**Industry-Supported Symposium 1**

**Wednesday, October 5**
**6:30 p.m.-9:30 p.m.**

## TAKING THE SCIENCE TO THE PATIENT: CONSIDERATIONS IN THE USE OF ATYPICALS

*Supported by AstraZeneca Pharmaceuticals*

Steven G. Potkin, M.D., *Professor, Department of Psychiatry, University of California at Irvine Medical Center, 101 The City Drive South, Orange, CA 92868*

### EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1. Recognize the important side-effect considerations in the use of atypical antipsychotics in the treatment of individuals with schizophrenia and bipolar disorder. 2. Better understand the metabolic issues that can affect individuals with life-long psychiatric disorders. 3. Review the current evidence for the acute and long-term pharmacological management of schizophrenia and bipolar disorder. 4. Evaluate the importance of the patient—clinician partnership in the treatment process and to encourage patient participation in their clinical management and improved understanding of the potential benefits and side effects of psychiatric medications.

### SUMMARY:

In the course of treating individuals with serious mental illness, it is important for clinicians to maintain an overall perspective that can help target a patient's specific needs and the treatment strategies that parallel those needs. In both schizophrenia and bipolar disorder, the specific approaches may differ but the underlying clinical strategy of symptom stabilization in the context of a complex management process while minimizing a side-effect burden is an important consideration.

Many clinicians treat individuals with life-long psychiatric illness it is helpful to conceptualize a treatment plan with the understanding that there are common threads that can impact patients and their physical as well as mental well-being. Careful medical and psychiatric histories, as well as a history of medications, can minimize adverse reactions that can impede compliance with treatment. Whether treating acute exacerbations or periods of stability, an understanding of the pharmacokinetics involved in the choice of medications can improve the treatment process. Metabolic issues can be an important factor in many psychiatric patients and realizing this early in the treatment process can help prevent or minimize the risk of diabetes or cardiovascular illnesses.

This symposium is intended for the practicing clinician and will review the salient issues involved in treating individuals with life-long psychiatric disorders.

## No. 1A
## MANAGEMENT CONSIDERATIONS IN BIPOLAR DISORDER

Lori L. Altshuler, M.D., *Department of Psychiatry and Behavioral Sciences, University of California at Los Angeles, 300 UCLA Medical Plaza, Room 1544, Los Angeles, CA 90095-7057*

### SUMMARY:

Bipolar disorder presents many challenges to the clinician. In treating individuals with bipolar disorder, it is important to keep in mind that this is a life-long disorder, yet many of the treatment goals are distinct from other long-term psychiatric illnesses. Bipolar patients and the treating clinicians generally expect more from treatment, with an overarching goal of remission and stability. When choosing an appropriate pharmacological intervention, in addition to the basic requirements of acute symptom control and mood stabilizing effects, bipolar individuals are very concerned about side effects that will interfere with their functioning. They are less likely to tolerate medications that will induce sedation, weight gain, or cognitive impairment.

Effective management needs to address treatment in the acute phase as well as long-term maintenance treatment of the disorder to ameliorate symptoms. Likewise, choosing appropriate pharmacological and psychosocial interventions can help to minimize adverse events and guide patients toward optimal physical as well as psychological stability.

### REFERENCES:

1. McElroy SL. Diagnosing and treating comorbid (complicated) bipolar disorder. J Clin Psychiatry. 2004;65 Suppl 15:35–44.
2. Keck PE. Defining and improving response to treatment in patients with bipolar disorder. J Clin Psychiatry. 2004:65 Suppl 15:25–9.

## No. 1B
## MANAGEMENT CONSIDERATIONS IN SCHIZOPHRENIA

Gustavo Alva, M.D., *Deputy Director, Clinical Research Division, University of California, 101 The City Drive, Orange, CA 92868*

### SUMMARY:

Schizophrenia is a chronic and disabling mental illness that affects men and women in equal numbers. Treating individuals with schizophrenia requires a clinician to address the variability in symptom presentation across the spectrum of the illness. Treating patients in an acute

phase requires a different set of interventions than working with someone with a chronic illness.

Treatment expectations for individuals with schizophrenia have traditionally been somewhat limited. Both the clinician and the patient often set minimal goals for improvement and the concept of recovery generally appears to be unattainable. With the introduction of atypical antipsychotics, patient functionality has improved and there is a new awareness on the part of both patients and clinicians of the impact of side effects on quality of life. Ongoing assessments for weight gain and other metabolic issues is an important consideration. Evaluating for symptom breakthrough and cognitive impairments in schizophrenia can improve overall attitudes toward treatment and can improve psychosocial functioning.

## REFERENCES:

1. Awad AG, Voruganti LN. Impact of atypical antipsychotics on quality of life in patients with schizophrenia. CNS Drugs. 2004:18(13):877–93
2. Citrome L. Volavka J. The promise of atypical antipsychotics fewer side effects mean enhanced compliance and improved functioning. Postgrad Med. 2004 Oct. 116(4):49–51, 55–9, 63.

## No. 1C
## PSYCHIATRIC EMERGENCIES

David G. Daniel, M.D., *President, Bioniche Development, Inc., 6850 Elm Street, Suite 200 D&E, McLean, VA 22101*

## SUMMARY:

Individuals who present as psychiatric emergencies are often the most challenging to treat. Emergency department (ED) physicians need to achieve control of patients with acute agitation of unknown etiology and ensure safety for patients, staff, and milieu. Rapid and effective pharmacologic intervention is often the most effective and safest choice for the patient as well as for the ED. Recent advances in atypical antipsychotic drugs may help ED physicians achieve their goals since they offer the benefits of fast-acting, parenteral delivery of effective antiagitation medication with significantly improved tolerability and safety.

Clinicians are becoming increasingly aware that the way a psychiatric emergency is managed can make a difference in the attitudes of the patient and family about treatment and medications. A well-tolerated transition from IM to oral continuation therapy can affect follow-up. This is especially true when dealing with the side effects of various medications and long-term compliance issues in patients.

## REFERENCES:

1. Allen MH, Currier GW, Hughes, DH, Reyes-Harde. M. Docherty, JP. Treatment of Behavioral Emergencies: The Expert Consensus Guideline Series May 2001 Postgraduate Medicine.
2. Swann AC, Daniel DG, Kochan LD, Wozniak PJ, Calabrese JR. Psychosis in mania: specificity of its role in severity and treatment response. J Clin Psychiatry. 2004 Jun;65(6) 825–9.

## No. 1D
## METABOLIC ISSUES AND OTHER ADVERSE EVENTS IN SCHIZOPHRENIA AND BIPOLAR DISORDER

John W. Newcomer, M.D., *Associate Professor of Psychiatry, Washington University School of Medicine, 660 South Euclid, Box 8134, St. Louis, MO 63110*

## SUMMARY:

The prevalence of obesity and diabetes mellitus has risen in the United States over the past several years, with epidemic characteristics. The prevalence of physician-diagnosed diabetes in 2001 was 7.9%, up from 4.9% a decade earlier. Obesity is strongly related to risk for diabetes, hypertension, dyslipidemia, arthritis, and cardiovascular disease.

Individuals with chronic mental illnesses such as schizophrenia or bipolar disorder are particularly vulnerable to obesity, with related risk for metabolic changes like hyperglycemia, dyslipidemia and hypertension, which can present as the metabolic syndrome (obesity, insulin resistance, dyslipidemia, impaired glucose tolerance and hypertension) This may be related to genetic factors or to a combination of environmental factors such as poor nutrition, inactivity, smoking, and use of prescribed drugs like antipsychotic medications.

Results of a Consensus Development Conference on Antipsychotics and Obesity and Diabetes concluded that atypical antipsychotics offer significant benefits to patients with a variety of psychotic disorders. However, some antipsychotics are associated with an increased risk of weight gain, dyslipidemia, diabetes, and potential diabetic complications such as diabetic ketoacidosis.

Increasing clinicians' understanding of the prevalence and impact of metabolic issues on psychiatric patients is an important first step toward long-term improvements in patient health and quality of life.

## REFERENCES:

1. Mokdad AH, Ford ES, Bowman BA, et al. Prevalence of obesity, diabetes, and obesity-related health risk factors, 2001. JAMA. 2003;289:76–79.
2. American Diabetes Association, American Psychiatric Association, American Association of Clinical

Endocrinologists, North American Association for the Study of Obesity. Consensus development conference on antipsychotic drugs and obesity and diabetes. Diabetes Care. 2004;27(2):596–601.

**Industry-Supported Symposium 2** **Thursday, October 6 12:00 noon-1:30 p.m.**

## INSULIN RESISTANCE AND METABOLIC SYNDROME IN NEUROPSYCHIATRY, PART 1

*Supported by Bristol-Myers Squibb Company and Otsuka America Pharmaceuticals, Inc.*

Natalie L. Rasgon, M.D., Ph.D., *Psychiatry and Behavioral Science, Stanford University School of Medicine, 401 Quarry Road, #2360, Stanford, CA 94305-5723*

### EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to: 1. Examine preclinical data on pathophysiology of metabolic syndrome. 2. Understand prevalence of metabolic syndrome in patients with affective disorders, schizophrenia and Alzheimer's disease. 3. Describe current metabolic data for medications used to treat psychiatric illness. 4. Discuss clinical implications of metabolic syndrome, weight gain, insulin resistance and lipid disorders.

### SUMMARY:

Obesity and diabetes have become national health epidemics with >50% of adults in the United States being overweight, and >17 million people having diabetes. Obesity and type 2 diabetes, along with insulin resistance, high LDL and triglyceride levels, and elevated blood pressure are a cluster of symptoms currently labeled as metabolic syndrome. Data show that individuals suffering from metabolic syndrome are 4–20 times more likely to suffer heart attacks. Patients who suffer from schizophrenia may have 2–3 times the risk of developing diabetes and metabolic syndrome compared with the general population.

The utility of second generation antipsychotics continues to escalate beyond schizophrenia into bipolar disorders, depression and other psychiatric illness. Due to this widespread use and data suggesting a link between certain second-generation antipsychotics and both obesity and diabetes, there is an increased need to understand the clinical implications of their use and the development of metabolic syndrome. Dr. Reaven will give an overview of metabolic syndrome. Dr. Newcomer will present clinical data on metabolic syndrome in patients with psychosis, and Dr. Zajecka will discuss insulin resistance in patients with affective disorders. Then, Dr. Craft will review insulin resistance in dementias. Finally, Dr. Rasgon will examine the association between metabolic syndrome, affective disorders and dementias.

## No. 2A
## THE INSULIN RESISTANCE SYNDROME: WHAT IS IT? WHY IS IT IMPORTANT?

Lawrence Blonde, M.D., *Director, Ochsner Diabetes Clinical Research Unit, 1514 Jefferson Highway, New Orleans, LA 70121*

### SUMMARY:

Insulin-mediated glucose disposal varies widely in the population at large, with approximately 50% of the variability related to differences in life style, and the remaining 50% likely to be genetic in origin. Failure to secrete enough insulin to overcome the insulin resistance results in type 2 diabetes. Although most insulin resistant individuals can sustain the degree of hyperinsulinemia needed to remain nondiabetic, they are likely to be somewhat glucose intolerant, dyslipidemic, with a high plasma triglyceride and low high-density lipoprotein cholesterol concentration; and have essential hypertension. In 1988 it was emphasized that this cluster of abnormalities significantly increased cardiovascular disease risk, and the term Syndrome X was proposed as a phrase to refer to the abnormalities associated with insulin resistance/hyperinsulinemia. Since the introduction of the concept of Syndrome X, the list of abnormalities more likely to occur in insulin resistant/hyperinsulinemic individuals has greatly expanded, as has the number of clinical syndromes associated with the defect in insulin action. Given these developments, it seems more reasonable to substitute the term Insulin Resistance Syndrome (IRS) for Syndrome X, and this presentation will review the abnormalities and clinical syndromes that make up the current version of the IRS.

### REFERENCE:

1. Reaven G. The metabolic syndrome or the insulin resistance syndrome? Different names, different concepts, and different goals. Endocrinol Metab Clin North Am 2004;33(2):283–303.

## No. 2B
## INSULIN RESISTANCE AND METABOLIC RISK DURING ANTIPSYCHOTIC TREATMENT

John W. Newcomer, M.D., *Associate Professor of Psychiatry, Washington University School of Medicine, 660 South Euclid, Box 8134, St. Louis, MO 63110*

**SUMMARY:**

Individuals with schizophrenia have an increased prevalence of obesity, type 2 diabetes mellitus (T2DM) and cardiovascular disease (CVD) compared to the general population. A range of evidence, including randomized clinical studies, suggests that antipsychotic treatment can increase risk of insulin resistance, hyperglycemia, dyslipidemia and T2DM. Interpretation of evidence concerning treatment effects has been complicated by reports of insulin resistance in untreated schizophrenia, with likely contributions from altered nutrition and activity. Research concerning the role of adiposity in the development of insulin resistance, the metabolic syndrome, T2DM and CVD, may increase our understanding of antipsychotic treatment effects. Drug effects on insulin sensitivity and secretion can be sensitively measured with various techniques, and fat mass can be quantified with direct measures like dual energy x-ray absorptiometry and magnetic resonance imaging. Increased adiposity in schizophrenia is associated with decreases in insulin sensitivity, leading to potential increases in plasma glucose and lipid levels and increases in inflammatory markers. These metabolic changes may contribute to the development of metabolic syndrome, increasing the risk of T2DM and cardiovascular disease. The results of studies in this area can be used to target basic research, identify potential therapeutic approaches, and guide clinical and regulatory decision-making.

**REFERENCE:**

1. Casey DE, Haupt DW, Newcomer JW, et al. Antipsychotic-induced weight gain and metabolic abnormalities: Implications for increased mortality in patients with schizophrenia. J Clin Psychiatry 65(Suppl 7):4–18, 2004.

## No. 2C
## INSULIN RESISTANCE AND COGNITIVE DISORDERS

Suzanne Craft, Ph.D., *1660 South Columbian Way, Seattle, WA 98108*

**SUMMARY:**

An emerging body of evidence suggests that an increased prevalence of insulin abnormalities and insulin resistance in Alzheimer's disease, vascular dementia and other neurodegenerative and psychiatric disorders may contribute to disease pathophysiology and clinical symptoms. Insulin is essential for energy metabolism in the periphery, and convergent findings have begun to demonstrate that insulin also plays a role in energy metabolism and other aspects of CNS function. It has recently been demonstrated that insulin-sensitive glucose transporters are localized to regions of the brain that support memory and that insulin, in fact, plays a role in memory functions. Insulin may also play a role in regulating the amyloid precursor protein and its derivative beta-amyloid (Abeta), which is associated with senile plaques, a neuropathological hallmark of Alzheimer's disease. Our recent studies show that administration of insulin improves cognitive performance. The role of insulin in normal brain function will be described. Then, a review of the mechanisms through which hyperinsulinemia and insulin resistance may impair recognition will be presented, including the possible contribution to the pathogenesis of late-life disease.

**REFERENCE:**

1. Craft S, Watson GS. Insulin and neurodegenerative disease: Shared and specific mechanisms. Lancet Neurology 2004;3:169–178.

**Industry-Supported Symposium 3** — **Thursday, October 6, 6:30 p.m.-9:30 p.m.**

## VIOLENCE AND IMPULSIVITY: A BIPOLAR VARIANT?

*Supported by AstraZeneca Pharmaceuticals*

William B. Lawson, M.D., Ph.D., *Professor and Chair, Department of Psychiatry, Howard University Hospital, 2041 Georgia Avenue, Washington, DC 20060*

**EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be able to: (1) recognize the diagnostic difficulties in recognizing axis 1 disorders when impulsivity or aggression are the presenting symptoms, (2) appreciate the expanding role of pharmacological agents that may treat both bipolar disorder and aggressive disorders, and (3) understand the public health issues around the spectrum of bipolar disorders and aggression.

**SUMMARY:**

Disorders of aggression and impulsivity are often addressed in the correctional system and frequently receive limited attention from mental health professions. Recent research has provided compelling evidence that some disorders of aggression and impulsivity significantly overlap with bipolar disorder in a number of key ways, suggesting that they may be a variant. Phenomenological and psychosocial studies in correctional systems and other settings have shown the usefulness of viewing impulsive disorders as a bipolar variant. We will review genotypical, neurochemical, neuroanatomical, and pharmacological evidence that indicate commonality in these disorders. The development of newer pharmacological interventions including newer antimanic agents, second generation antipsychotics, and anticonvulsives have both

increased the treatment options for aggression and expanded the treatment responsivity of bipolar variants. The underdiagnoses of bipolar disorder in many nonpsychiatric settings including the primary care and correctional setting has importance for ethnic minorities and special populations who often do not have access to newer pharmacological interventions. In addition the overlap of bipolar disorder with post traumatic stress disorder and the role of stress in both further indicates the public health significance.

## No. 3A
## THE NEUROPHYSIOLOGY OF BIPOLAR DISORDER: DEFICIENCIES IN IMPULSE CONTROL

Stephen M. Strakowski, M.D., *Professor, Department of Psychiatry, University of Cincinnati College of Medicine, 231 Bethesda Avenue, ML0559, Cincinnati, OH 45267*

### SUMMARY:

The symptoms and signs of bipolar disorder suggest abnormalities within the anterior limbic network (ALN). The ALN is conceptualized as an extended prefrontal-striatal-thalamic literative network that incorporates amygdala, ''cognitive'' regions of the prefrontal cortex, hypothalamus, and mid-line cerebellum. The ALN has bear implicated in affect regulation, and interacts reciprocally with cognitive networks, leading to complex human behaviors. Neuroimaging studies have permitted the in vivo exploration of the ALN in bipolar disorder, and suggest abnormalities throughout. Recent functional imaging studies specifically suggest that dysfunction of the ALN leads patients to compensatory brain activation patterns to manage cognitive tasks. When these compensatory activations fail, patients develop impairments. Additionally, brain systems associated with the ALN that modulate impulse control and error detection appear to also be dysfunctional in bipolar patients, leading to impulsive behaviors. By using neuroimaging to study tasks of impulse control, we hope to clarify the specific neurophysiology of bipolar disorder.

### REFERENCES:

1. Strakowski SM, et al. ''Abnormal fMRI brain activation in euthymic bipolar disorder during a counting Stroop task.'' Am J Psychiatry, in press.
2. Strakowski SM, et al. ''A preliminary fMRI study of sustained attention in unmedicated, euthymic bipolar disorder.'' Neuropsychopharmacology 2004;29: 1734–1740.

## No. 3B
## VIOLENCE AND BIPOLAR ILLNESS

Samuel Osifo Okpaku, M.D., Ph.D., *1233 17th Avenue South, Nashville, TN 37212-2801*

### SUMMARY:

Proper diagnosis is essential for the effective treatment, of patients with bipolar disorder, yet often the diagnosis is missed. In this paper I will discuss the differential diagnosis of bipolar disorder, and provide a framework for treatment in those cases where violence is a key aspect of the presenting behavioral pathology. Reasons for difficulties in making the diagnosis of bipolar disorder will be discussed, and clues to occult disease presence highlighted. Ongoing assessment of the risk of violence, risk reduction treatment planning, as well as psychotherapeutic approaches to the descalation of the violent patient will be discussed. The role of lithium in the treatment of the bipolar patient will be considered, as will the use of anti-epileptic medications for patients with this disorder. Use of anti-psychotic medications, particularly the second-generation agents, both with and without anti epileptic medication will also be reviewed.

### REFERENCES:

1. Feldman, TB Bipolar Disorder and Violence Psych Q 72(2):119–29 (2001).
2. Lindenmayer, JP Psychopathology of Agitation Clin Psychiatry 61 Supp 14:5 1 10 (2000)

## No. 3C
## RACE, BIPOLAR DISORDER AND AGGRESSION

William B. Lawson, M.D., Ph.D., *Professor and Chair, Department of Psychiatry, Howard University Hospital, 2041 Georgia Avenue, Washington, DC 20060*

### SUMMARY:

African Americans are often under diagnosed with bipolar disorder. As a result they often do not receive effective antimanic medication. We found that African American psychiatric inpatients are more likely to be perceived as violent. Violent patients with bipolar disorder were often more likely to receive a diagnosis of schizophrenia and more likely to receive excessive doses of first generation of antipsychotic medication rather then antimanic agents. Under recognition is a also special issue for mentally ill African Americans because many do not utilize mental health services. We found that nearly 10% of patients met DSMTV criteria for bipolar disorder using the SCII in a primary care clinic that was 90% African American. Only one of 18 was on a mood stabilizer. Over 50% of inmates in correctional systems

are African Americans and many have unrecognized mental disorders. We found that African American patients with mood disorders in a county jail were not previously diagnosed and received punitive interventions for disruptive behavior. They readily responded to antimanic agents. Unrecognized bipolar spectrum disorder is a public health problem for African Americans who often are perceived as having conduct problems and who could benefit from treatment with mood stabilizers.

## REFERENCE:

1. Lawson, WE, Strickland T Racial and ethnic issues affect treatment for bipolar disorder, Psychiatric Annuals 34, 17–20, 2004.

## No. 3D
## AGGRESSIVE IMPULSIVITY AND THE POST-TRAUMATIC STRESS DISORDER BIPOLAR SPECTRUM

Thomas A. Mellman, M.D., *2041 Georgia Avenue, North West, Washington, DC 20060*

## SUMMARY:

Both clinical and epidemiological studies document substantial comorbidity between bipolar affective disorders (BAD and posttraumatic stress disorder (PTSD). Reasons for high rates of co-occurrence appear to include syndromal overlap, and a bipolar diathesis being a risk factor for the development of PTSD as well as exposure to trauma.

The assessment and treatment of aggressive impulsivity can be challenging in the face of co-occurring PTSD and BAD. Criteria for BAD include impulsive behavior. PTSD often features problems with the expression of anger including irritability but also not infrequently an exaggerated fear of losing control. In addition, both of these conditions are not infrequently complicated by substance use disorders.

First-line treatments for PTSD and BAD can have therapeutic impact on impulsive aggression. Psychotherapeutic approaches that address anger management have been utilized with benefit for people with PTSD. Adjunctive use of anticonvulsant mood stabilizers and new generation antipsychotic medications is recommended as a strategy for targeting impulsive aggression in complicated cases of PTSD.

## REFERENCES:

1. Kessler RC, Sonnega A, Bromet F, Hughes M, Nelson CB: Posttraumatic stress disorder in the National Comorbidity Survey. Arch Gen Psychiatry: 52:1048–1060, 1995.
2. Friedman MJ, Davidson JRT, Mellman TA, Sonthwick SM. (2000) Pharmacotherapy. In Effective Treatments for PTSD. Practice Guidelines from the International Society for Traumatic Stress Studies. Eds E.B. Foa, T.M. Keane, M.J. Friedman. Guilford Press, New York, London.

**Industry-Supported Symposium 4** — **Friday, October 7 12:00 noon-1:30 p.m.**

## INSULIN RESISTANCE AND METABOLIC SYNDROME IN NEUROPSYCHIATRY, PART 2

*Supported by Bristol-Myers Squibb Company and Otsuka America Pharmaceuticals, Inc.*

Natalie L. Rasgon, M.D., Ph.D., *Psychiatry and Behavioral Science, Stanford University School of Medicine, 401 Quarry Road, #2360, Stanford, CA 94305-5723*

## EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to 1. Examine preclinical data on pathophysiology of metabolic syndrome. 2. Understand prevalence of metabolic syndrome in patients with affective disorders, schizophrenia and Alzheimer's disease. 3. Describe current metabolic data for medications used to beat psychiatric illness. 4. Discuss clinical implications of metabolic syndrome, weight gain, insulin resistance and lipid disorders.

## SUMMARY:

Obesity and diabetes have become national health epidemics with >50% of adults in the United States being overweight, and >17 million people having diabetes. Obesity and type 2 diabetes, along with insulin resistance, high LDL and triglyceride levels, and elevated blood pressure are a cluster of symptoms currently labeled as metabolic syndrome. Data show that individuals suffering from metabolic syndrome are 4–20 times more likely to suffer heart attacks. Patients who suffer from schizophrenia may have 2–3 times the risk of developing diabetes and metabolic syndrome compared with the general population.

The utility of second generation antipsychotics continues to escalate beyond schizophrenia into bipolar disorders, depression and other psychiatric illnesses. Due to this widespread use and data suggesting a link between certain second-generation antipsychotics and both obesity and diabetes, there is an increased need to understand the clinical implications of their use and the development of metabolic syndrome. Dr. Reaven will give an overview of metabolic syndrome. Dr. Newcomer will present clinical data on metabolic syndrome in patients with psychosis, and Dr. Zajecka will discuss insulin resistance in patients with affective disorders. Then, Dr. Craft will review insulin resistance in dementias. Finally, Dr. Ras-

gon will examine the association between metabolic syndrome, affective disorders and dementias.

## No. 4A
## RISK, ASSESSMENT AND MANAGEMENT OF INSULIN RESISTANCE IN AFFECTIVE DISORDERS

Hugh B. Solvason, M.D., *401 Quarry Road, Room 94305, Stanford, CA 94305*

### SUMMARY:

Relative to schizophrenia, there has been a paucity of information on the metabolic syndrome in affective disorders (bipolar and unipolar disorders). The high lifetime prevalence of affective disorders in the general population coupled with the epidemic of diabetes dictates the need to have a greater understanding of these disorders. The relative risk factors for glucose intolerance, i.e., insulin resistance/insulin deficiency, risk of morbidity and mortality and the role of pharmacologic treatments, including conventional mood stabilizers, atypical antipsychotics, antidepressants, and augmentation medications, will be reviewed. Guidelines in risk assessment, management and prevention will be presented.

### REFERENCE:

1. Kendall DM, Harmel AP. The metabolic syndrome, type 2 diabetes, and cardiovascular disease: understanding the role of insulin resistance. Am J Manag Care 2002;8(20 Suppl):S635–53.

## No. 4B
## INSULIN RESISTANCE: THE LINK BETWEEN AFFECTIVE DISORDERS AND ALZHEIMER'S DISEASE

Natalie L. Rasgon, M.D., Ph.D., *401 Quarry Road, #2360, Stanford, CA 94305-5723*

### SUMMARY:

Insulin resistance commonly occurs in both affective disorders (ad) and Alzheimer's disease (AD). This impaired glucose metabolism and reduced insulin sensitivity can lead to cognitive and memory impairment, and potentially other long-term sequelae.

Research regarding the possible association between ad and AD has yielded mixed results. Various neurophysiologic factors have been implicated as common biological markers for these disorders. We will review evidence suggesting that abnormal glucose metabolism (i.e., insulin resistance) is a missing link in the pathophysiology of both ad and AD.

### REFERENCE:

1. Rasgon N, Jarvik L. Insulin Resistance, Affective Disorders and Alzheimer's Disease: Review and Hypothesis. J Gerontology 2004;59A(2):178–183.

**Industry-Supported Symposium 5** — **Friday, October 7, 6:30 p.m.-9:30 p.m.**

## TARGETING EXECUTIVE DYSFUNCTIONS FOR TREATMENT

*Supported by Cephalon, Inc.*

Charles DeBattista, M.D., *Associate Professor, Psychiatry and Behavioral Sciences, Stanford University School of Medicine, 3915 Christian Drive, Belmont, CA 94002-1258*

### EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to review the circuits and symptoms associated with executive dysfunction and the role of executive dysfunction in deficit syndrome, geriatric depression, major depression, and attention deficit hyperactivity disorder; and to discuss therapeutic strategies targeted at resolving specific symptoms presented in each of these disorders.

### SUMMARY:

Executive function comprises higher order cognitive processes that continually integrate, prioritize, and manage cognitive, physical, behavioral, emotional, and social functioning. Previously referred to as frontal lobe functions, executive functions control response preparation and organization, implementation of activation-inhibition sequences, and balance short-term and long-term goals and planning. The structures and pathways, or circuits, that support executive function continue to develop through early adulthood and are themselves dependent on development of dopaminergic and norepinephrinergic pathways. Likewise, executive functioning is age dependent, developing in early adulthood and declining with advanced age. Diseases such as Alzheimer's, traumatic brain injury, major depression, and geriatric depression may impair executive function. The challenge in evaluating patients with these disorders is the careful collection of objective clinical information as well as patient-reported information. When combined, a complete assessment of the neurobiological dysfunctions and presented symptoms may allow the design of effective treatments targeted to the dysfunctional pathways.

### REFERENCE:

1. Stahl SM. The Psychopharmacology of energy and fatigue. J Clin Psychiatry 2002;63:7–8.

## No. 5A
## EXECUTIVE FUNCTION: CIRCUITS AND SYMPTOMS

Hugh B. Solvason, M.D., *Psychiatry Department, Stanford University School of Medicine, 401 Quarry Road, Room 94305, Stanford, CA 94305*

### SUMMARY:

Symptoms of executive dysfunction are strongly associated with brain circuits to and from frontal lobes and prefrontal cortex, specifically, dorsolateral prefrontal cortex (DLPFC). Ascending monoaminergic pathways for dopamine (DA) and norepinephrine (NE) from brainstem to DLPPC, as well as ascending cholinergic pathways for acetylcholine (Ach) from basal forebrain to DLPFC, may regulate executive functioning. Ascending histaminergic (HA) hypothalamic pathways may regulate executive function and may be regulated by the hypothalamic sleep-wake switch, a set of reciprocally innervated hypothalamic nuclei. Blocking HAI receptors can cause both executive dysfunction and sleepiness; enhancing histamine actions with modafinil can improve both executive functioning and wakefulness.

It is hypothetically possible to enhance executive functioning by boosting actions of one or more ''smart'' neurotransmitters (DA, NE, Ach, and HA) in DLPFC. Specifically, NE reuptake inhibitors (atomoxetine, bupropion) can enhance actions of both NE and DA, and atypical antipsychotics can enhance the release not only of NE and DA but also Ach. Thus, the strategy of targeting symptoms in circuits by enhancing neurotransmitters in DLPFC may lead to alleviation of symptoms of executive dysfunction such as problem solving, while simultaneously enhancing alertness, increasing energy, alleviating sleepiness and fatigue, and brightening mood.

### REFERENCE:

1. Chou TC, Bjorkum AA, Gaus SE, Lu J, Scammel TE, Saper CB. Afferents to the ventrolateral preoptic nucleus. J Neurosci 2002;22:977–990.

## No. 5B
## COGNITIVE DYSFUNCTION IN SCHIZOPHRENIA

Rona Hu, M.D., *401 Quarry Road, Stanford, CA 94305-5723*

### SUMMARY:

Deficit syndrome describes the cognitive impairments that can be present in schizophrenia, ADHD. Tourette's syndrome, and sleep apnea. A variety of neuropsychological deficits can be correlated with global diffuse brain impairment, while frontal lobe impairment is particularly implicated in executive dysfunction. While certain cognitive deficits and executive dysfunctions can be specific to the underlying disorder, evaluation of neuropsychological functioning, such as with functional magnetic resonance imaging (fMRI), provides insight into what brain areas mediate the cognitive deficits and executive dysfunctions. Once the structures, neurotransmitters and pathways involved in regulating cognitive and executive functioning are identified, treatments can be proposed (eg, targeting histamine, dopamine, or norepinephrine systems). In each of these disorders, enhancing cortical activity could significantly relieve symptoms of executive dysfunction.

### REFERENCE:

1. Bryson G, Whelahan HA, Bell M: Memory and executive function impairments in deficit syndrome schizophrenia. Psychiatry Res 2001;102:29–37.

## No. 5C
## EXECUTIVE DYSFUNCTION IN DEPRESSION

Charles DeBattista, M.D., *Associate Professor, Psychiatry and Behavioral Sciences, Stanford University School of Medicine, 3915 Christian Drive, Belmont, CA 94002-1258*

### SUMMARY:

Cognitive and executive dysfunctions are common symptoms in depression, with patients showing difficulty in short-term memory, learning, and motor skills independent of pharmacotherapy. These impairments are consistent with dysfunction of frontal and mediotemporal lobes. While cognitive symptoms usually improve with antidepressant therapy both during and after recovery, antidepressants have varying impact on cognitive functions and performance. Important to consider is that both cognitive and executive dysfunctions may be residual symptoms of depression or symptoms of antidepressant therapy. Augmentation strategies can enhance or boost antidepressant effects or manage residual symptoms.

A clear cause-and-effect relationship between cognitive and executive dysfunction in depressed patients and fatigue and disruption of sleep cycle is not yet established. However, DMS-IV recognizes symptoms of fatigue, reduced energy, and slowed speech and thinking as symptoms of major depressive disorder. Even when depressed patients achieve remission, residual symptoms of fatigue may remain and are predictive of relapse. Since the frontal cortex controls sleep cycle as well as executive functions, evaluation of neuropathways and neurotransmitters impaired in major depressive disorder may provide clues to assist with the development of

targeted pharmacologic agents that relieve symptoms of fatigue and thus reduce the likelihood of relapsing or recurring major depressive disorder.

## REFERENCES:

1. Farrin L, Hull L, Unwin C, Wykes T, David A: Effects of depressed mood on objective and subjective measures of attention. J Neuropsychiatry Clin Neurosci 2003;15:98–104
2. Porter RJ, Gallagher R, Thompson JM, Young AH: Neurocognitive impairment in drug-free patients with major depressive disorder. Br J Psychiatry 2003;182:214–220

## No. 5D
## ADDRESSING EXECUTIVE DYSFUNCTION IN ADHD

James M. Swanson, Ph.D., *Professor, Department of Pediatrics, University of California, Irvine, 19722 Macarthur Boulevard, Irvine, CA 92697*

## SUMMARY:

Attention deficit hyperactivity disorder (ADHD) refers to a group of cerebellar dysfunctions involving multiple neurological substrates and pathways of activation, vigilance, and motivation. Inattentiveness, overactivity, and impulsivity are classic symptoms of ADHD. Neurobiological dysfunctions associated with ADHD can adversely influence executive function. Currently, there are various models of executive function impairment in ADHD, and consensus has not yet been reached in the research community in this regard. However, the coexistence of underlying learning disabilities and other psychiatric comorbidities increases the severity of executive dysfunction in ADHD patients. Since executive dysfunction associated with ADHD is largely cognitive, the dysfunctions are not easily observed or captured in standard evaluations.

Stimulants such as methylphenidate, the mainstay of treatment for ADHD, have pronounced effects on cognitive functioning, improving attention and performance presumably due to their effects on increasing dopamine synaptically. However, on higher-order tasks, stimulants at high doses impair rather than improve performance. Moreover, the potential for abuse and side effects limit the usefulness of stimulants. Non-dopaminergic agents such as modafinil have been shown to improve executive functioning in ADHD and may represent a viable alternative to the widespread use of stimulants for the disorder.

## REFERENCES:

1. Denckla MB: Attention deficit hyperactivity disorder-residual type. J Child Neurol 1991;6 (Suppl): S44–S50
2. Seidman LJ, Biederman J, Monuteaux MC, Doyle AE, Faraone SV: Learning disabilities and executive dysfunction in boys with attention-deficit/hyperactivity disorder. Neuropsychology 2001;15:544–556.

## INNOVATIVE PROGRAMS: SESSION 1 THE USE OF DIALECTICAL BEHAVIOR THERAPY VARIATIONS IN TREATMENT

**Innovative Program 1 Wednesday, October 5 10:00 a.m.-11:30 a.m.**

### DIALECTICAL BEHAVIOR THERAPY FOR SUBSTANCE ABUSERS

Megan Schutt, A.C.S.W., *Mental Health Professional, Community Support Treatment Services, Washtenaw Community Health Organization, 2140 East Ellsworth, Ann Arbor, MI 48108*; Carol Hartford, M.S.W., *Mental Health Professional, Community Support Treatment Services, Washtenaw Community Health Organization, 2140 East Ellsworth, Ann Arbor, MI 48108*

### EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to learn about modifications to DBT to treat substance abuse in a community mental health setting, also bridging to peer-run recovery groups, such as AA, NA, etc.

### SUMMARY:

Washtenaw County Community Support and Treatment Services serves a population with chronic and persistent mental illness. The Dialectical Behavior Therapy unit was developed in 1993 to address Axis II symptoms that interfere with treatment of Axis I symptoms. While it is a best practice approach, it lacks specific focus on a diagnostically complicated population, namely people with substance related disorders and Axis II, who are difficult to engage and often drop out. The innovative approach is Dialectical Behavior Therapy for Substance Abusers (DBTs). This approach incorporates strategies developed by Marsha Linehan and Behavioral Tech, LLC, with the addition of principles found in peer-run community support groups. Hence, the people benefit from focused DBT strategies for substance abuse, building a support network of sobriety. APA attendees will learn about enhancements to traditional DBT to address substance abuse. Initial findings indicate an increase in the number of sober activities and recovery groups attended, as well as decrease in drug use and parasuicidal episodes.

### TARGET AUDIENCE(S):

Direct care providers involved in DBT and substance abuse.

### REFERENCES:

1. Linehan MM: Cognitive Behavioral Treatment of Borderline Personality Disorder. New York, Guilford, 1993.
2. Dimeff L, Davis G: Severe & Complicated Addictions: Dialectical Behavior Therapy for Substance Abusers.'' Workshop presented by Behavioral Tech, LLC, Milwaukee, Wisconsin, 2002.

**Innovative Program 2 Wednesday, October 5 10:00 a.m.-11:30 a.m.**

### DIALECTICAL BEHAVIOR THERAPY ORIENTATION GROUP

Megan Schutt, A.C.S.W., *Mental Health Professional, Community Support Treatment Services, Washtenaw Community Health Organization, 2140 East Ellsworth, Ann Arbor, MI 48108*

### EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should have learned about the content, structure, and advantages of providing an orientation to DBT in a group format.

### SUMMARY:

The Dialectical Behavior Therapy unit at Washtenaw County Community Support and Treatment Services was developed 11 years ago to address Axis II symptoms that commonly interfere with Axis I symptoms. While this treatment is effective, it was observed that some patients were unable to make the necessary commitment to DBT or did not meet diagnostic criteria. Due to these factors, patient and clinician time was spent ineffectively. DBT Orientation Group was developed as an innovative component to address this problem. Orientation content includes DBT theory and structure presented in a psycho-education group, meeting once a week for four weeks. The group is open to patients interested in DBT and exhibiting Axis II characteristics. DBT Orientation supports self-determination by giving the patient a clear understanding of DBT and the commitment required, allowing the patient to make a more informed decision about his or her treatment. The group allows a DBT clinician to assess a patient's willingness to participate in treatment. The data have shown that patients completing DBT Orientation are more likely to participate in DBT therapy and complete one year of treatment. The APA attendees will learn about the content, structure, and advantages of a DBT Orientation Group.

### TARGET AUDIENCE(S):

Direct-care providers involved in DBT.

### REFERENCES:

1. Linehan M: Cognitive Behavioral Treatment of Borderline Personality Disorder. New York, Guilford, 1993.

2. Bradshaw N, Verby P: Building Life Skills, Printed by Allied Professionals for Growth.

**Innovative Program 3 Wednesday, October 5 10:00 a.m.-11:30 a.m.**

## A MINDFULNESS-BASED APPROACH TO 12-STEP ORIENTED ADDICTIONS TREATMENT

Daniel H. Angres, M.D., *Director, Rush Behavioral Health, Rush Presbyterian/St. Luke's Hospital, 610 Maple Avenue, Suite 5600, Oak Park, Il 60304*

### EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: (1) identify and understand the five core goals of 12-step facilitate addiction treatment, (2) apply the seven principles of mindfulness practice to addiction treatment, (3) combine cognitive behavioral therapy (CBT) with Mindfulness Practice to enhance the effectives of addiction treatment, and (4) recognize the biogenetic disease process of addiction and how mindfulness can assist in reducing automatic responses to environmental cues.

### SUMMARY:

Addictive disease (e.g., chemical dependency, compulsive sexual behavior, certain eating disorders, and gambling) respond well to a 12-step oriented (TSF) programmatic approach. In our intensive day hospital program for high-accountability professionals (e.g. physicians, attorneys), we have introduced a mindfulness track, modified from the mindfulness stress-reduction (MBSR) eight-week program initiated at University of Massachusetts (Kabot-Zinn, 1990). We have also framed the elements of the program, like group therapy and didactic lectures in mindfulness-based cognitive treatment terms. We have added an eight-week MBSR course within our two-year aftercare program. TSO treatment of addiction has long been recognized as a primary and highly effective treatment approach. TSO programs provide a theoretical and practical framework from which to develop essential recovery tasks and core treatment goals. The author identifies six core treatment goals derived from the Twelve Steps of Alcoholics Anonymous (AA, 1953) to be (1) accepting powerlessness and unmanageability, (2) seeking help and connecting with others, (3) cultivating mindfulness and meditation techniques, (4) insight into the addictive disease and the self, and (5) taking responsibility for one's recovery. Mindfulness-based stress reduction can be adapted to TSO-based treatment to facilitate success in achieving these core treatment goals. Mindfulness cognitive therapy approaches have been demonstrated successful in treating and preventing relapse in depression (Segal, et. al 2002). By utilizing mindfulness techniques, we hope to enhance 12-step participation and reduce relapse. A workbook format has been instituted to succinctly present and monitor this therapeutic approach. The workbook elements will be shared with the attendees.

### TARGET AUDIENCE(S):

Addiction treatment providers, addiction psychiatrists.

### REFERENCES:

1. Angres DH, Delisi S, White Williams B: A programmatic approach to treating physicians with a dual diagnosis. Psychiatric Annals 2004; 34:10, 776–780.
2. Segal ZV: Mindfulness-Based Cognitive Therapy for Depression. New York. New York, The Gilford Press, 2002.

## INNOVATIVE PROGRAMS: SESSION 2 AN EXAMINATION OF EVIDENCE-BASED PRACTICES

**Innovative Program 4 Wednesday, October 5 1:30 p.m.-3:00 p.m.**

## IMPLEMENTATION OF EVIDENCE-BASED PRACTICES: CO-OCCURRING TREATMENT

Shauna Reitmeier, M.S.W., *Management Analyst Regional Coordinator, Washtenaw Community Health Organization, 555 Towner, Ypsilanti, MI 48197*; Diane Marie Schefke-Heinlein, M.S.W., *Member, National Association of Social Workers, 2280 East Grand River, Howell, MI 48843*

### EDUCATIONAL OBJECTIVES:

At the conclusion of this session, participants will have an understanding of how consensus building works and ways of identifying areas for implementing system change for co-occurring treatment.

### SUMMARY:

Today, many of the people receiving services in community mental health settings have a mental health disorder and a substance disorder. Building from the Kenneth Minkoff, M.D. and Robert Drake, M.D. models, this innovative approach is being implemented in five community mental health settings within a unique affiliated model to providing care. It is believed that consumers with a co-occurring disorder will have effective treatment situations while obtaining care through an integrated and collaborative model. This presentation will give information on how to use a consensus-building

model to decision making, the implementation of core administrative processes to address co-occurring disorders, and how to evaluate progress.

## TARGET AUDIENCE(S):

Community practitioners and administrators working with people that have a co-occurring disorder.

## REFERENCES:

1. Drake RE, Essock SM, et al: Implementing dual-diagnosis services for clients with severe mental illness. Psych Services 2001; 52(4).
2. Minkoff K: Model for the desired array of services and clinical competencies for a comprehensive, continuous, integrated system of care. Center for Mental Health Services Research, University of Mass Dept of Psychiatry, Worcester, MA, 1999.

**Innovative Program 5 Wednesday, October 5 1:30 p.m.-3:00 p.m.**

# DEFINING AND MEASURING PRINCIPLES FOR RECOVERY-ORIENTED CARE IN MENTAL HEALTH ORGANIZATIONS

Molly T. Finnerty, M.D., *Psychiatrist, New York State Office of Mental Health, and Former APA/Bristol-Myers Squibb Fellow, 330 Fifth Avenue, 9th Floor, New York, NY 10001*; Anthony D. Mancini, Ph.D., *Research Scientist, New York School of Mental Health, 330 Fifth Avenue, 9th Floor, New York, NY 10001*

## EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to identify specific principles of recovery-oriented care, approaches for measuring it, and potential uses. In addition, the participant should be able to understand the relevance of recovery orientation to his or her individual practice and the implications of recovery orientation for systems change.

## SUMMARY:

There is increasing interest in developing strategies for promoting evidence-based practices (EBPs) and recovery-oriented practices (ROPs) in routine settings. For example, a multi-state project funded by SAMHSA and coordinated by the Dartmouth Psychiatric Research Center is evaluating implementation toolkits for five EBPs in mental health organizations. As part of oversight for this project, a multi-stakeholder advisory board recently recommended that, in addition to supporting faithful implementation of the EBP model, implementation efforts should include methods for measuring and supporting ROPs. To meet this challenge, a working group of nationally prominent consumer advocates and researchers developed a ROP scale that is designed to augment traditional fidelity measurement for EBPs. In this presentation, we will describe the development process for the ROP scale, which included these steps: (1) review of existing literature and measures on recovery-oriented practice, (2) identification of recovery principles, (3) development of item content with specific behavioral focus, (4) content refinement through expert review, and (5) item generation using behaviorally-anchored response alternatives. We will then describe a pilot study of the ROP scale in assertive community treatment programs (N=10). Finally, we will discuss implications of recovery orientation for individual practice and for systems change.

## TARGET AUDIENCE(S):

Program administrators, clinicians, consumers, and families.

## REFERENCES:

1. New Freedom Commission on Mental Health: Achieving the promise: SAMHSA, 2003.
2. EBPs: Shaping mental health services toward recovery. Website: http://www.mentalhealth practices.org.

**Innovative Program 6 Wednesday, October 5 1:30 p.m.-3:00 p.m.**

# TECHNIQUES TO IMPLEMENT EVIDENCE-BASED PRACTICES AND BEST PRACTICES

Paul R. Miller, M.D., *Associate Clinical Professor, Department of Psychiatry, University of California at Los Angeles, 2406 Astral Drive, Los Angeles, CA 90046-1704*

## EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to describe: (1) outcome studies showing that traditional clinical psychiatric practices often produce poor results for diagnosis/treatment, compared with gold standards, (2) techniques that impose evidence-based best practices: patient questionnaires, computerized diagnoses, rating scales, treatment algorithms, and (3) results from managing three dissimilar patient groups that used these techniques and achieved significantly improved patient outcomes.

## SUMMARY:

*Purpose:* Find techniques to impose best practices and evidence-based practices and improve patient outcomes. This is needed, because numerous outcome studies show that standard clinical psychiatric practices, compared with gold standards, produce poor patient outcomes.

*Content:* Describe methods and results of using techniques to achieve evidence-based best practices with three patient groups. Compare results with results from traditional methods.

*Methodology:* Add the following techniques to traditional clinical practice. Apply to three dissimilar groups: outpatients treated by an ACT team, hospitalized inpatients, and clinical trial subjects during a four-month follow-up period. Measure outcome versus outcomes from traditional methods. (1) Patient Questionnaires: accurate, time efficient, educate patient about the disorder (2) Computerized Structured Interviews and Diagnoses—CADI (Computer Assisted Diagnostic Interview): Enhances reliability, completeness, accuracy for diagnoses (3) Rating Scales: enable comparative quantitative assessments a) across time and b) for outcomes. Use Beck, Ham-D, SADS, BPRS, Ham-A, CGI-S/I, GAF, etc. (4) Treatment Algorithms: collate many possibilities and options for intervention (5) Evidence-Based Psychotherapy: focused, goal directed (6) Teams: include all providers plus patient (7) Performance Improvement: semi-annual evaluations using objective measures

*Results:* All three groups had significantly improved outcomes measured by rating scales, versus outcomes for patients using traditional methods.

## TARGET AUDIENCE(S):

Clinicians/researchers who wish to adopt evidence-based best practices.

## REFERENCES:

1. Torrey WC, Drake RE, Dixon L, et al: Implementing evidence-based practices for persons with severe mental illnesses. Psychiatric Services 2001; 52:45–50.
2. Basco MR, Bostic JQ, Davies D, et al: Methods to improve diagnostic accuracy in a community mental health setting. American Journal of Psychiatry 2000; 157:1599–1605.

# INNOVATIVE PROGRAMS: SESSION 3 WHAT PREDICTS RECOVERY FROM SCHIZOPHRENIA?

**Innovative Program 7 Thursday, October 6 3:30 p.m.-5:00 p.m.**

## NEUROCOGNITIVE CORRELATES OF RECOVERY FROM SCHIZOPHRENIA

Alex J. Kopelowicz, M.D., *Medical Director, San Fernando Mental Health Center, University of California School of Medicine, 10605 Balboa Boulevard, Granada Hills, CA 90077*; Robert Paul Liberman, M.D., *Professor of Psychiatry, University of California at Los Angeles, Neuropsychiatric Institute, 760 Westwood Plaza, Los Angeles, CA 90095-1759*

## EDUCATIONAL OBJECTIVES:

At the conclusion of the presentation, participants should be able to identify at least one cognitive function that is associated with recovery from schizophrenia. Participants should be able to determine whether cognitive enhancement therapies improve outcome in schizophrenia.

## SUMMARY:

Well-designed studies of chronic and recent-onset patients with schizophrenia suggest that recovery is a feasible goal of comprehensive, coordinated, continuous and evidence-based treatment. Factors that predispose to poor outcomes, such as substance abuse, cognitive deficits, and limited social skills, are malleable and hence potentially responsive to treatment.

Using a specific, operational definition of recovery comprising symptomatic and functional improvements, two studies have demonstrated significant neurocognitive differences among schizophrenia patients who met recovery criteria, those who did not, and normal controls. Recovered patients and normal controls performed equally well, and significantly better, than non-recovered patients on tests of executive functioning, verbal fluency, and verbal working memory. On early visual processing, a measure reflecting the enduring vulnerability to schizophrenia, both patient groups performed significantly worse than normals. With recent controlled treatment trials evincing the benefits of various forms of cognitive enhancement therapy, prospects are improving for enlarging the proportion of schizophrenia patients who can recover.

## TARGET AUDIENCES:

Clinicians of all disciplines, researchers, administrators and policymakers.

## REFERENCES:

1. Liberman RP, Kopelowicz A, Ventura J, Gutkind D: Operational criteria and factors related to recovery from schizophrenia. International Review of Psychiatry 2002; 14:256–272.
2. Kopelowicz A, Liberman RP: Recovery from schizophrenia: searching for research. Psychiatric Services, in press, 2004.

**Innovative Program 8 Thursday, October 6 3:30 p.m.-5:00 p.m.**

## IS EARLY INTERVENTION JUSTIFIED?

Richard Warner, M.D., *Medical Director, Mental Health Center of Boulder County, Inc., 1333 Iris Avenue, Boul-*

*der, CO 80304*; David Whitehorn, Ph.D., *Director, Early Psychosis Program, Department of Psychiatry, Dalhousie University, 300 Pleasant Street, Halifax, NS, Canada B2Y 3Z9*

## EDUCATIONAL OBJECTIVES:

At the conclusion of the presentation, participants should be able to understand the difference between early identification and intervention for prodromal symptoms and psychotic symptoms. Participants should be able to state the evidence for and against the value of early identification and intervention in preventing chronicity of schizophrenia.

## SUMMARY:

Early intervention in psychosis is being used with individuals in the earliest stages of fully evident schizophrenia and in those who may have symptoms prodromal to psychosis. It is truism in psychiatry that early intervention brings better results, but it is a truism that may not be true. A critical analysis of research on the duration of untreated psychosis fails to support the popular conclusion that early intervention will reduce chronicity or promote recovery. The emphasis on *early intervention,* furthermore, overlooks the fact that many people with a psychotic disorder may *recover without formal treatment* and that intervention with good prognosis cases may result in a worse outcome. It is clear, nevertheless, that patients and their families with a first psychotic episode have special pharmacological and psycho-educational needs that must be addressed to ensure good outcome and promote recovery.

Attempts to treat people who manifest high-risk indicators of schizophrenia or symptoms suggestive of the schizophrenia prodrome present more serious problems. An examination of these approaches indicates that they have a low probability of reducing the incidence of schizophrenia and a high probability of unintended negative consequences. While available evidence does not offer optimism that early intervention facilitates recovery, we should recognize that under white ashes sometimes lies glowing embers.

## TARGET AUDIENCES:

Clinicians of all disciplines, researchers, consumers and family members.

## REFERENCES:

1. Edwards J, Maude D, McGorry PD, Harrigan SM, Cocks JT: Prolonged recovery in first episode psychosis. British Journal of Psychiatry 1998; 172:107–116.
2. Warner R: Recovery From Schizophrenia, 3rd Edition, New York, Oxford Univ Press. 2004.

**Innovative Program 9** **Thursday, October 6**
**3:30 p.m.-5:00 p.m.**

# WHAT PREDICTS THE EXTENT OF RECOVERY IN THE FIRST YEAR OF TREATMENT?

David Whitehorn, Ph.D., *Director, Early Psychosis Program, Department of Psychiatry, Dalhousie University, 300 Pleasant Street, Halifax, NS, Canada B2Y 3Z9*; Robert Paul Liberman, M.D.

## EDUCATIONAL OBJECTIVES:

At the conclusion of the presentation, participants should be able to delineate at least three factors in treatment programs that facilitate recovery from schizophrenia. Participants should be able to identify at least two personal or intra-individual factors that are associated with recovery from schizophrenia.

## SUMMARY:

For schizophrenia spectrum disorders, the extent of recovery varies widely among patients in the first year of treatment. Evidence from specialized, early intervention programs for psychosis provides an opportunity to examine both patient and program-related factors that may influence symptomatic and functional dimensions of recovery in the critical first year of treatment. Research on this topic is made possible by newly developed, operational criteria for defining recovery. The data demonstrate that patient-related factors such as poor social function in childhood and adolescence, prominent negative symptoms, and impairment of the sense of smell are all associated with relatively poor outcomes after one year of treatment.

Comparison of outcome data among early intervention programs for schizophrenia spectrum disorders suggests that the following program components may increase the extent of recovery: engagement in treatment and adherence to treatment, development of a therapeutic alliance, evidence-based pharmacotherapy and psychoeducation of patients and families. That these components are common to various early intervention program is suggested by their remarkably similar symptomatic and functional outcomes. Guidelines for improving the effectiveness of early intervention programs emerge from these findings.

## TARGET AUDIENCE(S):

Clinicians of all disciplines, researchers, administrators and policymakers.

## REFERENCES:

1. Whitehorn D, Brown J, Richard J, Rui Q, Kopala L: Multiple dimensions of recovery in early psychosis.

International Review of Psychiatry 2002; 14:273–283.
2. Robinson DG, Woerner MG, McMeniman M, Medelowitz A, Bilder RM: Symptomatic and functional recovery from a first episode of schizophrenia. American Journal of Psychiatry 2004; 161:473–479.

## INNOVATIVE PROGRAMS: SESSION 4 DIFFERENT APPROACHES TO INTEGRATION OF SERVICES

**Innovative Program 10** **Friday, October 7 8:00 a.m.-9:30 a.m.**

## INTEGRATING PHYSICAL AND MENTAL HEALTH CARE: PRIMARY CARE NURSING IN A COMMUNITY MENTAL HEALTH CENTER

Karen K. Milner, M.D., *Member, APA Institute Scientific Program Committee, and Assistant Clinical Professor of Psychiatry, University of Michigan, 1500 East Medical Center Drive, Ann Arbor, MI 48109-0020*; Daniel J. Healy, M.D., *Clinical Assistant Professor, Department of Psychiatry, University of Michigan, 1500 East Medical Center Drive, Ann Arbor, MI 48109*

### EDUCATIONAL OBJECTIVES:

At the conclusion of this session, participants should be able to discuss the benefits and challenges related to developing a primary care nursing site in an established community mental health center.

