque of the literature regarding prevalence of those psychiatric disorders reported to occur more frequently in the lesbian and gay population, and how this influences the clinical evaluation; and (3) case vignettes that illustrate frequently encountered issues in clinical practice with lesbians and gay men and possible strategies to address these issues.

TARGET AUDIENCE:

Mental health professionals and others who work with lesbian and gay men in clinical and other settings.

REFERENCES:

1. Textbook of Homosexuality and Mental Health. Edited by Cabaj RP, Stein TS. American Psychiatric Press, Inc., Washington, DC, 1996.
2. Oldham J, Riba M, Tasman A, (eds.): Diagnostic and Statistical Manual-IV. American Psychiatric Press, Inc., Washington, DC, 1993.

Workshop 46 **Monday, November 1**
1:30 p.m.-3:00 p.m.

SELF-HELP, THE NEXT GENERATION: GOING WHERE FEW CONSUMERS HAVE GONE BEFORE

Kenneth Steele, *350 West 49th Street, #2B, New York, NY 10019*; Stephen M. Goldfinger, M.D.; Rita Seiden, Ph.D., C.S.W.; Daniel Frey; Adrienne Williams

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, participants will recognize the advantages, parameters, and pitfalls in partnering with consumers to develop truly consumer-run services.

SUMMARY:

In this workshop, a panel of "awakened" consumers doing well on the new atypical medications, together with family members and clinicians, will describe our

journeys through the mental health system, from the inside, looking out. We will delineate the systematic barriers to our independence and propose the kinds of "relevant" support programs needed for us to achieve independent lives in the "mainstream" community (avoiding mental health ghetto life).

To demonstrate these activities, we will discuss how three consumer-initiated community-based programs have met our needs. Each of these programs has engaged us as *leaders* in program development, rather than as followers of clinicians and other professionals. These programs include a citywide mental health advocacy journal, "New York City Voices," a mental health voter empowerment project, and the creation of peer-run, community-based Awakening Groups: Living Successfully with Mental Illness.

We intend to briefly present these examples and then engage with the attendees in an open-ended discussion of how, in their own communities and service areas, they can apply these principles in a way that will allow for both "self-help" and "consumer-provider partnerships."

REFERENCES:

1. Segal SP, Silverman C, Temkin T: Program environments of self-help agencies for persons with mental disabilities. J Ment Health Adm 1997; 24:456–464.
2. New York City VOICES: A Consumer Journal for Mental Health Advocacy.

Workshop 47 **Monday, November 1**
1:30 p.m.-3:00 p.m.

RESEARCH ISSUES: A MANUAL AND ITS EVALUATION

Jack M. Barbour, M.D., *Co-Director, Barbour and Floyd Medical Associates, 2610 Industry Way, Suite A, Lynwood, CA 90262-4028*; Reta D. Floyd, M.D.; Linda Connery, M.S.W.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to understand the development of a manual for clinical interventions, and to analyze an evaluation plan and to discuss its practicality in a home-based setting.

SUMMARY:

This workshop will briefly present a SAMHSA-funded research project to develop a manual on a homelessness prevention intervention and a plan to evaluate the effectiveness of the manualized intervention. The intervention is a home-based intervention for ethnic minorities with a mentally ill family member. This research is significant since a literature search indicates that little if any work has been done with minority families (African Americans and Latinos) with a mentally ill family member. This study is being conducted in an innovative integrated services agency. The evaluation plan includes two control groups in addition to the implementation group: one control group will receive the ongoing family services, and the other control group will receive no family services. The findings from the first year will be presented.

Audience participation will be encouraged and this workshop will be cutting edge. This workshop will be interactive—manualized interventions, the development of a manual, the development of a logic model, the evaluation plan (both pros and cons), and the reliability and validity of the evaluation plan are some of the topics for audience stimulation and participation.

TARGET AUDIENCE:

Mental health professionals working with the persistently mentally ill.