### SUMMARY:

Numerous studies have shown that individuals with severe and persistent mental illness (SPMI) have higher mortality/morbidity rates than individuals in the general population. In January 2004, a primary care nursing clinic staffed by a clinical nurse practioner, opened on the premises of community support and treatment services, the community mental health center for Washtenaw County. The clinic was established to integrate delivery of medical and behavioral health care for individuals with SPMI. Data from the first nine months have been retrospectively reviewed to look at client demographic data, referral source, reason for referral, diagnostic impression, patient and CSTS staff satisfaction, as well as clinic utilization and insurance status. Additionally, information as to whether the client has an identified PCP, whether the client has seen the PCP in the year prior to presentation, and whether the client has been hospitalized medically in the past year was examined. Information related to number of PES visits/ medical ER visits, case manager contacts, and appointments with the psychiatrist in the six months prior to and since presentation to the clinic was also reviewed. These results, as well as next steps, will be presented and discussed during this session.

### REFERENCES:

1. Sokal J, Messias E, Dickerson FB, et al: Comorbidity of medical illnesses among adults with serious mental illness who are receiving community psychiatric services. J Nerv Ment Dis 2004; 192:421–427.
2. Warren MR, Santiago JM, Zent MR, Carbone CP: Health care utilization by persons with severe and persistent mental illness. Psychiatric Services.

**Innovative Program 11** **Friday, October 7 8:00 a.m.-9:30 a.m.**

## GOOD NEIGHBOR HEALTH CLINIC: MENTAL HEALTH SERVICES FOR THE UNINSURED

Patricia A. Daly, M.D., *Fellow, Department of Psychiatry, Dartmouth-Hitchcock, 1 Medical Center Drive, Lebanon, NH 03756*

### EDUCATIONAL OBJECTIVES:

At the end of the presentation, the participant should be able to (1) understand ways to provide mental health services to the uninsured in a free clinic setting, and (2) understand how to organize an internal referral process and coordination of care between primary care providers and psychiatrists.

### SUMMARY:

The Good Neighbor Health Clinic in White River Junction, VT, has provided primary care to uninsured residents (mostly working poor) in a broad geographic area of VT and NH since 1992. More recently, the clinic has begun to offer mental health services by utilizing psychiatry residents from Dartmouth-Hitchcock Medical Center as well as graduate students in mental health specialties from local colleges. Services offered include psychiatric evaluation, medication management, cognitive-behavioral therapy, and supportive therapy. Supervision and additional clinical care are provided by retired psychiatrists and Dartmouth-affiliated psychiatrists.

This presentation will describe the evolution of mental health services at the clinic and how services offered to the uninsured are coordinated. The internal referral process will be described and the interfaces with the smoking cessation, nutrition classes, and walking groups will be explained. Limitations on what services can safely be offered in a volunteer clinic in addition to ways to find services for those that exceed the clinic threshold will be examined. Finally, plans for expanding the current services will be described.

## TARGET AUDIENCE(S):

The presentation is geared toward psychiatrists and other clinicians interested in providing well-coordinated services to the uninsured.

## REFERENCES:

1. Committee on the Consequences of Uninsurance: A Shared Destiny: Community Effects of Uninsurance. Board on Healthcare Services, Institute of Medicine, 2003.
2. Committee on the Consequences of Uninsurance: Hidden Costs, Value Lost: Uninsurance in America. Board on Healthcare Services, Institute of Medicine, 2003.

**Innovative Program 12** **Friday, October 7 8:00 a.m.-9:30 a.m.**

## A HOMELESS ASSISTANCE PROGRAM AS RAPID ENTRY TO INTEGRATED SERVICES

Mark Ragins, M.D., *Medical Director, Village Integrated Services, 456 Elm Avenue, Long Beach, CA 90802-2426*; Shannon Legere, L.C.S.W., *Director, Homeless Assistance Program, Mental Health Association, 456 Elm Avenue, Long Beach, CA 90802*

## EDUCATIONAL OBJECTIVES:

At the conclusion of this session, participants should be able to conceptualize how to transform Homeless Assistance Programs into important, highly integrated parts of a system of care.

## SUMMARY:

The Homeless Assistance Program has gradually grown from a storefront drop-in center and a mobile outreach van into highly sophisticated outreach and engagement and fast track programs. Innovative program elements include: (1) heavy emphasis on street, jail, and hospital outreach; (2) integration of charity, treatment, and advocacy using a refugee-services model; (3) integration of multiple funding sources; (4) using our psychiatrist as the first clinician people see to welcome, engage, make sophisticated diagnosis in this highly variable group, do ''one-session psychotherapy,'' treatment planning, and triage; (5) using a multi-experiential team with lots of street smarts and hiring new consumers to run the drop-in center to create a counterculture of acceptance; (6) rapid entry into integrated services including intensive case management, day labor opportunities, job training and placement, a consumer-run supported apartment program, benefits assistance, money management-payee services, substance abuse treatment, medical care, and community integration services; (7) a strong effort to promote graduation after one year within a recovery culture.

## TARGET AUDIENCE(S):

Staff and administrators of homeless assistance programs.

## REFERENCES:

1. Lam J and Rosenneck R: Street Outreach for Homeless Persons with Serious Mental Illness: Is it effective? Medical Care 39(9). 894–907.
2. Erickson S and Page J: To Dance with Grace: Outreach and Engagement to Persons on the Street in Fosburg LB, Dennis DL (eds) Practical Lessons: The 1998 National Symposium on Homelessness Research. Nat'l Resource Center on Homelessness and Mental Illness 1999.

## INNOVATIVE PROGRAMS: SESSION 5 SPECIALIZED COMMUNITY-BASED TRAINING AND SERVICES

**Innovative Program 13** **Saturday, October 8 8:00 a.m.-9:30 a.m.**

## MEDICATING THE ELDERLY THROUGH TRANSLATION

Leila B. Laitman, M.D., *Psychiatric Consultant, Community Mental Health Services, Visiting Nurse Service of New York, 1200 Waters Place, Bronx, NY 10461*; Rebecca Morales, C.S.W., *Program Coordinator, Geriatric Mental Health, Visiting Nurse Service of New York, 1200 Bronxdale Avenue, Bronx, NY 10461*

## EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to (1) recognize the problems inherent in doing medication evaluations through translation, and (2) understand possible approaches to overcoming cultural resistances to medication.

## SUMMARY:

The In-Home Geriatric Mental Health Program (IHGMHP) of the Visiting Nurse Service of N.Y. (VNSNY) is a mental health outreach team that serves people, age 60 and over, who reside in Bronx, N.Y. The team consists of a program coordinator, three social work assistants, a psychiatric nurse, and a part-time geriatric psychiatrist. Three of them speak fluent Spanish. In the 300 referrals we received this past year, roughly 40% of them were Hispanic, many of whom did not speak English. Spanish-speaking clients are assigned to Hispanic clinicians. However, since the psychiatrist is not Spanish speaking, medication evaluations are done through translation.

In other mental health programs of VNSNY, medication evaluations are often done through the use of nonclinician, escort/translators who know nothing about mental health or medication. Many times, the Hispanic patients would either refuse the doctor visit altogether or refuse to consider medication when translators were used. In the IHGMHP, an innovative program was developed as part of a curriculum designed to teach effective engagement techniques to help the elderly accept mental health treatment in the community. Staff was taught to use specific methods to help diminish patients' resistance to taking medication. The Hispanic workers had to use their innate understanding of cultural resistance to get the patients to accept an M.D. visit and then to understand and follow the psychiatrist's recommendations. To accomplish this task, social work assistants had to be trained not only to recognize psychiatric symptoms, but also to attempt to make a psychiatric diagnosis so that an appropriate treatment plan could be developed under supervision. They then had to learn about psychiatric medications and their side effects and psychotherapeutic techniques in order to present a compelling argument to the patients that they should give medication a try.

Since the Hispanic population is the fastest growing minority group in the nation, and presently, only 7% of the psychiatrists are bilingual, programs such as these must be instituted to meet the needs of minority elderly. Cultural competence plans may need to incorporate programs like this to best serve non-English-speaking populations.

## TARGET AUDIENCE(S):

Psychiatrists, social workers, nurses.

## REFERENCES:

1. Vega WA, Loopez SR: Priority issues in Latino mental health services research. Mental Health Services Research 2001; 3,4:189–200.
2. USDHHS, Office of Minority Health: National standards for culturally and linguistically appropriate services in heath care. Washington, DC, 2001.

**Innovative Program 14 Saturday, October 8 8:00 a.m.-9:30 a.m.**

# BEYOND THE HOSPITAL: MEDICAL STUDENT EDUCATION IN COMMUNITY PSYCHIATRY

Richard C. Christensen, M.D., M.A., *Clinical Associate Professor, and Director, Community Psychiatry Program, Health Science Center, University of Florida College of Medicine at Jacksonville, and Former APA/Bristol-Myers Squibb Fellow, 655 West 8th Street, Jacksonville, FL 32209*

## EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should gain a greater understanding of how to incorporate ambulatory, community-based clinical initiatives in psychiatry that can be utilized to provide a comprehensive and educationally meaningful experience for third- and fourth-year medical students.

## SUMMARY:

Traditional third-year clerkship rotations for medical students occur primarily on busy inpatient psychiatry units affiliated with large academic centers or Veterans Administration hospitals. Unfortunately, these particular clinical experiences oftentimes lack relevance to the type of patients and situations most medical students will encounter in their future roles as primary care physicians and specialists. In general, third-year students on the inpatient setting will encounter a population of acutely ill patients who frequently present with psychotic disorders or suicidal intentions and are in need of institutional structure and rapid stabilization. Hence, the students develop a knowledge base and skill set in psychiatry that may have very little applicability to their future practice as physicians in the community. Moreover, by being based within the confines of an inpatient setting, the students frequently receive very little exposure to the broader ''outside'' community and the array of social, economic, and personal challenges their patients will encounter in their struggles to maintain stability and achieve recovery.

At the University of Florida, under the auspices of the Community Psychiatry Program, third-year medical students have the opportunity to complete their psychiatry clerkship rotation by working within three different outpatient, community-based settings: a shelter-based clinic for the homeless, an integrated primary care-community psychiatry clinic, and a multidisciplinary, assertive community outreach program to the homeless mentally ill. This presentation will describe each of these community-based outpatient initiatives, how they have been appropriately adapted for medical student education, and the educational goals and objectives pursued in each setting.

## TARGET AUDIENCE(S):

Medical students, medical school faculty, clerkship directors.

## REFERENCES:

1. Christensen RC: Community psychiatry education through homeless outreach. Psychiatric Services 2004; 55(8):942.

2. Christensen RC: Community-based, psychiatry clerkship in an ambulatory setting. Academic Medicine 1997; 72(7): 565.

**Innovative Program 15 Saturday, October 8 8:00 a.m.-9:30 a.m.**

## OUTBRIEFING STATE DEPARTMENT EMPLOYEES RETURNING FROM IRAQ: A NEW CONCEPT

Ray S. Leki, *Director, Transition Center, Foreign Service Institute, U.S. Department of State, SA42 E2122, Washington, DC 20522-4201*; Samuel B. Thielman, M.D., *Director, Mental Health Services, U.S. Department of State, 811 Ridge Place, Falls Church, VA 22046*

### EDUCATIONAL OBJECTIVES:

At the conclusion of this session, participants should be able to differentiate the outbrief approach from other debrief models and adapt the concept to their own needs.

### SUMMARY:

This presentation focuses on a new approach in dealing with individuals and communities in the aftermath of high threat events and experiences, and describes a program developed at the United States Department of State to service diplomats and other civilian employees returning from service in Iraq. The outbriefing process is primarily educational in nature, but also serves to empower employees to reach informed decisions on follow-up care they may elect to pursue. It includes content on repatriation dynamics, recognizing symptoms of post-traumatic stress disorder and related problems, and shares strategies for re-integrating into life, work, and relationships with partners and family members after an extended period of separation. Moreover, by providing employees with a vehicle for feeding back recommendations for how they might have better been prepared before and after returning from Iraq, it allows officers to productively share experiences with the Department of State as the subject of needed change or improvement, rather than the individual. Outbriefings are scheduled every two weeks and are mandatory for all employees who have returned from Iraq. The implementation of the program represents a partnership within a large organization between various stakeholder officers and officials, and has resulted in overwhelmingly positive feedback.

### TARGET AUDIENCE(S):

Practitioners in community, individual, and organizational mental health.

### REFERENCES:

1. Ursano RJ: Terrorism and Disaster Indiv. and Community Mental Health Intern. Cambridge Univ. Press, 2003.
2. Ursano RJ, McGaughy BG: Indiv and Community Responses to Trauma and Disaster: The Structure of Human Chaos. Cambridge Univ Press, 1994.

**Lecture 1** **Wednesday, October 5**
**10:00 a.m.-11:30 a.m.**

## ALGORITHMS FOR TREATMENT OF SCHIZOPHRENIA

*APA's Research in Psychiatry Award*

Herbert Y. Meltzer, M.D., *Bixler/Mays/Johnson Professor of Psychiatry and Pharmacology, and Director of the Division of Psychopharmacology, Vanderbilt University School of Medicine; Chairman of the International Psychopharmacology Algorithm Project; and Director of the Schizophrenia Program of Centerstone Mental Health System, 1601 23rd Avenue, South, #306, Nashville, TN 37212-8645*

### EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: (1) identify current problems in the treatment of schizophrenia, including polypharmacy and limited success in treatment of cognitive impairment and negative symptoms; (2) discuss the value of utilization of an algorithm to guide treatment of schizophrenia; (3) describe the International Psychopharmacology Algorithm for Schizophrenia (IPAP) and the basis for its recommendations on treatment of schizophrenia; and (4) compare IPAP and the Texas Medication Algorithm Project (TMAP).

### SUMMARY:

The International Psychopharmacology Algorithm for Schizophrenia (*www.IPAP.org*) provides a web-based approach to treating schizophrenia which can be a great asset to clinicians to guide their approach to disease management and optimal pharmacotherapy for schizophrenia and schizoaffective disorder. This algorithm was developed by an international group of experts who incorporated evidence-based medicine wherever possible, and then expert opinion, in reaching consensus for management. The algorithm directs the clinician to address a group of features which require immediate attention such as sucidality, agitation, catatonia, non-compliance, etc. The treatment strategy emphasizes monotherapy with a first-line atypical antipsychotic drug based upont their superiority with regard to extrapyramidal symptoms, cognitive improvement, and mood and suicidality and facilitates chosing among them on the basis of their differences in metabolic and other side effects. The IPAP algorithm will be compared with the Texas Medication Algorithm Project (TMAP).

### REFERENCES:

1. www.IPAP.org.
2. Miller AL, Crismon ML, Rush AJ, Chiles J. Kashner TM, Toprac M, Carmody T. Biggs M, Shores-Wilson K, Chiles J, Witte B. Bow-Thomas C. Velligan DI, Trivedi M. Suppes T. Shon S.
3. The Texas medication algorithm project: clinical results for schizophrenia. Schizophr Bull 2004; 30(3):627–47.

**Lecture 2** **Wednesday, October 5**
**1:30 p.m.-3:00 p.m.**

## COMMUNITY PSYCHIATRY: IS IT TIME TO GO GLOBAL?

Francine Cournos, M.D., *Professor of Clinical Psychiatry, Columbia University College of Physicians and Surgeons, and Deputy Director, New York State Psychiatric Institute, 5355 Hudson Parkway, 9-F, Bronx, NY 10471*

### EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participants should be able to learn about grass roots and formal approaches to international community psychiatry collaborations, and identify their own opportunities to do international work.

### SUMMARY:

Despite evidence that mental health disorders are among the most disabling illnesses in the developing world, integrating mental health into health care has been constrained by both stigma and limited resources. After three decades of practicing community psychiatry in the United States, the presenter became involved in international efforts to integrate mental health into medical care in preventing and treating HIV infection in resource poor countries. Using these efforts as a model, the presenter hopes to demonstrate that we have new opportunities to become involved in rewarding collaborations that will enhance the practice of community psychiatry at an international level.

### REFERENCES:

1. Integrated Management of Adolescent and Adult Illness WHO/CDS/IMAI/2004.1, 2004.2.
2. Report on the global HIV/AIDS epidemic 2004 www.unaids.org.

**Lecture 3** **Thursday, October 6**
**10:00 a.m.-11:30 a.m.**

## CONSUMER DIRECTED HEALTH CARE/ HEALTH SAVINGS ACCOUNT: WHAT'S IT ALL ABOUT, AND WHAT SHOULD I DO ABOUT IT?

James G. Knight, M.D., *CEO, Consumer Directed Health Care, Inc.; Past President, San Diego County Medical Society; Chairman, 1st Pacific Bank of California; Director of Health Care Strategy; Nuffer, Smith,*

*and Tucker Public Relations, 3405 Kenyon Street, Suite 401, San Diego, CA 92110-5007*

## EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to outline the interrelating concepts embodied in consumer directed health care (CDHC), focusing mainly on the rapidly growing use of health savings accounts; and identify the areas of clinical practice most likely to be affected by CDHC, so that they can better position themselves to take advantage of an historic transformation of the health care marketplace.

## SUMMARY:

Over the past 40 years, inflation adjusted per capita health care expenditures grew by more than 500% while out-of-pocket health care spending (personal payments) dropped from 48% to 14%.

Seventy-eight million baby boomers begin retiring in 2009; transitioning from being the largest payers, to net users of federal health care dollars.

Reconnecting consumers to the cost of day-to-day health care services has been shown to dramatically decrease utilization of health care services with little or no reduction in overall health.

Tax-favored health savings accounts reconnect consumers to the cost of day-to-day health care, creating long-term tax free savings available for future healthcare expenses or retirement needs.

The global effects of consumer directed health care/ health savings accounts will be dramatic. Physicians must develop real understanding of the changes taking place as well as develop strategies for capitalizing on this major market transformation.

## REFERENCES:

1. Manning WG, Newhouse JP, Duan N, Keeler E, et al: Health Insurance and the Demand For Medical Care. The Rand Corporation (Supported by a grant from the U.S. Department of Health and Human Services), 3476–HHS, 1988.
2. Smith C, Cowan C, Sensenig A, Catlin A, and the Health Accounts Team: Health spending growth slows in 2003. Health Affairs 2005; 24(1) 185–194.

**Lecture 4** **Thursday, October 6**
**3:30 p.m.-5:00 p.m.**

## EVIDENCE-BASED TREATMENT FOR PERSONS WITH SCHIZOPHRENIA

*American Psychiatric Foundation's Alexander Gralnick, Award for Research in Schizophrenia*

Anthony F. Lehman, M.D., *Professor and Chair, Department of Psychiatry, University of Maryland School of Medicine, 701 West Pratt Street, Suite 388, Baltimore, MD 21203*

## EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: (1) develop a better understanding of the efficacy of treatments for persons with schizophrenia; (2) list the Schizophrenia PORT Treatment Recommendations; (3) increase awareness about current patterns of care and how they might be improved; and (4) recognize the challenges in translating evidence-based practices into individualized care for patients.

## SUMMARY:

Considerable progress is occurring in our understanding of schizophrenia and the development of evidence-based approaches to treatment. With these advances is coming increased recognition that although available antipsychotic medications are effective at reducing positive symptoms and relapse, overall outcomes for persons with schizophrenia remain limited with many patients experiencing considerable disability. In addition, most patients lack adequate access to currently available evidence-based treatments, in particular, psychosocial treatments.

This lecture will examine the evidence for currently available, evidence-based psychosocial treatments, including cognitively oriented psychotherapy, family education and support, supported employment, skills training, cognitive remediation, and assertive community treatment. Current treatment practices and the barriers to access to these treatments will be presented. Finally, the emerging vision of how combined psychosocial and pharmacologic evidence-based treatments may enhance functional outcomes and quality of life for persons with schizophrenia will be put forth.

## REFERENCES:

1. U.S. Department of Health and Human Services, Public Health Service, National Institutes of Health, National Institute of Mental Health: Psychosocial Treatment for Schizophrenia. Schizophrenia Bulletin, 2000, 26(1):1–248.
2. Lehman AF, Kreyenbuhl J, Buchanan RW, Dickerson FB, Dixon LB, et al: The Schizophrenia Patient Outcomes Research Team (PORT): Updated treatment recommendations 2003, Schizophrenia Bulletin, 2004, 30(2):193–217.

**Lecture 5** **Thursday, October 6**
**3:30 p.m.-5:00 p.m.**

## THE OLD-ER, BLACK-ER PSYCHIATRIST IN AMERICA: OBSOLESCING, REINVIGORATING, OR REJUVENATING

Phyllis Harrison-Ross, M.D., *Emeriti Professor of Psychiatry and Behavioral Health Sciences, New York Med-*

*ical College, and Managing Partner, Black Psychiatrists of Greater New York and Associates, 41 Central Park West, # 10-C, New York, NY 10023*

## EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: (1) teach a strategy and review options for redefining a mission, goals, and objectives for older, historically traditional, black psychiatrists in America; (2) present a review of the historical mission of black psychiatrists in America; (3) define three priorities of older, historically traditional, black psychiatrists in America in 2005 and describe one strategy each to achieve each of these priorities; (4) understand five ways in which these priorities and strategies of older, historically traditional, black psychiatrists conflict with the priorities and strategies of younger black psychiatrists in 2005; (5) lead a discussion to attempt to achieve consensus around these priorities and strategies and develop a revised mission; and (6) create an agenda to address these conflicting concerns and define a vision for all black psychiatrists in America that is appealing to and worthy of the support and participation by all generations.

## SUMMARY:

This lecture will present a strategy and review options for redefining the professional, academic, clinical, and personal mission, goals and objectives of older, historically traditional, black psychiatrists in 2005 America including a historical review and anecdotal survey of recent activities and issues of concern.

Ill health and health care disparities for African Americans are an accepted fact. Fewer african american physicians and psychiatrists are being trained. Many that are trained lack the traditional cultural skills and support systems to help close these gaps and facilitate access to care for these patients. Older, black psychiatrists can be used to enhance and improve healthcare opportunities for African-American patients, while advocating for and participating in the education and training of additional clinicians. A very, senior, black psychiatrist utilizes her professional life experiences to stimulate a broader discussion with the audience. A summary of this discussion will be disseminated to participants.

## REFERENCES:

1. Spurlock J (ed): Black Psychiatrists and American Psychiatry, American Psychiatric Press, 1999.
2. Griffith EEH: Race and Excellence: My Dialog with Chester Pierce. Iowa City, University of Iowa Press, 1998.

**Lecture 6** **Thursday, October 6**
**3:30 p.m.-5:00 p.m.**

# CHANGING THE WORLD: DEVELOPING COMPREHENSIVE, CONTINUOUS, INTEGRATED SYSTEMS OF CARE FOR PSYCHIATRIC AND SUBSTANCE DISORDERS

Kenneth M. Minkoff, M.D., *Clinical Assistant Professor of Psychiatry, Harvard Medical School, and Senior System Consultant, Zialogic, 100 Powdermill Road, #319, Acton, MA 01720*

## EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: (1) identify eight principles of evidence-based treatment intervention upon which to base the design of a comprehensive, continuous, integrated system of care (CCISC); (2) describe the components of a CCISC, using Dual Diagnosis Capable and Dual Diagnosis Enhanced terminology; (3) identify characteristics of Dual Diagnosis Capable and Dual Diagnosis Enhanced programs and strategies for implementation; (4) identify funding strategies to maximize use of existing resources for developing Dual Diagnosis Capable treatment of dual diagnosis; and (5) delineate potential change strategies at the system, program, clinical practice, and clinician competency levels to implement a CCISC at any level of the system.

## SUMMARY:

Individuals with co-occurring disorders are associated with poor outcomes and high costs throughout the service system, yet have been traditionally defined as ''misfits'' rather than priorities within all systems of care. Recently, SAMHSA has begun to make system strategies to address the needs of these individuals a priority, and has funded COSIG grants in 11 states to create system change to support integrated treatment. This presentation reviews examples of systems difficulties faced by individuals with co-occurring psychiatric and substance disorders in public and private settings, and identifies research based principles of successful treatment intervention for these individuals in the context of a parallel disease and recovery integrated conceptual framework that uses a common language that makes sense from the perspective of both the addiction field and the mental health field. The presentation then illustrates the application of these principles to the design of a strategy for the resolution of these systems difficulties through the development of a comprehensive, continuous, integrated system of care (CCISC) for psychiatric and substance disorders that maximizes use of all existing resources to initiate integrated treatment, and develops expectations that all programs achieve Dual Diag-

nosis Capability to provide properly matched services within existing resources to the individuals with cod that they already are serving. This model is recognized by SAMHSA as a best practice, and is being utilized in nine of the eleven COSIG states.

The workshop discussion then illustrates a systematic process for implementing this model, building on work in 25 states and two Canadian provinces, utilizing simultaneous interventions at the system, program, clinical practice, and clinician levels, and reports on progress of various system changing initiatives from different parts of the US and Canada. The first part of the workshop emphasizes system and program level strategies; the second part of the workshop discusses clinical practice guidelines for assessment and treatment matching and the process of implementation of those guidelines.

## REFERENCES:

1. Minkoff K, Cline CA: Changing the world: the design and implementation of comprehensive continuous integrated systems of care for individuals with co-occurring disorders. Psych Clin N Am 2004; 24: 727–43.
2. Minkoff K, Cline CA: Developing welcoming systems of care for individuals with co-occurring disorders: the role of the CCISC model. J. Dual Diagnosis 2004; 1: 65–89.

**Lecture 7** **Friday, October 7**
**8:00 a.m.-9:30 a.m.**

## FINANCING PSYCHIATRIC CARE

Rodrigo A. Munoz, M.D., *Consultant, APA/IPS Scientific Program Committee; and Past President, American Psychiatric Association, 3130 5th Avenue, San Diego, CA 92103-5839*

## EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant will have an understanding of the rapidly evolving changes in health financing in the U.S.

## SUMMARY:

The emergence of HMOs 30 years ago drastically decreased funding for psychiatric services in the United States. Managed care rules permitted health care managers to reduce support for the diagnosis and treatment of psychiatric disorders, to the point that much psychiatric care became inadequate and ineffective. Psychiatrists and their patients made successful use of litigation and legislation to control the abuses, and create new strategies to finance mental health services. Change has been slow but often successful.

AMA and other medical organizations have advocated patient directed health care as an alternative to employer sponsored programs. The resulting proposals, that have included Health Savings Accounts, catastrophic insurance and direct use of tax reform to support medical services have produced new avenues for better finances. The new strategies of health financing are the main subject of this presentation.

## REFERENCES:

1. Herzlinger R: Market Driven Health Care. Addison-Wesley Publishing Company, Inc. NY, 1997.
2. Kazel R: Are HMOs Dead? Or Just on Life Support? AMNews. April 18, 2005.

**Lecture 8** **Friday, October 7**
**8:00 a.m.-9:30 a.m.**

## INTEGRATING PSYCHIATRY INTO ONCOLOGY: CHANGING CLINICAL PRACTICE

*APA's Adolf Meyer Award*

Jimmie C. Holland, M.D., *Wayne E. Chapman Chair in Psychiatric Oncology, Memorial Sloan-Kettering Cancer Center, 1275 York Avenue, New York, NY 10021-6007*

## EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: (1) understand how the development of psychiatry within the field of oncology occurred over the past 30 years; (2) learn how the principles laid out by Adolf Meyer continue to be applicable in consultation/liaison work today, and how clinical practice guidelines have evolved for management of psychiatric disorders in cancer; and (3) become aware of the model that psycho-oncology provides to guide the integration of subspecialties of psychiatry in to the other specialties of medicine, including what facilitates and what hinders the integration.

## SUMMARY:

The Adolf Meyer Lecture will recognize the historical contributions of Meyer to psychiatry in general and to psychosomatic medicine in particular, which is based on his concept of ''psychobiology''. A brief overview of consultation/liaison psychiatry will focus on strategies that have led to the establishment of psycho-oncology as a subspecialty of oncology. Clinical practice guidelines for management of distress in cancer patients now provide a defined minimum standard for psychiatric, psychological, and psychosocial care in cancer to which institutions can be held accountable, and policy makers can utilize in health care planning. Psycho-oncology today has exciting evolving translational research that returns us again to Meyer's ''psychobiology.''

**REFERENCES:**

1. Hewitt M, Herdman R, Holland JC (Eds): Meeting Psychosocial Needs of Women with Breast Cancer Report of the National Cancer Policy Board/Institute of Medicine and National Research Council, Washington, DC: The National Academies Press: 2004.
2. Holland JC, Andersen B, Booth-Jones M, et al: NCCN. Distress Management Clinical Practice Guidelines in Oncology. Journal of the NCCN. 2003; 1:344–74.

**Lecture 9** **Friday, October 7**
**8:00 a.m.-9:30 a.m.**

## THE TREATMENT OF AFRICAN-AMERICAN CLIENTS AND FAMILIES

*APA's Solomon Carter Fuller Award*

Nancy Boyd-Franklin, Ph.D., *Professor, Rutgers University Graduate School of Applied and Professional Psychology, 11 Angelica Court, Princeton, NJ 08540*

### EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: (1) obtain a greater understanding of the subtleties of African-American culture; (2) develop more effective strategies for joining and intervening with African-American clients and families; (3) illustrate the role of spirituality and religion in African-American families and learn how to utilize these strengths in therapy; (4) involve key extended family members in the treatment process; and (5) learn the importance of ''the therapist's use of self'' in the treatment of African-American clients and families.

### SUMMARY:

This presentation will provide participants with a greater understanding of the effective treatment of African-American clients and families. The diversity within the African-American community will be discussed. The process of utilizing cultural strengths such as the extended family network, religion and spirituality, and survival skills in the treatment process will be addressed. Issues of racism will be discussed and special attention will be paid to the fears for black male children. Cross-racial treatment issues will be explored. Clinical case examples and videotaped material will be presented.

### REFERENCES:

1. Boyd-Franklin N: Black families in therapy: Understanding the African American experience (2nd Edition). New York: Guilford Press, 2003.
2. Boyd-Franklin N, Franklin AJ, Toussaint P: (2001) Boys into men: Raising Our African American teenage sons. New York: Plume, 2001.
3. Boyd-Franklin N, Bry B: Reaching out in family therapy: Home-based, school, and community interventions. New York: Guilford Press, 2000.

**Lecture 10** **Friday, October 7**
**1:30 p.m.-3:00 p.m.**

## PRISONERS WITH SERIOUS MENTAL ILLNESS: THEIR PLIGHT, TREATMENT, AND PROGNOSIS

Terry A. Kupers, M.D., M.S.P., *Institute Professor, The Wright Institute, 8 Wildwood Avenue, Oakland, CA 94610-1044*

### EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: (1) understand the plight of prisoners, including prisoners suffering from serious mental illness; (2) recognize some of the difficulties faced by mental health service providers in correctional settings; and (3) discuss treatment issues and constructive interventions with this population of prisoners.

### SUMMARY:

A very large number of prisoners suffer from serious and persistent mental illness. They are prone to victimization by other prisoners and are disproportionately victims of rape. A large proportion of these prisoners do most of their time confined to their cells. Some find their way into punitive segregation, while others voluntarily remain in their cells all day in order to avoid victimization. But cell confinement, whether punitive or voluntary, can lead to further emotional deterioration. The same conditions that worsen psychiatric disorders make treatment problematic. For example, psychotropic medications alone are not very effective, especially when the patient is confined to a cell and the psychiatrist sees him or her only at cell front, within earshot of other prisoners and staff. Psychiatrists know how to establish and run all the components of a comprehensive mental health treatment program, and there is no reason not to do so in our jails and prisons.

### REFERENCES:

1. Kupers T: Prison Madness: The Mental Health Crisis Behind Bars and What We Must Do About It. New York: Wiley, 1999.
2. Pizarro J, Stenius V: Supermax prisons: their rise, current practices, and effect on inmates. The Prison Journal 2004; 84(2): 248–264.

**Lecture 11** **Friday, October 7**
**1:30 p.m.-3:00 p.m.**

## QUALITY OF PUBLICLY-FUNDED OUTPATIENT SPECIALTY MENTAL HEALTH CARE FOR COMMON CHILDHOOD PSYCHIATRIC DISORDERS IN CALIFORNIA

Bonnie T. Zima, M.D., M.P.H., *Professor-in-Residence, Department of Psychiatry and Biobehavioral Sciences, UCLA Neuropsychiatric Institute, 10920 Wilshire Boulevard, #300, Los Angeles, CA 90024-6505*

### EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: (1) become familiar with the RAND/UCLA appropriateness method and its application to examining quality of care for child psychiatric disorders; (2) describe how quality of care widely varies across components of care, i.e., comprehensiveness of assessment, service linkage, basic treatment principles, psychosocial treatment, safety; and (3) raise awareness of need to improve documentation of safety monitoring for children receiving psychotropic medication treatment.

### SUMMARY:

*Objective:* To describe the documented adherence to quality indicators for the outpatient care of attention deficit hyperactivity disorder, conduct disorder, and major depression for children in public mental health clinics, and to explore how adherence varies by child and clinic characteristics.

*Method:* A statewide, longitudinal cohort study of 813 children ages 6.0–16.9 years with at least three months of outpatient care, drawn from 4958 patients in 62 mental health clinics in California from August 1, 1998, through May 31, 1999. The main outcome was documented adherence to quality indicators based upon scientific evidence and clinical judgment, assessed by explicit medical record review.

*Results:* Relatively high adherence was recorded for clinical assessment (78%–95%), but documented adherence to quality indicators related to service linkage, parental involvement, use of evidence-based psychosocial treatment, and patient protection were moderate to poor (74.1%-8.0%). For children prescribed psychotropic medication, 28.3% of the records documented monitoring of at least one clinically indicated vital sign or laboratory study. Documented adherence to quality indicators varied little by child demographics or clinic factors.

*Conclusion:* Efforts to improve care should be directed broadly across clinics; with documentation of safe practices, particularly for children prescribed psychotropic medication, being of highest priority.

### REFERENCES:

1. McGlynn EA, Asch SM, Adams J, Keesey J, Hicks J, DeCristofaro A, Kerr EA: The quality of health care delivered to adults in the United States. N Engl J Med 2003; 348:2635–2645.
2. Institute of Medicine Committee on Quality Health Care in America: Crossing the Quality Chasm: A New Health System for the 21st Century. Washington, D.C.: National Academy Press, 2001.

**Lecture 12** **Friday, October 7**
**3:30 p.m.-5:00 p.m.**

## SSRI TREATMENT IN CHILDREN: RESPONSE TO THE CURRENT CONTROVERSY

Harold I. Eist, M.D., *Past President, American Psychiatric Association; Former Chair APA/IPS Scientific Program Committee; and Clinical Professor of Psychiatry, George Washington University, 10436 Snow Point Drive, Bethesda, MD 20814*

### EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: (1) understand appropriate and professional organization responses to official agency misinformation and media misinformation that negatively impact quality of care; (2) identify factors influencing inappropriate personal and professional organization responses; (3) assess the importance of front-line clinician input in the assessment of medication efficacy; and (4) recognize the necessity of all sectors, practitioners, researchers, and academics working together to provide accurate assessments of efficacy.

### SUMMARY:

This lecture will describe, capturing the drama of the recent SSRI controversy, the dynamics of flawed organizational responses to FDA and media misinformation and the creative and constructive approaches and understandings that were utilized to correct the public record for the benefit of patients, potential patients and the public. It will clarify the errors made by the FDA regarding the dangers of SSRIs in children and adolescents and the initial strategic failure of the field including the APA and AACAP, among others, to address these errors forcefully in order to protect the public and practitioners on the front lines. In this regard the lecture will draw attention to a number of reflexive responses of the medical community to official agency, in this instance, both the FDA and Congress, criticism. For example we traditionally shoot ourselves in the foot and point fingers and blame others. This leads to muddled responses that intensify the media circus, frighten the public, and add

to stigma. Suggestions for future constructive action are included.

## REFERENCES:

1. Wagner KD, Ambrosini P, et al: Efficacy of Sertraline in the Treatment of Children and Adolescents With Major Depressive Disorder. Two Randomized Controlled Trials. JAMA 2003; 290; 1033–1041.
2. Ambrosini PJ: A review of pharmacotherapy of major depression in children and adolescents. Psychiatr Serv. 2000; 51:627–633.

**Lecture 13** **Friday, October 7**
**3:30 p.m.-5:00 p.m.**

## THE IMPACT OF NEW TREATMENTS AND PAYMENT SYSTEMS ON THE PRACTICE OF PSYCHIATRY

Steven S. Sharfstein, M.D., M.P.A., *President, American Psychiatric Association; President and Chief Executive Officer, Sheppard Pratt Health System; and Clinical Professor of Psychiatry, University of Maryland at Baltimore, 6501 North Charles Street, Baltimore, MD 21285*

## EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: (1) review the trends in psychiatric practice for the past 35 years and assess these trends in relation to professional standards and the public health; and (2) understand the impact of prospective payment and managed care on practice and the quality of patient care.

## SUMMARY:

When lithium was approved in 1970 by the Food and Drug Administration, a paradigm shift occurred from a psychoanalytic to a psychobiological perspective. Compared with 1970, more patients are on medication, have fewer visits, and are less likely to receive psychotherapy, especially from psychiatrists. Psychiatrists are seeing more patients per week in less time. How much of this change is clinically or economically driven? The talk will review the ''clinical gray zone'' of care, distinguishing ''efficiency'' from ''clinical'' risk and assessing the impact that managed care has had on psychiatric practice. The strength of financial incentives in determining practice is evident by the change from long-term to short-term hospital treatment, the movement of patients from hospital to outpatient care, and the increased utilization of medication management over psychotherapy. Evidence-based treatment using randomized control trials and other experimental designs will hopefully replace ''medical necessity'' determinations by managed care over the next few years. Despite managed care, there is a sense of rising expectations for effective psychiatric treatment for more Americans.

## REFERENCES:

1. Marmor J: Psychiatrists & their Patients: a National Study of Private Office Practice. A publication of the Joint Information Service of the American Psychiatric Association and the National Association for Mental Health, Washington, D.C., 1975.
2. Olfson M, Marcus SC, Druss B, Pincus HA: National trends in the use of outpatient psychotherapy. Am J Psychiatry 2002; 159(11):1914–1920.

**Lecture 14** **Friday, October 7**
**3:30 p.m.-5:00 p.m.**

## THE SCIENTIFIC TRANSFORMATION OF SERVICE FOR TRAUMATIZED CHILDREN AND THEIR FAMILIES

Robert S. Pynoos, M.D., M.P.H., *Co-Director, National Center for Child Traumatic Stress; and Director, Trauma Psychiatry Program, Neuropsychiatric Institute and Hospital, University of California, Los Angeles*

## EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant would be able to: (1) Recognize a developmental psychopathology model of child traumatic stress, and understand its application to advances in assessment and intervention strategies; (2) List the advances in intervention strategies across developmental stages and trauma types; and (3) describe the organizational dynamics of major collaborative efforts to accelerate the transformation of child trauma services.

## SUMMARY:

The field of child traumatic stress has undergone a rapid progression in knowledge over the past 25 years. Trauma has been placed within a wider framework of the ontogenesis of the danger apparatus of the brain and mind, with concomitant advances in developmental neurobiology and developmental psychopathology. We are now at the cusp of achieving major advancements in treatment and services for children, adolescents, and their families. The development, dissemination, and adaptation of intervention strategies are progressing at a rapid rate across trauma types and developmental stages. The National Child Traumatic Stress Network (www.NCTSN.org) has been charged with a national mission to spearhead this reformation in order to enhance the standards of care and increase access to services for traumatized children and their families. This network represents a unique effort at large-scale collaboration, combining the expertise of major academic and medical

centers, the clinical wisdom of community practice sites, and the integral involvement of families, child serving systems, and policy leaders.

## REFERENCES:

1. Putnam FW: Ten-year research update and review: child trauma and abuse. Journal of the American Academy of Child & Adolescent Psychiatry 2003; 42(3): 269-278.
2. Caffo, Ernesto, Forresi, Barbera, Lievers, Luisa, Impact: Psychological sequelae and management of trauma affecting children and adolescents: Current Opinion in Psychiatry 2005; 18(4): 422-428.

**Lecture 15** **Saturday, October 8**
**8:00 a.m.-9:30 a.m.**

## SCHIZOPHRENIA AND AGING: SEPARATING FACTS FROM FICTION

*APA's Research in Psychiatry Award*

Dilip V. Jeste, M.D., *Estelle and Edgar Levi Chair in Aging, and Director, Stein Institute for Research on Aging; Distinguished Professor of Psychiatry and Neurosciences, University of California at San Diego; and VA Healthcare System, 3350 LaJolla Village Drive, #116A-1, San Diego, CA 92161*

## EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to differentiate between the similarities and differences of early-onset and late-onset schizophrenia, and should be able to identify the course of schizophrenia in later life.

## SUMMARY:

Snce Kraepelin described dementia praecox more than a century ago, schizophrenia has been considered to be a disease with onset restricted to adolescence or young adulthood, and with a progressively downhill course leading to dementia. Our studies over the last 18 years challenge both of these notions. We have found that schizophrenia can have onset in later life, and that the course of schizophrenia is associated with improvement more often than deterioration in old age. Indeed, sustained remission of schizophrenia, although uncommon, is a real phenomenon in a small minority of patients. The studies in older patients may suggest new ways of managing and even preventing schizophrenia across age groups.

## REFERENCES:

1. Jeste DV, Symonds LL, Harris MJ, Paulsen JS, Palmer BW, Heaton RK: Non-dementia non-praecox dementia praecox?: Late-onset schizophrenia. American Journal of Geriatric Psychiatry 1997; 5(4):302-317.
2. Jeste DV, Twamley EW, Eyler Zorrilla LT, Golshan S, Patterson TL, Palmer BW: Aging and outcome in schizophrenia. Acta Psychiatrica Scandinavica 2003; 107:336–343.
3. Auslander LA, Jeste DV: Sustained remission of schizophrenia among community-dwelling older outpatients. American Journal of Psychiatry 2004; 161:1490–1493.

**Lecture 16** **Saturday, October 8**
**8:00 a.m.-9:30 a.m.**

## NOBODY KNOWS THE TROUBLE I'VE SEEN: PREVENTING DEPRESSION IN AFRICAN-AMERICAN WOMEN

Annelle B. Primm, M.D., M.P.H., *Director, Division of Minority and National Affairs, American Psychiatric Association, 1000 Wilson Boulevard, Suite 1825, Arlington, VA 22209*

## EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: (1) learn the prevalence of depression and psychological distress in African-American women; (2) understand the social determinants of mental health among African-American women; and (3) identify potential strategies for primary and secondary prevention of depression in African-American women.

## SUMMARY:

This lecture will discuss determinants of depression in African American women by focusing on the Surgeon General's Healthy People 2000 description of health determinants. These six categories of health determinants include access to quality health care, policies and interventions, physical environment, social environment, individual behavior, and individual biology. Using these categories of determinants, a detailed description of how these exist as potential risk or resilient factors for depression in Afrodecendent women in the U.S. is presented. This is followed by a discussion of how preventive measures in policy, program, or practice may be targeted, given the previously described determinants. Preventive measures discussed include primary, secondary, tertiary interventions that may target individual or multiple categories of determinants, multiple types of determinants within a category, or multiple types of determinants across categories. Finally, policy implications and funding priorities are discussed.

## REFERENCES:

1. Bromberger JT, Harlow S, Avis N, Kravitz HM, Cordal A: Racial/Ethnic differences in the prevalence of depressive symptoms among middle-aged women: the Study of Women's Health Across the Nation (SWAN). Am J Pub Health 2004; 94:1378–1385.
2. Brown DR, Keith VM: In and Out of Our Right Minds. The Mental Health of African American Women. New York: Columbia University Press, 2004.


**Lecture 17** **Saturday, October 8**
**10:00 a.m.-11:30 a.m.**

## COMMUNITY INITIATIVES IN SAN DIEGO MEDICINE: GRASSROOTS AND BILLION DOLLAR COMPANIES. . . WORKING TOGETHER

C. H. Beck, Jr., M.D., *Vice President, Institutional Development, Scripps Health Foundation, 4275 Camous Point Court, CP-217, San Diego, CA 92121*

## EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize features of community collaboration that assure success.

## SUMMARY:

The Community Health Improvement Partners (CHIP) was established in San Diego 10 years ago. Its purpose has been to collaborate to measure community health needs and improve access to care. Forty diverse health related organizations convene monthly to deal with issues of access, mental health, violence prevention, immunization for children and adults and most recently chronic diseases. The organization has incorporated in order to manage grant funding. Despite this the spirit of the organization has not changed. No organization is dominant, all collaborate and everyone supports those who are chosen to lead the program initiatives. The member behavior is exemplary.

The issue of access to care in San Diego is huge. A small organization called Reach Out has managed to connect uninsured individuals with a net work of care givers who will accept discounted fees. With the initiation of 211/Info line in the community, Reach Out will become the health expertise component of the 211 service. CHIP has been an infrastructural partner for the 211 effort.

Seven years ago Project Dulce was created to serve the under insured and underserved diabetics in SD. Using the nurse educator model and promotoras, the program now serves 2078 individuals in 16 community clinics. The program also provides diabetes education classes by promotoras throughout the community. There are grant-funded activities for prevention and training/technical assistance. The total Project Dulce budget this year is $1.3 million. This is an affiliated program of CHIP

In the last year the Reach Out board and the San Diego County Medical Society Foundation have formed the Coalition for a Healthy San Diego, Diabetes Project. Over 30 community organizations have come together with goals to (1) identify all diabetics in the county of 3 million people, (2) get them all to care, (3) establish use of best practice by all care givers while involving patients in reaching therapeutic bench marks, and (4) model the effort financially to demonstrate cost effectiveness. The audacious goals have rallied the community with the Department of Health Services of the county offering an immediate $150,000 to support the infrastructure and hiring of an executive director.

None of this effort would have happened without the spirit of collaboration in the community. None would have happened without the involvement of grassroots organizations and billion dollar health care organizations.


## REFERENCES:

1. Kretzmann J, Mcknight JL: Building Communities from the Inside Out. ACT Publications, Chicago Ill., 1993.
2. Kathryn et al: Collaborating to Improve Community Health, Johnson, Jossey Bass Publishers, San Francisco, 1996.


**Lecture 18** **Saturday, October 8**
**10:00 a.m.-11:30 a.m.**

## HEALING THROUGH SOCIAL AND SPIRITUAL AFFILIATION

Marc Galanter, M.D., *Professor of Psychiatry, and Director, Division of Alcoholism and Drug Abuse, New York University School of Medicine, 285 Central Park West, New York, NY 10024-3006*

## EDUCATIONAL OBJECTIVES:

At the conclusion of this lecture, participants will have an understanding of an empirical basis of the role of spirituality in psychiatrically-related phenomena and the potential of a spiritual orientation in treatment approaches designed to address psychiatric problems.

## SUMMARY:

Two very different approaches can promote recovery from psychiatric disorders; both are of value, but only one has been effectively integrated into conventional practice. Biomedically-grounded techniques are clearly central to contemporary care. Social and spiritual affiliation, however, can also be valuable in promoting recov-

ery, but they have been eclipsed by widespread acceptance of the biomedical approach, where associated phenomena can be more readily observed and measured.

Research on the treatment of substance abuse will be highlighted to show how social and spiritual affiliation can be effective in promoting relief from illness. The response of highly compromised addicted patients to Alcoholics Anonymous' spiritual orientation will be used to illustrate the potent impact of its spiritual message when imparted in a cohesive social group. An absence of such approaches in contemporary medical care, on the other hand, has led many patients to turn to alternative medicine and away from standard medical care. Furthermore, behavioral changes observed in cultic, terrorist and mental health support groups can be understood better by considering the model of ideologically-grounded affiliation. Circumstances which prevent useful application of such influence modalities in general psychiatry will be examined, along with options for improved psychiatric training.

## REFERENCES:

1. Galanter M: Spirituality and the Healthy Mind: Science, Therapy and the Need for Personal Meaning. Oxford University Press, in press, 2005.
2. Galanter M: Healing through social and spiritual affiliation. Psychiatric Services 2002; 53: 1072-1074.

**Lecture 19** **Sunday, October 9**
**10:00 a.m.-11:30 a.m.**

## TOWARD A MENTALLY HEALTHY BORDER

Rosemarie Marshall Johnson, M.D., *Member, United States and Mexico Border Health Commission, 2919 Brant Street, San Diego, CA 92103*

## EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should have a clear understanding and distinction of the mental health conditions prevalent at the Mexico and U.S. border, and define how they differ from and impact on the rest of the countries of Mexico and the U.S. and what the Commission and other border-focused entities are doing to solve the problems, especially concentrating on substance abuse and depression.

*References and an abstract were not received for this lecture, therefore, only category 2 CME credit can be claimed for this session.*

**Medical Update 1** **Wednesday, October 5**
**3:30 p.m.-5:00 p.m.**

## CARDIOLOGY

Rodney G. Hood, M.D., *Cardiologist, 242 Euclid Avenue, Suite 210, San Diego, CA 92114*

*Educational Objectives, a summary, and literature references were not received for this session, therefore, only category 2 CME credit can be claimed for attending this session.*

**Medical Update 2** **Thursday, October 6**
**10:00 a.m.-11:30 a.m.**

## PAIN MANAGEMENT

Gary T. Buckholz, M.D., *Chief Fellow, Center for Palliative Studies, San Diego Hospice & Palliative Care*

### EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to assess and treat pain effectively using a multidisciplinary team.

### SUMMARY:

Pain is a common problem in any medical practice. It is the physical symptom that patients and families fear the most. It is also well known that there is often a psychological, social, or spiritual component to the way our patients experience pain. Use of an interdisciplinary team, including psychiatry, is helpful to adequately assess and treat pain effectively. Despite availability of very effective treatments for pain, it remains one of the most poorly assessed and treated symptoms.

Using specific case examples, the different types of pain (nociceptive, neuropathic, mixed) and ediology of pain will be explored. Nociceptive and neuropathic pain will be compared and contrasted. Critical elements of a pain assessment will be presented and Pharmacologic management of pain will be approached using the World Health Organization's three-step ladder. A world-wide consesus exists favoring its use for the management of all pain associated with serious illness. Using this guideline, frequently opioids are indicated for management of pain. There are many fears and misconceptions concerning the use of opioids to treat pain. These will be discussed in an interactive format. The concepts of physical and psychological dependence, tolerance, addiction, and pseudoaddiction will be integrated into the discussion.

After reviewing the basic pharmacokinetics of opiods, standard dosing guidelines will be presented using a case example. Finally, the role of psychiatry in pain management will be explored with open discussion.

### REFERENCES:

1. EPEC: Emanuel LL, von Gunten CF, Ferris FD. The education for physicians on end-of-life care (EPEC) curriculum. American Medical Association, Chicago, IL, 1999.
2. EPEC-O: Emanuel LL, Ferris FD, von Gunten CF, Von Roenn J. EPEC-O: Education in Palliative and End-of-life Care for Oncology.© The EPEC Project,™ Chicago, IL 2005.

**Medical Update 3** **Friday, October 7**
**1:30 p.m.-3:00 p.m.**

## ASTHMA

Timothy A. Morris, M.D., *Associate Professor of Medicine, Division of Pulmonary and Critical Care Medicine, University of California at San Diego, 200 West Arbor Drive, San Diego, CA 92103*

*Educational Objectives, a summary, and literature references were not received for this session, therefore, only category 2 CME credit can be claimed for attending this session.*

**Medical Update 4** **Saturday, October 8**
**10:00 a.m.-11:30 a.m.**

## OB/GYN AT THE CUTTING EDGE: WHAT THE PSYCHIATRIST NEEDS TO KNOW

Vivian M. Dickerson, M.D., *President, American College of Obstetricians and Gynecologists, and Associate Professor and Director, Division of General Obstetrics and Gynecology, University of California, Irvine, 101 The City Building, 56, Orange, CA 92868*

*Educational Objectives, a summary, and literature references were not received for this session, therefore, only category 2 CME credit can be claimed for attending this session.*

**Plenary Session 1** **Thursday, October 6**
**1:30 p.m.-3:00 p.m.**

## RECOVERY, COMMUNITY, AND SUBSTANCE ABUSE

*Substance Abuse and Mental Health Services Administration*

H. Westley Clark, M.D., J.D., *Director, Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services, 1 Choke Cherry Road, Suite 6-1057, Rockville, MD 20857*

*Educational Objectives, a summary, and literature references were not received for this session, therefore, only category 2 CME credit can be claimed for attending this session.*

**Plenary Session 2** **Friday, October 7**
**10:00 a.m.-11:30 a.m.**

## BLENDING CONSUMER, FAMILY, AND PROFESSIONAL PERSPECTIVES ON RECOVERY FROM SERIOUS MENTAL ILLNESS

Frederick J. Frese III, Ph.D., *Assistant Professor of Psychology in Clinical Psychiatry, Northeastern Ohio University College of Medicine; and Coordinator, Summit County Recovery Project, Summit County Alcohol Drug Addiction and Mental Health Services Board, 283 Hartford Drive, Hudson, OH 44236*

### EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: (1) appreciate differing perspectives on recovery; (2) gain an understanding of the implications of the recommendations of the report of the President's New Freedom Commission on Mental Health; and (3) learn the implications of transforming the mental health system to one focused on recovery.

### SUMMARY:

The report of the President's New Freedom Commission on Mental Illness (2003) calls for a transformation of the mental health system so that it becomes ''consumer and family driven'' and ''recovery focused.''

This presentation, by a psychologist with schizophrenia who is active in the consumer and family movements, will address various developing perspectives on transforming the mental health system and how these can be integrated with more traditional treatment approaches. Various interpretations of the concept of recovery will be highlighted.

The presentation will also address attempts under way to implement recommendations of the New Freedom Commission by Federal agencies such as SAMHSA, the VA etc., and the approaches of states such as California and Ohio.

Finally, the presentation will mention promising scientific advances that may affect expectations of recovery, including the joint NIMH/FDA, MATRICS (TURNS) project, which emphasizes pharmacological approaches to improving cognitive deficits (differences) in persons with schizophrenia.

### REFERENCES:

1. New Freedom Commission on Mental Health, Achieving the Promise: Transforming Mental Health Care in America. Final Report. DHHS Pub. No. SMA-03-3832. Rockville, MD: 2003.
2. Frese FJ, Stanley J, Kress K, Vogel-Schibilia S: Integrating evidence-based practices and the recovery model. Psychiatric Services 2001; 52(11): 1462–1486.

**Plenary Session 3** **Saturday, October 8**
**1:30 p.m.-3:00 p.m.**

## SAMHSA LEADERSHIP THROUGH PARTNERSHIP: RESILIENCE, RECOVERY, AND A LIFE IN THE COMMUNITY FOR EVERYONE

*Substance Abuse and Mental Health Services Administration*

Charles A. Curie, M.A., A.C.S.W., *Administrator, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services, 1 Choke Cherry Road, Suite 6-1057, Rockville, MD 20857*

*Educational Objectives, a summary, and literature references were not received for this session, therefore, only category 2 CME credit can be claimed for attending this session.*

# POSTER SESSION 1

**Posters 1–39**

## SCHIZOPHRENIA AND ITS TREATMENTS

**Poster 1** **Thursday, October 6**
**8:30 a.m.-10:00 a.m.**

### A MODEL FOR INTEGRATING CLINICAL TRIALS IN A COMMUNITY PRACTICE SETTING

Lawrence W. Adler, M.D., *Director, Clinical Insights, 7310-Ritchie Highway #512, Glen Burnie, MD 21061-5555*; Henri Zepp, R.N.C., *Director, Clinical Insights, 7310-Ritchie Highway #512, Glen Burnie, MD 21061-5555*; Lorraine Cerro, Ph.D.

### EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to describe the components needed to conduct clinical trials in a community practice setting.

### SUMMARY:

Community patients with severe psychiatric disorders often lack access to new, but expensive pharmacologic treatments. Clinical trials allow patients access to more effective treatments, but are conducted at remote academic centers or proprietary centers that do not provide post-study follow-up care.

This poster describes a model for clinical trials in a community treatment center setting. Salient features of the center are: (1) acceptance of indigent/uninsured patients; (2) recruitment only of subjects for whom study med is better than standard care; (3) conduct of trials using active comparators to study drug; (4) investigators and coordinators with profesional certification in clinical research; (5) ongoing training in diagnosis, ratings, and cGCPs; (6) computerized patient database, high-speed internet, advanced study equipment; (7) ensuring subject safety by privileges for emergency admission, access to medical consultation, and on-site emergency supplies; (8) six months of free follow up.

No funding source

### TARGET AUDIENCE:

Community mental health providers.

### REFERENCES:

1. March JS, Silva SG, et al: Am J Psychiatry 2005; 162 (5):836–46.
2. Swartz MS, Perkins DO, et al: Schizoph Bull 2003; 29(1):33–43.

**Poster 2** **Thursday, October 6**
**8:30 a.m.-10:00 a.m.**

### ARIPIPRAZOLE IN THE TREATMENT OF DELIRIUM

Kola O. Alao, M.D., *Associate Professor of Psychiatry, State University of New York Upstate Medical University, 750 East Adams Street, Syracuse, NY 13210*; Shiming Wu, B.S., *Department of Psychiatry, State University of New York Upstate Medical University, 60 Presidential Plaza #1208, Syracuse, NY 13202*; Maureen G. Soderberg, M.D.

### EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participants should be able to recognize the possible augmentation role of aripiprazole in the treatment of delirium.

### SUMMARY:

Delirium is an acute fluctuating condition, which affects attention and cognition. It is an indicator of the severity of a medical illness and may result in a higher morbidity, mortality, or longer hospitalization. The symptoms of delirium include delusions, hallucinations, confusion, and disorientation. Haloperidol has traditionally been the standard drug in delirium treatment. However, it is associated with serious side effects such as extrapramidal side effects and tardive dyskinasia. There have been some reports of using atypical antipsychotic, risperidone, quetiapine, and ziprasidone in treating delirium.

In this abstract we report two cases of delirium treated with aripiprazole.

Aripiprazole is a third-generation antipsychotic agent recently approved by the Food and Drug Administration. It demonstrates a mixed D2 and 5HT12-receptor agonist-antagonist activity and is thus hypothesized to improve the positive and negative symptoms of schizophrenia. To the best of our knowledge, there is no published material regarding its use in delirium.

*Conclusion:* Aripripazole appears to be effective in the treatment of confusion, agitation, and hallucinations that may occur in delirium. Controlled study is necessary to fully understand dosage of aripripazole in treating delirium.

### TARGET AUDIENCE:

Psychiatrist, Psychologist, Social worker.

### REFERENCES:

1. Fava M: Diagnosis and definition of treatment-of delirium. Biological Psychiatry 2003; 52(7):649–654.
2. All about Delirium and Its Treatment, Mark Seikowicz.

**Poster 3** **Thursday, October 6 8:30 a.m.-10:00 a.m.**

## DYNAMICS OF INSIGHT IN THE PRODROME OF SCHIZOPHRENIA

Robert G. Bota, M.D., *Resident, Department of Psychiatry, University of Missouri, 7638 Goddard Drive, Shawnee, KS 66214;* John S. Munro, M.D.; Kemal Sagduyu, M.D.

### EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to resubmitted by request from Dr. Signorelli presented of APA 2005.

### SUMMARY:

*Background:* Schizophrenia is characterized by diminished insight, which fluctuates with disease progression. Insight deterioration on in the prodrome of schizophrenia is poorly understood.

*Objective:* To determine if insight deterioration occurs during the prodrome, and if insight preservation predicts a better prognosis.

*Method:* Data were collected retrospectively from the records of patients initially diagnosed with schizophrenia during a two-year period. Their progress was then tracked over a three-year period.

*Results:* Ten of 24 patients were evaluated before a (fourth Diagnostic and Statistical Manual of Mental Disorders, Text Revision) DSM-IV-TR schizophrenia diagnosis was given, and 12 were evaluated at least once after the initial diagnosis. Insight preservation correlated with less need for emergency visits and fewer hospitalization days ($p<0.005$). It also was associated with more depressive and anxious mood. Patients and family members described early, ego-dystonic perceptual disturbances, followed by diminished insight. Willingness to get treatment significantly correlated (T-test) with decreased need for hospitalization, less medication for agitation, and more participation in group therapy.

*Conclusion:* Most patients maintain insight during the perceptual disturbance phase. Insight diminishes as the early delusional phase sets in. Higher levels of preserved insight correlate with less need for acute treatment.

No fundings were used for completion of this project.

### TARGET AUDIENCE:

Psychiatrists, psychologists, SW.

### REFERENCES:

1. Bota M, Arbib MA: Integrating databases and expert systems. Neuro informatics 2004.
2. Rathod S: Insight into schizophrenia: the effects of cognitive-behavior. Schiz Research 2001; 1:74/23/24.

**Poster 4** **Thursday, October 6 8:30 a.m.-10:00 a.m.**

## IDENTIFICATION OF THE PRODROME OF SCHIZOPHRENIA

Robert G. Bota, M.D., *Resident, Department of Psychiatry, University of Missouri, 7638 Goddard Drive, Shawnee, KS 66214;* John S. Munro, M.D.; Kemal Sagduyu, M.D.

### EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to resubmited by request from Dr. Signorelli presented of APA 2005.

### SUMMARY:

*Objective:* To determine if early assessment of patients and treatment of prodromal symptoms correlates with a better prognosis than patients evaluated initially at the time of schizophrenia diagnosis.

*Method:* Data were collected from the medical records of patients initially diagnosed with schizophrenia in a state-hospital over a two-year period. Their progress was then tracked over a three-year period.

*Results:* Of 24 patients diagnosed with schizophrenia, ten patients had already presented to the center with prodromal symptoms, referred by their families. Of those patients, 70% received treatment and 30% were discharged without medication. The patients treated during the prodromal period had significantly less hospitalization days (18 days) than patients evaluated for the first time at the time of schizophrenia diagnosis (27.14 days) and than patients that presented with prodromal symptoms but were not started on medication (69 days). The average length of treatment was seven months before the schizophrenia diagnosis. The patients had reported a prodromal period spanning 39 months. Behavior changes were reported 16 months later and bizarre behaviors were reported five months before the initial diagnosis.

*Conclusion:* Antipsychotic medication prescribed during the prodromal period appears to have a protective effect. Having early presentation did not predict prognosis.

No funding used for this project

### TARGET AUDIENCE:

Psychiatrists, MHCP.

### REFERENCES:

1. McGorry PD: Randomized Controlled trial of intervention. Arch Gen Psych 20, 59:291–8.
2. Faloon IR: Early interventions lorsch disorders. British of Psych 1998; 172:33–1.

**Poster 5** **Thursday, October 6**
**8:30 a.m.-10:00 a.m.**

## QUALITY CARE IN FIRST EPISODE PSYCHOSIS: USING THE BALANCED SCORE CARD

Siow A. Chong, M.D., *Senior Consultant Psychiatrist, Institute on Mental Health, 10 Buangkok view Singapore 539747*; Swapna Verma, M.D., *Associate Consultant Psychiatrist, Institute on Mental Health, 10 Buangkok view Singapore 539747*; Lye Yin Poon, B.S.

### EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to appreciate that a business model—the Balanced Score Card—can be adapted for a clinical service to provide high quality and cost-effective treatment.

### SUMMARY:

We describe here a national program for the early detection and intervention of psychosis in Singapore—an island state in South East Asia. Patients with psychosis had long duration of untreated psychosis (DUP) and would often seek help from traditional healers. The detrimental effects of this delay were the impetus for the Early Psychosis Intervention Program (EPIP), which is a comprehensive and integrated treatment program that focuses on early detection of psychosis, and provides evidence-based treatment by a multidisciplinary team. It also screens those at high risk of developing psychosis.

Our program is based on the balanced score card model with its four quadrants of customer satisfaction, financial health, internal business procedures, and learning and growth.

To date, more than 700 patients have been accepted into the program.

By using this business model, we have been able to provide high-quality and cost-effective care. We have seen a progressive reduction in the duration of untreated psychosis, significant clinical improvement and better functioning of the patients, reduced rate of polypharmacy, reduced hospitalization days, improved compliance rate, and a low suicide rate. At the same time, the model ensures a highly trained and motivated team.

### TARGET AUDIENCE:

Clinicians, Health Service Researchers and Mental Health Policy Makers.

### REFERENCES:

1. Chong SA, Mythily, Lum A, Chan YH, McGorry P. Determinants of duration of untreated psychosis and the pathway to care in Singapore. The International Journal of Social Psychiatry 2005; 51:55–62.
2. Kaplan RS, Norton DP: The balanced scorecard—measures that drive performance. Harvard Business Review. 1992; 1–2.

**Poster 6** **Thursday, October 6**
**8:30 a.m.-10:00 a.m.**

## THE EFFECTIVENESS OF NICOTINE-PATCH THERAPY FOR SMOKING CESSATION IN PATIENTS WITH SCHIZOPHRENIA

*Supported by The National Defense Medical Center*

Kuei-Ru Chou, Ph.D., *Associate Professor, School of Nursing, National Defense Medical Center, Ming-Chuan East Road, Taipei 114 Taiwan*; Ruey Chen, M.S.

### SUMMARY:

The purpose of this study was to determine the effectiveness of nicotine-patch therapy for smoking cessation in patients with schizophrenia. This was a longitudinal study and 68 schizophrenia patients were assigned to eight weeks of a nocotine-patch therapy program or a control group. The generalized estimating equation analysis revealed that there were significant reductions in the subjects' nicotine dependence (Fagerstrom Tolerance Questionnaire), the number of cigarettes per day, and CO levels over an eight-week period of nicotine-patch therapy and three-month follow up. The point-prevalence rates of abstinence from smoking were an abstinence of 26.9% at eight weeks and 26.9% at a three-month follow up. At the three-month follow up, the rate of continuous smoking abstinence in the nicotine-patch group was 23.1%.

### TARGET AUDIENCE:

Psychiatrists, Psychiatric Nurse, Social Worker.

### REFERENCES:

1. Bohadana A, Nilsson F, Rasmussen T, Martinet Y: Nicotine inhaler and nicotine patch as a combination therapy for smoking cessation: a randomized, double-blind, placebo-controlled trial. Archives of Internal Medicine 2000; 160(20), 3128–3134.
2. Tidey JW, O'Neill SC, Higgins, ST: Contingent monetary reinforcement of smoking reductions, with and without transdermal nicotine, in outpatients with schizophrenia. Experimental and Clinical Psychopharmacology 2002; 10(3), 241–247.

**Poster 7** **Thursday, October 6 8:30 a.m.-10:00 a.m.**

## LONG-ACTING STIMULANT USE IN PATIENTS WITH DEPRESSION

*Supported by Janssen Pharmaceutica*

Angelo Fallu, M.D., *Psychiatrist, Woodward Clinic, 685 Woodward, Sherbrooke, QC, Canada J1G 1W4*; Caroline Richard, M.P.S., *Psychologist, Woodward Clinic, 685 Woodward, Sherbrooke, QC, Canada J1G 1W4*

### EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participants should be able to better understand responses of stimulant adjunctive therapy in patients with depression.

### SUMMARY:

*Objective:* To determine the effectiveness and safety of once daily OROS[4] methylphenidate adjunctive therapy in adults with major depressive disorder (MDD).

*Methods:* This was a prospective, open-label trial of eight patients with DSM-IV TR diagnosed MDD (based on clinical interview). Patients with an inadequate response to current antidepressant therapy of adequate dosage and duration, and with a score of =3 on the CGI-S were eligible to participate.

*Results:* Interim results of five patients on three months of adjunctive therapy demonstrated a mean improvement of 2.2 points in CGI-S from a baseline mean of 3.5. Patients were on citalopram or venlafaxine. OROS[4] methylphenidate was well tolerated with minimal side effects. All patients met criteria for functional remission.

*Conclusion:* These interim data suggest that adjunctive, once daily formulation of OROS[4] methylphenidate is safe, well tolerated, and offers symptom control in patients with depression.

### REFERENCES:

1. Lavretsky H, Kumar A: Methylphenidate augmentation of citalopram in elderly depressed patients. Journal of the American Association for Geriatric Psychiatry 2001; 9(3):298–303.
2. Wallace A, Kofoed L, West A: Double-blind, placebo-controlled trial of methylphenidate in older, depressed, medically ill patients. Am J Psychiatry 1995; 152:6.

**Poster 8** **Thursday, October 6 8:30 a.m.-10:00 a.m.**

## SYMPTOM REMISSION ASSOCIATED WITH FUNCTIONAL IMPROVEMENT IN SCHIZOPHRENIA

*Supported by Janssen Pharmaceutica*

Georges M. Gharabawi, M.D., *Group Director, Central Nervous System Outcomes Research, Medical Affairs Department, Janssen Pharmaceutica Products, L.P., 1125 Trenton-Harbourton Road, Titusville, NJ 08560*; Cynthia A. Bossie, Ph.D.; Stephen C. Rodriguez, M.A.; Ibrahim Turkoz, M.S.; Natalie Ciliberto, Pharm.D.; George M. Simpson, M.D.

### EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to understand the importance of accepting and adhering to maintenance schizophrenia treatment and the newly developed structured clinical discussion tool, GAIN, to support use of antipsychotic therapy.

### SUMMARY:

*Objective:* This study evaluated a novel psychosocial tool (GAIN) to support schizophrenia treatment decisions.

*Method:* The START study compared GAIN (Goal setting, Action, Initiation, Nurturing) to Approach As Usual (AAU) in supporting acceptance of long-acting risperidone in patients with schizophrenia. Using a six-week psychosocial ''approach'' phase and a 12-week ''treatment'' phase. U.S. sites were randomly assigned to GAIN or AAU. The proportion of patients who accepted treatment over the 12-week treatment phase, clinician satisfaction, and illness severity (per Clinical Global Impression scale) were evaluated.

*Results:* 572 outpatients participated across 268 sites (141 GAIN, 127 AAU). Data indicated very high treatment acceptance across both groups: GAIN, 90.0%; AAU, 86.6%. Completion rates were equivalent across both groups; however, there was a two-fold higher discontinuation rate among AAU vs GAIN that consisted of withdrawal of consent or treatment refusal (GAIN 9.9%; AAU 25.3%). Clinicians using the GAIN approach were highly satisfied with the intervention (68.5%), finding it easy to implement (73.0%) and effective overall (64.9%).

*Conclusion:* The GAIN approach seemed to be an acceptable method of educating patients about the use of a long-acting atypical antipsychotic. Relative to AAU, the GAIN approach may help promote continued acceptance of long-acting antipsychotic therapy after initiation.

Source of funding: Medical Affairs Division, Janssen Pharmaceutica Products, LP.

### TARGET AUDIENCE:

Clinical psychiatrists.

### REFERENCES:

1. Kemp R, Hayward P, Applewhaite G, Everitt B, David A: Compliance therapy in psychotic patients: randomised controlled trial. BMJ 1996; 312:345–349.

2. Miller WR. Motivational Interviewing: research, practice, and puzzles. Addict Behav 1996; 21:835–842.

**Poster 9** **Thursday, October 6**
**8:30 a.m.-10:00 a.m.**

## METABOLIC SCREENING: A QUALITY INITIATION PROGRAM IN AN URBAN TRAINING CLINIC

Diane B. Gottlieb, M.D., *Assistant Professor, Department of Psychiatry and Behavioral Sciences, Temple University School of Medicine Health Sciences Center, 3401 North Broad Street, 719 Jones Hall, Philadelphia, PA 19140*; Aurelia N. Bizamcer, M.D., M.P.H., *Resident, Department of Psychiatry, Temple University, 7961-65 Summerdale Avenue, Apartment A4, Philadelphia, PA 19111*; Robert L. Boyd, M.D.; Diana Anita, M.D.

### EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should able to recognize the risks of obesity, glucose intolerance, and lipid abnormalities in patients on antipsychotics, and establish a mechanism to monitor clinical parameters.

### SUMMARY:

Increased awareness of the metabolic syndrome, characterized by obesity, the lipodystrophies, and glucose intolerance, has raised concern about the risks of treatment with antipsychotics. These changes may increase mortality in this population. Despite the need for interventions, programs to identify, prevent, and treat these disorders have been limited or minimally effective.

We have instituted a quality initiative (QI) in our inner-city university training clinic to identify patients on antipsychotic medication. Our goals are to teach residents to identify these health concerns, and train them to monitor these clinical parameters. We will demonstrate how this will maximize the quality of health care by providing appropriate diagnoses and referrals for our patients.

Our program will monitor clinical outcomes for these patients, communication with primary care physicians, and adherence to psychiatric treatment. We will demonstrate our flow sheet, and our monitor of compliance with the use of the flow sheet. Ongoing chart reviews determine whether patients are being adequately monitored for potential health problems, and detail the clinical decision making that occurs as a result of abnormal findings.

No funding was obtained for this project.

### TARGET AUDIENCE:

Mental health professionals who treat patients taking antipsychotic medication.

### REFERENCES:

1. Marder S, Essock S: Physical health monitoring of patients with schizophrenia. American Journal of Psychiatry 2004; 161:1334–1349.
2. ADA, APA, Consensus Development Conference on Antipsychotic Drugs and Obesity and Diabetes. Journal of Clinical Psychiatry 2004; 65:2:267–272.

**Poster 10** **Thursday, October 6**
**8:30 a.m.-10:00 a.m.**

## POLYPHARMACY IN SCHIZOPHRENIA: DATA FROM A RANDOMIZED, DOUBLE-BLIND STUDY

*Supported by Janssen Pharmaceutica*

Andrew Greenspan, M.D., *Associate Director, Central Nervous System, Medical Affairs Division, Janssen Pharmaceutica and Research Foundation, 1125 Trenton-Harbourton Road, Titusville, NJ 08560*; Marcia F.T. Rupnow, Ph.D.; Colette Kosik-Gonzalez, M.A.; Cynthia A. Bossie, Ph.D.; Young Zhu, Ph.D.; Georges M. Gharabawi, M.D.; Jennifer Potter, Pharm.D.; Jeni Bastean, Pharm.D.; Stephen M. Stahl, M.D., Ph.D.

### EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to evaluate the incidence and costs of polypharmacy in patients treated with antipsychotics.

### SUMMARY:

*Background:* The use and predictors of polypharmacy were examined in patients with an acute exacerbation of schizophrenia or schizoaffective disorder randomized to risperidone (N=133), quetiapine (N=122), or placebo (N=53).

*Methods:* In a double-blind study, a 14-day monotherapy phase was followed by a 28-day additive-therapy phase during which clinicians were allowed to add psychotropic medications. Risperidone and quetiapine doses were fixed by day 8. Predictors of polypharmacy were analyzed using multiple logistic and Cox regression models.

*Results:* Mean$\pm$SD doses at monotherapy endpoint were 4.7$\pm$0.9 mg/day of risperidone and 579.5$\pm$128.9 mg/day of quetiapine. During the additive-therapy phase, additional psychotropics (including antipsychotics, mood stabilizers, and antidepressants) were received by 35% of patients in the risperidone group and 53% in the quetiapine group ($P$<0.01); 59% of placebo patients received psychotropics. Additional antipsychotics were

received by 33% and 53% of risperidone- and quetiapine-treated patients, respectively ($P<0.01$); 57% of placebo patients received antipsychotics. The hazard ratio of antipsychotic polypharmacy for quetiapine vs risperidone was 1.90 ($P<0.001$; 95%Cl 1.29–2.80). CGI-S scores, the PANSS Hostility/Excitement factor, and patient satisfaction with medication were significantly associated with antipsychotic polypharmacy.

*Conclusions:* Quetiapine was associated with a significantly higher rate of polypharmacy than risperidone. Poor clinical improvement and hostility/excitement symptoms were among the strongest predictors of antipsychotic polypharmacy.

Supported by Medical Affairs Division, Janssen Pharmaceutica Products, L.P.

## TARGET AUDIENCE:

Psychiatrists, researchers.

## REFERENCES:

1. Stahl SM, Grady MM: A critical review of atypical antipsychotic utilization: comparing monotherapy with polypharmacy and augmentation. Curr Med Chem 2004; 11:313–327.
2. Clark RE, Banels SJ, Mellman TA, Pescock WJ: Recent trends in antipsychotic combination therapy of schizophronia and schizoaffective disorder: implications for State mental health policy. Schizophr Bull 2002; 28:75–84.

**Poster 11** **Thursday, October 6**
**8:30 a.m.-10:00 a.m.**

## META-ANALYSIS OF FOUR CONTROLLED RISPERIDONE TRIALS IN PATIENTS WITH ALZHEIMER'S DISEASE

*Supported by Janssen Pharmaceutica*

Andrew Greenspan, M.D., *Associate Director, Central Nervous System, Medical Affairs Division, Janssen Pharmaceutica and Research Foundation, 1125 Trenton-Harbourton Road, Titusville, NJ 08560*; Ira R. Katz, M.D., Ph.D.; Jacobo E. Mintzer, M.D.; Henry Brodaty, M.D.; Jeni Bastean, Pharm.D.; Peter DeDeyn, M.D.

## EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to (1) to discuss the diagnosis of psychosis of Alzheimers disease as a distinct treatable clinical entity, and (2) to discuss the efficacy, safety and tolerability of risperidone in an elderly population with PAD.

## SUMMARY:

*Objective:* To assess the efficacy of risperidone in the treatment of PAD.

*Methods:* Data from four placebo-controlled trials of risperidone (0.5–2.0 mg/day) in dementia patients. PAD defined as diagnosis of AD/mixed dementia and rating ≥2 on any delusion/hallucination item of the Behavioral Pathology in Alzheimer's Disease (BEHAVE-AD) rating scale at baseline. Assessments included BEHAVE-AD Psychosis and Clinical Global Impressions-Change (CGI-C).

*Results:* 895 patients met PAD criteria (risperidone n=515, placebo n=380). Risperidone treatment significantly reduced psychotic symptoms at endpoint compared with placebo, measured on the BEHAVE-AD Psychosis subscale (change±SE: −3.4±0.2 vs. −2.7±0.2; p=0.009). Endpoint CGI-C distribution scores similarly favored risperidone (p=0.024). Reported AEs (>10%) with risperidone and placebo, respectively, were injury (22.1% vs. 18.9%), somnolence (18.1% vs. 7.6%), fall (15.1% vs. 13.9%), urinary tract infection (14% vs. 11.3%), and agitation (9.5% vs. 11.3%). Cerebrovascular AEs reported in eight (1.6%) risperidone and three (0.8%) placebo patients (p=0.37). Incidence of mortality in PAD was 3.1% with risperidone and 1.8% with placebo.

*Conclusions:* This meta-analysis indicates that risperidone is effective for improving psychotic symptoms and overall clinical status in patients with PAD. However, an analysis of the risks and benefits should be performed before initiating risperidone treatment in the elderly.

Funded by Janssen Pharmaceutica Products L.P.

## TARGET AUDIENCE:

Psychiatrists, researchers.

## REFERENCES:

1. Katz IR, Jesle 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; 80:107–115.
2. Brodaly H, Ames D, Snowdon J, et al. A randomized placebo-controlled trial of risperidone for the treatment of aggression, agitation, and psychosis of dementia. J Clin Psychiatry 2003; 64:134–143.

**Poster 12** **Thursday, October 6**
**8:30 a.m.-10:00 a.m.**

## IMPACT OF ATYPICAL AGENTS ON OUTCOMES OF CARE IN SCHIZOPHRENIA

*Supported by Pfizer Inc.*

David J. Harrison, Ph.D., *Employee, Pfizer Inc., 235 East 42nd Street, New York, NY 10017;* Annie T. Joyce, M.P.H.; Daniel A. Ollendorf, M.P.H.

## EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to recognize the therapeutic and economic disparities between ziprasidone, risperidone, and olanzapine in the treatment of patients with schizophrenia.

## SUMMARY:

*Objective:* To compare persistence, adherence, and psychiatric treatment costs in patients initiating atypical antipsychotics.

*Methods:* Medical and pharmacy claims data were used to compare persistence (days of therapy between first and last prescription, allowing therapy gaps <90 days), adherence (ratio of days of medication supplied to total days on therapy), and treatment costs in adults with schizophrenia having claims for atypicals from 3/2001-8/2003 and enrollment for ≥6 months before and ≥12 months after therapy initiation. One-year psychiatric treatment costs were examined before and after therapy initiation. Differences in cost were tested by univariate analyses.

*Results:* Mean persistence was approximately 30 days longer for patients receiving ziprasidone (n=217; 228 days) than risperidone (n=831; 193 days) or olanzapine (n=762; 201 days). Adherence was significantly ($P<0.05$) higher among patients receiving ziprasidone (87%) than with other treatments (78%–80%). Ziprasidone patients had significantly larger decreases in mean annual psychiatric-related costs following therapy initiation (–$6,866) than those on risperidone (–$3,353; $P=0.012$) or olanzapine (–$4,764; $P=0.002$). The primary driver of cost savings was reduced hospitalization after treatment initiation.

*Conclusion:* Patients initiated on ziprasidone had longer persistence, better adherence, and greater decreases in psychiatric-related costs than those initiated on other atypicals.

Supported by funding from Pfizer Inc.

## TARGET AUDIENCE:

Psychiatrists, psychopharmacologists.

## REFERENCES:

1. Gilmer TP, Dolder CR, Lacro JP, et al: Adherence to treatment with antipsychotic medication and health care cost among Medicaid beneficiaries with schizophrenia. AM J Psychiatry 2004; 161:692–699.
2. Al-Zakwani IS, Barrem JJ, Bullano MF, et al: Analysis of healthcare utilization patterns and adherence in patients receiving typical and atypical antipsychotic medications. Curr Med Res Opin 2003; 19:619–626.

**Poster 13** **Thursday, October 6**
**8:30 a.m.-10:00 a.m.**

# STARTING DOSE AND PERSISTENCE FOR ZIPRASIDONE USERS IN MEDICAID

*Supported by Pfizer Inc.*

David J. Harrison, Ph.D., *Employee, Pfizer Inc., 235 East 42nd Street, New York, NY 10017;* C. Daniel Mullins, Ph.D.; Fadia T. Shaya, Ph.D.

## EDUCATIONAL OBJECTIVES:

At the conclusion of the presentation, the participants should comprehend the relationship between starting dose and persistence on ziprasidone therapy. Specifically, participants should recognize that doses in the medium to high range lead to longer persistence on therapy.

## SUMMARY:

*Objective:* To determine the relationship between ziprasidone starting dose and persistence among patients diagnosed with schizophrenia.

*Method:* Adult Medicaid recipients diagnosed with schizophrenia and having ziprasidone prescription claims between 7/1/01 and 9/30/03 were categorized by starting dosage: low (20-60mg) n=517, medium (61mg–119mg) n=339, and high (120–160 mg) n=341. Persistence was measured using refill patterns, allowing 15-day gaps between expected refill dates, and compared across starting doses using Chi-Square tests. Multivariate logistic analysis explored the simultaneous impact of age, gender, race, and year of treatment initiation in addition to starting dose.

*Results:* Discontinuation rates across the study period (maximum 30 months) were greater for patients initiated with low (p=0.001) and medium dose (p=0.02) than for high dose patients. Discontinuation rates were not statistically different for low and medium doses. Discontinuation rates at 365, 180, and 90 days were higher for low dose than high dose ($p < 0.05$), but not significantly different between low and medium or medium and high doses. These results were similar in the multivariate models.

*Conclusions:* Schizophrenia patients started on high doses of ziprasidone have greater persistence up to one year than did those who start on low doses.

## TARGET AUDIENCE:

Psychiatrists and psychopharmacologists.

## REFERENCES:

1. Sohler NL, Walkup J, McAlpine D, et al: Antipsychotic dosage at hospital discharge and outcomes among person with schizophrenia. Psychiatr Serv 2003; 54:1258–1263.

2. Larco JP, Dunn LB, Dokler CR, et al: Prevelence of and risk factors fro medication nonadherence in patients with schizophrenia: a comprehensive review of recent literature. J Clin Psychiatry 2002; 63:892–909.

**Poster 14** **Thursday, October 6 8:30 a.m.-10:00 a.m.**

## OLANZAPINE AND LITHIUM PROPHYLAXIS OF BIPOLAR DISORDER AND EPISODE HISTORY

*Supported by Eli Lilly and Company*

Jamal Hassan, *Scientific Communications Associate, Eli Lilly and Company, Lilly Corporate Center, DC4133, Indianapolis, IN 46285*; John P. Houston, M.D., Ph.D.; Terence A. Ketter, M.D.; Richard C. Risser, M.S.; David H. Adams, Ph.D.; Adam Meyers, M.S.; Douglas J. Williamson, M.D.; Mauricio Tohen, M.D., Ph.D.

### EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to discuss the relative merits of olanzapine and lithium for prevention of relapse/recurrence in bipolar I disorder with respect to patient history of mood episodes.

### SUMMARY:

*Objective:* Prevention of recurrent manic episodes early in bipolar disorder may improve overall patient prognosis. We assessed treatment differences in prevention of mood episodes in patients subgrouped by number of previous manic episodes.

*Method: Post hoc* analysis of data from a double-blind, randomized study of relapse/recurrence in 431 initially euthymic patients with bipolar I disorder randomized to olanzapine (OLZ) (n=217, 5-20 mg/day) or lithium (LI) (n=214, serum level of 0.6 to 1.2 mEq/L). Patients were subcategorized by number of previous manic episodes: early stage: 2 (n=48, OLZ; n=53, LI), intermediate: 3–5 (n=98, OLZ; n=80, LI), and late stage: >5 (n=71, OLZ; n=81, LI), and evaluated for rates of manic/mixed and depressive episode relapse/recurrence.

*Results:* Rates of manic/mixed recurrence for OLZ vs. LI were: 2.1% vs. 26.4% (p=.008), 13.3% vs. 23.8% (p=.073), and 23.9% vs. 33.3% (p=.204), for early stage, intermediate, and late stage groups, respectively. Rates of depressive recurrences were not significantly different by treatment for the same groups.

*Conclusions:* Early stage patients had significantly lower rates of recurrence of manic episodes with OLZ vs. LI. Intermediate and advanced patients did not have significant treatment differences in rates of manic recurrence.

Funded by Eli Lilly and Company.

### TARGET AUDIENCE:

Psychiatrists and other mental health professionals who treat patients with bipolar disorder.

### REFERENCES:

1. Post RM: Transduction of psychosocial stress into the neurobiology of recurrent affective disorder. American Journal of Psychiatry 1992; 149:999–1010.
2. Tohen M, Marneros A, Greil W. Calabrese JR, Sachs, GS, Yatham LN. Oerlinghausen, BM. Koukopoulos A, Cassano GB, Heinz G, Licht RW, Dell'Osso L, Evans AR Risser RR, Baker RW. Crane H, Dossenbach MR, Bowden CL: Olanzapine versus lithium in relapse/recurrence prevention in bipolar disorder: A randomized double-blind controlled 12-month clinical trial. American Journal of Psychiatry, 2004 in press.

**Poster 15** **Thursday, October 6 8:30 a.m.-10:00 a.m.**

## ORAL TRANSITION DOSE FOLLOWING INTRAMUSCULAR OLANZAPINE TREATMENT

*Supported by Eli Lilly and Company*

Jamal Hassan, *Scientific Communications Associate, Eli Lilly and Company, Lilly Corporate Center, DC4133, Indianapolis, IN 46285*; Joseph Battaglia, M.D.; John P. Houston, M.D., Ph.D.; John Ahl, Ph.D.; Adam Meyers, M.S.; Christopher J. Kaiser, Ph.D.

### EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to understand that transitioning from intramuscular to oral antipsychotic treatment may require a high versus low dosage.

### SUMMARY:

To assess the relationship between IM antipsychotic dose and transition oral dose in acutely agitated patients with schizophrenia, we conducted a *post hoc* analysis of a double-blind, randomized study in patients who received single or multiple injections of olanzapine 10 mg (n=92 or 29, respectively) or haloperidol 7.5 mg (n= 82 or 33, respectively), followed by four days of oral treatment with 5–20 mg/d olanzapine or haloperidol. Differences in oral dose, low (5–10 mg) vs. high (15–20 mg), were compared for patients who received single vs. multiple injections. Initially 72% of patients who received only one injection (n=92) of olanzapine were

transitioned to low dose as compared with 52% who received multiple injections (n=29; p=.07). More patients in the haloperidol single (n=82, 88%) and multiple injection subgroups (n=33, 70%; p=.03) were transitioned to low oral doses. Day 4 of oral treatment, proportionately more patients in single injection subgroups who received high oral doses increased significantly: olanzapine (28% on Day 1 vs. 51% on Day 4, p=.002) and haloperidol (12% vs. 32%, respectively, p=.002). Agitated patients with schizophrenia treated with IM antipsychotics may require high oral transition doses, even those responsive to single injections.

Funded by Eli Lilly and Company.

## TARGET AUDIENCE:

Clinicians who treat patients with acute agitation in schizophrenia.

## REFERENCES

1. Currier GW, Trenton A: Pharmacological treatment of psychotic agitation. CNS Drugs 2002; 16(4):219–28.
2. Jann MW, Bunt RM: Switching antipsychotic drugs: A pharmacokinetic, pharmacodynamic, and practical perspective. Psychopharmacology Bulletin 2002; 36(3):22–41.

**Poster 16** **Thursday, October 6**
**8:30 a.m.-10:00 a.m.**

## QUANTITATIVE ANALYSIS OF ATAXIC GAITS IN SCHIZOPHRENIA ACCORDING TO AGE

Hong Jin Jeon, M.D., *Clinical Instructor, Department of Psychiatry, Seoul National University College of Medicine, 28 Yongun-Dong, Chongno-Gu, Seoul, South Korea 110-744*; Maeng Je Cho, M.D., *Professor, Department of Psychiatry and Behavioral Science, Seoul National University College of Medicine, 28 Yongun-Dong, Chongno-Gu, Seoul, South Korea 110-744*; Sung M. Jang, M.D.; Bong-Jin Hahm, M.D.; Tong Woo Suh, M.D.

## EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to determine that dysfunction of the visuo-cerebellar circuit progresses according to age in patients who have been diagnosed with schizophrenia.

## SUMMARY:

Previous research has determined that schizophrenic patients classically exhibit ataxic gaits. Age and visual controls of balance are important factors, and may influence gait, but have not been controlled.

A total of 100 patients with schizophrenia were included in this study, along with 50 age- and sex-matched healthy controls. They were sampled with methods that stratified both groups according to age and sex. Tandem gait tests were conducted with eyes open and closed, and gait parameters were assessed by the footprint method. Ataxic gaits were found to be more frequent in the schizophrenic group ($p<0.001$). With eyes open, ataxic gaits increased in the schizophrenic group according to age ($r=0.45$, $p<0.001$), but not in the healthy control group ($r=0.22$, $p=0.14$). Multiple logistic regression analyses revealed that old age and previous history of alcohol dependence/abuse were the risk factors for ataxic gaits with eyes open.

This implies that dysfunction of the visuo-cerebellar circuit in the schizophrenic patients progresses according to age.

## TARGET AUDIENCE:

All audience.

## REFERENCES:

1. Sutbvan FV, Rosenbloom MJ, Pfefierbaum A: Balance and gait deficits in schizophrenia compounded by the comorbidity of alcoholism. Am J Psychiatry 2004; 161, 751–755.
2. Ichimaya T, Okubo Y, Suhara T, Sudo Y: Reduced volume of the cerebellar vermis in neuroleptic-naive schizophrenia. Biol Psychiatry 2001; 49, 20–27.

**Poster 17** **Thursday, October 6**
**8:30 a.m.-10:00 a.m.**

## VALPROIC ACID HYPERAMMONEMIA POTENTIALLY TRIGGERED BY LITHIUM

Sami Khalife, M.D., *Department of Psychiatry, Cleveland Clinic Foundation, 425 West Lakeside Avenue, #407, Cleveland, OH 44113;* Kathleen S. Franco, M.D.

## EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to assess the risks and benefits of each drug in patients on multiple medications and intervene to change medications if necessary.

## SUMMARY:

A 44-year-old Caucasian woman presents with generalized weakness, ataxia, and decrease attention span. She overdosed on lithium two weeks earlier and underwent hemodyalisis. Lithium level returned to normal. Her mental status cleared for several days before she started complaining of weakness, nausea, vomiting, and abdominal pain. GI work-up was negative. She became mute, bradykinetic, and catatonic. Her lab studies showed hypernatremia, hyperammonemia, but lithium level was

within normal limits. Her medications included lithium, valproic acid, risperidone, benztropine, and famotidine. EEG showed diffuse encephalopathy. Brain MRI was normal. The patient gradually improved after holding her meds and adding carnitine. Valproic-acid-induced hyperammonemia can develop in patients who previously received valproic acid without any problems. Mechanism of valproic-acid-induced hyperammonemia is complex since valproic acid has different actions on different organs: At the kidneys, valproic acid mainly inhibits beta oxidation cycle via its metabolite or by causing carnitine deficiency. At the liver, hyperammonemia is primarily caused by enzymatic defects leading to urea cycle inhibition. On the brain, hyperammonemia inhibits cellular oxidation and ATP production. Risk factors for Valproic-acid-induced hyperammonemia include high basal ammonia level, carnitine deficiency, congenital enzymatic defects including mitochondrial diseases, diet, and concomitant prescription of anti-epileptic drugs. Lithium has never been mentioned as a trigger for VPA-induced hyperammonemia. In our case, renal compromise from lithium toxicity triggered increased ammonia production in the kidneys contributing to her encephalopathy.

Psychiatric patients are frequently on complicated medical regimens that require internists to consider the risks and benefits of each agent. Early recognition of subtle cognitive and behavioral changes in patients on multiple medications may allow effective intervention avoiding progression to greater morbidity.

## REFERENCES:

1. Verrotti: Valproate induced hyperammonemia encephalopathy, Metab Brain Dis 2002.
2. McCall: Valproic and induced hyperammonemia, J of Clinical Psychopharmacology 2004.

**Poster 18** **Thursday, October 6**
**8:30 a.m.-10:00 a.m.**

## CARDIOVASCULAR RISK CHANGES ASSOCIATED WITH USE OF NEWER ANTIPSYCHOTIC MEDICATIONS

*Supported by Pfizer Inc.*

Dean K. Knudson, M.D., *800 East 28th Street, Mail Stop 17701, Minneapolis, MN 55407-3723*

## EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to (1) evaluate lipid profile value changes seen with patients on the newer antipsychotic medications, (2) determine CHD 10-year risk levels for all patients taking the newer antipsychotic medications in the study, and (3) determine how many patients with dyslipidemia are being treated to their NCEP-ATP III goals.

## SUMMARY:

Lipid profiles values were collected for 62 outpatients receiving second-generation antipsychotic medications over a 9–12 month period. The average age of the 55 males and seven females in this study was 45 years. Lipid values were outside the desirable range for total cholesterol (<200 mg/dL), LDL cholesterol (<130 mg/dL), HDL cholesterol (>40 mg/dL) and triglycerides (<200 mg/dL) in 37%, 27%, 50%, and 40% of patients, respectively. Our patients' 10-year risk of coronary heart disease (CHD) was 65% greater for men and 134% greater for women when compared with the standard risk group. To help minimize the long-term cardiovascular morbidity and mortality, our patients will be further evaluated for risk reduction opportunities. One such opportunity may be a modest dyslipidemia drug dosage increase in that small subset of our patients who are receiving therapy but have not yet achieved their LDL goal. Secondly, in this young patient population, initiate dyslipidemia treatment, which will in turn decrease their long-term overall cardiovascular risk.

Dr. Dean Knudson (MD) is on the Pfizer Pharmaceuticals speaker's bureau and received funding for the poster preparation.

## TARGET AUDIENCE:

Practicing providers for young, ambulatory, working schizophrenia patients.

## REFERENCES:

1. ADA, APA: Consensus development conference on antipsychotic drugs and obesity and diabetes. Diabetes Care 2004; 27:596–601.
2. Expert Panel on Detection, Evaluation and Treatment of High Blood Cholesterol in Adults. Summary of the Third Report of the National Cholesterol Education Program (NCEP) Expert Panel on Detection, Evaluation and Treatment of High Blood Cholesterol in Adults (Adult Treatment Panel III). JAMA 2001; 285:3015–3023.

**Poster 19** **Thursday, October 6**
**8:30 a.m.-10:00 a.m.**

## WEIGHT AND BLOOD PRESSURE CHANGES ASSOCIATED WITH THE USE OF NEWER ANTIPSYCHOTIC MEDICATIONS

*Supported by Pfizer Inc.*

Dean K. Knudson, M.D., *800 East 28th Street, Mail Stop 17701, Minneapolis, MN 55407-3723.*

## EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to (1) recognize significant weight changes seen with specific newer antipsychotic medications, (2) determine how many patients on the antipsychotic medications over the past 9-12 months also had elevations in blood pressure values, and (3) demonstrate what effect, if any, there was on weight and blood pressure by using combination regimens of the newer antipsychotic medications.

## SUMMARY:

Weight and blood pressure measurements were collected for 62 outpatients receiving second-generation antipsychotic medications over a 9-12 month period. The staff collected these measurements as patients were seen during routine office visits by their physician. The average age of the 55 males and seven females in this study was 45 years. Overall, 75% of patients gained a mean weight of 11 pounds over their baseline weight. Monotherapy with olanzapine, quetiapine, and risperidone each resulted in weight gain of approximately three pounds over baseline. Interestingly, monotherapy with clozapine resulted in a mean weight loss of three pounds. The following combinations were associated with a > 4% weight gain: risperidone/clozapine, risperidone/quetiapine, and quetiapine/clozapine. Nine patients developed new onset systolic hypertension during our study. Monotherapy with risperidone was associated with the greatest number of new-onset cases of systolic hypertension. With nearly three-fourths of study patients gaining nearly 11 pounds in less than one year, it is important to strongly consider the ramifications of weight gain and blood pressure changes that are possible when evaluating which medication patients should start on.

Dr. Dean Knudson (MD) is on Pfizer pharmaceuticals speaker's bureau, and received funding for the poster preparation.

## TARGET AUDIENCE:

Practicing providers for young ambulatory working schizophrenia patients.

## REFERENCES:

1. ADA, APA. Consensus development conference on antipsychotic drugs and obesity and diabetes. Diabetes Care 2004; 27:596–601.
2. The Seventh Report of the Joint National Committee on Prevention, Detection, Evaluation and Treatment of High Blood Pressure: the JNC 7 report. JAMA 2003; 289:2560–72.

**Poster 20** **Thursday, October 6**
**8:30 a.m.-10:00 a.m.**

# PREDICTORS OF PATIENT SATISFACTION WITH MEDICATION IN PATIENTS WITH SCHIZOPHRENIA

*Supported by Janssen Pharmaceutica*

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## EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to evaluate treatment with risperidone and quetiapine in patients with schizophrenia and assess possible predictors of medication satisfaction.

## SUMMARY:

*Background:* A study of atypical antipsychotics in patients with a recent exacerbation of schizophrenia included an evaluation of patient satisfaction using the Medication Satisfaction Questionnaire (MSQ).

*Methods:* In a double-blind study, patients received risperidone (N=153), quetiapine (N=156), or placebo (N=73) monotherapy for 2 weeks. The MSQ is a 7-point scale ranging from extremely dissatisfied (score of 1) to extremely satisfied (score of 7). For the predictor analysis, 11 variables of efficacy and safety were included in the model for the regression analyses.

*Results:* Significantly greater reductions in mean PANSS and HAM-D-17 scores were seen with risperidone than placebo. Differences between quetiapine and placebo were not significant. Mean (±SE) scores on the MSQ at endpoint were significantly higher in the risperidone group than in the quetiapine and placebo groups. According to the univariate linear regression model, PANSS and HAM-D change scores and treatment with risperidone significantly predicted medication satisfaction. According to the stepwise multiple linear regression, PANSS total change scores, age, and treatment with risperidone were significant predictors.

*Conclusion:* In both regression models, reduction in psychotic symptoms and risperidone treatment emerged as significant predictors of medication satisfaction. In the multiple regression model, increasing age was also predictive.

Supported by Medical Affairs Division, Janssen Pharmaceutica Products, L.P.

## TARGET AUDIENCE:

Psychiatrists, researchers.

## REFERENCES:

1. Greenspan A, Kosik-Gonzalez C, Bossle C, et al. Readiness to discharge among inpatients with schizophrenia: effects of risperidone, quetiapine, and placebo. Presented at the XXIVth Collegium Internationale Neuro-Psychopharmacologicum Congress, June 20–24, 2004 Paris France.
2. Awad AG, Voruganti LN: New antipsychotics, compliance, quality of life, and subjective tolerability—are patients better off? Can J Psychiatry 2004; 49:297–302.

**Poster 21** **Thursday, October 6**
**8:30 a.m.-10:00 a.m.**

## COST-EFFECTIVENESS EVALUATION OF LONG-ACTING RISPERIDONE

*Supported by Janssen Pharmaceutica*

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## EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to understand the methods associated with this cost-effectiveness analysis and utilize this information for decision-making purposes in the treatment of patients with schizophrenia.

## SUMMARY:

*Objective:* To assess the cost-effectiveness of long-acting risperidone (LAI-RIS), oral risperidone (RIS), olanzapine (OLA), quetiapine (QUE), ziprasidone (ZIP), aripiprazole (ARI), and haloperidol decanoate (HAL-DEC) in patients with schizophrenia over one year from a health care system perspective.

*Methods:* Published medical literature, an unpublished consumer health database, and a clinical expert panel were utilized to populate a decision-tree model. The model captured rates of compliance and relapse, frequency and duration of relapse, adverse events, resource utilization, and unit costs. Outcomes included percentage, number, and duration of relapses per patient per year and direct medical costs.

*Results:* The mean days of relapse requiring hospitalization per patient per year were 28 HAL-DEC, 18 RIS, OLA, QUE, ZIP and ARI, 11 LAI-RIS, while the mean days of exacerbation not requiring hospitalization were eight HAL-DEC, five RIS, OLA, QUE, ZIP and ARI, three LAI-RIS. Direct medical cost savings with LAI-RIS compared with RIS, OLA, QUE, ZIP, ARI, and HAL-DEC were $161, $1,425, $508, $259, $1,068, and $8,224, respectively.

*Conclusions:* Long-acting risperidone may lead to substantially lower rates and fewer days of symptom exacerbation and hospitalization compared with currently available treatments. These lower rates translate into direct medical cost savings with the use of long-acting risperidone.

Supported by Janssen Medical Affairs, LLC.

## REFERENCES:

1. Edwards N, Rupnow M, Pashos C, et al: Cost-effectiveness model of long-acting risperidone in schizophrenia in the US. Pharmacoeconomics 2005; 23(3):299–314.
2. Edwards N, Rupnow M, Locklear J, et al: Cost-effectiveness evaluation of long-acting risperidone. Poster presented at ISPOR 9th Annual International Meeting. May 2004, Washington, D.C.

**Poster 22** **Thursday, October 6**
**8:30 a.m.-10:00 a.m.**

## PATIENT ATTITUDES AND SATISFACTION WITH LONG-ACTING RISPERIDONE MAINTENANCE TREATMENT

*Supported by Janssen Pharmaceutica*

Julie Locklear, Pharm.D., M.B.A, *Assistant Director, Central Nervous System Outcomes Research, Janssen Medical Affairs, L.L.C., 1125 Trenton-Harbourton Road, Titusville, NJ 08560*; Stephen C. Rodriguez, M.A., Manager, *Clinical Operations, Janssen Pharmaceutica Products, L.P., 1125 Trenton-Harbourton Road, Titusville, NJ 08560*; Ibrahim Turkoz, M.S.; Cynthia A. Bossie, Ph.D.; Georges M. Gharabawi, M.D.

## EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to understand patient satisfaction and attitudes with long-acting risperidone maintenance treatment.

## SUMMARY:

*Objective:* To evaluate patient satisfaction and attitudes toward medication among patients treated with long-acting risperidone maintenance treatment.

*Methods:* In a one-year, double-blind study, 323 stable patients with schizophrenia or schizoaffective disorder previously treated with oral antipsychotics were randomized to long-acting injectable risperidone fixed doses of 25 or 50 mg every two weeks. Patient satisfaction was

collected via Likert scale (1=extremely dissatisfied to 7=extremely satisfied). Patient attitudes toward the study medication were collected via three-item questionnaire. Both were collected at baseline, weeks 12, 24, 36, 52, and endpoint (LOCF).

*Results:* Patient satisfaction in all patients increased from 4.7 ± 1.35 at baseline to 5.2 ± 1.58 at endpoint. Patients reporting very/extremely satisfied increased from 32.3% at baseline to 67.9% at week 52 and 53.3% at endpoint. Patient attitude toward concerns about pain remained mild throughout the study, 60.0% and 57.6% patients reported very mild or no concerns about pain at baseline and endpoint, respectively. The most common patient attitude around medication decision was ''more convenient'' at baseline and endpoint. At endpoint, 65.8% of patients reported feeling better or much better about their medication.

*Conclusion:* Overall, patient satisfaction and attitudes toward long-acting risperidone maintenance treatment were positive. Predictors of patient satisfaction will be explored and presented.

This study was supported by Janssen Medical Affairs, LLC.

## TARGET AUDIENCE:

Psychiatrists, health care decision makers.

## REFERENCES:

1. Locklear J, Lasser R, et al: Functioning and quality of life assessments in stable patients with psychotic illness receiving long-acting risperidone. [Poster] Presented at the 2005 American Psychiatric Association Meeting, Atlanta, GA. May 21–26, 2005.
2. Lasser R, Rodriguez S, et al: Optimization of Long-acting Risperidone for Maintenance Therapy in Schizophrenia. [Poster] Presented at the 2005 American Psychiatric Association Meeting, Atlanta, GA. May 21–26, 2005.

**Poster 23** **Thursday, October 6**
**8:30 a.m.-10:00 a.m.**

# UTILIZATION, RELAPSE, AND CLINICAL EVALUATION OF LONG-ACTING RISPERIDONE

*Supported by Janssen Pharmaceutica*

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## EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to (1) understand clinical characteristics of schizophrenia patients initiated on long-acting risperidone, and (2) understand functional and perceived health-related quality of life of schizophrenia patients initiated on long-acting risperidone.

## SUMMARY:

*Objective:* To examine baseline characteristics for patients enrolled in an ongoing two-year observational study in schizophrenia patients initiated on risperidone long-acting injection (RLAI).

*Methods:* Patient demographics, treatment history, reason for starting new treatment, Clinical Global Impression-Severity (CGI-S), Global Assessment of Functioning (GAF), Personal and Social Performance (PSP), Strauss-Carpenter Levels of Functioning (LOF), quality of life (SF-36), and resource utilization are collected at baseline and prospectively every three months for two years.

*Results:* Baseline data are available for 177 patients. The mean age of patients was 44.6 ± 12.5 (SD) years, 64.4% of patients were male, 68.9% had a diagnosis of paranoid schizophrenia with a mean length of illness of 20.7 ± 12.7 years. During the 12 months prior to initiating RLAI, 42.9% had at least one hospitalization. Most patients (69.5%) were initiated on a starting dose of RLAI 25 mg. The most common reason for initiating RLAI treatment was insufficient response to previous treatment (52.5%). Baseline CGI-S, GAF, PSP scores were 4.2 ± 1.18, 49.8 ± 14.6, and 50.7 ± 16.7, respectively.

*Conclusions:* In this naturalistic study, the majority of patients were male, had insufficient response to previous treatment, and were diagnosed with moderate to severe schizophrenia.

This study was supported by Janssen Medical Affairs, LLC.

## TARGET AUDIENCE:

Psychiatrists, health care decision makers, primary care physicians.

## REFERENCES:

1. Kennedy L, Craig A: Global registries for measuring pharmacoeconomic and quality of life outcomes. Pharmacoeconomics 2004; 22(9):551–568.
2. Franciosa J: The potential role of community-based registries to complement the limited applicability of clinical trial results to the community setting: heart failure as an example. Am J Manag Care 2004; 10:487–492.

**Poster 24** **Thursday, October 6 8:30 a.m.-10:00 a.m.**

## UNDERSTANDING THE STAGES OF SCHIZOPHRENIA: A DATA DRIVEN APPROACH

*Supported by Janssen Pharmaceutica*

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### EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be aware of the symptom patterns characteristic of different stages of remission in schizophrenia and understand the basis for the development of simple tools to simplify patient assessment and enhance clinician-patient communication.

### SUMMARY:

*Background:* Although criteria exist for the diagnosis of schizophrenia, there is a need for criteria to more effectively communicate the disease course to patients and families. In other areas of medicine, such communication is facilitated by well-established definitions of acute, stable, remitted, and recovered states. Defining or characterizing the stages of schizophrenia may advance care by: (1) assessing progress of current treatment, (2) identifying barriers to improvements, and (3) enhancing communication and setting expectations for patients, families, and caregivers.

*Methods/Results:* We built on a recently proposed definition of remission in schizophrenia and hypothesize that a definable and characteristic sequence of changes in patient status precedes the remitted state. Databases were used to define such changes in symptomatology, overall clinical status, quality of life, and functionality, and to characterize patients in the acute, stable, and remitted states. Representatives from treatment teams, caregivers, patients, and advocacy groups convened to: (1) refine data-based definitions of characteristic features of stages of schizophrenia, (2) develop a simple tool for patient assessment, and (3) create a tool to help clinicians communicate to patients, families, and caregivers.

*Conclusions:* An initiative to develop simple assessment and communication tools to facilitate patient care through characteristic stages of schizophrenia has started. Progress will be presented.

*Source of Funding:* Medical Affairs Division, Janssen Pharmaceutica Products, L.P.

### TARGET AUDIENCE:

Clinical psychiatrists.

### REFERENCES:

1. Andreasen NC, Carpenter W, Kane JM, et al: Remission in schizophrenia: proposed criteria and rationale for consensus. Am J Psychiatry 2005; 162:441–449.
2. Fleischhacker WW, Eerdekens M, Karcher K, et al: Treatment of schizophrenia with long-acting injectable risperidone: a 12-month open-label trial of the first long-acting second-generation antipsychotic. J Clin Psychiatry 2003; 64(10):1250–1257.

**Poster 25** **Thursday, October 6 8:30 a.m.-10:00 a.m.**

## DIFFERENTIAL EFFECTS OF ATYPICAL ANTIPSYCHOTICS ON METABOLIC SYNDROME

*Supported by Pfizer Inc.*

Antony D. Loebel, M.D., *Medical Director, Pfizer Inc., 235 East 42nd Street, 8th Floor, New York, NY 10017*; John W. Newcomer, M.D.; Jonathan M. Meyer, M.D.

### EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, participants should recognize that metabolic syndrome is a common medical problem in patients with schizophrenia taking second-generation antipsychotics, and that data from the complete ziprasidone clinical trials database show that it occurs more often in patients on olanzapine, quetiapine, and risperidone than in patients on ziprasidone.

### SUMMARY:

*Objective:* To determine rates of metabolic syndrome in subjects with schizophrenia given antipsychotics, using data abstracted from an integrated ziprasidone clinical trials database.

*Methods:* Data were pooled from studies examining 5,348 subjects with schizophrenia or schizoaffective disorder who received ziprasidone (N=3,778) or comparators (N=1,570) in 23 trials. To best capture the incidence of metabolic syndrome, the analysis was limited to trials where triglyceride or HDL-C levels were obtained. These included 11 short-term (≤12 week) and 10 long-term (>12 week) studies where relevant laboratory parameters were obtained randomly, and two short-term studies where they were collected in the fasting state. Per modified NCEP/ATP III guidelines, metabolic syndrome was defined by the presence of ≥3 of the following: blood pressure ≥130/≥85 mm Hg; HDL-C <40 mg/dL (males) or <50 mg/dL (females); triglycerides ≥150 mg/dL; glucose ≥140 mg/dL (if random) or ≥100 mg/

dL (if fasting); and, as a surrogate for waist circumference, BMI ≥25.