REFERENCES:

1. Belgrade FZ: Psychosocial predictors of adjustment to disability in African Americans. Journal of Rehabilitation 1991; 57:37–40.
2. Guarnaccia P, Parra P: Ethnicity, social status, and families' experiences of caring for a mentally ill family member. Community Mental Health Journal 1996; 32:243–260.

Workshop 48 **Monday, November 1**
1:30 p.m.-3:00 p.m.

CLASS ACTION SUITS AS A STRATEGY FOR CHANGE

Michael A. Hoge, Ph.D., *Associate Professor of Psychiatry, Department of Psychiatry, Yale University, 25 Park Street, 6th Floor, New Haven, CT 06519*; Larry Davidson, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to identify the legal bases for class action suits against states and their mental health departments, the role of mental health professionals in these actions, methods for evaluating the adequacy of care delivered by the state, and standards of care that can be applied in such evaluations.

SUMMARY:

Across the country, class action suits have been brought against states and state mental health departments on behalf of patients in their care. Typically these suits seek injunctions against practices perceived as harmful or overly restrictive and seek improvements in

the overall quality of care. During the workshop four critical issues will be reviewed and will be the focus of subsequent discussion with participants. These include (1) the legal bases for such suits, (2) the role of psychiatrists and mental health professionals in these legal actions (advocate, consultant, "neutral" expert), (3) methods for evaluating the adequacy of care provided by the state, and (4) the standards that might be applied in such evaluations (accreditation standards, comparison with other systems of care, published literature, expert opinion). Case examples of actual suits will be used to illustrate various approaches to these issues. In addition to considering these topics, the discussion will also focus on the positive and potentially negative effects of this legal and confrontational strategy for attempting to improve publicly funded mental health care.

TARGET AUDIENCE:

Consumers, advocates, and state administrators.

REFERENCES:

1. Bachrach LL: The state of the state mental health hospital in 1996. Psychiatric Services 1996; 47:1071–1078.
2. Kunze H, Priebe S: Assessing the quality of psychiatric hospital care: a German approach. Psychiatric Services 1998; 49:794–796.

Workshop 49 **Monday, November 1**
3:30 p.m.-5:00 p.m.

INPATIENT TREATMENT OF EATING DISORDERS

APA-Alliance

Deborah K. Marcontell, Ph.D., *Assistant Professor of Psychiatry, Department of Psychiatry, Tulane Medical School, 1430 Tulane Avenue, HC35, New Orleans, LA 70112*; Susan G. Willard, M.S.W.; George C. Daul, Jr., M.D.; Jan W. Johnson, R.D.; Jacqueline Le Blanc

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to recognize the need for multidisciplinary treatment of eating disorders, identify the multidisciplinary components of eating disorders treatment, understand the various levels of care required for successful treatment of eating disorders, and discuss a patient's need for inpatient eating disorders treatment with managed care companies.

SUMMARY:

This workshop will focus on the multidisciplinary inpatient treatment of anorexia and bulimia in adolescents and adults. It is targeted to any psychiatrist or mental health professional who works with eating-disordered patients. Attendees will be provided with both theoretical and clinical guidelines from which to approach eating disorders treatment. The guidelines are based on scientific knowledge as well as long-standing clinical experience with a successful eating disorders program. Attention will also be given to common problems encountered with managed care companies including coverage of hospitalization and length of inpatient stay. Participants are encouraged to ask questions and discuss the points presented with the multidisciplinary workshop panel. Slides will be used throughout the workshop in conjunction with case vignettes and handouts.

REFERENCES:

1. Eating Disorders and Obesity. Edited by Brownell KD, Fairburn CG. New York, Guilford, 1995.
2. Anderson AE: Practical Comprehensive Treatment of Anorexia Nervosa and Bulimia. Baltimore, John Hopkins University Press, 1985.

Workshop 50 **Monday, November 1**
3:30 p.m.-5:00 p.m.

WORKING WITH THE SPIRITUALITY OF OUR PATIENTS

Ramaswamy Viswanathan, M.D., *Department of Psychiatry, State University of New York Health Sciences Center, 450 Clarkson Avenue, Box 127, Brooklyn, NY 11203-2012*; Nalini V. Juthani, M.D., *Director of Psychiatric Education, Bronx-Lebanon Hospital, and Associate Professor of Psychiatry, Albert Einstein College of Medicine, 1276 Fulton Avenue, 4th Floor, Bronx, NY 10456*; Francis G. Lu, M.D.; Pierre R. Arty, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to recognize the spiritual dimension of patients, learn how to gather data regarding the spirituality of patients, and know how to help patients use their spirituality as part of their overall efforts to cope with their illness and other stressors.

SUMMARY:

There is growing recognition that among the American population religious/spiritual beliefs are widespread. A study by one of the presenters found that 80% of a sample of patients hospitalized with acquired immune deficiency syndrome (AIDS) expressed strong belief in God or a higher power, and 15% expressed moderate belief. Many of them found their religion/spirituality helpful in coping with their terrible illness. Yet most clinicans and trainees completely neglect the spiritual aspect of their patients. This workshop will present expe-

riences of clinicians in helping patients in medical-surgical and psychiatric settings utilize their spirituality, if they are so willing, in enhancing their coping with their illness and other stressors. We will discuss how to collect meaningful information from patients, differentiate healthy from unhealthy religiosity, and avoid pitfalls such as imposing one's own value system on the patient. We will also discuss educating clinicians, and present the experiences of an award-winning residency training program. Members of the audience will be invited to comment on each presentation as well as discuss their own experiences, successes and failures, problems encountered, and how the problems were addressed. In what direction the professions should move in this area will also be explored.

TARGET AUDIENCE:

Psychiatrists, other clinicians, and trainees.

REFERENCES:

1. Psychiatry and Religion: Overlapping Concerns. Edited by Robinson L. Washington. D.C., American Psychiatric Press, Inc., 1986.
2. Religion and Spirituality in Clinical Practice. Edited by Larson DB, Lu FG, Swyers JP: Washington, D.C., National Institute of Healthcare Research, 1997.

Workshop 51 **Monday, November 1**
3:30 p.m.-5:00 p.m.

SOME CHALLENGES OF COMMUNITY CONSULTATION

Samuel Packer, M.D., *Associate Professor, Department of Psychiatry, University of Toronto, St. Michael's Hospital, 30 Bond Street, Toronto, Ontario, Canada M5B 1W8*; John H. Langley, M.D.; Sharon S. Levine, M.D., M.P.H.; Adam Quastel, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to better manage challenges related to community work, such as assertive community treatment with homeless persons, communicating with family physicians, evaluating community agencies, and resident training in the community.

SUMMARY:

One way that psychiatrists provide expertise and advanced clinical wisdom to the community is through consultation. Working as a consultant in the community presents various challenges, among which are service to special populations, communicating one's recommendations, resident teaching, and helping agencies evaluate their programs. Although problematic, these issues can be approached creatively, yielding a satisfactory outcome for consultants and the community they serve.

Together with faculty, participants will consider: How consultants know what questions are being asked of them, and what are the best ways to communicate information back to the referral source. How the ACT model may be modified to serve homeless persons. The consultant's role within an aboriginal health center. How psychiatric residents can learn to work as consultants in the community. How to work with agencies to help them evaluate what they do using rigorous research methodologies. Ample time will be allowed for participants to discuss issues that are raised, present related problems, and share similar experiences.

TARGET AUDIENCE:

Psychiatrists, residents, and other mental health professionals working in the community.

REFERENCES:

1. Lehman AF, Dixon LB, Kernan E, et al: A randomized trial of assertive community treatment for homeless persons with severe mental illness. Archives of General Psychiatry 1997; 54:1038–1043.
2. Mental Health Outcome Measures. Edited by Thornicroft G, Tansella M. Springer, New York, 1996.