*Results:* Ziprasidone therapy was not commonly associated with the emergence of metabolic syndrome. The incidence of metabolic syndrome among patients receiving ziprasidone ranged from 1.4% in short-term studies (BMI≥30) to 5.4% in long-term studies (BMI≥25). Comparators, most notably olanzapine, but also risperidone and quetiapine, demonstrated higher rates of metabolic syndrome.

*Conclusions:* In this comprehensive review of the ziprasidone clinical trials database, a differential effect on emerging rates of metabolic syndrome at trial conclusion was observed. The observed differences at endpoint between groups were least with ziprasidone, intermediate with risperidone, and highest with olanzapine. This is consistent with findings from a recent ADA/APA consensus statement (Diabetes Care 2004; 27:596–601).

Supported by funding from Pfizer Inc

## TARGET AUDIENCE:

Psychiatrists, psychopharmacologists.

## REFERENCES:

1. Holt RI, Peveler RC, Byrne CD: Diabet Med 2004; 21:515–523.
2. Ryan MC, Thakore JH: Life Sci 2002; 71:239–257.

**Poster 26** **Thursday, October 6 8:30 a.m.-10:00 a.m.**

## LONG-TERM DEPRESSIVE SYMPTOM IMPROVEMENT AFTER SWITCHING TO ZIPRASIDONE

*Supported by Pfizer Inc.*

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## EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to discuss the reported findings on long-term improvement and control of depressive symptoms in patients with schizophrenia who were switched to ziprasidone.

## SUMMARY:

*Objective:* To evaluate long-term improvement and control of depressive symptoms in patients with schizophrenia switched to ziprasidone from other antipsychotics.

*Methods:* In three identically designed, six-week, open-label (core) studies, stable outpatients were switched to flexible-dose ziprasidone (40–160 mg/d) from conventional antipsychotics, olanzapine, or risperidone. Commpleters entered one-year extension studies. Using pooled data from patients who completed the extension studies (n=63), we calculated the change in MADRS Total and modified Total scores from core baseline to the core and extension study endpoints. Also calculated were rates of response (≥50% decrease in MADRS Total or modified Total scores from core baseline and extension endpoints).

*Results:* For pooled completers, baseline MADRS scores were 8.2 for Total and 7.4 for modified Total. Significant improvements were observed in MADRS Total (−2.6, $p<0.005$) and modified Total (−2.9, $p=0.0001$) scores. In the small number of patients (n=10) with baseline MADRS score ≥ 14, improvement of −4.4 in Total and −6.0 for modified Total was observed (*P*= NS). Responder rates were 60% based on MADRS Total score and 63% based on MADRS modified Total score.

*Conclusions:* Patients receiving long-term treatment with ziprasidone after a switch from other antipsychotics demonstrated sustained improvement in depressive symptoms and high rates of response for depressive symptoms. Controlled clinical studies are needed to confirm these findings.

Supported by funding from Pfizer Inc.

## TARGET AUDIENCE:

Psychiatrists, psychopharmacologists.

## REFERENCES:

1. Weiden PJ, Simpson GM, Potkin SG, O'Sullivan RL: Effectiveness of switching to ziprasidone for stable but symptomatic outpatients with schizophrenia. J Clin Psychiatry 2003; 64:580–588.
2. Schmidt AW, Level LA, Howard HR, et al: Ziprasidone: a novel antipsychotic agent with a unique human receptor binding profile. Eur J Pharmacol 2001; 425:197–201.

**Poster 27** **Thursday, October 6 8:30 a.m.-10:00 a.m.**

## ADJUNCTIVE ZIPRASIDONE IMPROVES MOOD IN TREATMENT-RESISTANT DEPRESSION: A RANDOMIZED, OPEN-LABEL PILOT STUDY

*Supported by Pfizer Inc.*

Antony D. Loebel, M.D., *Medical Director, Pfizer Inc., 235 East 42nd Street, 8th Floor, New York, NY 10017*; David L. Dunner, M.D.; Jay D. Amsterdam, M.D.; Richard C. Shelton, M.D.

## EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, participants should understand the role of ziprasidone augmentation in patients with treatment-resistant depression and its specific use with high-dose sertraline therapy.

## SUMMARY:

*Objective:* To evaluate the efficacy of ziprasidone as adjunctive therapy with sertraline (SER + ZIP) in treatment-resistant major depression without psychotic features.

*Methods:* Adults who failed ≥4 weeks of adequate therapy with ≥1 SSRI or non-SSRI antidepressants entered a six-week, open-label trial of sertraline (100–200 mg/day (Phase 1). Nonresponders were randomized to eight weeks of open-label sertraline (100–200 mg/day), SER + ZIP 80 mg/day, or SER + ZIP 160 mg/day (Phase 2). Efficacy measures: LS mean change from baseline (Phase 1 end) to endpoint (Phase 2 end) in MADRS Total (primary), CGI-S, individual MADRS items, and MADRS responder rates.

*Results:* Phase 2 subjects included 20 on sertraline, 22 on SER + ZIP 80 mg/day, and 19 on SER + ZIP 160 mg/day. At endpoint, MADRS Total change was greater with SER + ZIP 80 mg/day (−6.0) and 160 mg/day (−8.3) than with sertraline only (−4.4) (*P*=NS). Response rates (≥50% MADRS decrease) were 19%, 32%, and 10%, respectively (*P*=NS). Subjects given SER + ZIP 160 mg/day demonstrated greater mean change in CGI-S ($P<0.05$) scores than those on sertraline only. Combination therapy raised no specific safety concerns.

*Conclusions:* In treatment-resistant major depression, ziprasidone augmentation was associated with greater improvement in efficacy measures than sertraline monotherapy. Improvements and response rates were more robust with ziprasidone 160 mg/day vs 80 mg/day.

Supported by funding from Pfizer Inc.

## TARGET AUDIENCE:

Psychiatrists, psychopharmacologists.

## REFERENCES:

1. Schmidt AW, Level LA, Howard HR, Zom SH. Ziprasidone: a novel antipsychotic agent with a unique human receptor binding profile. Eur J Pharmacol 2001; 425:197–201.
2. Papakostas GI, Petersen TJ, Nierenberg AA, et al: Ziprasidone augmentation of selective serotonin reuptake inhibitors (SSRIs) for SSRI-resistant major depressive disorder. J Clin Psychiatry 2004; 65:217–221.

**Poster 28** **Thursday, October 6**
**8:30 a.m.-10:00 a.m.**

# IMPACT OF ATYPICAL ANTIPSYCHOTICS ON PATIENT COMPLIANCE IN SCHIZOPHRENIA

*Supported by Eli Lilly and Company*

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## EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to better understand the differential impact of atypical antipsychotics on patient-compliance relative to conventional antipsychotics and how these differences vary depending on the patient's antipsychotic drug use history at the time treatment is initiated.

## SUMMARY:

*Objective:* Estimate the impact of olanzapine, risperidone, and quetiapine on patient compliance with antipsychotic drug therapy relative to conventional antipsychotics.

*Methods:* Data from the California Medicaid program (Medi-Cal) were used to identify patients initiating antipsychotic drug therapy in the period January 2000 to mid-2003. Four types of treatment episodes were identified based on drug use data as far back as 1994: patients re-starting treatment after a break in therapy > 15 days using the drug used in their more recent treatment attempt (N=106, 728); patients restarting treatment on an alternative drug (N=32,443); patients switching antipsychotics with no break in therapy (N=26,024); and patients augmenting an existing antipsychotic regimen that is continued for at least 60 days (polypharmacy: N= 36,352). All causes of termination for the initial medications and all medications and changes in antipsychotic medications are investigated using multivariate statistical techniques.

*Results:* Patients are significantly more persistent when treated with second-generation antipsychotics relative to conventional drugs. For example, estimated differences in duration of therapy relative to conventional antipsychotics range from 13 to 15 days for restart episodes to 59 to 65 days for augmentation episodes. These narrow ranges of estimated effects indicate that differences across second-generation products are small.

*Conclusion:* Patients achieve better compliance using second generation antipsychotics.

Funding provided by Eli Lilly and Co.

## TARGET AUDIENCE:

Psychiatrist, Behavioral Health Benefit Managers.

## REFERENCES:

1. McCombs JS, Nichol MB, Stimmel, GL, et al: Use patterns for conventional anti-psychotic medications in Medicaid patients with schizophrenia. Journal of Clinical Psychiatry 1999; 60(suppl 19):5–11.
2. Lyu RR, McCombs JS, Johnstone BM, Muse DN: Use of conventional antipsychotics and the cost of treating schizophrenia. Health Care Financing Review 2001; 23(2):83–99.

**Poster 29** **Thursday, October 6**
**8:30 a.m.-10:00 a.m.**

## IMPACT OF ATYPICAL ANTIPSYCHOTICS ON THE COST OF TREATING SCHIZOPHRENIA

*Supported by Eli Lilly and Company*

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## EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to better understand differential impact of atypical antipsychotics on patient treatment costs and the use of institutional services relative conventional antipsychotics and how these differences vary depending on the patient's antipsychotic drug use history at the time treatment is initiated.

## SUMMARY:

*Objective:* Estimate the impact of olanzapine, risperidone, and quetiapine on patient treatment costs and institutionalization relative to conventional antipsychotics.

*Methods:* Data from the California Medicaid program (Medi-Cal) were used to identify patients initiating antipsychotic drug therapy in the period January 2000 to mid 2003. Four types of treatment episodes were identified: patients restarting treatment after a break in therapy >15 days using the drug used in their more recent treatment attempt (N=106, 728); patients restarting treatment on an alternative drug (N=32, 443); patients switching antipsychotics with no break in therapy (N=26, 024); and patients augmenting an existing antipsychotic regimen that is continued for at least 60 days (polypharmacy: N=36, 352). Patient treatment costs over a one-year post-treatment period and the likelihood of use of institutional care were investigated using multivariate statistical techniques.

*Results:* The use of second-generation antipsychotics was associated with significant reductions in the cost of non-drug medical costs and institutional care in restart, delayed switching, and augmentation episodes, but not for switching episodes. However, increased drug costs exceeded the estimated cost offsets in medical care in delayed switching episodes.

*Conclusion:* Treating patients with schizophrenia with second-generation antipsychotics was found to reduce total cost of treatment for most types of treatment episodes.

Funding provided by Eli Lilly and Co.

## TARGET AUDIENCE:

Psychiatrist, Behavioral Health Benefit Managers.

## REFERENCES:

1. McCombs JS, Nichol MB, Stimmel GL, et al: Use patterns for conventional anti-psychotic medications in Medicaid patients with schizophrenia. Journal of Clinical Psychiatry 1999; 60(suppl 19):5–11.
2. Lyu RR, McCombs JS, Johnstone BM, Muse DN: Use of conventional antipsychotics and the cost of treating schizophrenia. Health Care Financing Review 2001; 23(2):83–99.

**Poster 30** **Thursday, October 6**
**8:30 a.m.-10:00 a.m.**

## DIABETIC KETOACIDOSIS AMONG PATIENTS RECEIVING CLOZAPINE: A CASE SERIES AND A REVIEW OF SOCIO-DEMOGRAPHIC RISK FACTORS

Nikhil D. Nihalani, M.D., *Resident, Department of Psychiatry, Strong Memorial Hospital, 746 Spencerport Road, Rochester, NY 14606*; Steven Lamberti, M.D.; David Olson, Ph.D.; Telva E. Olivares, M.D.

## EDUCATIONAL OBJECTIVES:

At the end of the presentation, the participant should be able to understand the validity of DKA in the case reports and also the association between the risk factors and DKA.

## SUMMARY:

*Introduction:* Diabetes has been associated with the use of atypical antipsychotics. This may be due to an unknown mechanism or due to the weight gain caused by these agents. Diabetic ketoacidosis (DKA) has also been associated with the use of these agents, especially clozapine. The relationship between the emergence of

DKA and the various co-factors associated with DKA is unclear.

*Aim:* The main aim of the study is to review all case reports published to date and determine the validity of the diagnosis of diabetic ketoacidosis (DKA) for each case. The study will examine associated clinical and demographic risk factors, which include substance abuse, body weight change, time of onset, duration, poly psychopharmacology, new onset/new exacerbation of previous diabetes, and treatment compliance.

*Methods:* A literature search was conducted in Medline from 1966 to date for any case reports published on DKA and clozapine. The key words used were clozapine, diabetes, and diabetic ketoacidosis. In addition, a cohort of 26 patients with clozapine-associated diabetes will be examined to find additional cases of DKA.

*Results:* Twenty-three case reports have been published in English and one in Danish that associate DKA with the use of clozapine. There were four cases that we report from a cohort of 26 patients with clozapine-associated diabetes. Further results will be discussed in detail.

*Discussion:* A detailed discussion of the presence of risk factors and association with the diagnosis of diabetic ketoacidosis will follow.

## REFERENCES:

1. Koval MS, Ramy M, Christie S: Diabetic ketoacidosis associated with clozapine treatment. American Journal of Psychiatry 1994; 151:1520–21.

**Poster 31** **Thursday, October 6**
**8:30 a.m.-10:00 a.m.**

## FOUR-YEAR OUTCOMES OF NATURALISTIC OLANZAPINE OR CONVENTIONAL ANTIPSYCHOTIC

*Supported by Eli Lilly and Company*

Douglas L. Noordsy, M.D., *Associate Professor of Psychiatry, Dartmouth Medical School, 1 Medical Center Drive, Lebanon, NH 03756;* Christopher O'Keefe, M.A., *Administrative Director of Psychopharmacology, Department of Psychiatry, Dartmouth Medical School, 105 Pleasant Street, Concord, NH 03301;* Kim T. Mueser, Ph.D.; Haiyi Xie, Ph.D.

## EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize the importance of naturalistic data as a component of evidence bases that confirm generalizability to clinical practice settings.

## SUMMARY:

Long-term naturalistic treatment studies are needed to confirm the generalizability of the findings of controlled trials, and to extend our understanding of the effects of individually tailored treatment. This study evaluates four-year outcomes of patients treated naturalistically with either olanzapine or conventional antipsychotics, in combination with case management and vocational rehabilitation. Patients who remained on olanzapine at four-years demonstrated significantly greater improvement in global psychopathology and hostility, and significantly greater increases in participation in rehabilitation services and competitive employment than a matched group of patients in the same treatment program who remained on conventional antipsychotics. No differences in tolerability, including weight gain, were found among patients who continued long-term treatment with these agents. The findings of this study complement previous studies and extend the duration over which these relationships have been demonstrated.

This project was funded by a grant from Lilly Research Laboratories.

## TARGET AUDIENCE:

Community psychiatrists, vocational specialists.

## REFERENCES:

1. Noordsy DL: Six-month outcomes for patients. Psych Serv 2001; 52:501–507.
2. McHugo GI: Methodologic issues in assertive. AJOrthopsych 1998; 68:246–60.

**Poster 32** **Thursday, October 6**
**8:30 a.m.-10:00 a.m.**

## ANTIPSYCHOTIC ADHERENCE AND MEDICAL SERVICE USE AMONG MEDICAID RECIPIENTS

*Supported by Eli Lilly and Company*

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## EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to understand how medical service utilization rates (hospitalization, emergency room [ER] visits, etc.) compare between Medicaid recipients who continued to refill a newly prescribed antipsychotic medication and those who switched to a different antipsychotic treatment within three months.

## SUMMARY:

*Objectives:* Characterize resource utilization among those continuing vs. those discontinuing index antipsychotic treatment.

*Methods:* MediCal recipients with schizophrenia age 18-50, were identified from 1998-2001, excluding dual eligibles. Primary independent variable (antipsychotic use 91-180 days after initiation) classified as: abandoned all antipsychotic treatment; switched from index antipsychotic to another; or continued index antipsychotic (alone or with augmentation). Use of various medical services within six months of index date comprised the dependent variables of interest.

*Results:* Of 64,324 unique antipsychotic users, 3,990 met age and schizophrenia criteria, with 2,300 Medicaid only recipients. Medication continuation rate was 60%, (21% switched and 19% abandoned antipsychotic treatment). Compared with those continuing, more switchers utilized psychiatric and non-psychiatric ER, non-psychiatric outpatient hospital, and other outpatient services (all $p<0.01$), non-psychiatric physician visits and non-psychiatric hospital admissions (both $p<0.02$). No significant differences were observed for psychiatric hospitalizations, psychiatric outpatient hospital care, or psychiatric physician visits. Medical use patterns among those abandoning antipsychotic treatment were variable, perhaps from abandonment of all treatment or obtaining non-Medicaid covered care.

*Conclusions:* Medicaid recipients who fail an antipsychotic medication trial within three months demonstrate higher health care utilization, suggesting significant consequences resulting from sustained symptoms of schizophrenia.


Funded by Eli Lily and Company.

## TARGET AUDIENCE:

Clinicians and Payers.

## REFERENCES:


1. Weiden PJ, Kozma C, Grogg A, Locklear J: Partial compliance and risk of rehospitalization among california Medicaid patients with schizophrenia. Psychiatric Services 2004; 55(8):886–891.
2. Svarstad BL, Shireman TI, Sweeney JK: Using drug claims data to assess the relationship of medication adherence with hospitalization and costs. Psychiatric Services 2001; 52(6):80511.


**Poster 33** **Thursday, October 6**
**8:30 a.m.-10:00 a.m.**

# ANTICHOLINERGIC DRUG USE ASSOCIATED WITH INCREASED HOSPITAL LENGTH OF STAY

*Supported by Janssen Pharmaceutica*

Patricia W. Slattum, Ph.D., *Assistant Professor of Pharmacy, Virginia Commonwealth University, 410 North 12th Street, Box 980533, Richmond, VA 23298;* Michael S. Keith, Ph.D., *Regional Associate Director, Outcomes Research Department, Janssen Pharmaceutica and Research Foundation, 5507 Garden Arbor Drive, Lutz, FL 33558;* Andrew L. Wilson, Pharm.D.; Kimberly A. Cappuzzo, Pharm.D.; Michael Oinonen, Pharm.D.; Dilesh Doshi

## EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize that anticholinergic drug use is associated with increased length of hospital stay in elderly patients with or without dementia.


## SUMMARY:

*Objectives/Methods:* Anticholinergic (ACH) drug use can impair cognition and function in the elderly, particularly those with dementia. This study explored the association between ACH drug use and length of stay (LOS) in hospitalized elderly patients using data from the University HealthSystem Consortium (UHC) Clinical Database-Pharmacy from October 2003 to September 2004. Patients were assigned to the dementia group (n = 12,481) if they had dementia (by ICD-9 or drug use during hospitalization). Others were assigned to the no dementia group (n = 210,103). Stepwise multiple linear regression was used to evaluate the relationship between LOS and severity score, delirium, ACH drug use, discharge status, age, race, and sex.

*Results:* For patients without dementia, severity score, discharge status, ACH drug use and delirium contributed most significantly to the model ($r^2 = 0.29$). For patients with dementia, severity score, discharge status, ACH drug use and age contributed most significantly to the model ($r^2 = 0.14$). Of the seven variables studied, ACH use was the third largest contributor to length of stay.

*Conclusions:* ACH drug use is associated with increased LOS in elderly hospitalized patients. Attention to the potential impact of ACH drug use in elderly patients is needed.


*Support:* Janssen Medical Affairs.

## TARGET AUDIENCE:

Prescribers for Hospitalized Elderly.

## REFERENCES:


1. Flacker JM, Cummings V, Mach JR: Am J Geriatr Psychiatry 1998; 6:31–41.
2. Flacker JM, Wei JY: J Gerontol: Med Sci 2001; 56A:M353–355.

**Poster 34** **Thursday, October 6 8:30 a.m.-10:00 a.m.**

## DEPRESSION DIAGNOSES FOLLOWING BIPOLAR DIAGNOSES IN CLAIMS DATA

*Supported by Eli Lilly and Company*

Michael D. Stensland, Ph.D., *Outcomes Research Consultant, Department of Neuroscience, Eli Lilly and Company, Lilly Corporate Center, DC-4133, Indianapolis, IN 46285;* Jennifer Schultz, Ph.D.; Jennifer Frytak, Ph.D.

### EDUCATIONAL OBJECTIVES:

To highlight the importance of screening for a history bipolar disorder when an individual presents with depression. In the year following initial diagnosis of bipolar disorder, over one quarter of individuals were given a depression diagnoses. The individuals given the incongruent depression diagnoses had substantially higher treatment costs and hospitalizations.

### SUMMARY:

*Objective:* Following a diagnosis of bipolar disorder, future major depressive episodes are part of the bipolar disorder rather than major depression. Antidepressant monotherapy is contraindicated in bipolar disorder. This study assessed the rate of depression diagnoses in the year following a bipolar disorder diagnosis and compared annual treatment costs for those with and without a post-bipolar depression diagnosis.

*Methods:* In private claims data, we identified 3,119 adults with two bipolar disorder diagnoses in 2002, no bipolar diagnoses in the previous year, and continuous enrollment for the two-year study period. Propensity score models were used to control for baseline differences.

*Results:* 857 (27.5%) individuals received at least two post-bipolar depression diagnoses. Individuals with depression diagnoses incurred substantially higher total annual treatment costs ($12,594 vs. $9,405). Patients with depression diagnoses had 1.8 times more outpatient visits, 2.5 times more ER visits, and 1.8 times more mental health hospitalizations.

*Conclusions:* Depression symptoms following a bipolar diagnosis appear to be misdiagnosed as unipolar depression for one in four patients resulting in substantially increased treatment costs. Ruling out bipolar disorder prior to treating depression may result in better patient outcomes and substantial cost savings.

This study was funded by Eli Lilly and Company.

### TARGET AUDIENCE:

Psychiatrists and Payers.

### REFERENCES:

1. Das AK, Olfson M, Gameroff MJ, Pilowsky DJ, Blanco C, Feder A, et al: Screening for bipolar disorder in a primary care practice. JAMA 2005; 293:956–963.
2. Hirschfeld RM, Lewis L, Vornik LA: Perceptions and impact of bipolar disorder: how far have we really come? Results of the national depressive and manic-depressive association 2000 survey of individuals with bipolar disorder. J Clin Psychiatry 2003; 64:161–174.

**Poster 35** **Thursday, October 6 8:30 a.m.-10:00 a.m.**

## ATOMOXETINE TREATMENT FOR PEDIATRIC PATIENTS WITH ADHD AND COMORBID ANXIETY

*Supported by Eli Lilly and Company*

Calvin Sumner, M.D., *Clinical Research Physician, Neuroscience Medical Studies, Eli Lilly and Company, Lilly Corporate Center, Indianapolis, IN 46285*; Craig Donnelly, M.D.; Douglas K. Kelsey, M.D., Ph.D.

### EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the attendee will be able to summarize the efficacy of atomoxetine compared with placebo for treatment of pediatric patients with attention-deficit/hyperactivity disorder and comorbid anxiety.

### SUMMARY:

*Background:* Research indicates 25% to 50% comorbidity of anxiety disorders with attention-deficit/hyperactivity disorder (ADHD). Atomoxetine is a nonstimulant approved for treating ADHD that is not contraindicated in the presence of anxiety disorders.

*Objective:* This study compared atomoxetine with placebo in treating pediatric patients with ADHD and comorbid anxiety, as measured by the ADHDRS-IV-Parent:Inv (ADHDRS) Total Score and the Pediatric Anxiety Rating Scale (PARS) Total Score.

*Methods:* Patients in this double-blind, acute portion of an extended, multicenter trial were randomized to approximately 12 weeks of atomoxetine treatment (n= 87) or placebo (n=89). Patients met DSM-IV criteria for both ADHD and anxiety disorder (generalized anxiety, separation anxiety, or social phobia). ADHDRS and PARS total scores were analyzed using ANCOVA (LOCF). Patients who responded during a placebo lead-in period were excluded from ADHDRS and PARS (total scores) analyses.

*Results:* Mean ADHDRS total score improved significantly from baseline to endpoint for the atomoxetine group (n=55; 10.5, SD 10.6) relative to placebo (n=58; −1.4, SD 8.3; $p<.001$). Mean PARS total score also improved significantly, from baseline to endpoint for

the atomoxetine group (n=55; −5.5, SD 4.8) relative to placebo (n=58; −3.2, SD 5.0; *p*=.008).

*Conclusion:* Results suggest atomoxetine is efficacious in pediatric patients with ADHD and comorbid anxiety.

Funding provided by Eli Lilly and Company.

## TARGET AUDIENCE:

Clinicians who treat patients with ADHD.

## REFERENCES:

1. Biederman J, Newcorn J, Sprich S: Comorbidity of attention-deficit/hyperactivity disorder with conduct, depressive, anxiety and other disorders. Am J Psych 1991; 148:564–577.
2. Bird H, Gould M, Staghezza B: Patterns of diagnostic morbidity in a community sample of children aged 9 through 16 years. J Am Acad Child Adolesc Psychiatry 1993; 32:361–368.

**Poster 36** **Thursday, October 6**
**8:30 a.m.-10:00 a.m.**

## PATIENT ACCEPTANCE AND LONG-ACTING RISPERIDONE: START PROGRAM, GAIN APPROACH

*Supported by Janssen Pharmaceutica*

Ronald Urioste, M.S., *Associate Director, Department of Medical Affairs, Janssen Pharmaceutica and Research Foundation, 1125 Trenton-Harbourton Road, Titusville, NJ 08560*; Robert A. Lasser, M.D.; Georges M. Gharabawi, M.D.; Kathleen Jarboe, R.N.; Kimberly Litrell, R.N.; Alexander L. Miller, M.D.; Xavier Amador, Ph.D.; Peter J. Weiden, M.D.; Nina R. Schooler, Ph.D.; John P. Docherty, M.D.; Natalie Ciliberto, Pharm.D.

## EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to define criteria for remission in schizophrenia, and their application to characterizing a clinical dataset.

## SUMMARY:

*Background:* A recently published proposal defining remission in schizophrenia illustrates increasing interest in measures of wellness as targets of treatment outcome. This analysis studied how meeting remission criteria corresponded to various ratings of patient status.

*Methods:* In a one-year, double-blind study, stable patients with schizophrenia or schizoaffective disorder received long-acting injectable risperidone (25 or 50 mg every two weeks). Remission criteria were applied: absent-mild symptoms on eight core PANSS items for ≥6 months.

*Results:* Although patients were considered stable at entry, 61.4% (n=194) were not remitted (severity component only) at baseline. Among these patients, 21.6% (n=42) met remission criteria (severity and duration); 90.0% of remitted patients completed the study. Remitted patients experienced a low rate of protocol-defined relapse (n=1; 2.4%); CGI-S improvements at endpoint (not ill-mildly ill; 24.4%–88.1%); and significant improvements in mean Personal and Social Performance (60.6±14.1 to 71.5±10.9 $P<0.001$) and Strauss-Carpenter Level of Functioning (22.0±5.2 to 23.5±5.0; $P=0.05$) scores. Some improvements were noted in nonremitted patients, but to a much lesser extent. The most commonly reported adverse events (>15%) were headache (26%) and insomnia (26%) among remitted patients; and psychiatric disorder NOS (28%), insomnia (26%), anxiety (17%), and headache (16%) among nonremitted patients.

*Conclusion:* These findings add to a growing body of data linking these remission criteria with improvement in functioning.

*Source of funding:* Medical Affairs Division, Janssen Pharmaceutica Products, LP.

## TARGET AUDIENCE:

Clinical psychiatrists.

## REFERENCES:

1. Andreasen NC, Carpenter W, Kane JM, et al. Remission in schizophrenia: proposed criteria and rationale for consensus. Am J Psychiatry. 2005; 162:441–449.
2. Lasser RA, Bossie CB, Gharabawi, GM, et al: Remission in schizophrenia: results from a 1-year study of long-acting risperidone injection. Schizophr Res. in press.

**Poster 37** **Thursday, October 6**
**8:30 a.m.-10:00 a.m.**

## ZIPRASIDONE'S LONG-TERM EFFICACY IN SUBPOPULATIONS WITH BIPOLAR MANIA

*Supported by Pfizer Inc.*

Lewis E. Warrington, M.D., *Researcher, Pfizer Inc., 235 East 42nd Street, New York, NY 10017*; Steven G. Potkin, M.D.; Kathleen Ice, Ph.D.; Cynthia Siu, Ph.D.

## EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, participants should understand ziprasidone's potential for improving long-term symptom severity in patients with bipolar disorder who experience either manic or mixed episodes, with or without psychosis.

## SUMMARY:

*Objective:* To evaluate ziprasidone's long-term efficacy in clinically relevant subpopulations with acute bipolar mania.

*Methods:* Ziprasidone-treated completers of a 21-day, placebo-controlled trial of acute bipolar mania (N=62) were enrolled in a 52-week, open-label extension of flexibly-dosed ziprasidone 40–160 mg/day. Efficacy measures included change from core baseline in Mania Rating Scale (MRS) and Clinical Global Impression-Severity (CGI-S), as well as MRS responder rates (≥50% change from core baseline), in subpopulations with manic (n=43) or mixed (n=19) episodes, with (n=37) or without (n=25) psychotic symptoms.

*Results:* Mean change in MRS at last visit (LOCF) was −24.7 ($P<0.0001$) for manic and −20.8 ($P<0.0001$) for mixed subjects (baseline, 30.5 and 25.6, respectively). Respective changes in CGI-S change scores were −2.5 ($P<0.0001$) and −1.8 ($P<0.005$) (baseline, 5.1 and 4.7, respectively). MRS and CGI-S changes were comparable for subjects with and without baseline psychotic symptoms. Responder rates were 88% in manic, 79% in mixed, 85% in psychotic, and 88% in nonpsychotic subjects. Long-term improvement observed within subpopulations was comparable to that observed in the overall study population. Overall median ziprasidone dosage was 130 mg/day.

*Conclusion:* For patients with acute bipolar mania, ziprasidone demonstrated significant and sustained improvements in symptoms and global illness severity whether the baseline episode was manic or mixed, or involved psychotic symptoms.

## TARGET AUDIENCES:

Psychiatrists, Psychopharmacologists.

## REFERENCES:

1. Keck PE Jr, Versiani M, Potkin S, et al: Ziprasidone in the treatment of acute bipolar mania: a three-week, placebo-controlled, double-blind, randomized trial. Am J Psychiatry 2003; 160:741–748.
2. Bowden CI: Clinical correlates of therapeutic response in bipolar disorder. J Affect Disord 2001; 67:257–265.

**Poster 38** **Thursday, October 6**
**8:30 a.m.-10:00 a.m.**

# LIPID MONITORING IN PATIENTS PRESCRIBED SECOND-GENERATION ANTIPSYCHOTICS

Ellen M. Weissman, M.D., *Psychiatrist, Mount Sinai Hospital and Bronx Veterans Affairs Medical Center, 130 West Kingsbridge Road, Bronx, NY 10468*; Susan M. Essock, Ph.D., *Professor, Mount Sinai Hospital and Bronx Veterans Affairs Medical Center, 1 Gustave Levy Place, New York, NY 10029*; Carolyn W. Zhu, Ph.D.; Ray Goetz, Ph.D.; Nina R. Schooler, Ph.D.

## EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to identify the low frequency of lipid monitoring among patients with schizophrenia treated with second-generation antipsychotics, even in a treatment system that integrates primary medical and psychiatric care and has comprehensive medical records; recognize the importance of improving lipid monitoring in this population.

## SUMMARY:

*Background:* Individuals with schizophrenia experience increased risk for obesity, diabetes, and dyslipidemias. Certain second-generation antipsychotics (SGAs) exacerbate this risk, but rates of metabolic monitoring among patients prescribed SGAs are unknown.

*Objectives:* to determine: (1) lipid monitoring rates for outpatients with schizophrenia treated with SGAs, and (2) whether individuals with abnormal lipid levels receive follow-up monitoring sooner than individuals with normal levels.

*Method:* Using administrative data from the Bronx Veterans Affairs Medical Center, October 1999- October 2003, we calculated proportion of individuals with schizophrenia treated with SGAs receiving monitoring for total cholesterol (TC); triglycerides; LDL; and HDL. For individuals with ≥1 TC measurement, we categorized initial TC level as normal (<200 mg/dL) or abnormal (≥200 mg/dL) based on NCEP ATPIII guidelines and compared time-to-second-measure using survival analysis. We performed parallel analyses for triglycerides, LDL and HDL.

*Results:* 75% of individuals had ≥1 measurement for TC during the study period. Abnormal initial measurements predicted earlier follow-up monitoring. However, median time to second measure was 304 days even for individuals with abnormal levels. Similar results were found for triglycerides, LDL, and HDL.

*Conclusions:* Administrators and clinicians should assess adequacy of monitoring and support quality improvement initiatives in this area.

*Funding:* MIRECC, VA Integrated Services Network 3.

## TARGET AUDIENCE:

Clinicians, administrators and others who treat individuals with schizophrenia.

## REFERENCES:

1. Saari K, Jokelainen J, Veijola J, et al: Serum lipids in schizophrenia and other functional psychoses: a

general population northern Finland 1966 birth cohort survey. Act Psychiatr Scand 2004; 110:279–285.
2. Lindenmayer JP, Czobor P, Volavka J, et al: Changes in glucose and cholesterol levels in patients with schizophrenia treated with typical or atypical antipsychotics. Am J Psychiatry 2003; 160:290–96.

**Poster 39** **Thursday, October 6**
**8:30 a.m.-10:00 a.m.**

## TARDIVE DYSKINESIA: DEAD OR ALIVE?

Scott W. Woods, M.D., *Professor of Psychiatry, Yale School of Medicine, 38 Avon Street, # 1, New Haven, CT 06511-2523*

### EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to understand whether tardive dyskinesia continues to be an important clinical problem in the atypical antipsychotic era.

### SUMMARY:

A limited number of studies suggest that atypical antipsychotics are associated with tardive dyskinesia (TD) incidence rates lower than those associated with conventional antipsychotics, but most of these studies did not carefully train raters and monitor their ability to distinguish TD from extrapyramidal syndromes such as pseudoparkinsonian tremor and akathisia.

*Method:* We studied antipsychotic-maintained patients naturalistically at our community mental health center (CMHC) from 2000 to 2005. In a total of 17 taped examinations with a median of five raters per examination, the intraclass-r for agreement among raters on the AIMS total scores was 0.93.

*Results:* A total of 195 of 620 patients met TD criteria at baseline (estimated prevalence 31.5%, 95% CI 27.8-35.3%). At initial evaluation, 22% of at-risk patients were receiving conventional antipsychotic only, 63% atypical antipsychotic only, and 15% combination therapy. The cumulative incidence risk for appearance of new TD cases was 19.4% over 3.9 years of follow up (95% CI 15.1-24.6%).

*Discussion:* These prevalence and incidence rates are similar to those from a previous TD study in our CMHC 1988-1993 prior to the introduction of atypicals. TD unfortunately remains a common clinical problem in our CMHC now a decade into the atypical era.

Funded by NIMH R01-MH61008.

### TARGET AUDIENCE:

Psychiatrists, medical students, psychiatric nurses.

### REFERENCES:

1. Woods SW: Olanzapine and tardive dyskinesia. (letter) British Journal of Psychiatry 1999; 175:391–2.
2. Woods SW: Chlorpromazine equivalent doses for the newer atypical antipsychotics. J Clin Psychiatry 2003; 64:663–667.

# POSTER SESSION 2

**Posters 40–75**

## MOOD DISORDERS

**Poster 40** **Thursday, October 6**
**3:00 p.m.-4:30 p.m.**

## EFFECTS OF LAMOTRIGINE ON QUALITY OF LIFE AND COGNITIVE FUNCTION

*Supported by GlaxoSmithKline*

Eric J. Bourne, M.S., *Employee, GlaxoSmithKline, 5 Moore Drive, Research Triangle Park, NC 27709*; Jay A. Graham, Ph.D., *Employee, GlaxoSmithKline, 5 Moore Drive, Research Triangle Park, NC 27709*; Jeremy Roberts, M.S.; Thomas R. Thompson, M.D.; Steven Burch, Ph.D.

### EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize and assess the effects of lamotrigine on quality of life and cognitive function.

### SUMMARY:

*Objective:* The effect of lamotrigine on cognition and quality of life was assessed as secondary endpoints in this large outpatient study.

*Methods:* Adult and adolescent patients (≥13 years old) were administered open-label lamotrigine titrated to a target dosage of 200 mg/day, adjusting for concomitant bipolar medications, and continued for 12 weeks. Patients were administered the self-reported Quality of Life and Enjoyment and Satisfaction Questionnaire Short Form (Q-LES-Q-SF) and the Medical Outcomes Study Cognition Scale (MOS-Cog) via interactive voice response system (IVRS) at baseline and end of study (Week 12).

*Results:* 188 sites enrolled 1,139 patients. Mean scores from general activities of life enjoyment questions from the Q-LES-Q-SF improved during the 12 weeks of adjunctive treatment with lamotrigine with a change from baseline score of 10.1 (n=914, SD 20.07, $p<0.0001$). Mean scores from the MOS-Cog also improved during the 12-week study period with lamotrigine with a change from baseline score of 8.4 (n=912, SD 22.55, $p<0.0001$). Adverse events ≥5% included headache (8%), rash (6%),

insomnia (5%), dizziness (5%), and nausea (5%). No serious rash was reported.

*Conclusion:* Self-reported quality-of-life enjoyment and cognitive function scores improved over 12 weeks when lamotrigine was added to current bipolar therapy. Lamotrigine was generally well tolerated.

## TARGET AUDIENCE:

Psychiatrists.

## REFERENCES:

1. Morice R: Cognitive inflexibility and pre-frontal dysfunction in schizophrenia and mania. Br J Psychiatry 1990; 157:50–4.
2. Bulbena A, Berrious GE: Cognitive function in the affective disorders: a prospective study. Psychopathology 1993; 26(1):6–12.

**Poster 41** **Thursday, October 6**
**3:00 p.m.-4:30 p.m.**

## DERMATOLOGICAL PRECAUTION STUDY OF LAMOTRIGINE IN BIPOLAR DISORDER PATIENTS

*Supported by GlaxoSmithKline*

Jay A. Graham, Ph.D., *Employee, GlaxoSmithKline, 5 Moore Drive, Research Triangle Park, NC 27709*; Eric J. Bourne, M.S., *Employee, GlaxoSmithKline, 5 Moore Drive, Research Triangle Park, NC 27709*; Terence A. Ketter, M.D.; Jeremy Roberts, M.S.; Thomas R. Thompson, M.D.

## EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize, assess, rule out causes of rash in patients taking lamotrigine.

## SUMMARY:

*Objective:* Rash has been reported in about 10% of patients receiving lamotrigine. An open, uncontrolled, 100-patient case series suggested that utilizing dermatology precautions (DP, precautions to decrease environmental sources of rash) and slower titration may yield a lower (5/100, 5%) incidence of lamotrigine treatment-emergent rash. We assessed DP versus usual care precautions (UCP) in a randomized trial.

*Methods:* Bipolar disorder patients were randomized to receive either blinded UCP or DP for 12 weeks while open lamotrigine was initiated, titrated according to the prescribing information, adjusting for concomitant bipolar medications to a target dose of 200 mg/day, and maintained. Rates of rash, tolerability, and clinical responses (CGI-BP) were compared with DP versus UCP.

*Results:* 188 sites enrolled 1,175 subjects. No serious rash was reported. Rates of non-serious rash were 50/584 (8.6%) with DP and 52/591 (8.8%) with UCP. Adverse events included headache (8%), dizziness (5%), and insomnia (5%). Mean CGI-BP scores improved or remained stable similarly in both groups.

*Conclusion:* Lamotrigine was generally well-tolerated. UCP and DP had similar (8.8-8.6%) rates of non-serious rash, that were marginally lower than the approximately 10% rate reported previously. Possible reasons for the lack of replication of the even lower (5%) rate reported in an open, uncontrolled case series will be discussed.

## TARGET AUDIENCE:

Psychiatrists.

## REFERENCES:

1. Ketter TA, Wang PW, Chandler RA, et al: Dermatology precautions and slower titration yield low incidence of lamotrigine treatment-emergent rash. J Clin Psychiatry, (in press).
2. Calabrese JR. Sullivan JR, Bowden CL, et al.: Rash in multicenter trials of lamotrigine in mood disorders: clinical relevance and management. J Clin Psychiatry 2002; 63(11):1012–1019.

**Poster 42** **Thursday, October 6**
**3:00 p.m.-4:30 p.m.**

## EXTENDED-RELEASED CARBAMAZEPINE AND SLEEP: BENEFICIAL EFFECTS

*Supported by Shire US Inc.*

Andrew J. Cutler, M.D., *Assistant Professor, Department of Psychiatry, University of South Florida, 2300 Maitland Center Parkway, Suite 230, Maitland, Fl 32751;* Amir Kalali, M.D.

## EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to discuss the link between sleep patterns and disease relapse and response in bipolar disorder and understand new data regarding the effects of carbamazepine extended-release capsules on insomnia and sleep in patients with bipolar I disorder.

## SUMMARY:

Sleep patterns are reliable indicators of whether a patient with bipolar disorder is likely to relapse or sustain remission in the near term. Increased hours of nighttime sleep have also been correlated with increased response in patients with bipolar disorder. As decreased need for sleep is a hallmark of bipolar disorder, agents that

promote sleep could be useful therapies in achieving treatment response. This post hoc analysis details the effects of carbamazepine extended-release capsules (CBZ-ERC) (Equetro™; Shire, Wayne, Pa) on insomnia and sleep in patients with bipolar disorder. Both trials included in this analysis were 21-day, randomized, double-blind, placebo-controlled, phase-three studies that followed a five- to seven-day, single-blind, placebo lead-in period. Improvements in sleep were assessed with the Hamilton Depression Rating Scale (HDRS) and Young Mania Rating Scale (YMRS). Both scales contain subscores dealing with insomnia and sleep. Pooled data from these two trials indicated that patients with bipolar I disorder taking CBZ-ERC experienced a significant decrease in insomnia early, middle, and late as assessed by the HDRS when compared with those patients given placebo (all $P<.05$). Correspondingly, individual analysis of YMRS items indicated significant improvement in sleep at every time point taken for the manic population (all $P<.001$). The data indicate that CBZ-ERC may be beneficial to bipolar patients with insomnia through its promotion of sleep.

Supported by Shire.

## TARGET AUDIENCE:

Psychiatrists.

## REFERENCES:

1. Keck PE, Jr: Defining and improving response to treatment in patients with bipolar disorder. J Clin Psychiatry 2004; 65(suppl 15):25–29.
2. Post RM, Uhde TW, Roy-Byrne PP, Joffe RT: Correlates of antimanic response to carbamazepine. Psychiatry Res 1987; 21:71–83.

**Poster 43** **Thursday, October 6**
**3:00 p.m.-4:30 p.m.**

## EXTENDED-RELEASE CARBAMAZEPINE FOR MIXED EPISODES IN BIPOLAR DISORDER

*Supported by Shire US Inc.*

Andrew J. Cutler, M.D., *Assistant Professor, Department of Psychiatry, University of South Florida, 2300 Maitland Center Parkway, Suite 230, Maitland, FL 32751;* Amir Kalali, M.D.

## EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize the practical significance of depressive symptoms in bipolar I disorder and understand new findings regarding the therapeutic efficacy of carbamazepine extended-release capsules for both manic and depressive symptoms in patients with mixed episodes in bipolar I disorder.

## SUMMARY:

Although the manic phase of bipolar I disorder can cause severe morbidity, the mood episodes of the majority of patients will be depressive in nature. This fact is especially true for those patients with mixed episodes associated with bipolar disorder. The time spent in the depressive phase of the illness can lead to increased rates of suicide and other behaviors such as alcoholism and drug abuse. This post hoc analysis further supports the efficacy of carbamazepine extended-release capsules (CBZ-ERC) (Equetro™; Shire, Wayne, Pa) in the treatment of patients with mixed episodes, as assessed by a reduction in both manic and depressive symptomatology. Both trials included in this analysis were 21-day, randomized, double-blind, placebo-controlled, phase-three studies that followed a five- to seven-day, single-blind, placebo lead-in period. Improvement in mixed symptoms was assessed with the Young Mania Rating Scale (YMRS) and the Hamilton Depression Rating Scale (HDRS). Pooled data from these two trials indicated that patients with mixed episodes taking CBZ-ERC experienced a significant decrease in mean YMRS scores when compared to those patients given placebo ($P<.01$). At treatment end point, a statistically significant reduction in HDRS scores was also seen in those patients with mixed episodes receiving CBZ-ERC compared with those given placebo ($P<.05$).

Supported by Shire.

## TARGET AUDIENCE:

Psychiatrists.

## REFERENCES:

1. Judd LL, Akiskal HS, Schettler PJ, et al: The long-term natural history of the weekly symptomatic status of bipolar I disorder. Arch Gen Psychiatry 2002; 59:530–537.
2. Isometsa ET, Henriksson MM, Aro HM, Lonnqvist JK: Suicide in bipolar disorder in Finland. Am J Psychiatry 1994; 151:1020–1024.

**Poster 44** **Thursday, October 6**
**3:00 p.m.-4:30 p.m.**

## MANY FACES OF PTSD

Chandresh Shah, M.D., *Assistant Chief of Psychiatry, Los Angeles VA Outpatient Clinic, and Clinical Associate Professor of Psychiatry, University of Southern California, 351 East Temple Street, Los Angeles, CA 90012*

## EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should recognize commonly occurring psychiatric disorders among those also diagnosed with posttraumatic stress disorder.

## SUMMARY:

One of the inevitable outcomes of terror and war on terror is occurrence of posttraumatic stress disorder (PTSD) in affected, vulnerable populations. It is important that observations and experiences from managing veterans (vets) from the Vietnam War are revisited to better prepare for understanding and addressing needs of those affected by the current war. Medical records of 293 vets (287 male, six female) with PTSD who had been in treatment for at least 180 days were reviewed. They were 54.93 ± 8.05 years old. There were 235 (80.20%) vets who were also diagnosed with depressive disorders, and 174 (59.38%) with (other) anxiety disorders. Eighty-seven (29.69%) vets also carried a diagnosis of psychotic disorders, and 57 (19.45%) were treated for addictive disorders. The vets with co-occurring addictive disorders were noted to be younger in age (50.98±5.83 years; $p<0.05$). It was also noted that 45.39% of vets had two psychiatric comorbidities (PC), and only 6.14% of them had no other PC. These data show that there is a very high prevalence (93.86%) of PC among those with PTSD during their lifetime. Depressive and anxiety disorders are very prevalent among those with PTSD. Therefore, while screening and treating PTSD, attention should be paid to and emphasis be placed on psychiatric comorbidity.

## TARGET AUDIENCE:

Psychiatrists, Psychologists, Counselors.

## REFERENCES:

1. Brady KT, Killeen TK, Brewerton T, Lucerini D: Comorbidity of psychiatric disorders and posttraumatic disorder. J Clin Psychiatry 2000; 61 Suppl 7:22–32.
2. Elhai JD, Frueh BC, Davis JL, Jacobs GA, Hamner MB: Clinical presentations in combat veterans diagnosed with posttraumatic stress disorder. J Clin Psychology 2003; 59(3):385–397.

**Poster 45** **Thursday, October 6**
**3:00 p.m.-4:30 p.m.**

# EVALUATION OF LONG-TERM CARE RESIDENTS CONVERTED TO DIVALPROEX SODIUM EXTENDED RELEASE

*Supported by Abbott Laboratories*

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## EDUCATIONAL OBJECTIVES:

At the conclusion of the presentation, the participant should be able to recognize the importance of medication compliance in the elderly population and that the use of extended release divalproex sodium maintains or improves behavior outcomes and is well tolerated in this population.

## SUMMARY:

*Introduction:* Omnicare of Northern Illinois (ONI) supports 160 LTC facilities representing over 25,000 residents. In 2003, over 2700 of these residents received some form of valproate. In that year, we adopted an initiative to convert these patients, as appropriate, to once daily divalproex sodium extended release (DVPX ER) in an effort to improve patient compliance and reduce nursing time. Medication compliance has been identified as a serious issue in the elderly as comorbidities and complex dosing regimens abound. Agitated LTC residents are more likely to refuse medications that require multiple daily doses. This study retrospectively evaluated the efficacy, safety, and pharmaco-economic benefits of converting LTC residents from various forms of valproate to DVPX ER.

*Methods:* This chart review included 286 patients converted from valproic acid (VPA) or divalproex sodium (DVPX) to DVPX ER. Consultant pharmacists collected data on VPA levels and behavioral symptoms as noted in the Behavior Monitoring Tool pre and post conversion. The Behavior Monitoring Tool is an accepted industry standard in determining efficacy of drug therapies aimed at achieving optimal doses and in reducing distressing symptoms to patients and others. Pharmacoeconomic benefits were calculated using wage data derived from cost reports filed with the Illinois Department of Public Aid.

*Conclusion:* This study demonstrated that residents with behavior problems stabilized on the divalproex sodium extended release dosage form. In addition, a low fluctuation in VPA levels (mean change in VPA level following conversion was a decrease of 1.587) was noted and once daily dosing was well tolerated. Approximately 31% required some dose adjustment upward, whereas the majority had no change in dose. No significant drug-drug interactions were noted during the study period.

## REFERENCES:

1. Fulmer TT, et al: An intervention study to enhance medication compliance in community-dwelling elderly individuals. Journal Geront Nurs 1999; 25(8):6–14.

2. Zlotnick S, et al: Cost analysis of immediate versus controlled-release medication administrations in long-term care. Consult Pharm 1996; 11:689–692.

**Poster 46** **Thursday, October 6 3:00 p.m.-4:30 p.m.**

## MITOCHONDRIAL DISORDER MASQUERADING AS MULTIPLE PSYCHIATRIC SYMPTOMS

Tatiana A. Falcone, M.D., *Resident, Department of Psychiatry, Cleveland Clinic Foundation, 1310 Forest Hills Boulevard, Cleveland Heights, OH 44118*; Kathleen S. Franco, M.D., *Department of Psychiatry, Cleveland Clinic Foundation, 9500 Euclid Avenue, #P-57, Cleveland, OH 44195-0001*

### EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize mitochondrial disorders as part of differential diagnosis for psychiatric patients.

### SUMMARY:

Mitochondrial disorders are diverse in presentation and treatment. They often present in younger patients having multiple physical illnesses along with psychiatric disorder. A 36-year-old patient was referred for upsening depression, fatigue, anhedonia, insomnia, obsessive thoughts, decreased energy and libido. His past history included multiple failed medication trials with 4 different classes of psychotropics. After 1 year of treatment there was little to no improvement, in his energy, motivation or excessive daytime sleepiness. Electro-convulsive therapy was tried without benefits. Despite adequate trials his condition worsened. Additional history revealed involuntary leg movement during sleep. His sleep study revealed Obstructive Sleep apnea. While other metrabolic test concluded at least 80% of his amino acids in urine and blood were abnormal. He felt improvement from fatigue. After starting coenzyme Q10. His mood was better even after tapering 3 of his psychotropic medications. Mitochondrial disorders frequently go undiagnosed when clinicians look at individual symptoms as separate entities.

### TARGET AUDIENCE:

Psychiatrist, Med Students, Residents.

### REFERENCES:

1. Sato A: Genetic studies on mental disorders. Psychiatria at Neurolgia Japonica 2004; 106(12):16044.
2. Modica-Napolitano JS. Renshaw PF: Ethandamira inhibibit mitochondrial function: implications for dysfunction in depression and bipolandis. Biological Psychiatry 2004; 55(3):273–7.

**Poster 47** **Thursday, October 6 3:00 p.m.-4:30 p.m.**

## COMPARING OUTCOMES, SIDE EFFECTS, AND DONATION OF TREATMENT AMONGST SSRI'S

*Supported by Pfizer Inc.*

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### EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to compare SSRI's for side effects, efficacy, duration.

### SUMMARY:

*Objectives:* Compare overall improvement, treatment duration, and side effects among patients with major depression, receiving SSRIs (citalopram, escitalopram, fluoxetine, paroxetine or sertraline), in a real-world treatment setting.

*Methods:* We utilized a long-term clinical data repository from Duke Psychiatric Department. The repository is created from the use of a computer-based clinical patient record system. The information in the repository is fully anonymized, HIPAA compliant, and IRB exempt. At the time of this analysis, over 23,000 patients are included in the data repository, with clinical information including diagnosis, outcome, medications, and side effects.

Response to treatment is defined by the percentage of patients achieving very much or much improved on the CGI-I. Physicians record side effects and duration during the clinic encounter.

*Results:* Of the 2,292 patients with major depressive disorders selected, majority were female, 68% with an average age of 41. Dosage range was generally within manufacturers suggested parameters. The median duration of treatment ranged from escitalopram 140 days to fluoxetine at 321, respectively.

Response, as measured by CGI-I, ranged from a low 44% for paroxetine to a high of 53% for sertraline. Patients experiencing any side effect ranged from, 36% for escitalopram to low of 20% for sertraline, a statistically significant.

*Conclusion:* In a naturalistic, real-world setting, when matching patients between SSRIs, response, side effect profiles, and duration varied amongst the class.

## TARGET AUDIENCE:

Psychiatrists.

## REFERENCES:

1. Gersing K, Krishnan R: Clinical Management Research Information Systems. Psych Services 54.
2. Edwards JG: Systematic Review and Guide to Selection of SSRI, Drugs 1999; 57:507–533.

**Poster 48** **Thursday, October 6**
**3:00 p.m.-4:30 p.m.**

## SAFETY AND EFFICACY OF LAMOTRIGINE FOR ADULT BIPOLAR DISORDER PATIENTS

*Supported by GlaxoSmithKline*

Lawrence D. Ginsberg, M.D., *President and Chief Executive Officer, Red Oak Psychiatry Associates, 17115 Red Oak Drive, Suite 109, Houston, TX 77090-2607*

## EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize and treat.

## SUMMARY:

*Objective:* To assess the effectiveness and safety of lamotrigine in the treatment of bipolar disorder.

*Methods:* Chart reviews of 587 adult outpatients with DSM-IV bipolar disorder and treated with lamotrigine were conducted (mean age 37.6 ± 11.7 years; 72% female; 54.9% bipolar I, 28.3% bipolar II, 16.9% bipolar not otherwise specified). Charts of subjects who received lamotrigine in a private practice setting between October 1998 and May 2004 were reviewed. Treatment response was assessed with the Clinical Global Impression-Improvement (CGI-I) scale (1 = very marked improvement, 2 = moderate improvement). Relapse was defined as a mood change that occurs four weeks after initiation of medication or the return of symptoms from the original episode.

*Results:* Three hundred fifty-seven subjects (60.8%) taking lamotrigine had marked to moderate improvement (CGI-I scores: 1, 21.1%; 2, 39.7%). Two hundred nineteen subjects (37.3%) relapsed during lamotrigine treatment (mean time to relapse = 207 days). The final mean lamotrigine dose was 120.4±94.3 mg/d. Rash (12.8%) and headache (2.9%) were the most frequently reported side effects.

*Conclusion:* Lamotrigine appears effective in the treatment of bipolar disorder and was well tolerated.

## TARGET AUDIENCE:

Psychiatrists.

## REFERENCES:

1. Lamictal [package insert]. Research Triangle Park, NC: GlaxoSmithKline, 2004.
2. Calabrese JR, Bowden CL, McElroy SL, et al: Spectrum of activity of lamotrigine in treatment-refractory bipolar disorder. Am J Psychiatry 1999; 156:1019–1023.

**Poster 49** **Thursday, October 6**
**3:00 p.m.-4:30 p.m.**

## ANTIDEPRESSANT TREATMENT AND ITS EFFECTS ON MEDICAL RESOURCE UTILIZATION IN A HIGH-RISK MEDICAL POPULATION

*Supported by Pfizer Inc.*

Lisa B. Greenstein, Pharm.D., *Clinical Education Consultant, Pfizer Inc., 876 Willowdale Drive, Villa Hills, KY 41017*; Christopher Thomas, Pharm.D., *Pharmaist, Veterans Affairs Medical Center, 17273 State Route 104, Chillicothe, OH 45601*; Greg P. Schepers, Pharm.D.; Thomas A. Wolfe, Pharm.D.; Laura Manzey, Pharm.D.; Kevin A. Townsend, Pharm.D.; Tamara S. Evans, Pharm.D.

## EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to describe the prevalence adequate treatment of major depressive disorder in patients with medical comorbidities.

## SUMMARY:

*Objective:* Depression is common in patients with serious medical illnesses and its undertreatment may lead to poor medical outcomes. The purpose of this study was to determine adequate antidepressant drug therapy amongst new episodes of comorbid depression in veterans with serious medical conditions, and associated costs.

*Methods:* This retrospective cohort study utilized medical and pharmacy claims databases from two Department of Veterans Affairs hospitals to determine depression diagnosis, presence of a high-risk medical comorbidity, and adequacy of antidepressant therapy.

*Results:* Among the 317 patients included in this analysis, 96% were male; mean age of 65.7 ± 11.9 years. Prevalence of medical diagnoses included 51.1% diabetes and 73.2% with cardiovascular disease or stroke. Sixty-three percent of patients did not meet criteria for adequate antidepressant therapy. The mean total cost for the adequate therapy group was $6,736 ± $20,059 and

$3,555 ± $14,577 for the inadequate therapy group, respectively (p=0.14).

*Conclusion:* Thirty-seven percent of patients in this cohort received adequate acute and continuation antidepressant therapy, which is comparable to other national data. In this small cohort, we found no difference in total cost of care between patients who received adequate therapy and those who did not.

Pfizer Inc supported this study.

## TARGET AUDIENCE:

Psychiatrists—general practice, primary care, quality improvement managers.

## REFERENCES:

1. Depression Guideline Panel. Clinical Practice Guideline 5. Depression in Primary Care 2: Treatment of Major Depression. Rockville, MD: US Department of Health and Human Services, Agency for Health Care Policy and Research; AHCPR Publication No. 93-0551. April 1993: 7, 28, 109.
2. Kessler RC, Berglund P, Demler O, et al: The epidemiology of major depressive disorder: results from the National Comorbidity Survey Replication (NCS-R). JAMA 2003; 289(23):3095–3105.

**Poster 50** **Thursday, October 6**
**3:00 p.m.-4:30 p.m.**

## RETROSPECTIVE REVIEW OF LAMOTRIGINE IN TREATMENT-RESISTANT DEPRESSION

*Supported by GlaxoSmithKline*

Rosben L. Gutierrez, M.D., *Psychiatrist, PsyCare, Inc., 14234 Harrow Place, Poway, CA 92064-2373*; Ruth McKertcher, Ph.D., *Employee, PsyCare, Inc., 15525 Pomerado Road, Suite A-7, Poway, CA 92064*; Jason Galea, M.A.; Katrina L. Jamison, Pharm.D.

## EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize, treat

## SUMMARY:

*Objective:* To demonstrate that lamotrigine added to an antidepressant regimen reduces the symptoms of depression in treatment-resistant patients.

*Methods:* A retrospective chart review of 34 patients with a documented diagnosis of DSM-IV-TR major depressive disorder who received lamotrigine and met criteria for treatment-resistant depression was conducted. Data collection occurred at baseline and approximately 1, 3, 6, and 12 months between January 2000 and June 2004. A clinical data collection scale was used focusing on key study variables.

*Results:* Lamotrigine was initiated at 43 mg/d at one month and titrated up to 113 mg/d at 12 months. Results show a statistically significant reduction of scores as early as one month for the target symptoms of depressed mood, loss of interest, anxiety, irritability, (low) energy, and cognitive impairment. The difference from baseline remained statistically significant for these target symptoms at 3, 6, and 12 months (with the exception of irritability at six months). Additionally, the ''patient's response'' improved at all time points. Tiredness was the most common reason for discontinuation.

*Conclusion:* Lamotrigine added to an antidepressant regimen is an efficacious strategy for treating patients with treatment-resistant depression and has a tolerable side effect profile.

## TARGET AUDIENCE:

Psychiatrists.

## REFERENCES:

1. Roose SP, Glassman AH, Walsh BT, et al: Tricyclic nonresponders: phenomenology and treatment. Am J Psychiatry 1986; 143:345–348.
2. Thase MF: New approaches to managing difficult-to-treat depressions. J Clin Psychiatry 2003; 64: suppl I. 3–4.

**Poster 51** **Thursday, October 6**
**3:00 p.m.-4:30 p.m.**

## THE IMPACT OF ANTIDEPRESSANT WARNINGS ON PRESCRIPTION TRENDS

*Supported by AstraZeneca Pharmaceuticals*

Paul A. Kurdyak, M.D., *Research Fellow, Department of Psychiatry, Canadian Mental Health, 33 Russell Street, T-311, Toronto, ON, Canada M5S 2S1*; David N. Juurlink, M.D., Ph.D.; Muhammad M. Mamdani, Pharm.D.

## EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to understand the impact of types of antidepressant warnings on prescription trends.

## SUMMARY:

Between June 2003 and October 2004, four warnings about the possible increased risk of suicidal behavior during antidepressant therapy were released in the United Kingdom (UK) and North America. We explored the influence of these warnings on antidepressant prescribing trends using time-series analysis of new antidepressant prescriptions dispensed in Ontario in three age

categories (less than 20 years, 20 to 65 years, and greater than 65 years). Our main outcome measure was change in the rate of new antidepressant prescriptions in three antidepressant categories: paroxetine, other SSRIs, and newer antidepressants. The number new paroxetine prescriptions in patients less than 20 years of age dropped significantly immediately following the UK warning for paroxetine in June 2003 (P=0.01), but were not reduced in the other age categories. The UK warning had no effect on new prescriptions for other SSRIs or newer antidepressants in any age category. The North American warnings had no impact on new prescription rates for SSRIs or newer antidepressants. Antidepressant warnings that have a specific message and target a specific antidepressant result in change in prescribing behavior. Warnings that are less specific do not impact on prescribing behavior.

Funding sources: Canadian Institute of Health Research (CIHR) Rx&D/AstraZeneca/Canadian Psychiatric Research Foundation

## TARGET AUDIENCE:

Physicians and Policymakers.

## REFERENCES:

1. Jick H, Kaye JA, Jick SS: Antidepressants and the risk of suicidal behaviors. JAMA 2004; 292:338–43.
2. Waechler F: Paroxetine must not be given to patients under 18. BMJ 2003; 326:1282-b.

**Poster 52** **Thursday, October 6**
**3:00 p.m.-4:30 p.m.**

## LAMOTRIGINE AS MONOTHERAPY OR ADJUNCTIVE THERAPY FOR DEPRESSIVE SYMPTOMS

*Supported by GlaxoSmithKline*

Connie A. McKenzie, Pharm.D., *Employee, GlaxoSmithKline, Five Moore Drive, Research Triangle Park, NC 27709*; Kevin P. Nanry, *Employee, GlaxoSmithKline, Five Moore Drive, Research Triangle Park NC 27709*; Beth Bentley, Pharm.D.; Theodore Spankling, Ph.D.; Ronald Westlund, Ph.D.; Thomas R. Thompson, M.D.

## EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize and treat.

## SUMMARY:

*Objective:* We assessed the effects of lamotrigine monotherapy and adjunctive therapy in bipolar I patients with acute depressive symptoms.

*Methods:* Data were combined from the 8–16 week, open-label, preliminary phase of two lamotrigine maintenance trials for patients who were depressed (defined post-hoc as HAM-D17≥18 and MRS11<10). Patients received lamotrigine as monotherapy or concomitantly with other psychotropic medications.

*Results:* Of 1,305 enrolled patients, 897 had depressive symptoms and had efficacy assessments; 161 received lamotrigine monotherapy and 736 received lamotrigine as adjunctive treatment (most commonly antidepressants). Baseline HAM-D17 scores were similar for the monotherapy and adjunctive therapy groups (HAM-D=22.7 and 23.0, respectively). Mean change HAM-D17 scores at the end of the preliminary phase for the monotherapy group were −15 (observed case [OC] analysis) and −13 (LOCF analysis) and were −13 (OC analysis) and −12 (LOCF analysis) for the adjunctive therapy group. Patients on monotherapy had change scores that were statistically significantly greater ($p<0.05$) than those for patients on adjunctive therapy at the following timepoints (OC analysis: Weeks 1–8, 11, end of Preliminary Phase; LOCF analysis: Week 1, 3–8).

*Conclusion:* Lamotrigine may be useful for stabilization of acute bipolar depressive symptoms when used as monotherapy or adjunctive therapy.

## TARGET AUDIENCE:

Psychiatrists.

## REFERENCES:

1. Calabrese JR. Bowden CL. Sachs G. et al, Lamictal 605 Study Group: A placebo-controlled 18-month trial of lamotrigine and lithium maintenance treatment in recently depressed patients with bipolar I disorder. Journal of Clinical Psychiatry 2003; 64(9):1013–24.
2. Goodwin GM, Bowden CL, Calabrese JR, et al: A pooled analysis of two placebo-controlled 18-month trials of lamotrigine and lithium maintenance in bipolar I disorder. J Clin Psychiatry 2004; 65:432–441.

**Poster 53** **Thursday, October 6**
**3:00 p.m.-4:30 p.m.**

## PREVALENCE OF BIPOLAR DISORDER AND REAL WORLD UTILIZATION OF ATYPICAL ANTIPSYCHOTICS IN A MANAGED CARE POPULATION

*Supported by Janssen Pharmaceutica*

Dennis Meletiche, Pharm.D., *Manager, Outcomes Research, Janssen Pharmaceutica and Research Foundation, 1125 Trenton-Harbourton Road, P.O. Box 200, Titusville, NJ 08560-0200*; Michael S. Keith, Ph.D.; Ben

Gutierrez, Ph.D.; Angela Blount, M.P.H.; Steve Boccuzzi, Ph.D.

## EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to (1) understand utilization patterns of atypical antipsychotics in patients with Bipolar disorder enrolled in a managed care plan, and (2) recognize the prevalence of Bipolar disorder diagnosis, and understand dosing trends, and differences in compliance rates by atypical antipsychotic, use of mood stabilizers and other psychotropics in a managed care setting.

## SUMMARY:

*Study Objectives:* The objectives of this study were to determine the prevalence of bipolar disorder (BD) diagnosis and examine the utilization patterns of atypical antipsychotics in a managed care setting.

*Methods:* This was a retrospective, longitudinal, parallel cohort study using administrative claims. Subjects with a BD diagnosis and newly initiated on risperidone, olanzapine, or quetiapine between July 1, 2000, and December 31, 2002, were included in the study. Descriptive utilization measures were conducted over a 12-month period after initiation of treatment.

*Results:* The prevalence of BD diagnosis was 0.6%. There were 951 patients on risperidone, 1,660 on olanzapine, and 699 on quetiapine. During the follow-up period, over 65% of patients in each cohort were also treated with mood stabilizers (MS) and over 75% with antidepressants. The average antipsychotic daily doses were higher when used in combination with mood stabilizers (MS); risperidone, 1.8/2.0 mg (without MS/with MS); quetiapine, 159/182 mg; and olanzapine, 8.7/9.8 mg, and the compliance rate was 73% for all three cohorts receiving combination therapy with MS.

*Conclusions:* In this study of managed care enrollees, the prevalence of BD diagnosis appears to be lower than in the general population, while the utilization patterns of atypical antipsychotics were consistent with previously published naturalistic studies.

## REFERENCES:

1. Gianfrancesco F, Pesa J, Wang R: Comparison of mental health resources used by patients with bipolar disorder treated with risperidone, olanzapine, or quetiapine. J Manag Care Pharm 2005; 11(3):220–30.
2. Hirschfeld RM, Calabrese JR, Weissman MM, et al: Screening for bipolar disorder in the community. J Clin Psychiatry 2003; 64:53–59.

**Poster 54** **Thursday, October 6**
**3:00 p.m.-4:30 p.m.**

# A DOUBLE-BLIND, PLACEBO-CONTROLLED EVALUATION OF LAMOTRIGINE FOR OBESITY

*Supported by GlaxoSmithKline*

Charles H. Merideth, M.D., *Employee, Affiliated Research, 8989 Rio San Diego Drive, Suite 350, San Diego, CA 92108*; Chris Southard, M.A., *Employee, Affiliated Research, 8989 Rio San Diego Drive, Suite 350, San Diego, CA 92108*

## EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize and treat obesity with lamotrigine.

## SUMMARY:

*Objective:* Lamotrigine has been observed to decrease weight in patients as well as decrease appetite.

*Methods:* Patients were randomized to 200mg/day of lamotrigine or placebo. Eligibility included a body mass index (BMI) of 30-39.99. The primary endpoint was weight change after 26 weeks. Secondary endpoints included percent body fat and serum lipids. Analysis of covariance was carried out using change from baseline to week 26 or LOCF.

*Results:* Forty patients were randomized. The mean change in body weight from baseline to LOCF was $-6.4\text{lbs}^{\pm}$ 10.26 and $-1.21\text{lbs}^{\pm}$ 7.09 for lamotrigine and placebo, respectively. Mean baseline body weight was not statically different at baseline (207.9lbs-lamotrigine, 225.0lbs-placebo). There was a statistically significant difference (p=.0421) in mean change in BMI from baseline to LOCF $-1.5^{\pm}$ 2.78 and $-.01^{\pm}$ 1.05 for lamotrigine and placebo, respectively. No serious adverse events were reported. The most frequently reported adverse event was mild to moderate headaches for both treatment groups. There were no significant differences in the other secondary endpoints between the two treatment groups

*Conclusion:* Lamotrigine demonstrated a statistically significant difference in mean change in BMI, and a trend toward a decrease in body weight.

## TARGET AUDIENCE:

Psychiatrists.

## REFERENCES:

1. Aronne LJ, Segal KR: Weight gain in the treatment of mood disorders. J Clin Psychiatry 2003; 64 (suppl 8):22–29.
2. Potter D, Edwards KR, Norton J: Sustained weight loss associated with 12-month topiramate therapy. Epilepsia 1997; 38:1997:97.

**Poster 55** **Thursday, October 6 3:00 p.m.-4:30 p.m.**

## ADJUNCT QUETIAPINE FOR BIPOLAR DEPRESSION: NINE MONTH, OPEN-LABEL PROSPECTIVE TRIAL

Roumen V. Milev, M.D., Ph.D., *Mental Health Services, Providence Continuing Care Centre, 752 King Street, West, Kingston, ON, Canada K7L 4X3*; Gaby Abraham, M.D., *Department of Psychiatry, Queen's University Hospital, 752 King Street, West, Kingston, ON, Canada K7L 4X3*

### EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should (1) be aware of the longer-term use of adjunct quetiapine for patients with bipolar depression (2) be able to improve the outcome of treatment.

### SUMMARY:

*Objective:* Bipolar disorder is a chronic and disabling condition. While at least one-third of the time patients are depressed, mood stabilizers alone do not appear to help often. Attempts to treat them with antidepressants can provoke a switch to mania or increase the cycling pattern. With increasing number of reports suggesting that atypical antipsychotics are helpful, this study investigates the long-term role of quetiapine in achieving an antidepressant response.

*Method:* An open-label trial to assess the long-term response of patients with bipolar depression to quetiapine added to their usual treatment. Inclusion criteria: bipolar disorder type 1 or 2 (DSM IV), age 18 or above, currently depressed (HAM-D > 18), with no change of antidepressants for at least three weeks. Quetiapine was added open label and the dose increased, if tolerated, to 300 mg per day. Outcome measures were HAM-D, YMRS, CGI, and AIMS at base and then monthly.

*Results:* Nineteen patients were enrolled so far in this study, six males and 13 females. Data for 12 patients. (Last Observation Carried Forward, LOCF) at nine months: HAM-D21 reduced from 27.2 to 12.7, and CGI from 4.7 to 3.0. Only two patients discontinued due to side effects.

*Conclusions:* Quetiapine is effective and well tolerated in patients with bipolar depression when added to their usual treatment.

### REFERENCES:

1. Judd LL, Akiskal HS, Schettler PJ, et al: The long-term natural history of the weekly symptomatic status of bipolar I disorder. Archives of General Psychiatry 2002; 59(6):530–7.
2. Sajatovic M, Mullen JA, Sweitzer DE: Efficacy of quetiapine and risperidone against depressive symptoms in outpatients with psychosis. Journal of Clinical Psychiatry 2002; 63(12):1156–63.

**Poster 56** **Thursday, October 6 3:00 p.m.-4:30 p.m.**

## EFFICACY OF QUETIAPINE IN IMPROVING QUALITY OF LIFE IN BIPOLAR DEPRESSION

*Supported by AstraZeneca Pharmaceuticals*

Kitty Rajagopalan, Ph.D., *Employee, AstraZeneca Pharmaceuticals, 1800 Concord Pike, Wilmington, DE 19850*; Jean Endicott, Ph.D.; Wayne MacFadden, M.D.

### EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize the efficacy of quetiapine in improving health-related quality of life in patients with bipolar depression.

### SUMMARY:

*Objective:* To evaluate quality of life (QOL) in patients with bipolar depression treated with quetiapine monotherapy.

*Methods:* Patients with bipolar I or II disorder were randomized to receive quetiapine monotherapy 600 mg/d (n=180), quetiapine 300 mg/d (n=181), or placebo (n=181) in an eight-week, double-blind, placebo-controlled trial. QOL was evaluated using the 16-item short form of the Q-LES-Q at baseline, Week 4 and Week 8; Q-LES-Q scores were obtained by transformation of the linear average of the first 14 items with scores ranging from 0 to 100; higher scores indicate greater QOL.

*Results:* Baseline Q-LES-Q % maximum scores were low (quetiapine 600 mg/d group: 35.9 [n=157]; quetiapine 300 mg/d group: 39.5 [n=156]; placebo group: 36.0 [n=158]), consistent with poor QOL. At final assessment, the improvement in Q-LES-Q score was significantly greater in both quetiapine treatment groups (20.9 in the 600 mg/d group and 19.3 in the 300 mg/d group) than in the placebo group (11.5, $p<0.001$). Significant improvement was noted at Week 4 and continued to the final assessment in both quetiapine treatment groups versus placebo ($p\leq0.001$). Quetiapine was generally well tolerated.

*Conclusions:* Quetiapine monotherapy is effective in improving QOL in patients with bipolar depression.

Supported by funding from AstraZeneca Pharmaceuticals LP.

### TARGET AUDIENCE:

Psychiatrists.

### REFERENCES:

1. Cooke RG, Robb JC, Young LT, Joffe RT: J Affect Disord 1996; 39:93–97.

2. Endicott J, Nee J, Harrison W, Blumenthal R: Psychopharmacol Bull 1993; 29:321–326.

**Poster 57** **Thursday, October 6**
**3:00 p.m.-4:30 p.m.**

## COMPARISON OF THE FORMAL PUBLISHED HUMAN CLINICAL TRIAL DATABASES FOR THE SIX SSRI'S

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### EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to recognize the magnitude of the published data regarding the safety and efficacy of SSRIs. This will help clinicians understand research behind a frequently used class of medications.

### SUMMARY:

*Background:* Confidence in the predictability of the safety, tolerability, and efficacy of a medication is directly proportional to the magnitude and quality of its published clinical trials. The objective is to provide an assessment of the magnitude of information from well-controlled, systematic clinical trials.

*Methods:* Search PubMed (Medline) from 1966 to February 2003 for articles reporting randomized, controlled trials of citalopram, escitalopram, fluoxetine, fluvoxamine, paroxetine, or sertraline in humans. Used Reference Manager database software to manage retrieval. Analyzed citations and abstracts for trial information.

*Results:* The search retrieved 1,475 citations. Analysis indicates that articles represent 723 studies. There were more efficacy studies than safety studies. Drugs marketed for a longer period had more studies. The total number of safety studies was 419. There were 65 drug-drug interaction studies and 354 other safety studies. The total number of efficacy studies was 632.

*Conclusion:* It is important to study the safety and efficacy of SSRIs to help clinicians understand research behind a frequently used class of medications. The findings from this study provide information regarding the magnitude and the quality of data for safety and efficacy of SSRIs and make it available for clinicians using SSRIs. This information will help them to make an informed decision when using them.

### REFERENCES:

1. Geddes JR, Freemantle N, Mason J: SSRIs versus other antidepressants for depression.
2. Janica KPG, Davis JM, Preskorn SH, Aydf J: principles and practice of psychopharmacy.

**Poster 58** **Thursday, October 6**
**3:00 p.m.-4:30 p.m.**

## ACAMPROSATE IS SAFE AND WELL-TOLERATED FOR TREATMENT OF ALCOHOL DEPENDENCE

*Supported by Forest Pharmaceuticals, Inc.*

Richard N. Rosenthal, M.D., *Professor, Department of Psychiatry, St Luke's Roosevelt Hospital Center, 1090 Amsterdam Avenue, New York, NY 10025*; Allyson Gage, Assistant Director, *CNS Department, Forest Laboratories Inc., Harborside Financial Center, Plaza V, Jersey City, NJ 07311*; James Perhach, Ph.D.; Anita Goodman, M.D.

### EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to evaluate the safety and tolerability of acamprosate for the treatment of alcohol dependence; recognize treatment-emergent adverse effects in alcohol-dependent patients associated with acamprosate treatment.

### SUMMARY:

*Background:* Acamprosate, with adjunctive psychosocial support, has been shown to be effective for the maintenance of abstinence in alcohol-dependent patients.

*Methods:* Acamprosate safety was assessed in 4,234 alcohol-dependent patients in eight short-term (<=26 weeks) and five long-term (>=48 weeks) randomized, double-blind, placebo-controlled studies (U.S. and Europe). Eleven studies recorded adverse events (AEs) by spontaneous report from 3,725 alcohol-dependent patients, including 2,019 treated with acamprosate (1332–3000 mg/day) and 1,706 treated with placebo. Clinical laboratory tests and vital signs were recorded for all groups.

*Results:* Overall incidence of AEs was 61% for acamprosate compared with 56% with placebo. The majority of AEs in all groups were considered mild or moderate in severity, with discontinuation rates due to AEs comparable in both groups (8% for acamprosate, 6% for placebo in short-term studies; 7% for each group in long-term studies). The most commonly reported AE (>=3% in either treatment group) was diarrhea (16% acamprosate vs. 10% placebo). All AEs, including diarrhea, had the highest incidence in the first four weeks of treatment and subsequently declined to reach placebo levels. No clinically meaningful between-group differences were reported for any laboratory or vital sign parameters.

*Conclusion:* Acamprosate is a safe and well-tolerated medication for the maintenance of alcohol abstinence in patients with alcohol dependence.

Supported by funding from Forest Laboratories, Inc.

## TARGET AUDIENCE:

Addiction psychiatrists.

## REFERENCES:

1. Pelc I, Verbanck P, Le Bon, O, et al. Br J Psychiatry 1997; 171:73–77.
2. Sass H, Soyka M, Mann K, et al: Arch Gen Psychiatry 1996; 53:673–680.

**Poster 59** **Thursday, October 6 3:00 p.m.-4:30 p.m.**

## QUETIAPINE FOR THE TREATMENT OF BIPOLAR MANIA IN OLDER ADULTS

*Supported by AstraZeneca Pharmaceuticals*

Martha Sajatovic, M.D., *Associate Professor of Psychiatry, Case Western Reserve University, Cleveland VA Medical Center, 345 Timberidge Trail, Gates Mills, OH 44040-9319*; Jamie A. Mullen, M.D.; Joseph R. Calabrese, M.D.; Julia Kocal, Psy.D.

## EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize the potential treatment opportunities of quetiapine in older patients with bipolar mania.

## SUMMARY:

*Objective:* We report a secondary analysis from the quetiapine monotherapy clinical trials database among bipolar manic adults aged 55 years and older.

*Methods:* Data analysis combined results from two 12-week, double-blind, randomized, placebo-controlled studies comparing quetiapine and placebo for the treatment of bipolar I mania.

*Results:* Twenty-eight older adults and 181 younger adults received quetiapine; 31 older adults and 167 younger adults received placebo. Mean ages of the older group were 62.9 (SD 5.7) years in quetiapine-treated patients and 61.3 (5.0) years in placebo-treated patients, and mean ages of the younger group were 36.8 (9.7) and 37.0 (10.1) years, respectively. Both older and younger individuals receiving quetiapine had significant improvement from baseline in Young Mania Rating Scale (YMRS) scores. The older adult group demonstrated a particularly rapid and sustained reduction in YMRS score that was apparent by Day 4. For the quetiapine group, most common adverse effects were dry mouth, somnolence, and insomnia in younger patients and dry mouth, somnolence, postural hypotension, insomnia, weight gain, and dizziness in older patients.

*Conclusion:* This secondary analysis suggests quetiapine represents a potentially useful treatment option among older adults with bipolar I mania.

Supported by funding from AstraZeneca Pharmaceuticals LP.

## TARGET AUDIENCE:

Psychogeriatricians.

## REFERENCES:

1. Bowden CL, Grunze H, Mullen J, et al. J Clin Psychiatry 2005; 66:111–121.
2. McIntyre R, Brecher M, Paulsson B. Eur Neuropsychopharmacol 2005, in press.

**Poster 60** **Thursday, October 6 3:00 p.m.-4:30 p.m.**

## PREVALENCE OF BIPOLAR DISORDERS AMOUNG YOUNG ADULTS

Matthew Schumacher, M.A., *Clinical Psychiatry Doctoral Student, Department of Psychiatry, Northern Illinois University, Dekalb, IL 60115*

## EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to understand the prevalence of bipolar disorders among young adults and the utility of the MDQ in identifying individuals at high risk.

## SUMMARY:

*Objective:* To determine the prevalence of bipolar disorders (BD) in a young adult population using the Mood Disorders Questionnaire (MDQ Hirschfeld, et all 2000) and to describe factors associated with screening positive.

*Method:* Participants completed the MDQ, Suicidal Behaviors Questionnaire (SBQ-R), and the Beck Depression Inventory-II (BDI-II).

*Results:* A total of 181 college students who were 19.4+2.5 years, 52.2% Caucasian and evenly distributed by gender participated. Thirteen (7.2%) participants were MDQ positive. Of those, 23.1% and 46.2% reported historical suicide attempt and ideation, respectively. MDQ positives included 60% (3/5) of previous suicide attempts and 25% (6/24) of those reporting history of ideation. MDQ positives compared with negatives scored higher on both the SBQ-R (4.4+4.4 v. 1.2+2.2; p .001) and the BDI-II (19.2+10.5 v. 7.3+8.1 p .001).

*Conclusions:* Our results support recent work suggesting that rates of BD in young adults may be higher than previously thought, and may be associated with significant risk of suicide.

## TARGET AUDIENCE:

Psychiatrists & mental health professionals.

## REFERENCES:

1. Hirschfeld, et al: Screening for BD in the community. J Clin Psych 2003
2. Gutierrez, et al: Suicide risk assessment in a college student population. J Counseling Psychology

**Poster 61** **Thursday, October 6 3:00 p.m.-4:30 p.m.**

## DOES PAYER TYPE INFLUENCE TREATMENT METHOD IN ADULTS WITH DEPRESSION?

David A. Sclar, Ph.D., *Professor of Health Policy and Administration, Pharmacy Department, Washington State University, P.O. Box 646510, Pullman, WA 99164-6510*; Tracy L. Skaer, Pharm.D.; Linda M. Robison, M.S.P.H.

## EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to (1) recognize the nationwide magnitude of office visits for depression among adults 18–64 years old, and (2) recognize the existence of inequities in the use of treatment modalities for adults with depression by payer type (public versus private).

## SUMMARY:

*Purpose:* To examine whether the use of single and combination treatment modalities varies by public versus private payer, among adults age 18–64 years diagnosed with depression. Treatments include: (1) antidepressant pharmacotherapy alone, (2) psychotherapy alone, (3) the combination, or (4) no treatment.

*Methods:* Data from the 2002 U.S. National Ambulatory Medical Care Survey (NAMCS) were used for this analysis. Office-based physician-patient visits documenting a diagnosis of depression (*ICD-9-CM* codes 296.2–296.36; 300.4; or 311) were extracted from the NAMCS. Treatment modalities utilized in the management of depression are reported as percentiles by public versus private payer.

*Results:* During 2002, 20,552,341 office visits documented a diagnosis of depression (114.5 per 1,000 U.S. population). Twenty-two percent suffered additional comorbid mental disorders. Treatment modalities by public versus private payer respectfully were: (1) antidepressant alone, 60.4%, 52.9%; (2) psychotherapy alone, 3.6%, 12.1%; (3) the combination, 17.2%, 22.0%; (4) no treatment beyond the office visit, 18.8%, 13.1%.

*Conclusion:* Patients with a public payer were more likely to receive antidepressant pharmacotherapy alone, or no treatment, and less likely to receive psychotherapy, or combination treatment. Reasons for these inequities need further examination.

*Funding Source:* Pharmacoeconomics & Pharmacoepidemiology Research Unit, Washington State University.

## TARGET AUDIENCE:

Psychiatrists; health services researchers; stakeholders in public policy.

## REFERENCES:

1. Sclar DA, Robison LM, Skaer TL, Galin RS: What factors influence the prescribing of antidepressant pharmacotherapy? an assessment of national office-based encounters. Int J Psychiatry Med 1998; 28(4):407–419.
2. Sclar DA, Robison LM, Skaer TL, Galin RS: Ethnicity and the prescribing of antidepressant pharmacotherapy: 1992–1995. Harv Rev Psychiatry 1999; 7(1):29–36.

**Poster 62** **Thursday, October 6 3:00 p.m.-4:30 p.m.**

## THE ROLE OF PATIENT MEDICATION EXPERIENCE IN ANTIDEPRESSANT ADHERENCE

*Supported by Adheris, Inc.*

Mark R. Vanelli, M.D., *Chief Medical Officer, Adheris, Inc., 26 Bartlett Avenue, Burlington, MA 01803*; Marcelo Perraillon-Coca, M.A., *Senior Research Analyst, Adheris, Inc., 26 Bartlett Avenue, Burlington, MA 01803*; Yishu He, M.S.; Alex Pedan, Ph.D.

## EDUCATIONAL OBJECTIVES:

At the conclusion of this session, participants should be able to recognize that patients prescribed an antidepressant for the first time face the greatest likelihood of medication discontinuation 30 to 45 days after filling their initial prescription. Routine follow up and educational efforts at the time may improve antidepressant adherence and quality of care.

## SUMMARY:

*Objective:* Studies of patients with depressive and anxiety disorders under routine outpatient care suggest that apparent treatment failure is often due to poor medication adherence.

*Methods:* Kaplan-Meier survival analysis was used to compare the time-to-discontinuation over a 360-day period for 211,565 patients who filled a prescription for fluoxetine, sertraline, paroxetine cr, venlafaxine xr, citalopram, or escitalopram from October 1, 2003, to

March 31, 2004. Patients were divided into those without a history of antidepressant use in the prior 180-day period (rookies) and patients continuing antidepressant therapy (veterans). A proportional-hazards model quantified the relative risk between groups and included age, gender, index refills prescribed, co-pay, and income level as covariates.

*Results:* The median number of days to discontinuation was 67 days for rookies and 184 days for veterans. Risk of medication discontinuation was greatest at the time of the first refill. Veteran patients were 37.4% less likely to discontinue therapy.

*Conclusions:* This study helps identify who is at greatest risk of antidepressant discontinuation (patients new to therapy) and when (time of the first refill). A learning curve related to prior medication use appears to better predict adherence to antidepressants than age, co-pay level, gender, income, or the use of a specific antidepressant.

Funding Source: Adheris Inc., One Van de Graaff Drive, Burlington, Ma.

## TARGET AUDIENCE:

Psychiatrists, case managers, psychiatric nurses and outreach workers, health care administrators, medication benefits administrators, patients and family members.

## REFERENCES:

1. Melartin TK, et al: Continuity is the main challenge in treating major depressive disorder in psychiatric care. J Clin Psychiatry 2005; 66:220–227.
2. Cowley DS, Ha EH, Roy-Byrne PP: Determinants of pharmacologic treatment failure in panic disorder. J Clin Psychiatry 1997; 58(12):555–561.

**Poster 63** **Thursday, October 6**
**3:00 p.m.-4:30 p.m.**

# EFFICACY OF ZIPRASIDONE IN DYSPHORIC MANIA

*Supported by Pfizer Inc.*

Lewis E. Warrington, M.D., *Researcher, Pfizer Inc., 235 East 42nd Street, New York, NY 10017*; John M. Zajecka, M.D.; Stephen R. Murray, M.D., Ph.D.; Tanya Ramey, M.D., Ph.D.; Francine Mandel, Ph.D.

## EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to discuss the efficacy of ziprasidone in dysphoric mania based on the reported results of a dysphoric mania patients analysis in the ziprasidone bipolar mania trials.

## SUMMARY:

*Objective:* To evaluate efficacy of ziprasidone 80-160 mg/day in patients with bipolar mania who also exhibited dysphoria at baseline.

*Methods:* Data were pooled from two similar randomized, double-blind, three-week, placebo-controlled trials and from the first three weeks of a third study comparing ziprasidone and haloperidol with placebo. Dysphoria was defined as scores ≥2 on ≥2 of the SADS-C items 1–6, 16, and 20 (extracted HAM-D).

*Results:* Mean changes from baseline showed significantly greater improvement with ziprasidone (n=160) vs placebo (n=70) on the primary efficacy measures, as follows MRS-ziprasidone was superior to placebo at each visit, starting on day 2 ($p<0.001$); haloperidol (n=30) also was superior to placebo at each visit, starting at day 2 ($p<0.001$); CGI-S-ziprasidone was superior to placebo at all visits, starting on day 4 ($p\leq0.001$; P=0.03 for day 2), as was haloperidol (P≤0.005, day 4; $P<0.001$, day 7 forward). Results for the secondary efficacy assessments were as follows: HAM-D (extracted from the SADS-C)-ziprasidone was superior to placebo at each visit, starting on day 4 (P<0.01); haloperidol was superior to placebo only on day 14 (P=0.025); CGI-I-ziprasidone was superior to placebo at each visit, starting from day 3 forward (P=0.006, day 2; P<0.001, day 4 forward), as was haloperidol (P=0.02, day 2; P<0.001, day 4 forward); PANSS Total and Positive and GAF scores (endpoint)—ziprasidone was superior to placebo (P≤0.001).

*Conclusions:* In acutely manic bipolar I disorder patients with dysphoric mood (ie, dysphoric mania), ziprasidone demonstrated rapid symptom control and reduction of illness severity, with significantly improved overall functioning.

Supported by finding from Pfizer Inc.

## TARGET AUDIENCE:

Psychiatrists, psychopharmacologists.

## REFERENCES:

1. Keek PE, Jr. Versiani M. Potkin S, et al: for the Ziprasidone Mania Study Group. Ziprasidone in the treatment of acute bipolar mania: a three-week, placebo-controlled, double-blind, randomized trial. Am J Psychiatry 2003; 160:741–748.
2. Vieta E: Bipolar mixed states and their treatment. Expert Rev Neurother 2005; 5:63–68.

**Poster 64** **Thursday, October 6**
**3:00 p.m.-4:30 p.m.**

## LAMOTRIGINE FOR AFFECTIVE INSTABILITY IN BORDERLINE PERSONALITY DISORDER

*Supported by GlaxoSmithKline*

Wendy L. Weinstein, M.D., *Employee, Buffalo Medical Group, 295 Essjay Road, Williamsville, NY 14221*; Katrina L. Jamison, Pharm.D.

### EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize, treat

### SUMMARY:

*Objective:* This retrospective chart review was conducted to determine if lamotrigine is efficacious in treating affective instability in borderline personality disorder after other medications have failed.

*Methods:* Charts from a private practice were reviewed with the following inclusion criteria, patients must have been clinically diagnosed with borderline personality disorder according to the definition in the Diagnostic and Statistical Manual, Fourth Edition; must have continued to display affective instability on their previous medications before being started on lamotrigine; must have received a Clinical Global Impressions (CGI) Scale score pre and post lamotrigine therapy; must have been treated with lamotrigine, either as monotherapy or adjunct, at a dose ranging from 50mg/day to 200mg/day; and must have remained on lamotrigine for a minimum of three months.

*Results:* A total of 13 charts were reviewed. All patients were female and ranged in age from 19 to 43. All patients reported symptoms despite being on two to seven psychotropic drugs prior to lamotrigine therapy. Length of time on lamotrigine ranged for three to 15 months prior to the termination of the chart review. Initial CGI was 5–6 with a final CGI of 1–2 for all but one patient who had a final CGI score of 7.

*Conclusion:* Lamotrigine may be useful in treating patients with affective instability associated with borderline personality disorder either as an acute or long-term therapy.

### TARGET AUDIENCE:

Psychiatrists.

### REFERENCES:

1. American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition. Washington, DC, 1994.
2. Oldham J, Phillips K, Gabbard G, Goin M, et al: Practice Guidelines for the Treatment of Patients with Borderline Personality Disorder. APA Journ of Psychiatry. 2001; 158(10): suppl.

**Poster 65** **Thursday, October 6**
**3:00 p.m.-4:30 p.m.**

## THE IMPACT OF ANTIDEPRESSANT TREATMENT ON STATIN ADHERENCE

*Supported by GlaxoSmithKline*

Jeffrey B. Weilburg, M.D., *Depression Clinical and Research Program, Department of Psychiatry, Massachusetts General Hospital, 55 Fruit Street, Boston, MA 02114*; Kathleen M. O'Leary, B.A., *Data Analyst, Depression Clinical and Research Program, Department of Psychiatry, Massachusetts General Hospital, Zero Emerson Place, Suite 2G, Boston, MA 02114*; Richard W. Grant, M.D., M.P.H.; Stan N. Finkelstein, M.D.

### EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize the affect of antidepressant treatment on patients previously non-adherent to statin medications.

### SUMMARY:

*Background:* Depression or anxiety may negatively impact medication compliance in patients with chronic medical illness such as hyperlipidemia. We theorized that adequate AD treatment would improve statin adherence for patients with poor prior adherence.

*Method:* We analyzed 76 million pharmacy records of patients with statin prescriptions. We identified 5,659 patients on statin therapy with poor baseline adherence (<80% Medication Possession Ratio, defined as days dispensed/days between first and last prescription) who were newly started on ADs and continued statin therapy in the following year. We determined AD treatment adequacy and subsequent statin adherence.

*Results:* Statin MPR in the follow-up year increased from 61% to 80% for patients treated adequately with antidepressants compared with a 59% to 74% increase among inadequately treated patients ($p \leq 0.001$). Overall, the proportion of previously statin non-adherent patients with follow-up MPR > 80% was 56% among the adequately AD treated vs. 45% among inadequately AD treated patients ($p \leq 0.001$).

*Conclusion:* AD treatment improved statin adherence among patients with prior poor adherence. Patients receiving adequate AD treatment were significantly more likely to reach minimal acceptable statin adherence levels than those with inadequate treatment.

## TARGET AUDIENCE:

Psychiatric Clinicians and health policy administrators.

## REFERENCES:

1. Jackevicius CA, Mamdani M, Tu JV: Adherence with statin therapy in elderly patients with and without acute coronary syndromes. JAMA 2002; 288(4):462–467.
2. Weilburg JB, O'Leary KM, Meigs JB, Hennen J. Stafford RS: Evaluation of the adequacy of outpatient antidepressant treatment. Psychiatr Serv 2003; 54(9):1233–1239.

**Poster 66** **Thursday, October 6 3:00 p.m.-4:30 p.m.**

## ADEQUATE ANTIDEPRESSANT TREATMENT DOES NOT PREDICT A COST OFFSET

*Supported by Pfizer Inc.*

Jeffrey B. Weilburg, M.D., *Depression Clinical and Research Program, Department of Psychiatry, Massachusetts General Hospital, 55 Fruit Street, Boston, MA 02114*; Kathleen M. O'Leary, B.A., *Data Analyst, Depression Clinical and Research Program, Department of Psychiatry, Massachusetts General Hospital, Zero Emerson Place, Suite 2G, Boston, MA 02114*; Randall S. Stafford, M.D., Ph.D.; Stan N. Finkelstein, M.D.

## EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize the factors contributing to the ongoing high costs of antidepressant treatment.

## SUMMARY:

*Background:* Resolution of depression or anxiety with effective antidepressant (AD) treatment potentially can reduce post-treatment medical costs. A cost offset is present if averted medical costs exceed AD costs. We hypothesized that adequate, but not inadequate, AD treatment predicts a cost offset.

*Method:* We used pharmacy and medical claims from patients in a managed care plan from 7/99 through 12/03. Adequate AD treatment was defined as prescription of the lowest likely effective dose of an AD for at least one consecutive 90 day period.

*Results:* In the year before AD initiation, total medical cost/quarter were $756 for patients who went on to receive adequate treatment, and $735 for those who received inadequate treatment. In the year following treatment initiation, costs were $1,204/quarter for adequately and $895/quarter for inadequately treated patients. Treatment adequacy was the most powerful predictor of higher post treatment costs (OR = 1.94, 95% CI 1.69–2.22).

*Conclusions:* Contrary to expectations, adequately treated patients had increased post-treatment spending for non-psychiatric medical care and drugs, and also for ADs and psychiatric services. The hypothesized adequacy-related cost offset was not observed.

## TARGET AUDIENCE:

Psychiatric clinicians and health policy administrators.

## REFERENCES:

1. Thompson D, Hylan TR, McMullen W, Romeis ME, Buesching D, Oster G: Predictors of a medical-offset effect among patients receiving antidepressant therapy. Am J Psychiatry 1998; 155:824–7.
2. Weilburg JB, O'Leary KM, Meigs JB, Hennen J. Stafford RS: Evaluation of the adequacy of outpatient antidepressant treatment. Psychiatr Serv 2003; 54(9):1233–1239.

**Poster 67** **Thursday, October 6 3:00 p.m.-4:30 p.m.**

## PROPORTION OF PATIENTS TREATED WITH ANTIDEPRESSANTS EXCLUDED FROM HEDIS

*Supported by Pfizer Inc.*

Jeffrey B. Weilburg, M.D., *Depression Clinical and Research Program, Department of Psychiatry, Massachusetts General Hospital, 55 Fruit Street, Boston, MA 02112*; Vyshali Murthy, B.A., *Data Analyst, Massachusetts General Hospital, Zero Emerson Place, Suite 2-G, Boston, MA 02114*

## EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should recognize that the HEDIS measure for antidepressant management excludes a large percentage of patients who receive antidepressants.

## SUMMARY:

*Background:* Patients treated with antidepressants (ADs) in general medical settings often do not receive a claims diagnosis of depression. Patients without a depression diagnosis are excluded from consideration by the HEDIS antidepressant medication management (AMM) measures, and may therefore be overlooked when HEDIS is used to assess the quality of care for depression. We compared the total number of patients receiving ADs with the total included in the HEDIS antidepressant management measures to determine the proportion of patients excluded by the HEDIS measure.

*Method:* Pharmacy and medical claims from 2001 to 2003 for patients in a managed care plan associated with our institution were used to determine the number of patients receiving ADs, and the number eligible for inclusion into the HEDIS antidepressant measure.

*Results:* On average, over three years, 6.3% of patients receiving any AD medication were eligible for inclusion in the HEDIS antidepressant measure.

*Conclusion:* Approximately 94% of patients receiving AD medications were not eligible for inclusion in the HEDIS antidepressant measure. Obtaining a comprehensive understanding of AD use to evaluate quality may require inclusion of more patients than allowed by HEDIS.

Funding Source: Wyeth.

## TARGET AUDIENCE:

Psychiatric clinicians and health policy administrators.

## REFERENCES:

1. Way K, Young CH, Opland E, Whitehouse D, Hughes T: Antidepressant Utilization Patterns in a National Managed Care Organization. Drug Therapy 1999; 11:6BH–11BH.
2. NCQA, HEDIS 2005, Volume 2: Technical Specifications 2005. 2005; 134–39.

**Poster 68** **Thursday, October 6**
**3:00 p.m.-4:30 p.m.**

## EXTENDED-RELEASE CARBAMAZEPINE IN BIPOLAR I DISORDER: YOUNG MANIA RATING SCALE BREAKDOWN

*Supported by Shire US Inc.*

Richard H. Weisler, M.D., *Department of Psychiatry, University of North Carolina, 700 Spring Forest Road, Suite 125, Raleigh, NC 27609*

## EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to discuss recent research on carbamazepine extended-release capsules (CBZ-ERC) in the treatment of manic symptoms in bipolar I disorder and understand new data detailing the effects of CBZ-ERC monotherapy on each of the 11 items in the Young Mania Rating Scale.

## SUMMARY:

Recently, two clinical trials utilizing carbamazepine extended-release capsules (CBZ-ERC) (Equetro™; Shire, Wayne, Pa) have been completed. The efficacy of CBZ-ERC in reducing manic symptoms associated with bipolar I disorder was displayed in these two trials, as well as in the combined analysis of the two study populations. The primary treatment outcome in these trials was mean change in Young Mania Rating Scale (YMRS) score. The YMRS is an 11-item clinician-administered tool used to assess the degree of mania in persons with mood disorders. The purpose of this post hoc analysis is to evaluate the individual YMRS items that led to significant improvement in manic symptomatology in these two studies. Both trials included in this analysis were 21-day, randomized, double-blind, placebo-controlled, phase 3 studies. Pooled data from these two trials indicated that patients (manic and mixed combined) had significant reductions in mean YMRS score when given CBZ-ERC, compared with those patients given placebo ($P<.0001$). Subanalysis of the YMRS indicated a statistical improvement in 10 of 11 items on the scale. Significant improvements in areas such as irritability, language, sleep, mood elevation, and increased energy were seen. Data from YMRS items show a wide range of effectiveness for CBZ-ERC, indicating that no one area of improvement is responsible for the significant decrease in overall YMRS score seen in this population of patients with bipolar disorder.

Supported by Shire.

## TARGET AUDIENCE:

Psychiatrists.

## REFERENCES:

1. Weisler RH, Kalali AH, Ketter TA, and the SPD417 Study Group: A multicenter, randomized, double-blind, placebo-controlled trial of extended-release carbamazepine capsules as monotherapy for bipolar disorder patients with manic or mixed episodes. J Clin Psychiatry 2004; 65:478–484.
2. Weisler RH, Keck PE, Swann AC, Cutler AJ, Ketter TA, Kalali AH, for the SPD417 Study Group: Extended-release carbamazepine capsules as monotherapy for acute mania in bipolar disorder: a multicenter, randomized, double-blind, placebo-controlled trial. J Clin Psychiatry 2005; 66:323–330.

**Poster 69** **Thursday, October 6**
**3:00 p.m.-4:30 p.m.**

## EXTENDED-RELEASE CARBAMAZEPINE FOR MANIC EPISODES IN BIPOLAR I DISORDER

*Supported by Shire US Inc.*

Richard H. Weisler, M.D., *Department of Psychiatry, University of North Carolina, 700 Spring Forest Road, Suite 125, Raleigh, NC 27609*

## EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to comprehend new findings regarding the efficacy of carbamazepine extended-release capsules in ameliorating manic symptoms and overall symptom severity in patients with manic episodes in bipolar I disorder.

## SUMMARY:

Carbamazepine (CBZ) is a standard therapy for the treatment of acute mania. Several previous controlled evaluations of CBZ have been small or confounded by concomitant therapy with lithium or antipsychotics, and some have used immediate-release CBZ formulations. Recently, two clinical trials utilizing CBZ extended-release capsules (CBZ-ERC) (Equetro™; Shire, Wayne, Pa) have been completed. The purpose of this post hoc analysis of these trials is to evaluate the efficacy of CBZ-ERC in reducing manic symptoms associated with bipolar I disorder in the combined study population. Both trials included in this analysis were 21-day, randomized, double-blind, placebo-controlled, phase-3 studies that followed a five- to seven-day, single-blind, placebo lead-in period. Improvement in manic symptoms was assessed with the Young Mania Rating Scale (YMRS) and the Clinical Global Impression (CGI) scales. Pooled data from these two trials indicated that patients experiencing manic episodes had significant reductions in mean YMRS score when given CBZ-ERC, compared with those patients given placebo ($P<.0001$). Analysis of CGI-Improvement scores showed that the percentage of patients considered ''improved'' in the CBZ-ERC group at the primary end point was 55.6% vs 28.4% in the placebo group (LOCF analysis; $P<.0001$). Additionally, the severity of bipolar illness, as assessed by CGI-Severity scores, showed significant improvement from baseline in the CBZ-ERC group (LOCF analysis; $P<.0001$).

Supported by Shire.

## TARGET AUDIENCE:

Psychiatrists.

## REFERENCES:

1. Weisler RH, Kalali AH, Ketter TA, and the SPD417 Study Group: A multicenter, randomized, double-blind, placebo-controlled trial of extended-release carbamazepine capsules as monotherapy for bipolar disorder patients with manic or mixed episodes. J Clin Psychiatry 2004; 65:478–484.
2. Weisler RH, Keck PE, Swann AC, Cutler AJ, Ketter TA, Kalali AH, for the SPD417 Study Group: Extended-release carbamazepine capsules as monotherapy for acute mania in bipolar disorder: a multicenter, randomized, double-blind, placebo-controlled trial. J Clin Psychiatry 2005; 66:323–330.

**Poster 70** **Thursday, October 6**
**3:00 p.m.-4:30 p.m.**

# COGNITIVE EFFECTS OF LAMOTRIGINE MAINTENANCE TREATMENT IN BIPOLAR 1 DISORDER

*Supported by GlaxoSmithKline*

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## EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to assess the effect of lamotrigine over time on cognitive function.

## SUMMARY:

*Objective:* The objective of this analysis was to explore the neurocognitive effects of lamotrigine maintenance therapy in patients with bipolar I disorder (BPD-1) over time.

*Method:* Cognitive data from 542 patients with BPD-1 in two long-term maintenance studies of lamotrigine (N=213), lithium (N=153), and placebo (N=176) were assessed post hoc. The Medical Outcomes Study Cognitive Scale (MOS-Cog) and the AB-Neurological Assessment Scale (AB-NAS) were used as measures of cognitive functioning. Pattern mixture models were used to estimate the differential effect of treatment group on total MOS-COG scores over time, controlling for missing data patterns, baseline depression/mania severity, and history.

*Results:* More than 90% of subjects had at least one observed cognitive assessment in the randomized phase. Baseline depression scores (HAM-D) were a significant predictor of cognitive function; however, baseline mania scores (MRS) were not, suggesting that cognitive function was significantly associated with depression. The expected mean MOS-COG scores showed that cognitive function improved over time with lamotrigine therapy. However, the difference between lamotrigine, lithium, and placebo was not statistically significant. No significant time trends for the AB-NAS were found between treatment groups.

*Conclusion:* The effect of lamotrigine on cognitive function over time appeared to be similar to placebo.

*Funded:* Glaxo Smith Kline

## REFERENCES:

1. Calabrese J, Bowden C, Sachs G, Yatham L, et al. for the Lamictal 605 Study Group: Journal of Clinical Psychiatry 2003; 64:1013–1024.

2. Bowden C, Calabrese J, Sachs G, Yatham L, et al. for the Lamictal Study Group: Archives of General Psychiatry. 2003; 60:392–400.

**Poster 71** **Thursday, October 6**
**3:00 p.m.-4:30 p.m.**

## WHY ISN'T BUPROPION THE MOST FREQUENTLY PRESCRIBED ANTIDEPRESSANT?

Mark Zimmerman, M.D., *Director, Outpatient Psychiatry, Department of Psychiatry, Rhode Island Hospital, 235 Plain Street #501, Providence, RI 02905*; Michael Posternak, M.D.; Naureen Attiullah, M.D.

### EDUCATIONAL OBJECTIVES:

At the conclusion of the presentation, the participant should be able to discuss the factors used by psychiatrists to select antidepressant medication.

### SUMMARY:

Reviews of antidepressant medication efficacy suggest that all, antidepressants are equally effective. Bupropion is less likely than other antidepressants to cause weight gain and sexual dysfunction, the two side effects that are of greatest concern to patients and have the greatest impact on long-term compliance. If bupropion is as effective as other antidepressants, and it does not cause the side effects that are the most frequent causes of long-term noncompliance, then why isn't it the most frequently prescribed antidepressant medication? To understand psychiatrists' decision making at the time an antidepressant is chosen, we conducted the Rhode Island Factors Associated with Antidepressant Choice Survey (FAACS).

For 965 depressed patients initiated on an antidepressant, the treating psychiatrist completed a 43-item questionnaire listing factors that might have influenced the choice of medication. The questionnaire was filled out immediately after the antidepressant was prescribed to treat a depressive disorder.

*Results:* Bupropion was rarely prescribed when the presence of comorbid anxiety disorders or symptoms reflecting central nervous system activation influenced antidepressant selection. When the desire to avoid side effects, especially sexual dysfunction and weight gain, were the basis of selection, then bupropion was significantly more often prescribed than other antidepressants.

*Conclusions:* Although there is little evidence that patient factors predict differential medication response, psychiatrists are strongly inclined to base antidepressant selection on clinical profiles, and avoid prescribing bupropion for depressed patients with high anxiety. Possible reasons for the discrepancy between psychiatrists' prescribing habits and the results of empirical study are discussed.

There was no outside funding provided for this study.

### TARGET AUDIENCE:

Prescribing psychiatrists, primary care physicians and nurse practitioners.

### REFERENCES:

1. Zimmerman M, Posternak M, Friedman M, et al: Which factors influence psychiatrists' selection of an antidepressant? Am J Psychiatry 2004; 161:1285–1289.
2. American Psychiatric Association. Practice Guideline for the Treatment of Patients with Major Depressive Disorder (Revision) Washington, DC, 2000.

**Poster 72** **Thursday, October 6**
**3:00 p.m.-4:30 p.m.**

## PSYCHIATRIC DIAGNOSES AND MEDICATIONS IN FETAL ALCOHOL SPECTRUM DISORDERS

Julia H. Murray, M.D., *Clinical Assistant Professor, University of Washington, 2101 East Yesler Way, Suite 100, Seattle, WA 98122*; Heather Carmichael-Olson, Ph.D.; Rachel Montague, B.A.

### EDUCATIONAL OBJECTIVES:

At the conclusion of the presentation, the participant should be able to: (1) describe psychiatric diagnoses and psychotropic medications used for children with fetal alcohol spectrum disorders; and (2) recognize the complex issues involved in the treatment of this child population.

### SUMMARY:

*Introduction:* We describe psychiatric diagnoses and psychotropic medications used in community practice with a sample of children with fetal alcohol spectrum disorders (FASD) and externalizing behavior problems.

*Method:* Chart abstraction and review was performed for 50 school-aged children with FASD and significant externalizing problems enrolled in a therapeutic intervention. Community provider records from an approximately 1 1/2-year period were examined by a chold psychiatrist. Parent telephone survey was performed.

*Results:* 76% of children had received psychiatric diagnoses, including: ADHD (74%), learning disorders (26%), cognitive disorders (26%), disruptive behavior disorders (21%), and anxiety disorders (18%). Twenty-one children had two or more diagnoses. Twenty-three different psychiatric conditions were found. 56% had been prescribed psychotropic medications (mean=2.23

simultaneous medications), ranging from stimulants to atypical antipsycholics. Children had diverse other medical conditions. Prescribing professionals included psychiatrists (42%), primary care providers (50%), or both (8%).

*Conclusions:* A variety of psychiatric disorders are diagnosed in children with FASD and externalizing behavior problems. In community practice, psychotropic medication use is relatively common. A full range of medications are used, and polypharmacy occurs frequently. Treatment of alcohol-affected children is complex. Involving professionals with expertise in using psychotropic medications is advisable.