Workshop 52 **Tuesday, November 2**
8:00 a.m.-9:30 a.m.

FROM PSYCHOPATHOLOGY TO DISABILITY

Marie-Claude Rigaud, M.D., *Associate Medical Director, Met Disability, P.O. Box 2816, Aurora, IL 60507-2816*; Alexander E. Obolsky, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to demonstrate skill in assessing mental impairment and determine how clinical symptoms translate into functional limitation. As a result, they will be more able to assess and determine mental disability in an individual with psychiatric conditions.

SUMMARY:

Psychiatric/psychological disability claims are increasing, and psychological factors are playing an increasing role in claims for physical/medical conditions. In addition to the increase in number, the inherent complexity of psychiatric conditions and the appearance of parity have forced employers and insurers to rely heavily on information from psychiatrists in order to manage mental disability benefits. While this creates new opportunities for psychiatrists, it also brings new challenges. It requires psychiatrists to be well skilled in providing

independent evaluations, which focus on functionality in the claimants being examined. Mere diagnosis and/or symptoms are no longer acceptable in support of a disability status. Specific functional impairments or limitations related to job requirements must be identified when psychiatrists complete disability claims and/or provide evaluation reports. Discussion will focus on the concept of "functionality" and its specific applications in assessing mental disability. The discussion will expand into the value of translating "clinical" information such as symptoms into functional manifestations or limitations as they relate to mental requirements of the job. The process by which this can occur will be addressed. The group will then practice on actual claims, which will allow participants to exercise and test their skills in the area of functional assessment.

REFERENCES:

1. Enelow Criteria: Functionality Grids—Case Management References.
2. H.I.A.A.: 1997 Report on Increasing Incidence of Psychiatric Claims Submission.

Workshop 53 **Tuesday, November 2**
10:00 a.m.-11:30 a.m.

PENTAVALENT TREATMENT FOR STATE HOSPITAL RECIDIVISTS: PRELIMINARY OUTCOMES

Wolfram Glaser, M.D., *Medical Director, Western Mental Health Center, 1701 Avenue D Ensley, Birmingham, AL 35218*; Homer E. Hayes, M.S.; Patricia L. Scheifler, M.S.W.; Tom R. Hobbs, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to list factors contributing to recidivism, describe components of pentavalent treatment, discuss preliminary program outcomes, and compare and contrast the pentavalent treatment with other programs for recidivists.

SUMMARY:

The problem of recidivism has been well documented. Traditional outpatient therapy combined with medication is usually insufficient to help recidivists sustain community tenure. These patients are often labeled noncompliant, adding stigma and reinforcing the sense of futility clinicians experience when treatment attempts are unsuccessful. Establishing a flexible range of services that patients are willing to engage in may help reduce recidivism without legal coercion. This session will review factors contributing to recidivism, present one approach to working with recidivists, and provide preliminary outcome data that indicate effectiveness. Thirty recidivists engaged in pentavalent treatment were matched with 30 recidivists in other parts of the state. No significant differences were found between the two groups on any demographic or clinical factors. The match group used an average of 1,487 state hospital bed days per year over a 10-year baseline (mean=51 days/patient/year), and the treatment group used 1,518 (mean=52). During the one-year study period, the match group used 1,628 state hospital bed days and the treatment group used 182. Participants will be encouraged to discuss the program, review the outcomes, and contrast pentavalent treatment to other approaches that reduce recidivism.

REFERENCES:

1. Dincin J, Wasmer D, Witheridge T, et al: Impact of assertive community treatment on the use of state hospital inpatient bed-days. H&CP 1993; 44:833–838.
2. Cohen NL: Stigmatization and the "noncompliant" recidivist. H&CP 1993; 44:1029.

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SYLLABUS INDEX

E

F

G

H

Y

Z