This research was supported by a grant awarded to Susan Astley, Ph.D., from the Centers for Disease Control, Grant # U84-CCU020163-01.

## TARGET AUDIENCE:

Professionals diagnosing and treating/prescribing for children with Fetal Alcohol Spectrum Disorders.

## REFERENCES:

1. Coe J, Sidders J, Riley K, Waltermire J, Hagerman R: A survey of medication responses in children and adolescents with fetal alcohol syndromes. Mental Health Aspects of Developmental Disabilities 2001; 4(4):148–155.
2. Famy C, Streissguth A, Unis A: Mental illness in adults with fetal alcohol syndrome or fetal alcohol effects. American Journal of Psychiatry 1998; 155(4):552–554.

**Poster 73** **Thursday, October 6 3:00 p.m.-4:30 p.m.**

## HEPATITIS C SCREENING IN BIPOLAR VETERANS: A RETROSPECTIVE CHART REVIEW

*Supported by Bristol-Myers Squibb Company*

Annette M. Matthews, M.D., *Psychiatry Resident, Oregon Health Science University, and 2004–2006 APA/Bristol-Myers Squibb Fellow, 3591 Southeast Francis, #E, Portland, OR 97202*; Peter Hauser, M.D., *Department of Psychiatry, Portland VA Medical Center, 782 Northwest Powhatan Terrace, Portland, OR 97210-2731*

## EDUCATIONAL OBJECTIVES:

Participants should know that hepatitis C has been targeted as the most important emerging blood-born pathogen in the Veteran's Administration health care system, bipolar disorder is associated with increased risk of both hepatitis C and alcoholism, and this comorbidity results in unique screening, harm reduction, and proscribing implications for those with bipolar disorder.

## SUMMARY:

*Objective:* To determine the rates of hepatitis C testing and diagnosis, risk factors, and comorbid substance abuse or dependence in bipolar veterans.

*Method:* Subjects included all 112 veterans enrolled in the Systematic Treatment Enhancement Program for Bipolar Disorder at the Portland Veteran's Administration Medical Center as of August 6, 2004. Charts were reviewed for demographic data (including era of service), testing and diagnosis of hepatitis C, and having a current or former substance use disorder.

*Results:* 82 (64.3%) of veterans were tested for hepatitis C and of these, 10 (12.3%) were positive for hepatitis C. Of the 10 patients positive for hepatitis C, all had at least one risk factor for hepatitis C: six had a current or past substance use disorder, and six were Vietnam era veterans (2 had both). Of the 30 veterans not tested for hepatitis C, 20 (60.0%) had at least one risk factor for hepatitis C: 13 had a current or past substance use disorder, and nine were Vietnam era Veterans (2 had both). There was no significant difference between those tested and not tested in the proportion of those with substance use disorders ($\chi^2$ =0.36, df=1, p=.850), nor those who served during the Vietnam era ($\chi^2$ =2.89, df= 1, p=.089). Alcohol was the predominant substance of abuse in both groups.

## REFERENCES:

1. Mishra G, Sninsky C, Roswell R, Fitzwilliam S, Hyams KC: Risk factors for hepatitis C virus infection among patients receiving health care in a Department of Veterans Affairs hospital. Digestive Diseases & Sciences 2003; 48:815–20.
2. el-Serag HB, Kunik M, Richardson P, Rabeneck L: Psychiatric disorders among veterans with hepatitis C infection. Gastroenterology 2002; 123:476–82.

**Poster 74** **Thursday, October 6 3:00 p.m.-4:30 p.m.**

## SUSTAINED REMISSION AFTER A SWITCH TO TREATMENT WITH A NEW ATYPICAL MEDICATION

*Supported by Pfizer Inc.*

Philip D. Harvey, Ph.D., *Professor of Psychiatry, Mount Sinai School of Medicine, 1425 Madison Avenue, Room L4-42, New York, NY 10029*; Christopher Bowie, Ph.D., *Instructor of Psychiatry, Mount Sinai School of Medicine, 1425 Madison Avenue, New York, NY 10029*; Peter F. Buckley, M.D.; Antony D. Loebel, M.D.

## EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to understand the prevalence and predictions of achieving remission with a new treatment.

## SUMMARY:

*Background:* A systematic definition of remission in schizophrenia has been recently proposed. We examined the development and prevalence of sustained remission in a sample of patients with schizophrenia whose medication was switched to ziprasidone.

*Methods:* One hundred and seventy-seven patients were switched from their previous treatment with risperidone, olanzapine, or conventional antipsychotics to open-label ziprasidone treatment. One hundred and thirty-seven patients were not in remission at baseline and 40 met the clinical criteria for remission at the baseline assessment. We rated their symptoms with the PANSS at baseline prior to the switch and after six weeks and six months of treatment.

*Results:* Of the patients who met clinical remission criteria at baseline, 85.7% sustained their remission for six months. Of the other patients, 40% met the symptomatic severity criteria for remission by six weeks. At six months, 43% of the patients met full remission criteria.

*Implications:* After a switch from previous treatment to open-label ziprasidone, more than half of patients with schizophrenia experienced sustained remission over six months. This response was rapid, detectable by six weeks, and sustained over six months for over 85% of the patients who achieved it.

This research was funded by Pfizer, Inc.

## TARGET AUDIENCE:

Clinicians treating schizophrenia.

## REFERENCES:

1. Anderson UC, et al: Remission in schizophrenia. Am J Psychiatry 2005; 162:441–449.
2. Weiden PJ, et al: Effectiveness of switching to ziprasidone. J Clin Psychiatry 2003; 64:580–588.

**Poster 75** **Thursday, October 6**
**3:00 p.m.-4:30 p.m.**

# A MODEL OF INTERGRATED TREATMENT FOR HOMELESS INDIVIDUALS WITH CO-OCCURRING DISORDERS

*Supported by Bristol-Myers Squibb Company*

Lorrie K. Garces, M.D., *Liaison, APA/IPS Scientific Program Committee; Psychiatry Resident, University of Florida College of Medicine; and 2004–2006 APA/Bristol-Myers Squibb Fellow, P.O. Box 100256, Gainesville, FL 32610*; Richard C. Christensen, M.D., M.A., *Clinical Associate Professor, and Director, Community Psychiatry Program, Health Science Center, University of Florida College of Medicine at Jacksonville, and Former APA/Bristol-Myers Squibb Fellow, 655 West 8th Street, Jacksonville, FL 32209*; David Miller, Ph.D.; Candace C. Hodgkins, Ph.D.; Kathleen L. Estlund, M.A.

## EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to identify components of a successful interagency, transdisciplinary system of integrated behavioral health care for individuals with co-occurring mental illness and substance abuse.

## SUMMARY:

Homeless individuals with co-occurring mental illness and substance abuse disorders are an especially vulnerable group who encounter multiple obstacles and barriers to treatment. The Seeking Treatment and Recovery (STAR) Program has been in existence in Jacksonville, Florida, for almost three years and has provided services to approximately 180 homeless individuals, to date, with co-occurring disorders. In addition to providing integrated psychiatric and addiction services, the program has also closely monitored the history of trauma among participating clients and considered this empirical data in programming development and implementation. This poster will outline a best practices model targeting homeless persons with co-occurring disorders and will highlight the aspects of this federally-funded initiative that make it the first and only interagency, transdisciplinary model of integrated behavioral health care for homeless persons in Northeast Florida. Six- and 12-month outcome data from the program showing changes in substance use, housing, depression (based on Beck's scale), and employment will also be reviewed.

## TARGET AUDIENCE:

Mental health clinicians, case managers and administrators working with homeless individuals with co-occurring disorders.

## REFERENCES:

1. Gonzalez G: Outcomes and service use among homeless persons with serious mental illness and substance abuse. Psychiatric Services 2002; 52: 437–446.
2. McQuiston HL, Finnerty M, Hirschowitz J, Susser ES: Challenges for psychiatry in serving homeless people with psychiatric disorders. Psychiatric Services 2003: 54:669–676.

# POSTER SESSION 3

## Posters 76–105

## TREATMENT AND TRAINING ISSUES

**Poster 76** **Friday, October 7**
**8:30 a.m.-10:00 a.m.**

### CHRONIC BACK PAIN SUCCESSFULLY TREATED WITH PSYCHOEDUCATION

Kola O. Alao, M.D., *Associate Professor of Psychiatry, State University of New York Upstate Medical University, 750 East Adams Street, Syracuse, NY 13210*; Shiming Wu, B.S., *Department of Psychiatry, State University of New York Upstate Medical University, 60 Presidential Plaza, #1208, Syracuse, NY 13202*; Ellen Faynberg, M.A.

### EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the clinician should understand the role of repressed emotions in the etiology of chronic back pain as well as treating chronic back pain in psychiatric patients.

### SUMMARY:

*Introduction:* Chronic back pain is one of the most frequently encountered clinical diagnoses by a primary care physician. Despite the fact that the impact of psychological functioning is well recognized in the etiology and treatment of chronic back pain, most interventions are focused on pain reduction and surgical intervention. This abstract describes an open-label study of five patients with chronic back pain. All patients were successfully treated with a structured program involving psychoeducation.

*Methods:* Five patients with chronic low back pain who failed various surgical interventions were assessed at baseline, six months, and at one year. All patients were examined to rule out any systemic illness such as malignancy. They were assessed subjectively regarding their level of disability/impairment and with the visual analogue pain scale (VAS). They were started in a structured program of psychoeducation. This involved requesting all patients to identify present and past sources of rage, previous physical, sexual, or emotional abuse; and to review the list on a daily basis. The patients were encouraged to discontinue or limit treatment that was directed at a structural abnormality. However, they were allowed to continue with their pain medications. Lastly, they were encouraged to resume non-strenous physical activities as the intensity of the pain subsided.

### TARGET AUDIENCE:

Psychiatrists, psychologists, social workers.

### REFERENCES:

1. Sarno JE: Healing Back Pain: The Mind Body Connection. New York, Warner Books, 1991.
2. Alao AO, Faynberg E. Chronic back pain successfully treated with supportive psychotherapy. West Afr J Med 2002; 21 (2):108–11.

**Poster 77** **Friday, October 7**
**8:30 a.m.-10:00 a.m.**

### SIX PATIENTS WITH INFERTILITY SUCCESSFULLY TREATED IN PSYCHODYNAMIC PSYCHOTHERAPY

Anne E.H. Bernstein, M.D., *Clinical Professor, Department of Psychiatry, Columbia University, 1160 Greacen Point Road, Mamaroneck, NY 10543-4611*; Lili A. Bernstein, B.A., *Doctorial Candidate, Department of Psychology, Ferkauf Graduate School, 274 West 96th Street, New York, NY 10025*

### EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to determine if psychodynamic treatment of female infertility without the use of psychotropic medications is feasible or not.

### SUMMARY:

*Objective:* To report clinical data about depressed female patients in psychotherapy who failed to achieve conception spontaneously or by medical/surgical means. These patients conceived after psychodynamic issues involving their mothers were resolved. Unexpectedly, the maternal conflict was resolved in the presence of an unremittingly positive maternal transference.

*Methods:* Six depressed women ages 35 to 40 were seen in psychoanalytically oriented psychotherapy for depression one to two times weekly for a period of between six months and two years. Each entered therapy to resolve marriage and career issues. When those were resolved, these women tried unsuccessfully to conceive, both naturally and with medical and surgical interventions. While trying to conceive, those not on antidepressants were not started on these medication, and those currently on antidepressants were tapered off. Five attempted artificial insemination with the husband's sperm. One of these five paused infertility treatment to try to come to psychodynamic terms with using a donor ovum and spontaneously became pregnant. One refused all artificial means of contraception. One had a child previously.

*Results:* All six conceived spontaneously after resolution of longstanding conflicts with their mothers. These conflicts were discussed but not reinacted in the transference. Some speculations are offered as to why this occurred.

*Conclusions:* Psychodynamic treatment of female infertility without use of psychotropic medications is feasible.

## REFERENCES:

1. Shedea A, Taglon P. Danhic J., Infertility and its Psychological Impact on Human Behaviors: Journal of Clinical Psychiatry, Vol. 14: 461–467.
2. Cunningham JA, Lin E, Ross HE, Walsh G. Factors Associated With Using Psychodynamic Psychotherapy to Treat Infertility. Psychol Med 2001; 31(6) 1001–1015.

**Poster 78** **Friday, October 7**
**8:30 a.m.-10:00 a.m.**

## HEALTH LITERACY IN AN OUTPATIENT PSYCHIATRIC POPULATION

Aurelia N. Bizamcer, M.D., M.P.H., Resident, *Department of Psychiatry, Temple University, 7961-65 Summerdale Avenue, Apartment A4, Philadelphia, PA 19111*; Ruth M. Lamdan, M.D., *Associate Professor, Department of Psychiatry, Temple University, 197 Lynnebrook Lane, Philadelphia, PA 19118*

## EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should recognize the impact of health literacy on health status, psychiatric illness, and adherence to psychiatric treatment.

## SUMMARY:

*Background:* The 1993 National Health Literacy Survey found an alarming 90 million Americans scored on two most basic literacy levels. Since then, an impressive literature emerged linking low literacy to poor health outcomes for chronic illnesses and underutilization of preventive services. To our knowledge there is no study of the association between low literacy and outcome of psychiatric patients. We have designed a study to attempt to shed light upon this possible association in our inner-city University Outpatient Psychiatry Department serving predominantly African-American and Latino patients.

*Methods:* With IRB approval, all the returning outpatients are invited to answer the Test of Functional Health Literacy in Adults (TOFHLA), a standardized, self-administered bilingual instrument. TOFHLA results will be correlated with demographic and clinical data collected through chart audit in an attempt to answer (1) what is the level of health literacy in this population of patients? (2) what are the determinants of the health literacy level in this population? and most importantly (3) how does health literacy influence adherence to treatment and outcome of psychiatric patients?

*Results:* We will present the preliminary results of this ongoing study, a review of the pertinent literature, and recommendations for future research and funding.

## TARGET AUDIENCE:

Community psychiatrists, health policy makers, residents, social workers.

## REFERENCES:

1. Agency for Healthcare Research and Quality: Evidence report/Technology assessment: Literacy and health outcomes. No. 87 2004. Available on-line. http://www.ahrq.gov/clinic/epcsums/litsam.htm.
2. Vastag B: Low health literacy called a major problem. JAMA 2004; 291(18):2181–2182.

**Poster 79** **Friday, October 7**
**8:30 a.m.-10:00 a.m.**

## DSM-IV DIAGNOSES OF PATHOLOGICALLY-BIASED PSYCHOTHERAPY PATIENTS

Edward W. Dunbar, Ed.D., *Department of Psychiatry, University of California at Los Angeles, Franz Hall, Los Angeles, CA 90024*; Desiree A. Crevecoeur, Ph.D., *Project Director, Department of Psychiatry, University of California at Los Angeles, 1640 South Sepulveda Boulevard #200, Los Angeles, CA 90025*

## EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to (1) identify clinical problems of pathological bias, (2) determine the role of bias as a violence risk factor, (3) consider the comorbidity of bias and DSM diagnostic issues.

## SUMMARY:

The base rates and comorbidity of pathological bias as a clinical problem were examined with 159 psychotherapy outpatients (study 1) and 36 claimants in a cleric abuse class action suit (study 2). Ratings were assigned for the Outgroup Hostility Scale (OHS), Outgroup Empathy Scale (OES), DSM-IV diagnoses, the MMPI-2, Gough's Pr scale, and MINI. In study one, 11.6% of the psychotherapy patients evidenced aversive and 12.6% empathic outgroup concerns. Outgroup aversive patients remained significantly longer in treatment and had higher MMPI-2 scale scores for F, Pa, and Pt. OHS scores were higher for men; patients in committed inter-

racial/ethnic relationships had higher OES scores. In study two, bias concerning gay men attributable to molestation experiences was found in 11.1% of the cases; OHS scores were correlated to lower GAF scores and MINI hypomania, hostility, and panic symptoms. Establishment of a methodology that examines bias as a mental health problem is considered in terms of assessment, treatment, and legal applications.

No Funding source for this study.

## TARGET AUDIENCE:

Practicing psychiatrists, forensic evaluators, clinical researchers.

## REFERENCES:

1. Bell CC: Racism: Diagnostic and Treatment Considerations. 150§/ APA Convention, 2003.
2. Dunbar E: Reconsidering the clinical utility of bias. Psychotherapy 2004.

**Poster 80** **Friday, October 7**
**8:30 a.m.-10:00 a.m.**

## ADJUNCTIVE ESZOPICLONE WITH FLUOXETINE FOR MAJOR DEPRESSIVE DISORDER AND INSOMNIA: SLEEP EFFECTS

*Supported by Sepracor Inc.*

H. Heith Durrence, Ph.D., *Manager, Publication Planning, Department of Medical Affairs, Sepracor Inc., 84 Waterford Drive, Marlborough, MA 01752*; Samuel M. Allen, Ph.D., *Medical Liaison, Department of Medical Affairs, Sepracor Inc., 84 Waterford Drive, Marlborough, MA 01752*; Daniel Buysse, M.D.; Vaughn McCall, M.D.; Robert Rubens, M.D.; Thomas Wessel, M.D., Ph.D.; Phoebe Wilson, M.S.; Judy Caron, Ph.D.; Thomas Roth, Ph.D.

## EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to evaluate the effects of adjunctive eszopiclone treatment in patients with insomnia associated with MDD during concurrent fluxetine treatment on measures or sleep and on daytime function.

## SUMMARY:

*Introduction:* Insomnia and depression can co-exist. This study evaluated the efficacy of eszopiclone in patients with MDD and comorbid insomnia during concurrent fluoxetine treatment.

*Methods:* Patients (n=545) met DSM-IV criteria for MDD and insomnia, including reported sleep latency (SL) ≥30 min (median 74), wake time after sleep onset (WASO) ≥45 min (median 90), and total sleep time (TST) ≤390 min (median 294). All patients received fluoxetine QAM, and were randomly assigned to double-blind treatment with eszopiclone 3mg or placebo QHS for eight weeks. Subjective sleep and daytime function were assessed weekly.

*Results:* Compared with placebo, eszopiclone was associated with significantly shorter SL and WASO and greater TST at each treatment week ($p<0.03$); higher ratings across the treatment period in sleep quality and depth ($p<0.005$); and higher ratings of daytime alertness, ability to concentrate, and well-being ($p\leq0.02$). The Insomnia Severity Index indicated that more eszopiclone patients had no clinically meaningful insomnia at Week 8 (55% versus 37%). Combined treatment was well tolerated. Unpleasant taste was more common with eszopiclone.

*Conclusions:* In this study, co-administration of eszopiclone with fluoxetine was well tolerated and associated with rapid, sustained improvement in sleep and daytime symptoms in patients with MDD and insomnia.

Support for this study provided by Sepracor Inc., Marlborough, Ma.

## TARGET AUDIENCE:

Psychiatrists who treat insomnia.

## REFERENCES:

1. Krystal Ad, et al.: Sustained efficacy of eszopiclone over 6 months of nightly treatment Sleep 2003; 26:793–9.
2. Londborg PD, Smith WT, Glaudin V, Painter Jr: Short-term cotherapy with clonazepam and fluoxetine: anxiety, sleep disturbance and dore symptoms of depression. J Affect Disord 2000; 61:73–79.

**Poster 81** **Friday, October 7**
**8:30 a.m.-10:00 a.m.**

## A CROSSOVER STUDY OF ESZOPICLONE IN THE TREATMENT OF PRIMARY INSOMNIA

*Supported by Sepracor Inc.*

H. Heith Durrence, Ph.D., *Manager, Publication Planning, Department of Medical Affairs, Sepracor Inc., 84 Waterford Drive, Marlborough, MA 01752*; Milton K. Erman, M.D., *Clinical Professor of Psychiatry, University of California at San Diego Medical School; Medical Director, San Diego Center; and Director of Medical Research, Pacific Sleep Medicine Services, 10052 Mesa Ridge Court, Suite 101, San Diego, CA 92121*; James K. Walsh, Ph.D.; Thomas Wessel, M.D., Ph.D.; Judy Caron, Ph.D.; David Amato, Ph.D.

## EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to evaluate the effects of treating primary insomnia in adults.

## SUMMARY:

*Objective:* Evaluate efficacy and safety of eszopiclone vs placebo in adults with primary insomnia.

*Methods:* Multicenter, double-blind, placebo-controlled, six-way crossover study. Patients received two nights of treatment with placebo, eszopiclone 1, 2, 2.5, and 3mg, or zolpidem 10mg in a random order. Visits were separated by a three to seven day washout.

*Results:* By polysomnography, all active treatments reduced latency to persistent sleep ($P \leq 0.0001$) and increased sleep efficiency ($P \leq 0.05$) compared with placebo. Only eszopiclone 3mg significantly reduced wake time after sleep onset and number of awakenings versus placebo ($P \leq 0.05$). All active treatment groups improved sleep quality and depth relative to placebo ($P < 0.05$). Morning sleepiness was significantly improved with eszopiclone 2.5 and 3mg vs placebo, but not with lower doses of eszopiclone or with zolpidem. Dizziness and somnolence were reported more with zolpidem 10mg compared with eszopiclone 3mg (combined incidence 20% for zolpidem, 9.4% for eszopiclone 3mg). Hallucinations were only reported following zolpidem 10mg (4.7%).

*Conclusions:* All treatments were effective in reducing time to sleep onset; only eszopiclone 3mg had a significant impact on PSG measures of sleep maintenance. In this study, eszopiclone 3mg was effective and well tolerated for the management of chronic insomnia in adults.

Support for this study provided by Sepracor Inc., Marlborough, Ma.

## TARGET AUDIENCE:

Psychiatrists who treat insomnia.

## REFERENCES:

1. Krystal AD, et al: Sustained efficacy of eszopiclone over 6 months off nightly treatment. results of a randomized, double-blind, placebo-controlled study in adults with chronic insomnia. Sleep 2003; 26:793–9.

**Poster 82** **Friday, October 7**
**8:30 a.m.-10:00 a.m.**

# PSYCHIATRIC COMORBIDITY IN 36 ADULT PATIENTS WITH MITOCHONDRIAL CYTOPATHIES

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## EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to gain basic knowledge about mitochondrial diseases, realize the high prevalence rates of depression and anxiety among patients with mitochondrial disease, and early recognition of mitochondrial diseases in patients presenting with atypical psychiatric complaints

## SUMMARY:

Mitochondrial cytopathies represent numerous specific disorders resulting in inadequate production of ATP within the mitochondria, resulting in a well-described variety of clinical presentations. Little is known about psychiatric comorbidity in mitochondrial disease.

*Objectives:* (1) Review patients with mitochondrial disease for prevalence of psychiatric co-morbidity (2) Review the temporal relationship between onset of the psychiatric symptoms and the ultimate diagnosis of the mitochondrial disease (3) Compare demographic, clinical, and quality of life measures in patients with and without psychiatric comorbidity.

*Methods:* Thirty-six adults with probable or definite mitochondrial disease were interviewed for demographic, medical, and psychiatric history. MMSE, Mini International Neuropsychiatric Interview (MINI), and the SF-36 Health Survey were performed.

*Results:* Seventy percent of the participants met criteria for major mental illness. Lifetime diagnoses for psychiatric co-morbidity included 54% major depressive disorder, 17% bipolar disorder, and 11% panic disorder. Currently, 11% met criteria for generalized anxiety disorder, 11% for dysthymia, and 6% for social phobia. Patients with mitochondrial disease and a psychiatric diagnosis were older ($p=0.05$), had significantly more hospital admissions ($p=0.02$), more medical conditions ($p=0.01$), positive family history of mitochondrial disease ($p=0.04$), and lower quality of life ($p=0.01$) than patients with mitochondrial disease alone.

*Conclusion:* Psychiatric problems are common in mitochondrial disorders. Mood disorders are more common than anxiety disorders. Clinicians caring for patients with mitochondrial disease should be aware of the high prevalence of psychiatric problems. Psychiatrists should consider the possibility of mitochondrial disease in patients presenting with physical signs and symptoms that are part of the mitochondrial spectrum.

## REFERENCES:

1. Massimo Zoviani M, Stefano Di Donato S: Mitochondrial disorders. Brain 2004; 127:2153–2172.
2. Chinnery PF, Schon EA: Mitochondria. Journal of Neurology, Neurosurgery, and Psychiatry 2003; 74(9):1188–1199.

**Poster 83** **Friday, October 7**
**8:30 a.m.-10:00 a.m.**

## ACAMPROSATE EFFICACY IN ALCOHOL-DEPENDENT PATIENTS

*Supported by Forest Pharmaceuticals, Inc.*

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### EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize that acamprosate is an effective treatment for alcohol dependence, using the most stringent definition of complete abstinence; appreciate that acamprosate provides incremental benefits to psychosocial support in reducing drinking among alcohol-dependent patients.

### SUMMARY:

*Background:* Acamprosate is indicated, in conjunction with psychosocial support, for the maintenance of abstinence in alcohol-dependent patients. Data from three previously published trials have been reanalyzed, applying a consistent definition of ''complete abstinence,'' the primary measure of efficacy.

*Methods:* Using uniform patient tracking and data recording methodology in the three double-blind, placebo-controlled, pivotal efficacy trials of acamprosate, the rate of complete abstinence was reassessed. Additional efficacy outcomes examined in this reanalysis were the percent days abstinent and time to first drink. For all efficacy parameters, dropouts were considered treatment failures. A total of 998 alcohol-dependent patients (623 treated with acamprosate 1,332 mg/day or 1,998 mg/day and 375 who received placebo) were included in the reanalysis.

*Results:* The efficacy of acamprosate was confirmed across all efficacy measures in all three pivotal studies. The rate of complete abstinence was statistically significantly higher with acamprosate 1,998 mg/day (16%-38%) compared with placebo (9%-13%, $p<0.05$). Both percent days abstinent and time to first drink were statistically significantly greater among acamprosate-treated patients compared with placebo ($p<0.01$).

*Conclusion:* Reanalysis of three pivotal trials using a more stringent definition of abstinence confirmed that acamprosate is effective in the treatment of alcohol dependence.

Supported by funding from Forest Laboratories, Inc.

### TARGET AUDIENCE:

Addiction psychiatrists.

### REFERENCES:

1. Paille FM, et al: Alcohol. Alcohol 1995; 30:239–47.
2. Pelc I, et al: Br J Psychiatry 1997; 171:73–7.

**Poster 84** **Friday, October 7**
**8:30 a.m.-10:00 a.m.**

## PROFILING SMOKING HABITS AND CESSATION AIDS IN A LONG-TERM PSYCHIATRIC PATIENT POPULATION

Jeffery J. Grace, M.D., *Clinical Director, Department of Psychiatry, Buffalo Psychiatric Center, 400 Forest Avenue, Buffalo, NY 14213*; Josie Lim Olympia, M.D., *Psychiatrist, Staff Growth Department, Buffalo Psychiatric Center, 400 Forest Avenue, Buffalo, NY 14213*; Reni L. Steinwachs, M.S.; Eileen Trigoboff, R.N.

### EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to (1) define Restricted Smoking, (2) list the potential impacts of restricted smoking on psychiatric treatment and recovery, (3) identify types of smoking cessation supports for this special population.

### SUMMARY:

Indoor smoking bans introduced new dimensions to nicotine dependence for psychiatric patients residing in long-term care, offering an opportunity to study how restricted smoking affects treatment and recovery. This study retrospectively gathered smoking habit information on schizophrenic/schizoaffective inpatients (N= 240) and residential/outpatients (N=123) of a state psychiatric facility. The effect of indoor smoking bans on smoking rates, addiction levels, motivation to quit, and violence levels was examined. Atypical and conventional antipsychotic use and the number of cigarettes smoked per day (CPD) were compared to see if there was any indication that use of atypical agents reduced the amount of smoking (N=149). Participants (N=25) were surveyed regarding preferred smoking cessation aids.

*Results:* the smoking rate for this population was high at 74% as compared with the rate in local counties for the general population at 19%. Number of CPD was notably higher in the less restrictive setting; inpatients had a mean of 7.5 CPD, while those in residential/ outpatient settings smoked a mean of 24.4 CPD. Staff perceived subjects' level of addiction as lower than subjects rated themselves. Subjects' self-reports of CPD were reflected in Carbon Monoxide readings. Reasons for Quitting Scale results were consistent with similar

samples of other published studies. Safety issues related to smoking occurred in 57% of inpatient subjects (N= 14). There were lower numbers of cigarettes smoked by individuals who were taking atypical antipsychotic medications than those taking conventional antipsychotics, although the difference was not statistically significant. Subjects' most preferred smoking cessation aid was the nicotine inhaler (32%, N=25).

*Conclusion:* Indoor smoking bans may impact safety/violence with long-term psychiatric patients; further study is warranted.

## TARGET AUDIENCE:

Clinicians serving Seriously and Persistently Mentally Ill recipients and recipients being treated in long term and intermediate hospital settings.

## REFERENCES:

1. Prochaska JJ, Gill P, Hall SM: Treatment of tobacco use in an inpatient psychiatric setting. Psychiatr Serv 2004; 55:1265–1270.
2. el-Guebaly N, Cathcart J, et al: Public health and therapeutic aspects of smoking bans in mental health and addiction settings. Psychiatr Serv 2002; 53:1617–1622.

**Poster 85** **Friday, October 7**
**8:30 a.m.-10:00 a.m.**

## EFFECTIVE TEACHING FOR PSYCHIATRY RESIDENTS: A PILOT PROGRAM

Tana A. Grady-Weliky, M.D., *Senior Associate Dean for Medical Education, and Associate Professor of Psychiatry and Obstetrics/Gynecology, University of Rochester School of Medicine and Dentistry, 601 Elmwood Avenue, P.O. Box 601, Rochester, NY 14642*; Linda H. Chaudron, M.D., *Assistant Professor of Psychiatry, University of Rochester School of Medicine and Dentistry, 300 Crittenden Boulevard, Rochester, NY 14642*; Sue DiGiovanni, M.D.

## EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to develop a curriculum for residents as teachers and recognize the value of such programs for medical student and resident education.

## SUMMARY:

Resident physicians provide up to 40% of medical student teaching, particularly in clinical clerkships. Residents are important role models and mentors for medical students in addition to their role in students' formal education. However, many residents are not fully prepared for their teaching roles and responsibilities because most undergraduate medical school curricula do not have formal courses on teaching. There are current accreditation mandates for residents to receive formal training in teaching and evaluation and to have an understanding of the institutional and core clerkship learning objectives. Although a growing body of literature on the development of curricula on ''teaching residents to teach'' exists in some medical specialties, there is a paucity of reports on this topic in general psychiatry residency education. In response to the need for a structured curriculum for teaching psychiatry residents how to teach, a brief course (4 hours) was created and implemented for PGY-2 general psychiatry residents at the University of Rochester School of Medicine and Dentistry. Course learning objectives are (1) understand the background and components of Rochester's Double Helix Curriculum (the medical student curriculum); (2) understand key learning theories; (3) learn practical teaching skills; (4) learn how to give effective feedback; and (5) understand the importance of role modeling and mentoring in medical education. A 12-item Likert-type instrument that assessed a range of items including level of comfort teaching peers, students, knowledge and use of specific teaching techniques and understanding of the medical student curriculum was completed before and after the course. Preliminary results demonstrate improvement in the resident's knowledge of the Double Helix Curriculum and their level of comfort in teaching students and peers. These data will be presented at the meeting. Development of curricula designed to ''teach residents how to teach'' will improve the overall education of resident physicians as well as medical students.

Development and implementation of this curriculum was supported by the Department of Psychiatry at the University of Rochester SMD.

## TARGET AUDIENCE:

Medical students residents, residency program directors, early career psychiatrists.

## REFERENCES:

1. www.psych.org/edu/resfellows/psychresident guide.pdf.
2. Wamsley MA, Julian KA, WipF JE: A Literature Review of ''Residents as-Teacher'' Curricula Do Teaching Courses Make a Difference? JBIH, 2004; 19:574–581.

**Poster 86** **Friday, October 7**
**8:30 a.m.-10:00 a.m.**

## APA/BRISTOL-MYERS SQUIBB FELLOWSHIP IN PUBLIC PSYCHIATRY: 25 YEARS OF SUCCESS

*Supported by Bristol-Myers Squibb Company*

Tana A. Grady-Weliky, M.D., *Senior Associate Dean for Medical Education, and Associate Professor of Psy-*

*chiatry and Obstetrics/Gynecology, 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 recognize the role of honorary fellowships in the personal and professional development of psychiatric residents.

## SUMMARY:

A variety of honorary fellowships have been designed to enhance the professional development of psychiatric residents. Roberts and colleagues demonstrated that participation in one of the honorary fellowship programs is beneficial to the career development of psychiatric residents. The American Psychiatric Association Bristol Myers Squibb (formerly Mead Johnson) Public Psychiatry Fellowship was created in 1980 to recognize psychiatric residents with a demonstrated interest and potential leadership ability in public psychiatry. Five years ago a survey was completed to measure the success of the APA/BMS honorary fellowship program. On the occasion of its silver anniversary, a follow up survey instrument was developed and implemented in an effort to further measure the success of the program through identification of the fellowship's role in the personal and professional development of 1980–2005 program alumni. In addition to demographic data, the survey included questions related to the participants' career achievements, such as leadership positions within national, regional, or community public and/or academic organizations; number of research grants, presentations or publications; and impact of the fellowship on the participants' ultimate career development. Results of the follow-up survey will be presented at the meeting.

Development of the survey and analysis of the results were jointly supported through an unrestricted educational grant from Bristol Myers Squibb and the Department of Psychiatry at the University of Rochester School of Medicine and Dentistry.

## TARGET AUDIENCE:

Residents, Residency Program Directors, Early Career Psychiatrists.

## REFERENCES:

1. Roberts LW, et al: Honorary Fellowship Awards and Professional Development in Psychiatry, Academic Psychiatry 1999; 23:210–221.

**Poster 87** **Friday, October 7**
**8:30 a.m.-10:00 a.m.**

# AN INTERDISCIPLINARY CLINICAL STATE-UNIVERSITY COLLABORATION: FIVE PLUS YEARS

Peg Grandison, M.S.W., *Clinical Administrator, University Medical and Dental of New Jersey Behavioral Health, 99 Central Avenue, Second Floor Administration, Greystone Park, NJ 07950*; Steven J. Schleifer, M.D., *183 South Orange Avenue, Newark, NJ 07103*; Jeffry R. Nurenberg, M.D.; Elaine Fitzgerald, R.N.; Kenneth Gill, Ph.D.; Janet Monroe

## EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to better understand the potential and realizable contributions of multidisciplinary state-university affiliations to clinical care in state hospital systems. In addition, the challenges associated with implementing such clinically-oriented collaborations and their secondary impact on teaching and research will be better understood.

## SUMMARY:

State-university collaborations tend to be structured around education or research, with psychiatry the primary collaborating discipline. Our state-funded collaboration (initiated 1999) includes a university team (n= 12–15) of nursing, psychiatry, rehabilitation, and social work faculty. Focusing on training, programming, and clinical care, it now extends to two hospitals (>1,200 patients). Goals include improved staff competencies, service delivery, and rehabilitation-recovery. Methods include on-site undergraduate courses, in-service training, program development, staff mentoring, and organizational and clinical consultation. Interventions by the multidisciplinary university team are largely at the multidisciplinary treatment team and unit level. Initial challenges included a residual custodial/symptom-oriented institutional culture, interdisciplinary differences (within university and hospital teams), and diffuse team leadership. Projects included team consultations (structural and patient care), nursing leadership consultation (nurse-directed-care model), therapeutic communication training, and out-of-bed, seclusion/restraint reduction and discharge readiness programs. Hospital-wide projects included task force co-leadership (discharge, an orientation/training unit, strategic planning projects) and participation on hospital committees. Certificate courses in rehabilitation are offered. Service-oriented research, an unanticipated outgrowth of the collaboration, has involved hospital staff, with faculty collaborators and mentors. Peer reviewed products have reported on polypharmacy reduction, nursing staff attitudes, valproate

toxicity, patient intrusiveness, discharge programming, and therapeutic engagement.

Supported by NJ Division of Human Services.

## TARGET AUDIENCE:

Psychiatrists, clinicians, administrators in public psychiatry settings

## REFERENCES:

1. Talbott, JA, Robinowitz, CB (Eds.): Working together: state-university collaboration in mental health. Washington, DC, American Psychiatric Press, 1986.
2. Fitzgerald E, Caldwell BA, McQuaide T: Working together to improve care: Collaboration between a State psychiatric hospital and an academic institution. J Psychosoc Nursing in press.

**Poster 88** **Friday, October 7**
**8:30 a.m.-10:00 a.m.**

## ONLINE RESOURCES FOR FINDING PSYCHIATRISTS

Alexander C. Green, M.D., *Psychiatrist, Private Practice, 12520 High Bluff Drive, Suite 375, San Diego, CA 92130*

## EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize online resources for improving visibility of their agencies, and identify useful web sites for finding and effectively referring to outside psychiatrists and allied mental health professionals in their communities. They will improve their ability to search the Internet for providers for their clients, and become more sophisticated at comparing the features, credibility, and usability of the many mental health professional/therapist directories.

## SUMMARY:

A major goal recommended by the New Freedom Commission is to use technology to maximize access to culturally appropriate and geographically relevant clinicians. Internet directories, perhaps the most valuable web resources of the future, are surprisingly underutilized by psychiatrists. Allied mental health professionals have been quicker to promote their expertise in this medium, but their numbers still remain limited. These web sites are used by a wide range of referral sources, including patients, colleagues, primary care physicians, attorneys, educators, and health care organizations. A survey of 76 APA DBs revealed that only half had unique web sites, and only a few contained directories of members were searchable by potential patients. Comparable medical directories differentiate at most about six subspecialties of psychiatry, and several charge a user fee.

This presentation reviews currently available online resources. This includes therapist directories, comparing their ''curb appeal,'' disciplines and profiles listed, and their internal search engine sophistication for such criteria as subspecialties, languages, and locations. Also noted are links, web promotion, friendliness, charges, and licensing details. Features are compared in a matrix on the poster for ease of analysis. The availability of these matching and referral mechanisms should be especially relevant to community mental health agencies.

This project is completely self-funded.

## TARGET AUDIENCE:

Mental health professionals and agencies who research for care providers.

## REFERENCES:

1. Internet searches for mental health resources—M.D. Computing, November/December 1999
2. According to the New Freedom Commission on Mental Health Achieving the Promise: Transforming Mental Health Care in America final report, the strongest recommendations are for improving access. Major goals included using technology to improve access to care that is appropriate, culturally competent, located in rural or geographically remote areas, and to coordinate with both the private and public sectors. Psychiatric News—August 15, 2003, Page 27.

**Poster 89** **Friday, October 7**
**8:30 a.m.-10:00 a.m.**

## ASSESSING PATIENT SATISFACTION IN AN OUTPATIENT PSYCHIATRY TEACHING FACILITY

Himani Janapana, M.D., *Resident, Department of Psychiatry, Brookdale Hospital, 7 Hegeman Avenue, Apartment #6A, Brooklyn, NY 11212*; Pierre A. Jean-Noel, M.D., *Resident, Department of Psychiatry, Brookdale Hospital, 7 Hegeman Avenue, Apartment #6A, Brooklyn, NY 11212*; Raj V. Addepalli, M.D.; Jeffery Braunstein, Ph.D.

## EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to compare patient satisfaction between psychiatry residents versus other clinicians.

## SUMMARY:

*Objectives:* To measure overall patient satisfaction with treatment and patient satisfaction as a function of

health professional's discipline and to compare patient satisfaction with residents versus attending physicians, and allied clinicians in a teaching outpatient psychiatry clinic.

*Methods:* A sample of 200 adult patients from outpatient psychiatry training clinic was chosen, of which 173 responded. Patients who consented completed the CSQ-8 Questionnaire and provided names of their respective treating clinicians. A chart review was conducted to obtain the demographic data. Descriptive statistics and analysis of variance (ANOVA) was conducted to examine patient satisfaction as a function of health professional category.

*Results:* No significant differences in patient satisfaction were found comparing residents, attending psychiatrists, licensed clinicians, and unlicensed clinicians. All the means were at three or above—high satisfaction across categories. No significant difference was found in patient satisfaction as a function of ethnicity, length of treatment, or DSM-IV Axis I diagnosis.

*Conclusions:* This study is the first to compare patient satisfaction with psychiatry residents versus other clinicians. Our results contradict previous studies conducted in the primary care setting where age, sex, and level of training of the provider had an effect on the level of satisfaction. The results concur with prior results done in a psychology-training clinic, which showed no difference in patient satisfaction depending on training status. However, our results contradicted studies that showed that satisfaction depended on age, sex, and ethnicity of patient, diagnosis, and length of treatment.

## TARGET AUDIENCE:

Residents, medical students, attendings and other clinicians in psychiatry.

## REFERENCES:

1. Moore KE, Kenning M: Assessing client satisfaction in a psychology training clinic. The Journal of Mental Health Administration 1996; 23:2:180–189.
2. Yancy Jr WS, et al: Patient satisfaction in resident and attending ambulatory care clinics. Journal of General Internal Medicine 2001; 16:755–762.

**Poster 90** **Friday, October 7**
**8:30 a.m.-10:00 a.m.**

## CLINICAL SUPERVISION IN THE NETHERLANDS

Jaap A. Kool, M.D., *Psychiatrist, St. Reinier van Arkel, P.O. Box 70058, 5201 DZ, Hertogenbosch, Netherlands*; Ida Boer de, M.D.; Robert Schoevers, M.D.; Paul Spronhem, M.D.

## EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to define useful strategies about how to supervise residents who are in training to become psychiatrists.

## SUMMARY:

The authors performed a qualitative survey on Clinical Supervision during residency in Psychiatry in The Netherlands. This research was performed at the request of the Board of Directors of Residency Training of the Dutch Psychiatric Association. It should be noted the Dutch distinguish patient and resident centred supervision.

100 Residents and 200 supervising psychiatrists were asked complete a questionnaire. Sixty seven residents and 109 psychiatrists responded. This poster presents definitions of clinical supervision, methods of research and the results of this survey.

We concluded that special training for supervisors is needed. In addition, a set of normative rules should be implemented to safeguard the interests of residents.

First, handling of fears and ''counter transference'' during residency must be the centre of training for supervisors. We recommend implementing a systems approach and an organizational perspective.

Objective and regular evaluation in terms of competencies (CANMEDS) should be used with clear evaluation standards. Strict rules should regulate communication on evaluations, problem resolution in case of conflicts, requirements for supervisors, etc.

## TARGET AUDIENCE:

The target audiences for this poster are directors of residency training, residents, and supervisors.

## REFERENCES:

1. Holloway E: Clinical Supervision, London; Sage Publications, 1995.
2. Elliot, RL, et al: Quality in psychiatric training Academic Psychiatry 2000; 24:41–46.

**Poster 91** **WITHDRAWN**

**Poster 92** **Friday, October 7**
**8:30 a.m.-10:00 a.m.**

## IMPACT OF ATYPICAL ANTIPSYCHOTICS ON TREATMENT EMERGENT DIABETES

*Supported by Eli Lilly and Company*

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*Alcazar Street., Room CHP140, Los Angeles, CA 90089*; Lei Chen, M.D., *Research Assistant, Department of Psychiatry, University of Southern California, 1540 East Alcazar Street, Room CHP140, Los Angeles, CA 90089*

## EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to better understand the differential impact of atypical antipsychotics on the risk of treatment-emergent diabetes relative to conventional antipsychotics in patients restarting antipsychotic drug therapy after a break in treatment.

## SUMMARY:

*Objective:* Estimate the impact of olanzapine, risperidone, and quetiapine on the risk of treatment-emergent diabetes relative to conventional antipsychotics.

*Methods:* Data from the California Medicaid program (Medi-Cal) were used to identify patients restarting treatment on an alternative drug after a break in therapy of greater than 15 days (N=32, 443). Patients with a diabetes diagnosis or who used a medication to treat diabetes, including insulin, in the six months prior to restarting antipsychotic treatment were excluded. Patients with treatment-emergent diabetes were then identified based on a diagnosis or drug use in a six-month post-treatment period. Multiple sensitivity analyses were conducted testing the robustness of results to the length of the pre- and post-treatment screening periods and other factors.

*Results:* This study found no evidence that the use of second-generation antipsychotics increased the risk of treatment-emergent diabetes relative to treating patients with conventional antipsychotics. Results were robust across multiple sensitivity analyses.

*Conclusion:* The risk of treatment-emergent diabetes did not increase with the use of second-generation antipsychotics, due in part to the selective use of these medications in patients at increased risk for this disease as evidenced in a negative correlation between their use and a history of diabetes.

Funding provided by Eli Lilly and Co.

## TARGET AUDIENCE:

Psychiatrist, Behavioral Health Benefit Managers.

## REFERENCES:

1. Rosack J: FDA to require diabetes warning on antipsychotics. Psychiatric News 2003; 38(20):1.
2. American Diabetes Association: Consensus development conference on antipsychotic drugs and obesity and diabetes (Consensus Statement). Diabetes Care 2004; 27:596–601.

**Poster 93** **Friday, October 7**
**8:30 a.m.-10:00 a.m.**

# LONG-TERM OUTCOME EFFECTS OF BEHAVIORAL THERAPY WITH PSYCHOSOMATIC INPATIENTS

Roll Meermann, M.D., *Medical Director, Psychosomatic Hospital, Bombergallee 10, Bad Pyrmont, Germany 31812*; Ernst-Jorgen Borgart, Ph.D., *Chief Psychologist, Psychosomatic Hospital, Bombergallee 10, Bad Pyrmont, Germany 31812*

## EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize the long-term effects of inpatient behavior therapy.

## SUMMARY:

The long-term effects of behavior therapy treatment with psychosomatic inpatients are analyzed in a two-year follow-up study.

The sample consisted of 229 inpatients particularly with depression, anxiety disorders, and eating disorders treated in the Psychosomatic Hospital Bad Pyrmont/ Germany and two other hospitals. Our patients received behavior therapy treatment lasting 54 days on average. At the beginning of treatment (T1), at the end of treatment (T2), and two years after discharge (T3) patients were personally interviewed. The effectiveness of therapy was measured by three questionnaires: the Psychosomatic Symptom Check-List (PSCL), the Beck Depression Inventory (BDI), and the Beck Anxiety Inventory (BAI). The patients who were fit for work (N=132) and those unfit for work (N=94) were also analyzed separately.

T-tests show that in all measures (PSCL, BDI, and BAI) patients improved significantly ($p<0.001$) from the beginning (T1) to the end of treatment (T2). The differences from the beginning up to two years later also remained significant ($p<0.001$). Our results show that psychologically tested therapeutic effects are relatively stable up to two years. The results suggest that patients fit for work show greater short-term improvements, whereas patients unfit for work seem to need more time to obtain comparable improvements.

## TARGET AUDIENCE:

Behavior Therapists.

## REFERENCES:

1. Borgart EJ, Meermann R: Stationäre Verhaltenstherapie-Behandlungskonzepte und Therapiemanuale. Bern: Huber, 2004.
2. Meerman R, Borgart E-J: Langzeitveränderungen stationärer Verhaltenstherapie bei psychosomat-

ischen. Patienten unter besonderer Berücksichtigung gesundheitsökonomischer Aspekte: Eine 2-Jahres-Katamnese. Der Nervenarzt, Suppl. 2 2004; 75, S304.

**Poster 94** **Friday, October 7**
**8:30 a.m.-10:00 a.m.**

## ECT: A TWELVE-MONTH SAMPLE FROM A COMMUNITY HOSPITAL

Brian P. Miller, M.D., *Psychiatrist, Grossmont Hospital, P.O. Box 158, La Mesa, CA 91944*; Rebecca Adams, R.N., *Registered Nurse, Department of Psychiatry, Grossmont Hospital, P.O. Box 158, La Mesa, CA 91944*

### EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize the diverse patient populations that can benefit from electroconvulsive therapy.

### SUMMARY:

Electroconvulsive therapy is one of the longest standing treatments available in psychiatry today. Safety and efficacy have been established in many different patient populations and for a variety of diagnoses. The most common diagnoses are affective disorder, followed by psychotic disorders. ECT can be used in special populations such as elderly patients, pregnant patients, and adolescents. Few comorbid medical conditions are absolute contraindications to ECT. Mental health laws provide a mechanism in which ECT can be administered to patients who are deemed incapable of giving informed consent.

We present data on a 12-month sample of patients who received at least one treatment of ECT either on an inpatient or outpatient basis at a community hospital in San Diego, California. Specifics characteristics such as gender, number of treatments, psychiatric diagnosis, comorbid axis II and axis III disorders, concomitant medications, anesthetic medications, complications, perceived efficacy, legal status, and ability to provide informed consent are included. This is followed by a short discussion regarding the trends in data and need for further education about the availability of ECT for a number of different patient populations.

### TARGET AUDIENCE:

Psychiatrists, psychologists, nurses, social workers.

### REFERENCES:

1. Abrams R: Electroconvulsive Therapy, third edition. Oxford University Press, Inc, 1997.
2. Fergusson GM, et al: Electroconvulsive therapy in Scottish clinical practice, J ECT 2004; 20:166–173.

**Poster 95** **Friday, October 7**
**8:30 a.m.-10:00 a.m.**

## PAIN MANAGEMENT: A PSYCHIATRIC-BASED, COMPREHENSIVE PAIN PROGRAM

Siavash Nael, M.D., *Medical Director, Neuropsychiatric, 4720 South Western Avenue, Oklahoma City, OK 73109-3834*; Angelia K. Moore, C.M.A.; Marie A. Stump, B.S.

### EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should understand the primary goals of cronic pain management including reduced pain level, and improved overall quality of life; and identify treatment modalities for chronic pain, such as medication management, psychosocial education, non-invasive pain treatments, and cognitive-behavioral therapy.

### SUMMARY:

This presentation focuses on the treatment of patients with chronic, intractable, non-malignant pain. The Intensive Outpatient Pain Program (IOP) uses a multidisciplinary approach to offer medical education, decrease pain perception, increase functioning, and improve overall quality of life. The IOP consists of three phases that address the complex physical, psychological, and social problems of patients with chronic pain syndrome. During Phase I, patients attend small group sessions daily for four weeks. They learn the biopsychosocial aspect of chronic pain, physical conditioning, nutrition, relaxation, acupuncture, biofeedback, and proper use of medication. Patients learn the difference between drug dependency, abuse, and addiction. They are encouraged to accept limitations caused by chronic pain, yet set realistic goals for the future. Families are encouraged to participate also. Phase II consists of weekly group sessions continuing medication management, education, and positive interactions through group dynamics, and lasts approximately three months. Phase III is the maintenance phase. All phases also focus on the recognition of psychiatric comorbidities, which will be managed and stabilized using pharmacotherapy, cognitive-behavioral therapy, group and family therapy. With continued medication monitoring, group support, and a sense of success, patients can continue to work toward rehabilitation and more productive lives.

### REFERENCES:

1. Costa PT, McCrae RR: The Essentials of Managing Pain. Arch Gen Psychiatry 2003; 58(7):661–671.
2. Colom F, Vieta E: The Biopsychosocial Aspects of Chronic Pain. JAMA 2003; 279:42–53.

**Poster 96** **Friday, October 7 8:30 a.m.-10:00 a.m.**

## TELEMEDICINE IN INTENSIVE CASE MANAGEMENT

Jose E. Nieves, M.D., *Department of Psychiatry, Veterans Hospital, 100 Emancipation Drive, Hampton, VA 23667*

### EDUCATIONAL OBJECTIVES:

At the conclusion of this session, participant should be able to identify uses for videophones in case management.

### SUMMARY:

Mental Health Intensive Case Management (MHICM) is community-based treatment for the severely mentally ill who are high users of psychiatric inpatient services. MHICM has successfully decreased bed days of care and admissions at the Hampton Va., yet there are still obstacles to overcome. The catchment area is extensive and case managers spend a considerable portion of their time traveling to make community visits. The patients also have high medical comorbidity that makes travel uncomfortable or impractical for them and results in missed visits and negative health outcomes.

MHICM began using videophones to increase access to medical support while being seen in community visits. Case managers carry the videophones to the veteran's home and if needed access the MHICM psychiatrist for evaluation of increased symptoms, medication side effects, etc.

A small pilot group of veterans were seen in this manner. In three months, eight veterans were seen using videophones. All had an increased total mental health contacts and no psychiatric emergency room visits. Neither the staff nor the veterans had any complaints about the use of the phones. Case managers expressed a high level of satisfaction with videophone technology as an adjunct to face to visits, particularly with those who have medical comorbidities. Plans are under way to expand their use.

### REFERENCES:

1. Cukor P, Baer L, Willis B, Leahy L, et al: Use of videophones and low-cost standard telephone lines to provide social presence in psychiatry. Telemedicine Journal 1998: 4(4):313–21.
2. Rotchild E: Telepsychiatry: Why do it? Psychiatric Annals 1999; 29:394–401.

**Poster 97** **Friday, October 7 8:30 a.m.-10:00 a.m.**

## INTERPERSONAL AND COMMUNICATION SKILLS TRAINING PROGRAM: PSYCHIATRY RESIDENTS

J. Kim Penberthy, Ph.D., *Department of Psychiatry, University of Virginia, Box 801210, Charlottesville, VA 22908*; Edward M. Kantor, M.D.; Zachariah C. Dameron III, M.D.

### EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant will be able to identify and understand the impact and necessity of teaching effective therapeutic interpersonal and communication skills to resident physicians and will be introduced to an innovative and effective program to maximize the teaching and assessment of this core competency.

### SUMMARY:

*Introduction/Hypothesis:* Interpersonal and communication skills are listed among the general competencies of the ACGME/ABMS, and are defined as ''the ability to develop a therapeutic relationship with patients and their families; use verbal and non-verbal skills to communicate effectively with patients and their families; [and] work effectively as a team member or leader.'' These skills are crucial to the education of residents, but are difficult to quantify, teach, and assess via traditional medical education.

*Methods:* We have developed an interpersonal/communication skills training program utilizing contemporary interpersonal theory and a well-researched, objective measure of interpersonal communications style, the Impact Message Inventory (IMI) to provide education, assessment, and feedback.

*Results:* Preliminary results indicate: (1) minimal intrusion of program in clinic flow; (2) high completion rates of the IMI for peers, patients, and resident physicians; (3) ratings on the IMI that are compatible with a therapeutic interpersonal stance, and indicative of appropriate interpersonal/communication skills for an effective initial interpersonal encounter.

*Conclusions/Discussion:* We have successfully developed and implemented an innovative, effective, and non-intrusive training and assessment program addressing interpersonal/communication skills that promotes a well-rounded educational experience for residents, and provides competency-based training and research quality assessment.

Research funded by GME Innovations Committee UVA Health System.

## TARGET AUDIENCE:

Psychiatry educators, supervisors, and residency training directors; psychiatrists; psychiatrists in training; professionals involved in educational research.

## REFERENCES:

1. Kiesler DJ, Auerbach SM: Integrating measurement of control and affiliation in studies of physician-patient interaction: the interpersonal circumplex. Social Science & Medicine 2003; 57(9):1707–1722.
2. Auerbach SM, Penberthy AR, Kiesler DJ: Opportunity for control, interpersonal impacts, and adjustment to a long-term invasive health care procedure. Journal of Behavioral Medicine 2003; 27(1), 11–29.

**Poster 98** **Friday, October 7**
**8:30 a.m.-10:00 a.m.**

## EVALUATION OF ESZOPICLONE OVER SIX MONTHS IN PATIENTS WITH INSOMNIA

*Supported by Sepracor Inc.*

Andrea J. Anderson, Pharm.D., *Director, Medical Education and Publication Plan, Department of Medical Affairs, Sepracor Inc., 84 Waterford Drive, Marlborough, MA 01752*; Robert Rubens, M.D., *Medical Director, Department of Medical Affairs, Sepracor Inc., 84 Waterford Drive, Marlborough, MA 01752*; Andrew Krystal, M.A.; James K. Walsh, Ph.D.; Thomas Roth, Ph.D.; Phebe Wilson, M.S.; Thomas Wessel, M.D., Ph.D.

## EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to evaluate the effects of treating primary insomnia in adults.

## SUMMARY:

*Introduction:* Eszopiclone is a non-benzodiazepine insomnia treatment. Results of a second randomized, double-blind, six-month study are presented.

*Methods:* Adults (age 21–64) with DSM-IV primary insomnia sleeping <6.5 hours and/or sleep latency (SL)> 30 minutes received nightly placebo (n=280) or eszopiclone 3mg (n=550) for six months, followed by a two-week placebo run-out. Patient-reported endpoints included sleep and daytime function (alertness, daytime sleepiness, ability to function/concentrate, physical well-being).

*Results:* At all monthly assessments, eszopiclone significantly improved SL, wake time after sleep onset (WASO), total sleep time (TST), and sleep quality versus placebo ($p<0.0001$). Eszopiclone patients had average changes from baseline of −39.8, −19.6, and 80.9 minutes for latency, WASO, and TST, respectively. The Insomnia Severity Index indicated that more eszopiclone patients had no clinically meaningful insomnia at Month 6 (50% versus 19%). Eszopiclone significantly improved all monthly daytime parameters vs placebo ($p<0.05$). Pharmacologic tolerance was not observed, nor was rebound insomnia or withdrawal effects. Eszopiclone was well tolerated; the most common adverse event was unpleasant taste.

*Conclusions:* Results were consistent with previous 12-month data and indicate that, in this study, nightly use produced consistent and sustained improvements across all sleep and daytime parameters, and was well tolerated with no pharmacologic tolerance, withdrawal or rebound insomnia.

Support for this study provided by Sepracor Inc., Marlborough, MA

## TARGET AUDIENCE:

Psychiatrists who treat insomnia.

## REFERENCES:

1. Krystal AD, et al: Sustained efficacy of eszopiclone over 6 months of nightly treatment Sleep 2003; 26:793–9.

**Poster 99** **Friday, October 7**
**8:30 a.m.-10:00 a.m.**

## EVALUATION OF ESZOPICLONE IN INSOMNIA ASSOCIATED WITH MENOPAUSAL TRANSITION

*Supported by Sepracor Inc.*

Robert Rubens, M.D., *Medical Director, Department of Medical Affairs, Sepracor Inc., 84 Waterford Drive, Marlborough, MA 01752*; Thomas Mariani, *Medical Liaison, Department of Medical Affairs, Sepracor Inc., 84 Waterford Drive, Marlborough, MA 01752*; Claudio Soars, M.D.; David Amato, Ph.D.; Thomas Roth, Ph.D.; Judy Caron, Ph.D.; Thomas Wessel, M.D., Ph.D.

## EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to evaluate the effects of treating sleep difficulty in patients with insomnia associated with menopausal transition.

## SUMMARY:

*Introduction:* Perimenopausal and menopausal women may develop insomnia. This four-week study evaluated the efficacy of eszopiclone 3mg for insomnia associated with perimenopausal transition.

*Methods:* Perimenopausal women (40–60 yrs; n= 201), without major psychiatric diagnoses, who met

STRAW stages −2, −1, or 1a, reported sleep latency (SL) ≥30min, and total sleep time (TST) ≤ 6hrs/night were randomized to eszopiclone 3mg or placebo nightly. Endpoints included SL, wake time after sleep onset (WASO), TST, awakenings due to hot flashes (HF), daytime HF, physician global evaluations (PGEs), and mood (Montgomery Aspberg Depression Rating Scale; MADRS).

*Results:* Eszopiclone produced significantly greater reductions in median SL (18.6 vs 8.1 min) and WASO (30.6 vs 16 min) each week versus placebo ($p<0.007$). The increase in TST was greater with eszopiclone (48.9 vs 29.7 min, $p<0.0002$). Eszopiclone, while not affecting frequency or duration of daytime HF, decreased nocturnal awakenings due to HF ($p<0.05$), and improved total MADRS scores ($p<0.03$) and PGEs ($p<0.0001$). Unpleasant taste was the most frequent adverse event with eszopiclone (17.7% vs 0.5%). Others adverse events were similar across groups.

*Conclusion:* In this study, eszopiclone significantly improved sleep, decreased nocturnal awakenings due to hot flashes, and positively affected mood in peri menopausal women.

Support for this study provided by Sepracor Inc., Marlborough, Ma.

## TARGET AUDIENCE:

Psychiatrists treating insomnia associated with menopause.

## REFERENCES:

1. Krystal AD, et al: Sustained efficacy of eszopiclone over 6 months of nightly treatment: results of a randomized, double-blind, placebo-controlled study in adults with chronic insomnia. Sleep 2003; 26:793–9.
2. Polo-Kantola P, Erkkola R: Sleep and menopause. J BR Menopause Soc 2004; 10:145–150.

**Poster 100** **Friday, October 7**
**8:30 a.m.-10:00 a.m.**

# ADJUNCTIVE ESZOPICLONE AND FLUOXETINE IN MAJOR DEPRESSIVE DISORDER AND INSOMNIA: DEPRESSION EFFECTS

*Supported by Sepracor Inc.*

Kendyl Schaefer, M.S., *Department of Medical Affairs, Sepracor Inc., 84 Waterford Drive, Marlborough, MA 01752*; Robert Herman, Medical Liaison, *Department of Medical Affairs, Sepracor Inc., 84 Waterford Drive, Marborough, MA 01752*; Vaughn McCall, M.D.; Maurizio Fava, M.D.; Thomas Wessel, M.D., Ph.D.; Robert Rubens, M.D.; Judy Caron, Ph.D.; David Amato, Ph.D., Thomas Roth, Ph.D.

## EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to evaluate the effects of adjunctive eszopiclone treatment in patients with insomnia associated with MDD during concurrent fluoxetine treatment on clinician-rated measures of depression.

## SUMMARY:

*Introduction:* Insomnia can co-exist with depression. This study evaluated eszopiclone and fluoxetine co-administration in depressed patients with comorbid insomnia.

*Methods:* Patients who met DSM-IV criteria for new MDD and insomnia received fluoxetine 20mg QAM plus either eszopiclone 3mg (n=270) or placebo (n=275) nightly for eight weeks. Efficacy was assessed using HAMD17 and Clinical Global Impression Improvement (CGI-I) and Severity (CGI-S). Response=50% decrease from baseline HAMD17; remission=HAMD17≤7.

*Results:* Eszopiclone co-administration resulted in significantly greater changes in HAMD17 scores at Week 4 (−10.0 vs −8.4 for placebo, $p=0.012$) with progressive improvement at Week 8 (−13.6 vs −11.5, $p<0.002$). At Week 8, significantly more eszopiclone patients were responders (59% vs 48%, $p<0.009$) and remitters (42% vs 33%, $p<0.03$). Even after removing insomnia items, significant changes in HAMD17 were found at Week 8 ($p<0.04$). HAMD17 differences were greater in patients with more severe depression (baseline HAMD17≥22). CGI-I and CGI-S scores were significantly improved with eszopiclone co-administration ($p<0.05$). Fewer eszopiclone patients required fluoxetine dose increases (44% vs 54%; $p<0.05$). Treatment was well tolerated; dropouts due to adverse events were comparable.

*Conclusions:* in this study, eszopiclone/fluoxetine co-administration significantly improved the clinician-rated antidepressant response in patients with MDD and insomnia.

Support for this study provided by Sepracor Inc., Marlborough, Ma.

## TARGET AUDIENCE:

Psychiatrists who treat insomnia.

## REFERENCES:

1. Krystal AD, et al: Sustained efficacy of eszopiclone over six months of nightly treatment. Sleep 2003, 26:793–9.
2. Breslau N, Roth T, Rosenthal L, Andreski P. Sleep disturbance and psychiatric disorders: a longitudinal epidemiological study of young adults. Biol Psychiatry 1996; 39:411–418.

**Poster 101** **Friday, October 7**
**8:30 a.m.-10:00 a.m.**

## EEG GUIDANCE OF PSYCHOPHARMACOLOGIC TREATMENT: MULTI-SITE EXPERIENCE

Mark J. Schiller, M.D., *Associate Clinical Professor of Psychiatry, University of California at San Francisco, 2299 Post Street, Suite 104A, San Francisco, CA 94115*; Stephen C. Suffin, M.D.; Warden H. Emory, M.D.

### EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: (1) understand the background and methodology of Referenced-EEG; (2) understand the clinical use of Referenced-EEG in guiding psychopharmacologic treatment; and (3) assess the potential benefits of use of Referenced-EEG in the treatment of non-psychotic treatment-refractory patients.

### SUMMARY:

*Introduction:* Referenced-EEG (rEEG) provides a neurophysiological basis for the selection of effective psychiatric medications for patients with non-psychotic psychiatric disorders. Referenced-EEG utilizes commonly used digital electroencephalography (EEG) in conjunction with normative and clinical treatment (symptomatic) databases to identify abnormal patient physiology. Appropriate medications are then statistically selected specifically to normalize identified electrophysiological abnormalities. This process has been correlated to treatment outcome in a database of over 1,600 patients and their cumulative 10,000 medication trials.

*Methods:* This is a multi-site case series to assess clinical outcomes to date and the value of further research. Psychiatrists in five clinical sites chose to use rEEG to guide psychopharmacologic treatment of non-psychotic, treatment-refractory psychiatric patients. They assessed clinical improvement using the CGI-Improvement Scale and rated the helpfulness of rEEG in achieving clinical outcome using a seven-point scale.

*Results:* A total of 247 patients were treated following Referenced-EEG guidance. In all, 182 (74%) of these treatment-refractory patients were rated as much improved or very much improved.

*Conclusions:* Referenced-EEG led to significant clinical improvement in a greater number of treatment-refractory patients than would normally be expected with standard treatment. These initial results warrant a randomized, double-blind study of this innovative, neurophysiologio-based technology.

### TARGET AUDIENCE:

Physicians treating non-psychotic, treatment refractory patients.

### REFERENCES:

1. Suffin SC, Emory WH: Neurometric subgroups in attentional and affective disorders and their association with pharmacotherapeutic outcome. Clin EEG Neurosci 1995; 26:76–83.
2. Emory WH, Schiller M, Suffin SC: Referenced-EEG in the Treatment of Eating Disorders. In New Clinical Drug Evaluation Unit 2004 Program Abstracts. Washington, DC, NCDEU, 2004, poster 221.

**Poster 102** **Friday, October 7**
**8:30 a.m.-10:00 a.m.**

## REEG-GUIDED PHARMACOTHERAPY FOR SEVERELY ILL, DUALLY DIAGNOSED PATIENTS

Jay H. Shaffer, M.D., *18091 Bee Canyon Road, Dulzura, CA 91917*; Mark J. Schiller, M.D., *Associate Clinical Professor of Psychiatry, University of California at San Francisco, 2299 Post Street, Suite 104A, San Francisco, CA 94115*; John Milner, M.D.

### EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to understand the basic technology and premises of referenced electroencephalography (rEEG), how it is used to guide pharmacotherapy, the general results of prior studies, and the specific findings of this first use of rEEG-guided prescribing in a severely ill population of dually diagnosed patients.

### SUMMARY:

*Introduction:* Free of drugs and alcohol for at least 21 days, 56 severely ill residents at Rancho L'Abri are treated with referenced electroencephalography (rEEG)-guided prescribing. In seven prior studies using rEEG-guided pharmacotherapy to treat non-psychotic DSM-IV diagnoses (N=422), 338 patients (80%) were rated much improved or very much improved. No prior reports using rEEG-guided pharmacotherapy in treating severely ill patients meeting *both* DSM-IV non-psychotic psychiatric illness *and* DSM-IV alcoholism/substance abuse criteria.

*Methods:* After 21 days drug/alcohol free, patients aged 14 to 62 evaluated for DSM-IV Diagnoses and Severity of illness on 7-point scale. After >6 weeks on medication, patients rated on a 7-point CGI Scale by treatment team. Physicians rated rEEG helpfulness in prescribing.

*Results:* 48 patients (83%) rated at least Markedly ill; 10 (17%) rated Mildly ill or Moderately ill 35 (73%) Markedly ill or worse patients rated Very Much Improved. 9 (90%) Mildly ill or Moderately ill group rated

Very Much Improved. rEEG guidance rated Essential in 58 cases (96%).

*Conclusions:* rEEG-guided prescribing yields both high quality and frequent clinical improvement in this severely ill and dually diagnosed population. While these findings compare with rEEG results in other populations, randomized, double-blind studies are needed to validate rEEG efficacy.

Supported by funding from CNS Response.

## TARGET AUDIENCE:

Physicians treating severely ill, dually diagnosed patients.

## REFERENCES:

1. Suffin SC, Emery WH: Neurometric subgroups in attentiona and affective disorders and their association with pharmacotherapeutic outcome. Clin EEG Neurosci 1995; 26:76–83.
2. Emory WH, Schiller M, Suffin SC: Referenced-EEG in the treatment of eating disorders in New Clinical Drug Evaluation Unit 2004 Program Abstracts. Washington, DC, NCDEU, 2004, poster 221.

**Poster 103** **Friday, October 7**
**8:30 a.m.-10:00 a.m.**

## TEACHING ELECTROCONVULSIVE THERAPY TO MEDICAL STUDENTS: EFFECTS OF METHOD

Ronald Lee Warnell, M.D., *Associate Professor of Psychiatry, Loma Linda University, 11374 Mountain View Avenue, Loma Linda, CA 92354*; Anthony D. Duk, M.D., *Resident, Department of Psychiatry, Loma Linda University, 11374 Mountain View Avenue, Loma Linda, CA 92354*; George W. Christison, M.D.; Mark G. Haviland, Ph.D.

## EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize the effect of using videotape and live demonstration of electroconvulsive treatment on knowledge of and attitudes towards ECT of medical students.

## SUMMARY:

*Objective:* To determine the effects of instructional method (live demonstration versus videotape) on medical students' knowledge of and attitudes toward electroconvulsive therapy (ECT).

*Methods:* Medical students (N=122 in their junior year psychiatry clerkship) were randomly assigned to either a live ECT demonstration or a 30-minute videotape containing instructional material and a demonstration. At the beginning and the end of the clerkship, knowledge of and attitudes toward ECT were assessed. To evaluate pre- and post-survey differences; we used repeated measures analysis of variance (ANOVA), one for knowledge scores and three for attitude scores.

*Results:* In the knowledge ANOVA, the clerkship effect was statistically significant (i.e., post-test scores were higher than pre-test scores). The group effect (live versus videotape), however, was not significant. In the attitudes ANOVAs, the clerkship effect was statistically significant (post-test scores were higher than pretest scores) in all three instances, and the group effect was not.

*Conclusion:* Both live demonstration and viewing a videotape of ECT appear to be equally effective methods for teaching ECT to medical students.

## TARGET AUDIENCE:

Psychiatric Educators; Academic ECT Programs.

## REFERENCES:

1. The Practice of Electroconvulsive therapy: Recommendations for Treatment, Training, and Privileging, Second edition. American Psychiatric Assoc., Wash, DC, 2001.
2. Tancer ME, Golden RW, Ekstrom RD, Evans DL: Use of electroconvulsive therapy at a university hospital. 1970 and 1980–81. Hosp. Community Psychiatry 1989; 40:64–68.

**Poster 104** **Friday, October 7**
**8:30 a.m.-10:00 a.m.**

## PSYCHOSIS IN EPILEPSY: A SURVEY

Christina M. Vanderfeltz-Cornelis, Ph.D., *Psychiatrist, Netherlands Institute of Mental Health and Addiction, Da Costakade 45, Utrecht, Netherlands*

## EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize four clusters of psychotic symptoms in epilepsy patients, recognize the clinical relevance of left-sided cerebral pathology, mental retardatian and PDD-NOS, and know a basic treatment algorithm for the several clusters.

## SUMMARY:

*Objective:* To establish the prevalence of psychotic disorder in clinical epilepsy patients, to describe the phenomenology, and to explore relevant pedisposing variables.

*Methods:* In this survey, a two-stage screening method was followed to describe all cases of psychosis in 901 consecutive patients in a tertiary care epilepsy clinic.

*Results:* A total of 126 of these patients with epilepsy were deemed to have a mental disorder after CIDI screening. Of these, 49 (38.9%) received a diagnosis of a DSM-IV psychotic disorder after a standardized psychiatric interview. Four psychotic symptom clusters were found: affective (34.6%), seizure-related (30.7%), chronic (18.3%), and stressor-aggression-related (16.4%). The cluster of seizure-related psychosis shows psychotic symptoms associated with seizure frequency and severity. Stressor-aggression-related psychosis occurs in more than half of cases of left-sided cerebral pathology, in mentally retarded patients. Treatment with atypical neuroleptics was effective and did not have an adverse effect on seizure control or antiepileptic drug use.

*Conclusions:* The notion that psychosis occurs more often in patients with epilepsy than in the general population is confirmed in this study. The high number of affective psychoses confirms the view that psychotic symptoms in epilepsy patients are preceded or accompanied by mood disorder. The psychosis of epilepsy should be considered a complex cerebral disorder, involving epilepsy, left-sided cerebral pathology, chronic psychosis, mental retardation, and other developmental disorders, such as PDD-NOS, and resulting in chronicity of symptoms and gradually occurring severe impairment of general functioning.

## REFERENCES:

1. Slater E, Beard AW: The schizophrenia-like psychoses of epilepsy I. psychiatric aspects. Brit J Psychiat 1963; 109:95–150.
2. Van der Feltz-Cornelis CM: Treatment of interictal psychiatric disorder in epilepsy. II. chronic psychosis. Acta Neuropsychiatrica 2002; 14:1:44–48.

**Poster 105** **Friday, October 7**
**8:30 a.m.-10:00 a.m.**

# PEER-FACILITATED PSYCHOEDUCATION FOR BORDERLINE PERSONALITY DISORDER

Kiera A. Van Gelder, M.A., *Director and President, Middle Path, 40 Elson Road, Waltham, MA 02451*; Kim K. Holt, B.A., *Vice President, Middle Path, 23 Lincoln Street, Arlington, MA 02476*

## EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to (1) understand the psychosocial interventions used in this model, (2) identify the benefits and limitations of peer-facilitated support for borderline personality disorder, and (3) recognize the value of educating consumers with BPD on their illness as a means of reducing stigma and empowering individuals to take control of their symptoms.

## SUMMARY:

This presentation discusses the development of a peer-facilitated psychoeducation model for individuals who have been diagnosed with BPD and who have achieved a level of stability through professional intervention but continue to experience distress around symptoms related to their illness.

The model relies on Dr. Perry Hoffman's definition of psychoeducation as ''a modality of treatment for a specific illness that includes engagement, education, coping skills training along with a set of guidelines for recovery and maintenance in conjunction with problem solving techniques for either illness, family stabilization, or both'' (Hoffman, 2005).

In this model, peer facilitators educate consumers on borderline personality disorder using a support group format interwoven with practices from Mary Ellen Copeland's Wellness Recovery Action Plan (WRAP) and Dr. Marsha Linehan's Dialectical Behavior Therapy. The aims of the group include stigma reduction, increasing self-management skills, illness education, and the development of a wellness plan for relapse prevention and, in the case of increased care, for self-direction and engagement with mental health professionals.

Developers of this program will present initial outcomes of a 12-week pilot group and discuss strategies for implementing this model in outpatient treatment and community settings.

## TARGET AUDIENCE:

Psychiatrists, clinicians, health care professionals, and rehabilitation counselors who treat individuals with borderline personality disorder.

## REFERENCES:

1. Hoffman, PD, Fruzzetti; AE. Psychoeducation, The American Psychiatric Publishing Textbook of Personality Disorders. Edited by Oldham J, Skodol A, Bender D. American Psychiatric Press Inc, 2005.
2. Lequesne ER, Hersh RG: Disclosure of a diagnosis of borderline personality disorder. Journal of Psychiatric Practice 2004; 10(3):170–176.

# POSTER SESSION 4

## Posters 106–142

## MENTAL HEALTH ISSUES ACROSS THE LIFESPAN

**Poster 106** **Friday, October 7**
**3:00 p.m.-4:30 p.m.**

### QUETIAPINE EFFICACY IN BIPOLAR ADOLESCENTS WITH DEPRESSIVE SYMPTOMS

*Supported by AstraZeneca Pharmaceuticals*

Henri Zepp, R.N.C., *Director, Clinical Insights, 7310 Ritchie Highway, #512, Glen Burnie, MD 21061*; Melissa P. DelBello, M.D.; Robert A. Kowatch, M.D.; K.E. Stanford, M.D.; Jeffrey A. Welge, Ph.D.; Stephen M. Strakowski, M.D.

### EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize that quetiapine reduces symptoms of depression and suicidal ideation in adolescents with bipolar disorder

### SUMMARY:

*Objective:* Investigate the efficacy of quetiapine in reducing depressive symptoms and suicidal ideation in adolescents with bipolar disorder in three prospective studies.

*Methods:* Study 1: 30 adolescents with mixed or manic episodes received quetiapine and divalproex or divalproex alone for six weeks. Study 2: 50 adolescents with mixed or manic episodes received quetiapine or divalproex monotherapy for four weeks. Study 3: 25 adolescents with mood disorder (major depressive disorder, bipolar disorder types I, II or NOS) and a parent with bipolar disorder received quetiapine for 12 weeks.

*Results:* Study 1: quetiapine (mean 423 mg/day) with divalproex reduced mean CDRS score from 50 to 24 ($P<0.0001$). Study 2: quetiapine (412 mg/day) decreased CDRS score from 52 to 25 ($P<0.0001$). Study 3: quetiapine (447 mg/day) decreased CDRS score from 40 to 29 ($P<0.0001$). CDRS suicidality item score decreased ($P<0.0001$) from 3.0 to 1.5 in 65 adolescents with episodes of depression and from 4.4 to 1.7 in 38 patients with baseline CDRS suicide item score > 1.

*Conclusions:* Quetiapine reduces depressive symptoms in adolescents with or at familial risk for bipolar disorder. Based on CDRS suicidality item score change, quetiapine may improve suicidal ideation in these patients.

Supported by funding from AstraZeneca Pharmaceuticals LP.

### TARGET AUDIENCE:

Child and Adolescent Psychiatrists.

### REFERENCES:

1. Calabrese JR, Keck PE Jr, Macfadden W. et al. Am J Psychiatry 2005, in press.
2. Delbello MP, Schwiers ML, Rosenberg HL, Strakowski SM: J Am Acad Child Adolesc Psychiatry 2002; 41:1216–1223.

**Poster 107** **Friday, October 7**
**3:00 p.m.-4:30 p.m.**

### UPDATE OF MEMANTINE SAFETY IN SHORT-AND LONG-TERM TREATMENT OF DEMENTIA

*Supported by Forest Pharmaceuticals, Inc.*

Gustavo Alva, M.D., *Deputy Director, Clinical Research Division, University of California, 101 The City Drive, Orange, CA 92868*; Martin Farlow, M.D.; Anton P. Porsteinsson, M.D.; Stephen M. Graham, Ph.D.; Eugene J. Schneider, M.D.; Jeffrey M. Jonas, M.D.; Albrecht Stoffler, M.D.

### EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to assess the safety and tolerability of memantine in the short- and long-term treatment of dementia.

### SUMMARY:

*Objective:* Memantine, a moderate affinity, uncompetitive NMDA-receptor antagonist, is approved for the treatment of moderate to severe Alzheimer's disease (AD) in the U.S. and is available in Europe. Safety and tolerability of memantine for dementia was assessed in eight controlled trials and five open-label extension studies.

*Methods:* Short-term safety of memantine in mild to moderate AD (N=1306; 24 weeks) and moderate to severe AD (N=734; 12–28 weeks) was assessed in six double-blind, placebo-controlled trials. Two 28-week, double-blind blind trials examined 900 mild to moderate vascular dementia (VaD) patients. Long-term safety was assessed by pooling data from five open-label extension studies in moderate to severe AD and VaD (N=1416; 24–104 weeks).

*Results:* Headache, confusion (AD trials), and constipation (VaD trials) were reported in ≥ 5% of memantine-treated patients at an incidence at least twice that of placebo. The overall AE profile in the long-term trials

was similar to the short-term studies in moderate to severe AD. Overall, most AEs reported were not judged by the investigator to be related to memantine and were not rated severe. No clinically relevant differences between memantine and placebo patients in vital signs or laboratory values were observed.

*Conclusion:* Short-and long-term treatment of dementia with memantine is safe and well tolerated.

*Funding Source(s):* Forest Laboratories, Inc. and Merz Pharmaceuticals GmbH

## TARGET AUDIENCE:

The target audience consists of general practitioners and geriatic specialists.

## REFERENCES:

1. Reisberg B, Doody R, Stöffler A, et al: Memantine in moderate-to-severe Alzheimer's disease. N Engl J Med 2003; 348(14):1333–1341.
2. Peskiad E, Potkin S, Pomara N, et al: Memantine monotherapy is effective and safe for the treatment of mild to moderate Alzheimer's disease a randomized controlled trial (abstract). Eur J Neurol, 2004; 11(Suppl2)186.

**Poster 108** **Friday, October 7**
**3:00 p.m.-4:30 p.m.**

## MEMANTINE AND INDIVIDUAL ACTIVITIES OF DAILY LIVING IN MODERATE TO SEVERE ALZHEIMER'S DISEASE

*Supported by Forest Pharmaceuticals, Inc.*

Paul LeVasseur, *Employee, Forest Pharmaceuticals, Inc., 909 Third Avenue, New York, NY 10022*; Howard Feldman, M.D.; Frederick A. Schmitt, Ph.D.; Eric A. Pfeiffer, M.D.; Stephen M. Graham, Ph.D.

## EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to assess the efficacy of memantine on functional abilities in moderate to severe Alzheimer's disease patients based on measures of individual activities of daily living.

## SUMMARY:

*Objective:* Alzheimer's disease (AD) leads to functional decline, affecting activities of daily living (ADLs). Memantine is a moderate affinity, uncompetitive NMDA-receptor antagonist approved for moderate to severe AD in the U.S. and is available in Europe. This report analyzed the effect of memantine on ADLs.

*Methods:* Two double-blind, placebo-controlled U.S. trials evaluated the efficacy of memantine in moderate to severe AD. The 28-week trial evaluated memantine monotherapy; the 24-week trial evaluated memantine on donepezil-treated patients. Both used the 19-item Alzheimer's Disease Cooperative Study-Activities of Daily Living Inventory (ADCS-ADL(19)). Total score and item analyses were performed (OC and/or LOCF).

*Results:* For both trials, ADCS-ADL(19) total scores demonstrated significantly less deterioration for memantine versus placebo (P<.05). Items demonstrating statistical significance in the 28-week trial were: makes conversation, clears a table, disposes of litter (P<.05). For the 24-week trial significant items were: grooming, watching television, being left alone, finding belongings (P<.05). When the 24-week trial ADLs were consolidated into four subscales, statistical significance favoring memantine was found on higher level functions and autonomy (P<.05).

*Conclusions:* These data suggest that memantine provides benefit in ADL performance in moderate to severe AD, and that memantine has measurable benefits on autonomy and higher level functioning.

*Funding Source:* Forest Laboratories, Inc. and Merz Pharmaceuticals GmbH

## TARGET AUDIENCE:

The target audience consists of general practitioners and geriatric specialists.

## REFERENCES:

1. Tariot P. Farlow M, Grossberg G. et al: Memantine treatment in patients with moderate to severe Alzheimer disease already receiving donepezil: a randomized controlled trial. JAMA 2004; 291(3):317–324.
2. Reisberg B, Doody R, Stöffler A, et al: Memantine in moderate-to-severe Alzheimer's disease. N Engl J Med 2003; 348(14):1333–1341.

**Poster 109** **Friday, October 7**
**3:00 p.m.-4:30 p.m.**

## META-ANALYSIS OF SIX-MONTH MEMANTINE CLINICAL TRIALS IN ALZHEIMER'S DISEASE

*Supported by Forest Pharmaceuticals, Inc.*

Paul LeVasseur, *Employee, Forest Pharmaceuticals Inc., 909 Third Avenue, New York, NY 10022*; Rachelle S. Doody, M.D., Ph.D.; Pierre N. Tariot, M.D.; Eric A. Pfeiffer, M.D.; Jason T. Olin, Ph.D.; Stephen M. Graham, Ph.D.

## EDUCATIONAL OBJECTIVES:

At the conclusion of this session, audience participants should be able to explain the benefit of memantine treatment on cognition, function, and global status. Audience

participants should be able to identify the favorable safety and tolerability of memantine treatment in AD patients.

## SUMMARY:

*Objective:* Memantine is a novel Alzheimer's disease (AD) therapy approved in the U.S. for moderate to severe AD and is available in Europe. Evidence for its efficacy and safety in AD comes from six six-month, large-scale, placebo-controlled trials.

*Methods:* Six randomized, parallel-group trials compared memantine (20 mg/day) with placebo. Two trials included patients on stable cholinesterase inhibitor treatment, one in moderate to severe AD and one in mild to moderate AD. Measures analyzed included cognition, function, global status, and behavior.

*Results:* Significant differences between the memantine and placebo groups were observed on cognition (P=.001), function (P=.02), and global status (P<.0001), but not on behavior (P=.16). Evidence of heterogeneity occurred on measures of cognition (LOCF), behavior (LOCF), and function (OC). Differences between treatment groups in efficacy were not driven by an outlier trial. OC findings were similar in magnitude to LOCF. The rate of all cause discontinuations for memantine (16.8%) was lower than placebo (19.9%). The rate of serious adverse events for memantine was similar to placebo (11.8% vs. 12.1%).

*Conclusions:* This meta-analysis of six-month trials in AD indicates that memantine imparts a statistically significant benefit over placebo on measures of cognition, function, and global status with good safety and tolerability.

*Funding Source:* Forest Laboratories, Inc., Merz Pharmaceuticals GmbH., and H. Lundbeck A/S.

## TARGET AUDIENCE:

The target audience consists of general practitioners and geriatric specialists.

## REFERENCES:

1. Reisberg B, Doody R, Stöffler A, et al: Memantine in moderate-to-severe Alzheimer's disease. N Engl J Med 2003; 348:1333–41.
2. Tariot, PN, Farlow M, Grossberg G, et al: Memantine treatment in patients with moderate to severe Alzheimer disease already receiving donepezil: a randomized controlled trial. JAMA 2004; 291:317–24.

**Poster 110** **Friday, October 7**
**3:00 p.m.-4:30 p.m.**

# INPATIENT MENTAL HEALTH TREATMENT OF YOUTH IN U.S. COMMUNITY HOSPITALS

Brady G. Case, M.D., *Resident, Department of Psychiatry, New York University Medical School, 1 West 72nd Street, #46, New York, NY 10023*; Mark Olfson, M.D.; Steven C. Marcus, Ph.D.

## EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to describe trends in inpatient treatment of child and adolescents with mental disorders between 1990 and 2000.

## SUMMARY:

*Objective:* Previous work has demonstrated marked changes in inpatient mental health service utilization by children and adolescents in the 1980s and early 1990s, but more recent comprehensive, nationally representative data are unavailable. This ponter examines trends in the inpatient treatment of children and adolescents aged 17 and younger with mental disorders between 1990 and 2000.

*Method:* The authors analyze data from the Healthcare Cost and Utilization Project Nationwide Inpatient Sample, a nationally representative sample of discharges from U.S. community hospitals.

*Results:* While the total number of discharges, population adjusted discharge rate, and daily charges did not significantly change, the total number of inpatient days and mean charge per visit each fell by approximately half. Median length of stay (LOS) declined from 12.2 days to 4.5 days, and reductions in LOS were observed for most diagnostic categories. Rates of discharges of psychotic and mood disorders, as well as intentional self-injuries increased, while discharges for adjustment disorders fell. Discharges to short-term, nursing, and other inpatient facilities also declined.

*Conclusions:* The period between 1990 and 2000 was characterized by a transformation in the length of inpatient mental health treatment for young people. Community hospitals evaluated, treated, and discharged mentally ill children and adolescents far more quickly than 10 years earlier, despite higher apparent rates of serious illness and self-harm and fewer transfers to intermediate and inpatient care.

Dr. Case received support from the American Psychiatric Institute for Research and Education.

## TARGET AUDIENCE:

Mental health and child health services administrators, policy makers, researchers, and advocates.

## REFERENCES:

1. Bao Y, Sturm R: How do trends for behavioral health inpatient care differ from medical inpatient care in U.S. community hospitals? J Med: Health Policy Econ 2001; 4(2):55–63.
2. Pottick KJ, McAlpine DD, Andelmas RB: Changing patterns of psychiatric inpatient care for children and

adolescents in general hospitals. 1988–1995. Am J Psychiatry 2000; 157(8):1267–73.

**Poster 111** **Friday, October 7**
**3:00 p.m.-4:30 p.m.**

## CORICIDIN HBP ABUSE: INCIDENCE AND PATIENT CHARACTERISTICS OF ABUSERS IN AN INPATIENT CHILD AND ADOLESCENT UNIT

Daniel L. Dickerson, D.O., *Program Director, Department of Psychiatry, Loma Linda University, 11374 Mountain View Avenue, Loma Linda, CA 92354*; Mary Ann Schaepper, M.D., *Program Director, Department of Psychiatry, Loma Linda University, 11374 Mountain View Avenue, Loma Linda, CA 92354*; Mark D. Peterson, M.D.; Michelle D. Ashworth, B.S.N.

### EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant will be able to recognize symptoms associated with Coricidin intoxication in the inpatient child and adolescent psychiatric setting. Also, the participant will be able to recognize psychiatric comorbidities, patient characteristics, and risk factors associated with Coricidin misuse.

### SUMMARY:

*Objectives:* Corícidin HBP, an over-the-counter cough and cold medication, has become a popular agent of dextromethorphan abuse in the teenage population. This study attempts to identify psychiatric comorbidities and patient characteristics as observed in an inpatient child and adolescent psychiatric unit.

*Method:* A retrospective review of hospital records covering a 36-month period (July 2001–June 2004) was conducted in the child and adolescent inpatient psychiatric unit at Loma Linda University Medical Center. Presenting psychiatric symptomatology, misuse intentions, admitting psychiatric diagnosis, and sociodemographic information were scrutinized.

*Results:* 47 documented cases of Coricidin HBP misuse were identified. 60% were males, 40% females. 79% were 15–17 years of age. 83% were Caucasian, 15% Hispanic, and 2% African American. Admitting axis I comorbid diagnoses included depressive disorders (66%), psychosis (13%), mania (13%), and polysubstance abuse (36%). Twelve patients used Coricidin within 48 hours of admission, presenting with various psychotic symptoms. All 12 were discharged with complete resolution of symptoms.

*Conclusions:* A higher-than-expected number of charts found in this retrospective study confirm patterns of Coricidin misuse in the teenage population. Recognizing clinical manifestations and risk factors of Coricidin misuse along with routine screening is recommended for physicians treating adolescents.

### TARGET AUDIENCE:

Child and adolescent psychiatrists, addiction psychiatrists.

### REFERENCES:

1. Banerj S: Abuse of Coricidin HBP cough & cold tablets: episodes recorded by a poison control center. Am. Health-Syst-Pharm 2001; 58:1811–1814.
2. Baker SD: A possible trend suggesting increased abuse from Coricidin exposures recorded to the Texas Poison Network: comparing 1998 to 1999. Vet Hum Toxicol 2002; 44(3):169–171.

**Poster 112** **Friday, October 7**
**3:00 p.m.-4:30 p.m.**

## GENDER AND COMORBIDITIES IN CHILDREN AND ADOLESCENTS WITH ADHD

Anela Bolfek, M.D., *Department of Psychiatry, Tufts New England Medical Center, 750 Washington Street, Boston, MA 02111*; Atilla Turgay, M.D., *Chief of Staff, The Scarborough Hospital, 3050 Lawrence Avenue, East, Scarborough, Canada*

### EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize the importance of screening for comorbidities in children with ADHD.

### SUMMARY:

*Objective:* to study the gender differences in comorbidities of children and adolescents with ADHD.

*Methods:* The study involved 433 children and adolescents (age range 2–18) assessed by DSM-IV diagnostic criteria as having ADHD. Offord-Boyle Ontario Child Health Study Based Parent and Teacher Screening and Rating Scales were used in reviewing comorbid disorders. DuPaul ADHD Rating scale aided the diagnosis; 1.5 SD above the mean of the age and gender norms was expected.

*Results:* The most common comorbidity in girls (52.53%) and boys (58.98%) was oppositional defiant disorder. Other common comorbid disorders in boys were conduct disorder (15.27%), anxiety disorder (11.38%), speech disorder (10.18%), PDD (4.79%), and tick disorder (4.49%). Statistically significant differences in comorbidities in boys and girls were observed in anxiety disorders (16.16% vs. 11.38%), dysthymic disorder (8.08% vs. 3.89%), obesity (7.07% vs. 1.8%), PDD (6.06% vs. 4.79%), MDD (5.05% vs. 1.8%), devel-

opmental delay (5.05% vs. 0.9%), and elimination disorders (5.05% vs. 1.5%). Boys in comparison to girls were diagnosed more with ODD (58.98% vs. 52.53%), conduct disorder (15.27% vs. 11.11%), and speech disorder (10.18% vs. 5.05%).

*Conclusion:* All children with ADHD should be screened for associated disorders since the treatment with different comorbidity require modifications in treatment.

## TARGET AUDIENCE:

Pyschiatrists (child, general), pediatricians.

## REFERENCES:

1. DuPaul GJ, Power TJ, Anastopoulos AD, Reid R. ADHD Rating Scale-IV: Checklists, Norms and Clinical Interpretation. Guilford Press, 1998.
2. Turgay A, Ansari R, Zafar M, and the Scarborough Hospital ADHD Institute Study Group: ADHD subtypes change dramatically with age and gender. John Hopkins University School of Medicine Advanced Studies in Medicine 2002; 2:930–931.
3. Boyle MH, Offord DR, Racine, et al: Evaluation of the revised Ontario Child Health Study Scales. Journal of Child Psychiatry, 1993; 34:189–213.

**Poster 113** **Friday, October 7**
**3:00 p.m.-4:30 p.m.**

# ASSOCIATIONS BETWEEN ANXIETY, HEALTH-RELATED QUALITY OF LIFE, AND HEALTH BEHAVIORS

Tara W. Strine, M.P.H., *Epidemiologist, Division of Adult and Community Health, Depart of Behavioral Health Sciences, National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention, 4770 Bufford Highway, N.E., MS K-67, Atlanta, GA 30341*; Daniel P. Chapman, Ph.D., *Psychiatric Epidemiologist, Division of Adult and Community Health, Department of Health Care and Aging, National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention, 4770 Buford Highway, N.E., Mailstop K-67, Atlanta, GA 30341*; Rosemarie Koban, M.P.H.; Lina Ballyz, Sc.D.

## EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should appreciate the prevalence of anxiety symptoms among persons in the community and the relationships between these symptoms, adverse health behaviors, and health-related quality of life.

## SUMMARY:

*Background:* Anxiety disorders affect approximately 19 million American adults annually and have been associated with impaired health-related quality of life (HRQOL), an increased rate of adverse health behaviors, and poor outcomes related to chronic illness in studies conducted in clinical populations.

*Methods:* Data were obtained from the Behavioral Risk Factor Surveillance System, an ongoing, state-based, random-digit telephone survey of the noninstitutionalized U.S. population aged ≥18 years. In 2002, HRQOL measures were administered in 18 states and the District of Columbia.

*Results:* An estimated 15% of persons reported frequent (≥ 14 days in the past 30 days) anxiety symptoms. After adjusting for frequent depressive symptoms and sociodemographic characteristics, those with frequent anxiety symptoms were significantly more likely than those without to report fair or poor general health (vs excellent, very good, or good general health), frequent physical distress, frequent activity limitations, frequent sleep insufficiency, infrequent vitality, frequent mental distress, and frequent pain. In addition, they were more likely to smoke, to be obese, to be physically inactive, and to drink heavily.

*Conclusion:* Given the association of anxiety disorders with impaired HRQOL and adverse health behaviors, our results suggest that assessment of anxiety symptoms should be a facet of routine standard medical examinations.

## TARGET AUDIENCE:

Psychiatrist, non-psychiatric physicians, nurses, psychologists, social workers and other mental health professionals.

## REFERENCES:

1. Lépine JP: The epidemiology of anxiety disorders: prevalence and societal cost. J Clin Psychiatry 2002; 63 (Suppl 14):4–8.
2. Lecrubier Y: The burden of depression and anxiety in general medicine. J Clin Psychiatry 2001; 62(Suppl 8):4–9.

**Poster 114** **Friday, October 7**
**3:00 p.m.-4:30 p.m.**

# PSYCHIATRIC EMERGENCIES IN OLDER AMERICANS: 1997 AND 2000

Daniel P. Chapman, Ph.D., *Psychiatric Epidemiologist, Division of Adult and Community Health, Department of Health Care and Aging, National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention, 4770 Buford Highway,*

*N.E., Mailstop K-67, Atlanta, GA 30341*; Robert F. Anda, M.D.

## EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to describe the prevalence of psychiatric admitting diagnoses for emergency admissions of older adults in 1997 and 2000.

## SUMMARY:

*Objectives:* While believed to underutilize psychiatric services relative to their younger peers, older adults are more likely to be hospitalized with psychiatric disorders following an emergency room visit. Given the aging of the U.S. population, a better understanding of trends in the psychiatric emergency hospitalization of older adults is warranted.

*Methods:* Using Medicare Part A claims data, we assessed the prevalence of psychiatric admitting diagnoses among persons 65 years or older in the U.S. in the years 1997 and 2000.

*Results:* A greater number of psychiatric emergency admissions were reported among older adults in the U.S. in 2000 (N=110.036) than in 1997 (N=96,344). Dementia, delirium, and amnestic disorders comprised a greater percentage of admitting diagnoses in 2000 than in 1997 (44.4% vs. 38.8%) as did schizophrenia and psychotic disorders (21.0% vs. 19.8%). Conversely, decreased percentages of mood disorders were reported in 2000 than in 1997 (24.4% vs. 29.5%), as were substance use disorders (7.7% vs. 8.9%) and medication induced disorders (0.4% vs. 0.7%).

*Conclusions:* With the aging of the U.S. population, the number of older adults hospitalized for psychiatric emergencies will likely increase. Assessment of the proportion of diagnoses precipitating emergency hospitalization may suggest areas for further investigation and intervention in this population.

## TARGET AUDIENCE:

Psychiatrists, nonpsychiatric physicians, nurses, psychologists.

## REFERENCES:

1. Chapman DP, Currier GW, Miller JK, Anda RF: Medication-induced emergency hospitalizations for psychiatric disorders among older adults in the US. Int J Geriatr Psychiatry 2003; 18:185–186.
2. Coyne AC, Gjertsen R: Characteristics of older adults referred to a psychiatric emergency outreach service. J Ment Health Adm 1993; 20:208–211.

**Poster 115** **Friday, October 7**
**3:00 p.m.-4:30 p.m.**

# ALCOHOL CONSUMPTION PATTERN IN ACTIVELY DRINKING BIPOLAR PATIENTS

*Supported by Abbott Laboratories*

Jason W. Chirichigno, M.A., *Clinical Research Associate, Mood Disorders, University of California at Los Angeles, 300 UCLA Medical Plaza, Suite 1544, Los Angeles, CA 90024*; Mark A. Frye, M.D., *Assistant Professor, Department of Psychiatry and Behavioral Sciences, University of California at Los Angeles, 300 UCLA Medical Plaza, Suite 1544, Los Angeles, CA 90095-7057*; Lori L. Altshuler, M.D.; Michael A. Griffin, M.D.

## EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize the alcohol consumption pattern in bipolar disorder with specific emphasis on the distruction between Bipolar I and Bipolar II diagnosing drinking patterns.

## SUMMARY:

Despite a high prevalence rate, patients with bipolar disorder and active alcohol use are routinely excluded from controlled clinical trials, leaving clinicians with little evidence-based medicine to guide treatment. This report evaluates preliminary data of alcohol consumption patterns utilizing the Alcohol Timeline Followback (TLFB) method in actively drinking bipolar patients. A sample of 56 patients underwent a Structured Diagnostic Interview for DSM-IV (SCID-IV) as well as completed various measures of alcohol use and associated morbidity. In the month prior to study entry, the TLFB reported 19.31 $\pm$ 9.37 drinking days, 9.76 $\pm$ 5.67 drinks per drinking day, and 177.80 $\pm$ 141.36 total standard drinks for the entire study cohort. BPI (n=36) and BPII (n= 20) reported 151.22 $\pm$ 113.88 total standard drinks and 206.48 $\pm$ 173.17 total standard drinks, respectively. This study highlights heavy alcohol use in patients with bipolar disorder and alcohol comorbidity. The TLFB method provides real-world quantification of use. Further studies are encouraged to elucidate the implications bipolar diagnosis can have on alcohol consumption.

This work was supported by grants from the Stanley Medical Research Institute and Abbott Laboratories.

## TARGET AUDIENCE

Mental health professionals.

## REFERENCES:

1. Frye et al: Gender difference in prevalence, risk, and clinical correlates at alcoholism comorbidity in bipolar disease. J. Clin Psychiatry 2003

2. McElny et al.: Am. J psychiatric comorbidity and its relationship to historical illness variables in 288 patients of bipolar disorder. Am J Psychiatry 2001.

**Poster 116** **Friday, October 7**
**3:00 p.m.-4:30 p.m.**

## PREVALENCE AND CORRELATES OF ALCOHOL DEPENDENCE AMONG INDUSTRIAL WORKERS IN A KOREAN URBAN AREA

Maeng Je Cho, M.D., *Professor, Department of Psychiatry and Behavioral Science, Seoul National University College of Medicine, 28 Yongun-Dong, Chongno-Gu, Seoul, South Korea 110-744*; Hong Jin Jeon, M.D., *Clinical Instructor, Department of Psychiatry, Seoul National University College of Medicine, 28 Yongun-Dong, Chongno-Gu, Seoul, South Korea 110-744*; Sung M. Jang, M.D.; Bong-Jin Hahm, M.D.; Tong Woo Suh, M.D.

### EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to evaluate the prevelance of alcohol dependence among industrial workers in an urban setting in Korea.

### SUMMARY:

To estimate the prevalence and social correlates of alcohol dependence (AD) among industrial workers in an urban area of Korea, we interviewed 613 industrial workers in five selected workspaces to generate DSM-IV AD diagnosis. Each subject was administered the CES-D (Center for Epidemiologic Studies Depression scale). MAST (Michigan Alcoholism Screening Test), and a questionnaire developed by the authors. We analyzed the data focusing on the difference between drinkers without AD and with probable AD. Among the 613 respondents who completed the interview, 71% (male 77.5%, female 57.1%) of industrial workers were drinkers. Prevalence of the AD was 4.7% (male: 4.5%, female: 4.6%), lower than that of the general population. The male to female ratio of probable AD was 1 to 1, which was far lower than previous studies (3 to 1). Among sociodemographic factors, the only significant difference between drinkers with AD and drinkers without AD was marital state (not married and divorced) in female workers. We found a strong relationship between AD and depressive symptoms in both male and female. It was concluded that in the industrial workplace, frequent screening and early identification of depression among drinkers would be helpful in preventing AD, and more attention was needed to unmarried female workers.

### TARGET AUDIENCE:

All audience.

### REFERENCES:

1. Janes CR, Ames GM. Recent developments in alcoholism: the workplace. Recent Dev Alcohol 1993; 11:123–41.
2. Ames GN, Grube JW, Moore RS: The relationship of drinking and hangovers to workplace problems: an empirical study. J Stud Alcohol 1997; 58:37–47.

**Poster 117** **Friday, October 7**
**3:00 p.m.-4:30 p.m.**

## THE IMPORTANCE OF FAMILY RE-INTEGRATION FOR WOMEN RECOVERING FROM ADDICTION

Laila F.M. Contractor, M.D., *Resident, Department of Psychiatry, Western Psychiatric Institute and Clinic, 5600 Munhall Road, Pittsburgh, PA 15217*

### EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to (1) recognize the need for more government and state funding and the importance of increased research on family residential services for recovering addicts, and (2) understand a multidisciplinary care team model that identifies the value of integrating family goals in recovery plans for women with children.

### SUMMARY:

Homelessness and separation from children is a harsh reality many women face as a consequence of their substance use. Unfortunately, the mental health system often fails to incorporate family needs and obligations when designing recovery interventions. Research that examines issues of residential rehabilitation and aftercare for mothers and their children are scarce, but studies that have been done demonstrate that homelessness and low-income women are more susceptible to substance use and psychiatric illnesses. This is important given the increase in prevalence of homelessness amongst women and children. This poster takes a close look at Amanda, a 46-year-old mother of nine with a 30-year history of cocaine and alcohol dependence, who was diagnosed with major depression and posttraumatic stress disorder. Living in a halfway house, Amanda was separated from her younger children, who were cared for by relatives. Others were taken into custody by the state because they had no place to live. After nearly three years of sobriety, Amanda was hospitalized with severe depression, stemming largely from the separation. Although she did not relapse, Amanda's inability to reunite with her family presented the greatest obstacle to her recovery.

Amanda is a representative example of women whose recovery needs cannot be fully addressed by our mental health system without including child-care and family considerations.

## TARGET AUDIENCE:

Doctors, nurses, social workers and therapists working in substance use disorders treatment facilities as well as in women's health.

## REFERENCES:

1. Arkansas Center for Addictions Research, Education, and Services: Integrated services for mothers with dual diagnoses and their children. Psychiatric Services 2002; 53(10):1311–1313.
2. Smith EM, North CS, Fox LW: Eighteen-month follow-up data on a treatment program for homeless substance abusing mothers. Journal of Addictive Diseases 1995; 14(4):57–72.

**Poster 118** **Friday, October 7**
**3:00 p.m.-4:30 p.m.**

## A GERO-PSYCHIATRIC UNIT WITHOUT WALLS

Charles V. Ettari, M.D., *Psychiatrist, Department of Psychiatry, Scripps Mercy Hospital, 3130 5th Avenue, San Diego, CA 92103*; Marlene-Moodie, M.S.N., *Clinical Nurse Specialist, Department of Behavioral Health, Scripps Mercy Hospital, 4077 5th Avenue, San Diego, CA 92103*; Jerry Gold, Ph.D.

## EDUCATIONAL OBJECTIVES:

At the conclusion of the presentation, the participant should understand the benefits and challenges of establishing a separate treatment milieu for geriatic psychiatric patients; and understand the working model program for a ''unit without walls.''

## SUMMARY:

To provide an optimum level of care for seniors admitted to this psychiatric unit, modifications were made to the floor plan as well as program planning specifically geared to replicate best practices of a designated gero-psychiatric unit with positive results. Seniors in need of psychiatric inpatient treatment had historically been admitted to any available bed on this 46-bed acute care psychiatric unit. A review of best practice models for caring for this population led us to attempts at opening a segregated unit but a variety of constraints did not allow for this. As a compromise, the ''gero-psychiatric unit without walls'' was conceptualized and realized. The project was a great undertaking by interdisciplinary staff at the point of service along with direction and support from the leadership team.

There were numerous challenges including nursing staff concerns related to medically compromised patients, and environmental issues related to patient safety and the specific needs of seniors. Performance improvement activities were incorporated and evidence-based practice outcomes monitored for both the positive and negative effects upon the unit as a whole. No significant negative outcomes for the patients has occurred and no senior has been placed in restraints.

The project has been a work in progress for the past two years and continues. Modifications have been made along the way to the environment as well as staff and skill mix as we learn from our work with these patients.

We continue to monitor for patient and staff satisfaction on a continual basis. Given similar financial and regulatory constraints that other units similar to ours might find themselves in, the option of this program might be beneficial to learn about. We believe the success of this unit without walls can be replicated elsewhere.

## REFERENCES:

1. Bartels S: Improving the system of care for older adults with mental illness in the United States. American Journal Geriatric Psychiatry 2003; 11(5):486–497.
2. Jeste DV, Alexopoulos GS, Bartels SJ, Cummings L, Gallo J, Gottlieb G, et al: Consensus statement on the upcoming crisis in geriatric mental health: Research agenda for the next two decades. Archives of General Psychiatry 1999; 56:848–853.

**Poster 119** **Friday, October 7**
**3:00 p.m.-4:30 p.m.**

## VALIDATION OF A STRUCTURED INSTRUMENT FOR THE DIAGNOSIS OF DELIRIUM IN THE INTENSIVE CARE UNIT

Maricarmen Flores-Miranda, M.S., *Psychiatrist, Department of Neurology and Psychiatry, National Institute of Ciencias Medicas y, Nutricion Salvador Zubrican, Mexico City, Mexico, Cuauhtemoc 46, Col Toriello-Guerra, Tlalpan 14050, Mexico*; Juan Calva, M.S.C.; Guillermo Dominquez-Cheritt, M.D.; Adrian Gonzalez, M.D.; Gabriel Alejo, M.D.; Juan Gutierrez, M.D.; Angeles Vargas, M.D.; Virgilio Santiago, M.D.; Silvina Sanchez; Michel Martinez, M.D.; Silvia Medellin, M.D.; Juan Posadas, M.D.; Mario Yanez, M.D.; Monica Rojas, M.D.; Gabriela Alvarez; Elena Garcia; Ileana Alquicira; Beatriz Alvarez; Blanca Hernandez; Alejandra Najera; Rafael Salin-Pascual, Ph.D.; Bernardino Ordonez, M.D.

## EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to diagnose and quantify delirium in critically ill patients who are often nonverbal because of mechanical ventilation and sedative medication.

## SUMMARY:

*Objective:* To develop a structured instrument for the diagnosis of delirium for the intensive care unit (SIDDM-ICU), that comprehensively takes into account the DSM-IV diagnostic criteria, assess its interrate reliability among intubated and non-mechanically ventilated patients, with and without sedation, compare the scale reliability index among psychiatrists and non-psychiatrists professionals, and validate it against the Delirium Rating Scale-Revised-98 (DRS-R-98).

*Design:* Cross Sectional Setting: The adult Intensive care unit of the Instituto 'Nacional de Ciencias Médicas y Nutrición Salvador Zubirán.

*Methods:* We created a structured instrument in two formats, 296 blind paired evaluations were performed.

*Results:* The interrater agreement obtained with kappa statistics were .97 for nonintubated patients, .85 for intubated patients, .85 for patients receiving sedative medications, .97 for patients without these medications, 1 within the intensivists group, .94 withing the nurses group, .85 within the psychiatrists group. The sensitivity and specificity were 100%.

## REFERENCES:

1. Elly W, et al: Validation of the confusion assessment method. Crit Care Med 2001; 29:7.
2. Trzepacz PT, et al: Validation of the Delirium Rating Scale-98. J Neuropsychiatry Clin Neurosci 2001; 13(2):229–242.

**Poster 120** **Friday, October 7**
**3:00 p.m.-4:30 p.m.**

# INCIDENCE OF DELIRIUM IN AN INTENSIVE CARE UNIT AT A HOSPITAL IN MEXICO

Maricarmen Flores-Miranda, M.S., *Psychiatrist, Department of Neurology and Psychiatry, National Institute of Ciencias Medicas y, Nutricion Salvador Zubrican, Mexico City, Mexico, Cuauhtemoc 46, Col Toriello-Guerra, Tlalpan, 14050 Mexico*; Juan Calva, M.S.C.; Guillermo Dominquez-Cheritt, M.D.; Silvia Medellin, M.D.; Michel Martinez, M.D.; Betania Rossette, M.D.; Elizabeth Medina, M.D.

## EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should know the incidence of delirium in patients from the intensive care unit.

## SUMMARY:

*Objective:* Determine the incidence of delirium.

*Design:* Cohort. Setting: The medical-surgical adult intensive care unit of the Instituto Nacional de Ciencias Médicas y Nutrición Salvador Zubirán.

*Methods:* We followed patients daily from their first day at the intensive care unit (ICU) to the day of their discharge. Inclusion Criteria: (1) Patients without mechanical ventilation and sedation, (2) patients with mechanical ventilation and a Ramsay sedation level from 1 to 4, (3) patients free of delirium prior to their ICU stay. Exclusion Criteria: (1) Patients who remained in a Ramsay sedation level above 4, (2) patients who develop their delirium prior to the ICU. We used the structured instrument for the diagnosis of delirium and its measurement SIDDM-ICU.

*Results:* The incidence calculated was 50%.

*Conclusion:* The incidence of delirium at the ICU is very high. This could be explained because the ICU seems to pose a higher hazard for delirium as patients commonly suffer multi-organ failures, comorbidities, and receive anticholinergic drugs.

## REFERENCES:

1. Elly W, et al: Evaluation of delirium in critically ill patients: validation of the Confusion Assessment Method for the ICU. CritCare Med 2001; 29.
2. Chan D, et al: Delirium: Making the Diagnosis, improving the prognosis. Geriatrics 1999; 54:3:28–42.

**Poster 121** **Friday, October 7**
**3:00 p.m.-4:30 p.m.**

# ADULT ATTACHMENT AND EMOTIONAL HEALTH IN SURVIVORS OF WAR TRAUMA

*Supported by The Institute for Research on Unlimited Love*

Robert W. Hierholzer, M.D., *Chief, Mental Health Service, Veterans Affairs Central California Health Care System, and Associate Clinical Professor of Psychiatry, University of California at San Francisco, 2615 East Clinton Avenue, Fresno, CA 93703*; Bita Ghafoori, Ph.D.; Barbara Howsepian, Ph.D.; Angela Boardman, M.A.

## EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to describe the importance of considering adult attachment in maintaining mental health in the face of psychological trauma.

## EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to diagnose and quantify delirium in critically ill patients who are often nonverbal because of mechanical ventilation and sedative medication.

## SUMMARY:

*Objective:* To develop a structured instrument for the diagnosis of delirium for the intensive care unit (SIDDM-ICU), that comprehensively takes into account the DSM-IV diagnostic criteria, assess its interrate reliability among intubated and non-mechanically ventilated patients, with and without sedation, compare the scale reliability index among psychiatrists and non-psychiatrists professionals, and validate it against the Delirium Rating Scale-Revised-98 (DRS-R-98).

*Design:* Cross Sectional Setting: The adult Intensive care unit of the Instituto 'Nacional de Ciencias Médicas y Nutrición Salvador Zubirán.

*Methods:* We created a structured instrument in two formats, 296 blind paired evaluations were performed.

*Results:* The interrater agreement obtained with kappa statistics were .97 for nonintubated patients, .85 for intubated patients, .85 for patients receiving sedative medications, .97 for patients without these medications, 1 within the intensivists group, .94 withing the nurses group, .85 within the psychiatrists group. The sensitivity and specificity were 100%.

## REFERENCES:

1. Elly W, et al: Validation of the confusion assessment method. Crit Care Med 2001; 29:7.
2. Trzepacz PT, et al: Validation of the Delirium Rating Scale-98. J Neuropsychiatry Clin Neurosci 2001; 13(2):229–242.

**Poster 120** **Friday, October 7**
**3:00 p.m.-4:30 p.m.**

# INCIDENCE OF DELIRIUM IN AN INTENSIVE CARE UNIT AT A HOSPITAL IN MEXICO

Maricarmen Flores-Miranda, M.S., *Psychiatrist, Department of Neurology and Psychiatry, National Institute of Ciencias Medicas y, Nutricion Salvador Zubrican, Mexico City, Mexico, Cuauhtemoc 46, Col Toriello-Guerra, Tlalpan, 14050 Mexico*; Juan Calva, M.S.C.; Guillermo Dominquez-Cheritt, M.D.; Silvia Medellin, M.D.; Michel Martinez, M.D.; Betania Rossette, M.D.; Elizabeth Medina, M.D.

## EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should know the incidence of delirium in patients from the intensive care unit.

## SUMMARY:

*Objective:* Determine the incidence of delirium.

*Design:* Cohort. Setting: The medical-surgical adult intensive care unit of the Instituto Nacional de Ciencias Médicas y Nutrición Salvador Zubirán.

*Methods:* We followed patients daily from their first day at the intensive care unit (ICU) to the day of their discharge. Inclusion Criteria: (1) Patients without mechanical ventilation and sedation, (2) patients with mechanical ventilation and a Ramsay sedation level from 1 to 4, (3) patients free of delirium prior to their ICU stay. Exclusion Criteria: (1) Patients who remained in a Ramsay sedation level above 4, (2) patients who develop their delirium prior to the ICU. We used the structured instrument for the diagnosis of delirium and its measurement SIDDM-ICU.

*Results:* The incidence calculated was 50%.

*Conclusion:* The incidence of delirium at the ICU is very high. This could be explained because the ICU seems to pose a higher hazard for delirium as patients commonly suffer multi-organ failures, comorbidities, and receive anticholinergic drugs.

## REFERENCES:

1. Elly W, et al: Evaluation of delirium in critically ill patients: validation of the Confusion Assessment Method for the ICU. CritCare Med 2001; 29.
2. Chan D, et al: Delirium: Making the Diagnosis, improving the prognosis. Geriatrics 1999; 54:3:28–42.

**Poster 121** **Friday, October 7**
**3:00 p.m.-4:30 p.m.**

# ADULT ATTACHMENT AND EMOTIONAL HEALTH IN SURVIVORS OF WAR TRAUMA

*Supported by The Institute for Research on Unlimited Love*

Robert W. Hierholzer, M.D., *Chief, Mental Health Service, Veterans Affairs Central California Health Care System, and Associate Clinical Professor of Psychiatry, University of California at San Francisco, 2615 East Clinton Avenue, Fresno, CA 93703*; Bita Ghafoori, Ph.D.; Barbara Howsepian, Ph.D.; Angela Boardman, M.A.

## EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to describe the importance of considering adult attachment in maintaining mental health in the face of psychological trauma.

## SUMMARY:

*Objective:* To explore whether secure attachments are associated with emotional health in those exposed to military trauma.

*Method:* 95 veterans who had experienced combat trauma completed measures of attachment and psychopathology: Relationship Scales Questionnaire (RSQ); Clinician Administered Posttraumatic Stress Disorder Scale; Global Severity Index on the Symptom Checklist 90-Revised; Millon Clinical Multiaxial Inventory-III.

*Results:* Analyses of variance (ANOVA) indicated that different adult attachment styles, as measured by RSQ were associated with different PTSD levels ($F(3,95)=7.37$, $p=.000$). Tukey's post-hoc analyses revealed veterans with fearful ($M=69.17$, $SD=24.65$) and dismissive attachment styles ($M=61.50$, $SD=21.76$) had higher PTSD levels than those with secure attachment styles (respectively, $M=34.81$, $SD=27.89$; $M=34.81$, $SD=27.89$). ANOVA ($F(3,95)=4.66$, $p=.004$) with Tukey's post-hoc analyses showed that veterans with fearful attachments ($M=76.75$, $SD=5.56$) had higher perceived distress levels as measured by the Global Severity Index than veterans with secure attachments (M=66.56, SD=12.32). The most commonly occurring personality patterns, depressive, negativistic, and avoidant, were associated with different adult attachment styles.

*Conclusions:* These findings suggest that secure attachments may help protect against deleterious psychological effects of combat trauma.

*Funding Source:* The Institute for Research on Unlimited Love.

## TARGET AUDIENCE:

Clinicians and researchers with an interest in trauma and PTSD combat trauma.

## REFERENCES:

1. Dieperink M, et al: Attachment style classification and posttraumatic stress disorder in former prisoners of war. American Journal of Orthopsychiatry 2001; 71:374–78.
2. Schnurr PP, et al: Risk factors for the development versus maintenance of posttraumatic stress disorder. Journal of Traumatic Stress 2004; 17:85–95.

**Poster 122** **Friday, October 7**
**3:00 p.m.-4:30 p.m.**

## AN OPEN-LABEL STUDY TO EVALUATE SWITCHING FROM SSRI TO TIAGABINE TO ALLEVIA

*Supported by Cephalon, Inc.*

David E. Kang, M.D., *Clinical Assistant Instructor, Department of Psychiatry, State University of New York Upstate Medical University, 713 Harrison Street, Syracuse, NY 13210*; Thomas L. Schwartz, M.D., *Assistant Professor of Psychiatry, State University of New York Upstate Medical University, 750 East Adams Street, Syracuse, NY 13210*; Hari G. Kumaresan, M.D.

## EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to examine whether or not a tolerance is built up in the body when using benzodiazepines for a long period of time to treat GAD.

## SUMMARY:

*Background:* Long-term use of benzodiazepines is a prevalent treatment for generalized anxiety disorder (GAD). Such use may be associated with the development of tolerance. Selective serotonin reuptake inhibitor (SSRI) and serotonin-norepinephrine reuptake inhibitor (SNRI) antidepressants are equally effective and safer, but are associated with sexual dysfunction as a major side effect. Tiagabine, FDA approved for epilsepsy, has been shown to facilitate GABA neurotransmission by blocking GABA re-uptake pumps, which does not promote tolerance, nor addiction. It also is not associated with sexual dysfunction as an adverse effect. Preliminary studies have suggested that tiagabine may be effective in treating GAD. This study is an open-label, switch study where subjects with GAD on SSRI or SNRI, who are GAD responders, but have sexual dysfunction side effects, have agreed to switch from their original treatment to tiagabine monotherapy.

*Methods:* Fifteen GAD subjects were enrolled to see if a change from their SSRI/SNRI to tiagabine would alleviate sexual dysfunction while maintaining a non-anxious state comparable with their SSRI/SNRI at baseline. Subjects were tapered off their baseline drug and titrated onto tiagabine (4–12mg/d) over four weeks. Subjects were followed for an additional two visits over ten weeks of tiagabine monotherapy while sexual dysfunction was measured via the Arizona Sexual Experience Scale (ASEX) and anxiety was measured via the Hamilton Anxiety Scale (HAMA) and the Hospital Anxiety and Depression Scale (HADS).

*Results:* Fifteen subjects have completed this study to date. When comparing subjects' baseline scores of sexual dysfunction to their scores at the 14-week endpoint while on tiagabine monotherapy, there was an average improvement change of 6.1 points, which is a statistically significant improvement in sexual functioning ($p < 0.001$). As far as tiagabine's ability to maintain anxiolytic efficacy comparable with SSRI/SNRI, there was no statistical difference between the original SSRI/SNRI treatment and tiagabine monotherapy at endpoint on any measure: HAMA ($p = 0.346$), HADS-A ($p = 0.093$). Typical side effects included fatigue, GI upset, and headache.

*Conclusions:* In this open-label, switch study, tiagabine appears to be more tolerable in that it may diminish sexual side effects induced by SSRI/SNRI and may be effective in maintaining a non-anxious state as a monotherapy treatment for GAD. Future controlled studies are warranted.

## REFERENCES:

1. Borden LA, Murali Dhar TG, Smith KE, et al: Tiagabine, SK&F 89976-A, CI-966, and NNC-711 are selective for the cloned GABA transporter GAT-1. Eur J Pharmacol 1994; 269:219–224.
2. Rosenthal M: Tiagabine in the treatment of generalized anxiety disorder: a randomized, open-label clinical trial with paroxetine as a positive control. J Clin Psychiatry 2003; 64:1245–1249.

**Poster 123** **Friday, October 7**
**3:00 p.m.-4:30 p.m.**

## THE CONVENTION OF NOT REPORTING NON-RESPONDERS IN PTSD MEDICATION TRIALS

Neal A. Kline, M.D., *Associate Clinical Professor of Psychiatry, University of California at San Diego, 8950 Villa La Jolla Drive, La Jolla, CA 92037-1714*

## EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize that in PTSD clinical trials, CGI-Is for global assessment of overall medication effect are usually reported only for medication responders (with CGI-Is of 1 or 2), while CGI-Is for medication non-responders (with CGI-Is of 3–7) most often remain unreported.

## SUMMARY:

*Objective:* This poster shall examine the manner in which the widely-used global assessment instrument, the Clinical Global Impression-Improvement scale (CGI-I), is reported in Posttraumatic Stress Disorder (PTSD) medication trials. This scale rates overall therapeutic effect (including both efficacy and side effect burden), relative to the start of treatment. The CGI-I's anchor points are: 1 (very much improved), 2 (much improved), 3 (minimally improved), 4 (unchanged), 5 (minimally worse), 6 (much worse), and 7 (very much worse).

*Method:* Articles which reported original medication trials for PTSD were identified by a PubMed ''PTSD/drug trials'' subject-search of the *American Journal of Psychiatry, Journal of Clinical Psychiatry, Archives of General Psychiatry,* and the *Journal of the American Medical Association* (JAMA), for the period January 2000 through July 2003.

*Results:* Nine articles reported CGI-I scores for medication responders (1 and 2, very much improved and much improved). One article (11%) of the 9 articles reporting CGI-Is of 1 and 2 additionally designated CGI-I scores of ''≥3'' as a criterion (with other obligatory criteria) for classifying ''relapse.'' Only one article (11%) of the 9 articles reporting CGI-Is of 1 and 2 also reported CGI-I scores of 3 to 7, documenting CGI-Is for every member of the intent-to-treat cohort.

*Conclusion:* The convention of selectively reporting CGI-Is of 1 and 2 (responders), and very rarely reporting CGI-Is of 3–7 (non-responders), results in the cohort of medication non-responders becoming invisible. Lost is CGI-I clinical outcome data that may range from minimally improved (3) to unchanged (4) to minimally worse (5) to significantly worse (6, 7) due to lack of medication efficacy, from prohibitive side effects, or acute illness exacerbation or relapse. Self-funded.

## TARGET AUDIENCE:

Healthcare professionals who read medication clinical trial reports.

## REFERENCES:

1. Guy W: ECDEU Assessment Manual for Psychopharmacology, Revised. US Department Health, Education, and Welfare publication (ADM) 76-338, Rockville, MD, National Institute of Mental Health, 1976, pp 218–222.
2. Shalev AY: Measuring outcome in posttraumatic stress disorder. J Clin Psychiatry 2000; 61[suppl 5]:33–39.

**Poster 124** **Friday, October 7**
**3:00 p.m.-4:30 p.m.**

## COURSE OF PSYCHOSOCIAL FUNCTIONING AFTER REMISSION FROM GENERALIZED ANXIETY DISORDER

*Supported by Pfizer Inc.*

Kristin Maki, Ph.D., *Instructor, Brown Medical School, Box G-BH, Duncan Building, Providence, RI 02912*; Risa Weisberg, Ph.D.; Kevin T. Smith, Ph.D.

## EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to describe the relationship between change in diagnostic status of GAD and subsequent functioning.

## SUMMARY:

Although previous cross-sectional research has revealed a relationship between psychiatric symptomatology and psychosocial functioning, few studies have ex-

amined the time course of change in functioning after a change in diagnostic status. The aim of the current study is to examine the course of psychosocial functioning after remission from generalized anxiety disorder. Data are from the Primary Care Anxiety Project, a naturalistic, longitudinal study of primary care patients with anxiety disorders. Participants were 135 adults, recruited from 15 primary care practices throughout New England, who met DSM-IV criteria for GAD. Psychiatric disorders and psychosocial functioning were assessed yearly using the Longitudinal Interval Follow-up Evaluation (LIFE). Latent growth analyses revealed that remission from GAD positively affected clinician-rated global functioning in the subsequent six months. Conversely, patient-rated global functioning also predicted consequent remission from GAD. Proportional hazard regression analyses indicated that, for each one unit increase in global functioning scores (denoting a worsening), the hazard of remission from GAD decreased by 44%. Further analyses will examine the rapidity of functional improvement, as well as the course of other domains of impairment, including employment, household responsibilities, recreation, and interpersonal relationships. In addition, the effect of comorbid major depression on the course of functioning will be examined.

Research funded by an unrestricted education grant from Pfizer Pharmaceuticals, Inc.

## REFERENCES:

1. Stout RL, Dolan R, Duck I, Eisen J, Keller M: Course of social functioning after remission from panic disorder. Comprehensive Psychiatry 2001.
2. Scheibe G, Albua M. Predictors and outcome in panic disorder: a 2-year (1997) prospective follow-up study. Psychopathology; 30:177.

**Poster 125** **Friday, October 7**
**3:00 p.m.-4:30 p.m.**

## COMPARATIVE EFFICACY OF AMPHETAMINE AND ATOMOXETINE BY SYMPTOM SEVERITY

*Supported by Shire US Inc.*

James J. McGough, M.D., *Associate Professor of Psychiatry, University of California at Los Angeles, 300 UCLA Medical Plaza, Los Angeles, CA 90095*; Sharon B. Wigal, Ph.D., *Director of Clinical Trials, Department of Pediatrics, University of California at Irvine, 19722 MacArthur Boulevard, Irvine, CA 92697*; James T. Mc Cracken, M.D.; David A. Mays, Pharm.D.; Garrick Fiddler, M.D.

## EDUCATIONAL OBJECTIVES:

After reviewing this poster, the participant should be able to compare the response rates of school-aged children with attention-deficit/hyperactivity disorder (ADHD) to mixed amphefamine salts extended release (MAS XR) and atomoxetine.

## SUMMARY:

*Objective:* To compare the efficacy of mixed amphetamine salts extended release (MAS XR; Adderall XR®) and a once-daily selective norepinephrine reuptake inhibitor (atomoxetine; Strattera®) in children with ADHD.

*Methods:* A multicenter, randomized, double-blind, forced—dose-escalation classroom analog study. Subjects (N=215) were randomized in a 1:1 ratio to receive once-daily MAS XR or atomoxetine. Efficacy measures included the SKAMP Teacher Rating Scale. This is a post-hoc analysis of subjects with a baseline CGI-Severity score that indicated marked or severe impairment who were ''improved'' or ''not improved'' on the SKAMP deportment and attention scores at endpoint.

*Results:* The markedly or severely impaired ITT sample at endpoint included 71 subjects (MAS XR, n=33 and atomoxetine, n=38). Of the 33 subjects receiving MAS XR, 82% demonstrated improvement from baseline on SKAMP deportment ($P<0.0001$) and attention ($P=0.001$) scores. In contrast, 34% of those receiving atomoxetine were noted to have improvement. Approximately 66% of those subjects who received atomoxetine did not demonstrate improvement in SKAMP deportment or attention scores at endpoint. Both agents were well tolerated, and most AEs were mild or moderate.

*Conclusion:* These data suggest that in ADHD subjects with at least a marked impairment, more than twice as many may respond to MAS XR compared to atomoxetine.

Supported by Shire Pharmaceuticals Inc.

## TARGET AUDIENCE:

Child and adolescent psychiatrists, clinicians treating patients with ADHD.

## REFERENCES:

1. McCracken JT et al: J Am Acad Child Adolesc Psychiatry 2003; 42:673–683.
2. Michelson D et al: Am J Psychiatry 2002; 159:1896–1901.

**Poster 126** **WITHDRAWN**

**Poster 127** **Friday, October 7 3:00 p.m.-4:30 p.m.**

## EXAMINING THE COURSE OF COMORBID PANIC AND GENERALIZED ANXIETY DISORDER ON PRIMARY CARE PATIENTS

*Supported by Pfizer Inc.*

Wendy A. Ossman, Psy.D., *Postdoctoral Fellow, Department of Psychiatry, Brown University, Box 6-BH, Providence, RI 02906*; Kristen M. Maki, Ph.D.; Kevin T. Smith, Ph.D.

### EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize the potential impact that the course of panic disorder can have on generalized anxiety disorder (GAD).

### SUMMARY:

The course of panic disorder and generalized anxiety disorder (GAD) was examined in 44 participants in The Primary Care Anxiety Project (PCAP), a naturalistic, longitudinal study of the course of anxiety disorders in primary care patients. The study participants were all diagnosed with both disorders at baseline. The data analyses focused on how the course of one disorder affected the course of the other disorder. Data were collected at six, 12, and 24 month intervals. Using a time-varying covariate model, analyses revealed that an increase in panic disorder symptoms (as measured by an increase in psychiatric status rating (PBR)) significantly predicted a decreased likelihood that participants would recover from GAD (Wald chi-square = 6.26, p =.012). The hazard ratio was 0.22, indicating a 78% decrease in the chance of remission from GAD for each one point increase in the panic PSR. While the reverse relationship was not statistically significant, the analyses revealed a relatively large hazard ratio of 0.59. The data have implications for the theory that anxiety disorders share common underlying components. Specifically, the results support a supposition that the autonomic arousal symptoms associated with panic disorder affect the course of GAD, a disorder that shares this component.

Funding provided by an unrestricted grant from Pfizer Inc.

### REFERENCES:

1. Keller MB: The long-term clinical course of generalized anxiety disorder. The Journal of Clinical Psychiatry 1995; 63; Suppl8:11.
2. Brown TA, Antony MM, & Burlow DH: Diagnostic comorbidity in panic disorder effect on treatment outcome and course of comorbid diagnosis following treatment. Journal of Consulting and Clinical Psychology 1995; 163:(3)408–415.

**Poster 128** **Friday, October 7 3:00 p.m.-4:30 p.m.**

## METABOLIC PROFILE OF RISPERIDONE IN TREATING DISRUPTIVE BEHAVIOR DISORDERS

*Supported by Janssen Pharmaceutica*

Gahan Pandina, Ph.D., *Assistant Director of Medical Affairs, Janssen Pharmaceutica Products, L.P., 1125 Trenton-Harbourton Road, Titusville, NJ 08560*; Magali Reyes, M.D., Ph.D.; Hetal Patel, Pharm.D.; Llse Augustyns, Ph.D.

### EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to (1) discuss the safety aspects of using risperidone in the treatment of children and adolescents, and (2) discuss the effect of risperidone treatment on weight gain, and insulin and glucose levels.

### SUMMARY:

*Methods:* Patients (5–17 years) with DBD who responded to 12 weeks of acute risperidone treatment were randomized in a six-month, double-blind, placebo-controlled study. Body weight, height, BMI, laboratory values, and spontaneous reports of metabolic adverse events were recorded.

*Results:* 527 patients entered the trial, and 335 entered the double-blind phase (median dose: 0.75 mg/day [patients <50 kg]. 1.5 mg/day [patients ≥50kg]). Weight z-scores increased during the 12-week acute treatment (mean change (SD): +0.2 (0.27); n=505). During the six-month, double-blind phase, weight z-scores stabilized for risperidone-treated patients (n=156) and decreased for placebo-treated patients (n=149); mean changes: 0.0 (0.29) and −0.1 (0.22), respectively. Insulin levels increased during the first 12 weeks (median change: +14 pmol/L; n=414) and decreased over the six-month, double-blind phase (median change: −13 pmol/L with placebo, n=132; −7 pmol/L with risperidone, n=138). No clinically relevant changes in glucose levels or glucose-related adverse events were recorded, no patient met the ADA criteria for diabetes, and there was no observed correlation between weight gain and change in insulin levels.

*Conclusions:* Initial weight gain associated with risperidone stabilized over the study and was partially reversible upon treatment discontinuation. No evidence was seen for an increased risk of metabolic disorders with risperidone treatment.

Supported by funding from the Medical Affairs Division, Janssen Pharmaceutica Products L.P.

## TARGET AUDIENCE:

Psychiatrists, researchers.

## REFERENCES:

1. Stigler KA, Polenza MN, Posey DJ, McDougle CJ. Weight gain associated with atypical antipsychotic use in children and adolescents: prevalence, clinical relevance, and management. Paediatr Drugs 2004: 6:33–44.
2. Leslie DL, Rosenheck RA: Incidence of newly diagnosed diabetes attributable to atypical antipsychotic medications. Am J Psychiatry 2004; 161:1709–11.

**Poster 129** **Friday, October 7**
**3:00 p.m.-4:30 p.m.**

## EFFECT OF MEMANTINE ON BEHAVIOR IN MILD TO SEVERE ALZHEIMER'S DISEASE

*Supported by Forest Pharmaceuticals, Inc.*

Elaine R. Peskind, M.D., *Professor, Department of Psychiatry, University of Washington, 1959 Northeast Pacific, Seattle, WA 98195*; Jeffrey L. Cummings, M.D.; Eugene J. Schneider, M.D.; Pierre N. Tariot, M.D.; Stephen M. Graham, Ph.D.

## EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to determine the effect of memantine on behavioral outcomes in Alzheimer's disease patients across disease severity, from mild to severe stages of the illness.

## SUMMARY:

*Objective:* Memantine is a moderate affinity, uncompetitive NMDA receptor antagonist approved for the treatment of moderate to severe Alzheimer's disease (AD), and currently under investigation for mild AD; it is also available in Europe. The effect of memantine on behavior was assessed in two 24-week, double-blind, placebo-controlled trials, one in moderate to severe AD patients on stable donepezil therapy (study MEM-MD-02; N=404) and one in mild to moderate AD patients (study MEM-MD-10; N=403).

*Methods:* Behavioral symptoms were assessed using the Neuropsychiatric Inventory (NPI). The statistical analysis (ANCOVA) was based on the ITT population (LOCF).

*Results:* Baseline characteristics between treatment groups were comparable within each trial. Statistical significance in favor of memantine was observed in both trials at endpoint (NPI total). Several NPI domains demonstrated statistical significance in favor of memantine (MEM-MD-02: agitation/aggression, irritability/lability, appetite/eating; MEM-MD-10: irritability/lability, aberrant motor behavior, appetite/eating). Significantly fewer memantine patients asymptomatic at baseline exhibited agitation/aggression, irritability/lability and nighttime behavioral disturbances (MEM-MD-02), and delusions and irritability/lability (MEM-MD-10) at study endpoint. Patients with baseline symptoms exhibited significantly less worsening of agitation/aggression, apathy, irritability (MEM-MD-02), and delusions and apathy (MEM-MD-10) at study endpoint.

*Conclusions:* These results support the use of memantine to reduce behavioral symptoms associated with AD.

Funding Source(s): Forest Laboratories, Inc.

## TARGET AUDIENCE:

General practitioners and geriatric specialists.

## REFERENCES:

1. Tariot P, Farlow M, Grossberg G, et al: Memantine treatment in patients with moderate to severe Alzheimer disease already receiving donepezil: a randomized controlled trial. JAMA 2004; 291(3):317–324.
2. Peskind E, Potkin S, Pomara N, et al: Memantine monotherapy is effective and safe for the treatment of mild to moderate Alzheimer's disease: a randomized, controlled trial (abstract). Eur J Neurol 2004: 11(Suppl 2)186.

**Poster 130** **Friday, October 7**
**3:00 p.m.-4:30 p.m.**

## EFFICACY OF MEMANTINE ON COGNITION IN MILD TO SEVERE ALZHEIMER'S DISEASE

*Supported by Forest Pharmaceuticals, Inc.*

Elaine R. Peskind, M.D., *Professor, Department of Psychiatry, University of Washington, 1959 Northeast Pacific, Seattle, WA 98195*; Frederick A. Schmitt, Ph.D.; Christopher H. van Dyck, M.D.; Howard Feldman, M.D.; Pierre N. Tariot, M.D.; Malca Resnick, Ph.D.

## EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to assess the efficacy of memantine for cognitive deficits in Alzheimer's disease patients across disease severity.

## SUMMARY:

*Objective:* Memantine, a moderate affinity, uncompetitive NMDA-receptor antagonist, is approved for moderate to severe Alzheimer's disease (AD) in the

U.S. and is available in Europe. This report provides additional analyses from two clinical trials.

*Methods:* A 24-week, double-blind, placebo-controlled trial in mild to moderate AD patients (N=403) randomized to memantine or placebo assessed cognition with the ADAS-cog. Another 24-week, double-blind, placebo-controlled trial conducted in moderate to severe AD patients treated with ongoing donepezil therapy (N=404) and randomized to memantine or placebo assessed cognition using the SIB. ANCOVAs were performed on total score, items, and subscales (LOCF).

*Results:* Memantine-treated patients showed statistically significant improvement compared with placebo-treated patients. For mild to moderate AD, significant (P<.05) ADAS-cog items were: commands, orientation, comprehension, recall of instructions. Previously published factor analytically derived subscales revealed a significant effect of memantine on language and memory. For moderate to severe AD, three SIB subscales revealed significant effects: language, memory, praxis.

*Conclusions:* These findings support the efficacy of memantine in moderate to severe AD and suggest that memantine may provide cognitive benefits across disease severity through effects on memory, language, and possibly praxis.

*Funding Source:* Forest Laboratories, Inc.

## TARGET AUDIENCE:

The target audience consists of general practitioners and geriatric specialists.

## REFERENCES:

1. Tariot P, Farlow M, Grossberg G, et al: Memantine treatment in patients with moderate to severe Alzheimer disease already receiving donepezil: a randomized controlled trial. JAMA 2004; 291(3):317–324.
2. Peskind E, Potkin S, Pomara N, et al: Memantine monotherapy is effective and safe for the treatment of mild to moderate Alzheimer's disease a randomized, controlled trial (abstract). Eur J Neurol 2004: 11(Suppl 2)186.

**Poster 131** **Friday, October 7**
**3:00 p.m.-4:30 p.m.**

# DIALECTICAL BEHAVIOR THERAPY WITH TRANSITIONAL YOUTH

Jaak Rakfeldt, Ph.D., *Professor, Department of Social Work, Southern Connecticut State University, 101 Farnham Avenue, New Haven, CT 06515*

## EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: (1) to identify the major DBT techniques, (2) describe effective interventions used to engage young people both individually, and in groups, and (3) apply dialectical-behavioral therapy (DBT) interventions with young persons in participants' own clinical settings.

## SUMMARY:

*Purpose:* This study explored the efficacy of dialectical behavior therapy (DBT) for young people aging out of the department of children and families system.

*Method:* The project was conducted with participants at a residential program for transitional youth who have serious emotional disturbance and emerging mental illness (N=15). The research method combined a posttest-only comparison group design, with pretest-posttest observations for the DBT group. The research question explored the efficacy of DBT for this population, and used a mixed-method approach combining both quantitative and qualitative data collection. All participants received individual therapy, with 24/7 wraparound residential services. The DBT intervention consisted of an additional two hours of weekly skills-training groups. The mean length of exposure to the DBT intervention was 12.4 months. The quantitative measures included the Modified Global Assessment of Functioning Scale, and the Purposeful Productive Activity and Quality of Life Scale. The qualitative portion of the study involved semi-structured interviews and focus groups.

*Results:* Members of the DBT group improved from pretest to post test, and when judged against the comparison group improvement was in terms of global functioning, social relationships, and productive use of time or ''intentionality,'' but not in terms of vocational functioning. The qualitative data suggest that DBT group members used the groups to work on specific interpersonal relationship, emotion regulation, and distress tolerance skills, as well as to get feedback and support from others in the group.

*Conclusion:* The potential implications of these findings for clinical practice may be to suggest DBT as a promising, evidence-based intervention leading to recovery and greater community integration for this vulnerable and heretofore under-served population.

## TARGET AUDIENCE:

Clinicians who work with young people in various Community-based clinical settings. Clinical researchers who are interested in evidence-based, best practices, and recovery oriented clinical research.

## REFERENCES:

1. Rakfeldt J, Rybash JM, Roodin PA: Affirmative coping: a marker of success in adult therapeutic intervention, in M. L. Commons, J. Demick, and C. Goldberg (Eds.): Clinical Approaches to Adult Development, Norwood, NJ: Ablex, 1996, pp 295–310.

2. Rakfeldt J: Dialectical behavior therapy with transitional youth: preliminary findings. Best Practices in Mental Health: An International Journal, in press.

**Poster 132** **Friday, October 7**
**3:00 p.m.-4:30 p.m.**

## THE SAFETY OF A GALANTANINE-MEMANTINE COMBINATION FOR MILD TO MODERATE ALZHEIMER'S DISEASE

*Supported by Janssen Pharmaceutica*

Krishnan Ramaswamy, Ph.D., *Associate Director, Central Nervous System Outcomes Research, Janssen Pharmaceutica and Research Foundation, 1125 Trenton-Harbourton Road, Titusville, NJ 08560*; Joan Amatniek, M.D., *Employee, Ortho-McNeil Neurologics, Inc., 1125 Trenton-Harbourton Road, Titusville, NJ 08560*; Young Zhu, Ph.D.

### EDUCATIONAL OBJECTIVES:

Assess the safety and tolerability associated with the combination of galantamine and memantine in the treatment of patients with mild to moderate Alzheimer's disease, and compare and contrast the rate of adverse events in patients who received galantamine, galantamine plus memantine, and untreated subjects.

### SUMMARY:

*Introduction:* No published data exist on the safety and tolerability of concomitant galantamine (GAL) and memantine (MEM) for Alzheimer's disease (AD). An interim safety analysis from an ongoing study of mild to moderate AD patients was performed.

*Methods:* In this two-year, multicenter, prospective, open-label, observational study, patients received GAL or no AD medications at entry. Physicians altered therapy as needed. Data collected at the first interim observed-case analysis included patients receiving MEM and other treatments. Because of uneven follow-up times, analyses were adjusted for years at risk.

*Results:* 429 subjects were analyzed in ≥1 groups: GAL (319), MEM (9), GAL+MEM (48), AChEI other than GAL (other-AChEI, 18), and untreated (141). Adverse event (AE) data were compiled for 259.9 patient years at risk (y) (GAL, 158.9; MEM, 1.7; GAL+MEM 24.5; other-AChEI, 4.5; untreated, 70.3). 19.3% of patients reported AEs (0.32 per year at risk [PYR]). AEs were reported by 14.1% (0.28 PYR) of GAL, 16.7% (0.33) of GAL+MEM and 19.1% (0.38) of untreated subjects. AEs were reported by 22.2% (1.18) and 5.6% (0.22) of MEM and other-AChEI subjects, respectively.

*Conclusions:* This analysis suggests GAL+MEM appears safe and well tolerated when compared with an untreated group in mild to moderate patients in a real-world observational study.

This study was funded by Janssen Pharmaceutica Products, L.P. (Titusville, New Jersey).

### REFERENCES:

1. Shua-Haim JR, Smith J, Pass M, Patel P: Safety, tolerability, and caregiver's impressions of combination therapy with galantamine and memantine for the treatment of Alzheimer's disease. July 17–22, 2004; Philadelphia, Pennsylvania. Abstract P1–392.
2. Yao C, Raoufinia A, Gold M, et al: Steady-state pharmacokinetics of galantamine are not affected by addition of memantine in healthy subjects. J Clin Pharmacol 2005.

**Poster 133** **Friday, October 7**
**3:00 p.m.-4:30 p.m.**

## TRENDS IN ADHD AND STIMULANT USE AMONG ADULTS: 1995–2002

Linda M. Robison, M.S.P.H., *Research Coordinator, Pharmacy Department, Washington State University, P.O. Box 646510, Pullman, WA 99164-6510*; David A. Sclar, Ph.D.; Tracy L. Skaer, Pharm.D.

### EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize the significant increase in the rate of adults seeking medical care for ADHD in the U.S., and in the use of stimulants for its treatment.

### SUMMARY:

*Purpose:* To evaluate whether the trend in adults seeking medical care for the treatment of ADHD reflects the upward pattern seen among children.

*Methods:* Data from the U.S. National Ambulatory Medical Care Survey were utilized for this analysis. The number and rate of office-based physician visits resulting in a diagnosis of ADHD (*ICD-9-CM* code 314.00 or 314.01) among patients ≥20 years old, were discerned for the years 1995 through 2002. Trend analysis was conducted using four time intervals: 1995–96; 1997–98; 1999–00, 2001–02.

*Results:* Over the time frame, national estimates of the number of annualized office-based physician visits documenting a diagnosis of ADHD among adults increased 2.5-fold; from 582,728 in 1995–96, to 1,462,432 in 2001–02. Adjusted for population growth, the rate per year of office visits per 1,000 U.S. population ≥20 years old resulting in a diagnosis of ADHD more than doubled, increasing from 3.1 per 1,000 in 1995–96, to 7.1 in 2001–02. The majority of office visits documented a prescription for stimulant pharmacotherapy, increasing from 61.7% in 1995–96, to 76.2% in 2001–02.

*Conclusions:* As with children, the rate of adults seeking medical care for ADHD has increased significantly. By 2001–02, adults accounted for more than one in five (21.8%) office visits resulting in a diagnosis of ADHD.

*Funding Source:* Pharmacoeconomics & Pharmacoepidemiology Research Unit, Washington State University.

## TARGET AUDIENCE:

Psychiatrists, mental health policy stakeholders.

## REFERENCES:

1. Robison LM, Skaer TL, Sclar DA, Galin RS. Is attention deficit hyperactivity disorder increasing among girls in the US?: Trends in diagnosis and the prescribing of stimulants. CNS Drugs 2002; 16(2):129–137.
2. Robison LM, Sclar DA, Skaer TL: Attention-deficit/hyperactivity disorder among adults. New England Journal of Medicine 1999; 340(22):1767.

**Poster 134** **Friday, October 7**
**3:00 p.m.-4:30 p.m.**

## PROFILE OF PATIENTS WHO LOOKED FOR SUBSTANCE ABUSE TREATMENT FROM JULY 1999 TO JULY 2004 AND THEIR GENDER DIFFERENCES IN RIO DE JANEIRO, BRAZIL

*Supported by FAPERJ*

Ana C. Saad, M.D., *Medical Director, Department of Integral Prevention to Drug Abuse of the Antidrug State Council, Rua Bogari 15, Apt. #0501, Rio de Janeiro, Brazil 22471-340*; Marcia L. Carualho, M.D., *Medical Director, Department of Integral Prevention to Drug Abuse of the Antidrug State Council, Rua Bogari 15, Apt. #0501, Rio de Janeiro, Brazil 22471-340*; Erika Asfora; Marlucia Van Der Put; Milton A. Mattos; Denise V. Rosa; Barbosa Fernanda

## EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize a Brazilian substance abuse program with its cultural specificity, demonstrate in this program the differences between the male and female group in matters of sociodemographic data and the history of drug abuse.

## SUMMARY:

*Objective:* to identify the profile of the patients who sought treatment for substance abuse at the Department of Integral Prevention to Drug Abuse of the Antidrugs State Council (DEPRID/CEAD) of Rio de Janeiro, Brazil, from 1999 to July 2004 and the differences between the male and female population.

*Methods:* We studied a sample of 1,971 (20%) male and 1,701 (100%) female. We compared proportions using the chi-square test; $p<0.001$ was considered statistically significant.

*Results:* The sample was a majority of male (85.0%) who lived alone (55.1%); 48.6% had elementary school education, and 62.5% were unemployed. The beginning of drug use was between 10 and 17 years of age but 8.3% of male and 9.1% of female started before age 10. Alcohol was the drug most used (62%) followed by cocaine and marijuana. There were statistically significant differences between male and female on variables: spontaneously seeking treatment; family history of drug abuse; mother and spouse history of drug abuse; alcohol as the initial drug and alcohol, marijuana, and cocaine as drug of choice.

*Conclusion:* Although substance abuse treatment is sometimes a unique program, we must consider gender differences. It is important to consider the impact of alcohol on the Brazilian culture and its consequences on the public health system.

This research was funded by FAPERJ.

## TARGET AUDIENCE:

Substance abuse practitioners.

## REFERENCES:

1. Saad AC: O discurso da droga e a droga na história de pacientes em tratamento no Brasil e nos Estados Unidos''. Instituto do Psiquiatria/UFRJ, 1998. Tese de Doutorado.
2. Castel S, Malbergier A: Farmacodependencias: estudo comparativo de uma população atendida em serviço especializado''. Revista ABP-APAL 1989; 11(3):126–132.

**Poster 135** **Friday, October 7**
**3:00 p.m.-4:30 p.m.**

## DROP-OUTS AND RETENTION AT A UNIVERSITY SUBSTANCE ABUSE PROGRAM

*Supported by the National Antidrug Secretariat of Brazil*

Ana C. Saad, M.D., *Medical Director, Department of Integral Prevention to Drug Abuse of the Antidrug State Council, Rua Bogari 15, Apt # 0501, Rio de Janeiro, Brazil 22471-340*; Marcelo S. Cruz, M.D., *Medical Director, National Antidrug Secretariat of Brazil, Rua Bogari 15, Apt. #0501, Rio de Janeiro, Brazil 22471-340*; Nilzete R. Costa; Marcio M. Barbuto, M.D.

## EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to describe the benefits of staying in an intense drug treatment program for at least six months or more.

## SUMMARY:

*Objective:* to identify the differences between patients who stayed in treatment (rettention) for six or more than six months with those who dropped out (dropouts) before six months in their sociodemographic characteristics, previous treatments, and drug used.

*Methods:* the two groups of patients were compared (n=90 patients): 41 from the group who abandoned treatment and 49 who did not. We compared proportions using the chi-square and Fisher Exact test; *t Student* test for mean age and *Mann-Whitney* for time of treatment; p=0,05 was considered statistically significant.

*Results:* The sample was a majority of male (80%) who lived by themselves (74.4%). The age varied from 18 to 68 years old, mean age 38.39; 38.9% had elementary school education; 34.1% had a legal problem. Alcohol was the drug most used followed by cocaine and marijuana. About 78% of the patients had had a previous treatment.

There were statistically significant differences between the two groups on the variables age and educational level. There were no statistically significant differences between the two groups on the other variables.

*Conclusion:* The youngest people leave treatment more frequently and are at risk for intense drug use. It is very important for substance abuse programs to direct treatment toward this population.

This research was funded by National Antidrugs Secretariat of Brazil - SENAD.

## TARGET AUDIENCE:

Substance abuse practitioner.

**Poster 136 WITHDRAWN**

**Poster 137** **Friday, October 7**
**3:00 p.m.-4:30 p.m.**

## EFFICACY AND SAFETY OF EXTENDED-RELEASE DEXMETHYLPHENIDATE IN CHILDREN WITH ADHD

*Supported by Novartis Pharmaceuticals Corporation*

Raul A. Silva, M.D., *Deputy Director, Division of Child and Adolescent Psychiatry, New York University School of Medicine, 550 First Avenue, NB2156, New York, NY 10016*; Rafael Muniz, M.D.; Linda Pestreich, M.D.; Jim Wang, Ph.D.; Frank Lopez, M.D.; Matthew N. Brams, M.D.; Ann C. Childress, M.D.

## EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to describe the efficacy and safety of once-daily dexmethylphenidate extended-release (d-MPH-ER) in children with attention-deficit/hyperactivity disorder (ADHD).

## SUMMARY:

*Objective:* To evaluate dexmethylphenidate extended-release (d-MPH-ER) capsules 20 mg QD, in pediatric ADHD in a laboratory classroom.

*Methods:* This double-blind, fixed-dose, two-way crossover study randomized 54 children aged 6–12 years, previously stabilized on methylphenidate 20–40 mg/d. They received d-MPH-ER 20 mg/d or placebo for five days at home. After a one-day washout, they received one dose of assigned treatment in the classroom. Evaluations took place predose and at several time points up to 12 hours postdose. They were then crossed over to the alternate treatment using the identical protocol. The primary efficacy variable was SKAMP-Combined score at one hour postdose; secondary efficacy variables included SKAMP-Attention and -Department scores and written math test results over 12 hours.

*Results:* Improvements in SKAMP-Combined,-Attention, and -Deportment scores were significantly greater with d-MPH-ER than with placebo at all time points through 12 hours (*P* values ranging from <.001 to .046). The number of math problems attempted and answered correctly was also significantly greater with d-MPH-ER at all time points (*P*<.001 vs placebo). D-MPH-ER was well tolerated, with no serious or severe adverse events.

*Conclusion:* D-MPH-ER 20 mg QD significantly improves classroom attention, deportment, and performance in pediatric ADHD.

Supported with funding from Novartis Pharmaceuticals Corporation.

## TARGET AUDIENCE:

Child & Adolescent Psychiatrists.

## REFERENCES:

1. Ding YS, Fowler JS, Volkow ND, et al: Psychopharmacology (Berl) 1997; 131:71–78.
2. Quinn D, Wigal S, Swanson J, et al: JAACAP 2004; 43:1422–1429.

**Poster 138** **Friday, October 7 3:00 p.m.-4:30 p.m.**

## DECREASED TEMPORAL LOBE VOLUME IN PANIC DISORDER: A QUANTITATIVE MRI STUDY

Thomas Sobanski, M.D., *Medical Doctor, Thuringen-Kliniken, Rainweg 68, Saalfeld, Russia*; Gerd Wagner, Ph.D.; Gwe Gruhn, M.D.; Kathrw Schluttig, M.D.; Gregor Peikert, Ph.D.; Ralf Tauber, M.D.; Heinrich Sager, M.D.

### EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to discuss pathogenetic involvement of the temporal lobes in panic disorder.

### SUMMARY:

*Introduction:* Functional neuroimaging studies have provided evidence for the involvement of temporal and frontal lobes, amygdala, and hippocampus in the pathophysiology of panic disorder, but findings are inconsistent.

*Methods:* Magnetic resonance imaging (MRI) scans were performed in a group of 17 inpatients with panic disorder and a control group matched for age and gender. Volumetric analyses of regions of interest were made semi-automatically by two raters who were unaware of identifying subject data. The following structures were measured: temporal lobe, amygdala-hippocampus complex, frontal lobe, caudate nucleus, putamen, and whole brain volume. Statistical analysis was done by multivariate and univariate variance analyses. Data were corrected for whole brain volume.

*Results:* In patients with panic disorder volumes of both temporal lobes and of the right frontal lobe were decreased. The amygdala-hippocampus complexes of the patients and healthy control subjects did not differ.

*Conclusions:* Earlier results of temporal lobe atrophy in panic disorder (Vythilingam et al. 2000) are confirmed by our study and the hypothesis of a pathogenetic involvement of the temporal lobes in panic disorder is supported. Our finding of reduced right frontal lobe volume stands in line with abnormalities reported in functional imaging studies.

### REFERENCES:

1. Gorman J, et al: Neuroanatomical hypotheses of panic disorder, revised. Am J Psychiatry 2000; 157:493–505.
2. Vythilingam M, et al: Temporal lobe volume in panic disorder—a quantitative magnetic resonance imaging study. Psychiatry Res 2000; 99:75–82.

**Poster 139** **Friday, October 7 3:00 p.m.-4:30 p.m.**

## MEDIA COVERAGE OF WAR AS A TRIGGER FOR RELAPSE OF MAJOR DEPRESSION

Scott G. Williams, M.D., *Psychiatrist, Walter Reed Army Medical Center, 631 D Street, N.W., Apt. 1129, Washington, DC 20004*; Alex G. Trvesdell, M.D.

### EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize the importance of media coverage of war as a potential trigger of relapse in major depressive disorder especially in military personnel and understand the importance of thorough history taking.

### SUMMARY:

Major depressive episodes are very common, affecting approximately 16% of the U.S. population and reaching as high as 50% in primary care clinics. Recurrence of MDE is also extremely common, with a second episode occurring in over 50% of patients and subsequent episodes occurring more and more frequently such that the risk of a fourth episode is 90% following a third recurrence. We present a case of recurrent major depressive disorder in a retired soldier who was initially hospitalized for three months due to depression during the 1991 Gulf War. He was treated and returned to his premorbid level of functioning. By the late 1990s he did not require any antidepressant medication and was working two to three part time jobs without difficulty. In March 2003, shortly after the invasion of Iraq began, he presented to his primary physician disheveled, with symptoms consistent with those that precipitated his hospitalization in 1991, but denied suicidal ideation. MMSE at that time was 27/30. He admitted that watching the war coverage elicited feelings reminiscent of his prior MDE. He was started on Zoloft and Klonopin. By May 2003 he endorsed modest symptom improvement and was started on Wellbutrin. In August 2003 he was back at baseline. Depression manifests in a variety of ways, and patients are often reluctant to tell their primary physician the whole story when it comes to their mood. Knowledge of past experiences and a caring, sympathetic attitude will elicit subtle but significant findings that can often result in dramatic improvement in quality of life.

### TARGET AUDIENCE:

General psychiatrists especially those who work closely with primary care physicians.

### REFERENCES:

1. Kessler RC, et al: The epidemiology of major depressive disorder: results from the National Comor-

bidity Survey Replication. JAMA 2003; 289:3095–3105.
2. Mueller TI, et al: Recurrence after recovery from major depressive disorder during 15 years of observational follow-up. Am J Psychiatry 1999; 156:1000–1006.

**Poster 140** **Friday, October 7**
**3:00 p.m.-4:30 p.m.**

## NON-MEDICAL USE AND DIVERSION OF STIMULANTS IN THE U.S. IN 2002

*Supported by Eli Lilly and Company*

David L. Van Brunt, Ph.D., *Research Scientist, Health Outcomes Research, Eli Lilly and Company, Lilly Corporate Center, Drop Code 4025, Indianapolis, IN 46285*; Larry A. Kroutil, M.P.H.; Mindy Herman Stahl, Ph.D.; David C. Heller, B.S.; Robert M. Bray, Ph.D.; Michael A. Penne, M.P.H.

### EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to discuss the scope of stimulant misuse in the United States, and demographic factors associated with misuse.

### SUMMARY:

*Objective:* To describe rates of prescription stimulant diversion (either non-medical use or non-prescribed use of a prescription drug) in the United States, and to compare the use of diverted prescriptions with methamphetamine across demographic groups.

*Method:* Computed weighted frequencies from the National Survey on Drug Use and Health to obtain unbiased estimates of rates and correlates of non-medical stimulant use in the U.S. civilian population age 12 or older (sample N=54, 079). Logistic regressions provided adjusted odds ratios within demographic subgroups.

*Results:* In 2002, about 3.2 million persons (1.4% of U.S. population >= age 12) used any stimulant non-medically in the past year. Of these, 1.6 million (50.4%) principally used diverted prescription (i.e, not methamphetamine). Persons under age 26 were more likely than older adults to abuse both methamphetamine (OR=2.46, 95% ci=1.78-3.39) and prescription stimulants (OR= 3.84, 95% ci=3.05–4.83). Although males were more likely than females to report methamphetamine use (OR=1.40, 95% ci=1.07–1.82), non-medical use of prescription stimulants did not vary significantly by gender. There were no significant differences in methamphetamine or prescription stimulant estimates by population density. Long-acting stimulants were not exempt from non-medical use.

*Conclusions:* The diversion of prescription stimulants is numerically substantial and statistically comparable to methamphetamine use. Stimulant diversion is not constrained by urban boundaries.

### REFERENCES:

1. Substance Abuse and Mental Health Services Administration. Results from the 2002 National Survey on Drug Use and Health: National Findings (Office of Applied Studies, NSDUH Series H-22, DHHS Publication No. SMA 03-3836). Rockville, MD, 2003.
2. Stockl KM, Hughes TE, Jarrar MA, Secnik K, Perwien AR: Physician perceptions of the use of medications for attention deficit hyperactivity disorder. J Manag Care Pharm 2003; 9(5):416–423.

**Poster 141** **Friday, October 7**
**3:00 p.m.-4:30 p.m.**

## METHYLPHENIDATE IN ADULT ADHD PATIENTS WITH EPILEPSY

Christina M. Vanderfeltz-Cornelis, Ph.D., *Psychiatrist, Netherlands Institute of Mental Health and Addiction, Da Costakade 45, Utrecht, Netherlands*

### EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize the high prevalence of adult ADHD in epilepsy patients, recognize the concomitant psychiatric comorbidity, and know how to treat patients with adult ADHD in treatment-refractive epilepsy effectively and safely with methylphenidate.

### SUMMARY:

In order to establish effectiveness and safety of methylphenidate treatment in adult ADHD patients, an open trial was performed in 126 consecutive patients with pseudo seizures. A prevalence of 2.4% was found for adult ADHD. This is higher than in the general population. Methylphenidate 10 mg twice daily was prescribed in three patients with epilepsy and three with pseudo seizures, diagnosed with adult ADHD. Follow up after six weeks showed clinical improvement of ADHD symptoms during treatments in both groups.

None of the patients experienced adverse effects on seizure control or anti-epileptic drug use.

### REFERENCES:

1. Gucuyener K, Kemal Erdemogu A, Senol S, Serdaroglu A, Soysal S, Kockar I: Use of methylphenidate for attention-deficit hyperactivity disorder in patients with epilepsy or electroencephalographic abnormalities. J Child Neurol 2003; 18:109–112.
2. Van der Feltz-Cornelis CM. Intractable obsessive-compulsive disorder: co-morbidity with unrecog-

nized adult attention-deficit hyperactivity disorder? J Nerv Ment Dis 1999; 187:4:243–5.

**Poster 142** **Friday, October 7**
**3:00 p.m.-4:30 p.m.**

## PARATONIA AS A POSSIBLE CLINICAL MARKER OF ALZHEIMER'S DISEASE

Ipsit V. Vahia, M.D., *Resident, Department of Psychiatry, State University of New York, Downstate Medical Center, 372 State Street, #1, Brooklyn, NY 11217*; Alla Prehogan, M.D.; Carl I. Cohen, M.D.

### EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to appreciate how paratonia may serve as a neurological indicator of progression of AD that is independent of race and other demographic variables.

### SUMMARY:

Paratonia may occur commonly in Alzheimer's disease (AD), but it is not well studied. This study examines the prevalence of paratonia and its association with various clinical and sociodemographic variables in a multiracial sample of 80 AD outpatients. Paratonia was significantly associated with stage of illness and number of frontal symptoms, but not with other variables. Significantly, it was not found to be correlated with level of functioning in Alzheimer's disease, suggesting that it may serve as an indicator of frontal lobe degeneration, independent of level of functioning. A heightened awareness of paratonia may be warranted in light of its potential utility as an independent clinical marker of disease stage and its role in signifying frontal lobe dysfunction.

This study was supported in part by NIA Grant P30AG08051.

### REFERENCES:

1. Beversdorf DQ, Heilman KM: Facilitory paratonia and frontal lobe functioning. Neurology 1998; 51(4): p. 968–71.
2. Risse SC, et al: Myoclonus, seizures, and paratonia in Alzheimer disease. Alzheimer Dis Assoc Disord 1990; 4(4): p. 217–25.

# POSTER SESSION 5

**Posters 143–185**

## COMMUNITY PSYCHIATRY

**Poster 143** **Saturday, October 8**
**8:30 a.m.-10:00 a.m.**

## RISK FACTORS RELATED TO USING SECLUSION AND RESTRAINT IN ACUTE ADULT PSYCHIATRIC UNITS

Amel A. Badr, M.D., *Department of Psychiatry, Bergen Regional Medical Center, 230 East Ridgewood Avenue, Paramus, NJ 07652*; Asghar Hossain, M.D., *Distinguished Fellow, Department of Psychiatry, Bergen Regional Medical Center, 230 East Ridgewood Avenue, Paramus, NJ 07652*; Akbar Khan, M.D.; Javed M. Iqbal, M.D.

### EDUCATIONAL OBJECTIVES:

The aim of this study is to identify the risk factors associated with the use of seclusion and restraint in acute adult psychiatric wards. This would allow early recognition and effective intervention to prevent or limit the use of seclusion and restraint.

### SUMMARY:

*Background and rationale:* The use of seclusion and restraint in psychiatric services remains a subject of debate. These measures have valid clinical applications yet can result in serious physical and psychological trauma to the patients and staff. Identifying the risk factors is important for their safety.

*Method:* Retrospective chart review was done for all adult psychiatric admissions during the time period of January 1, 2003, December 1, 2003 and all episodes of seclusion and restraint were reviewed. Demographic and clinical data of patients, date, time, and reason for each episode were recorded.

*Results:* Of 2,315 admissions, there were 53 episodes of seclusion and restraint (2.9%). Males, mean age 36+/−11, admitted involuntarily accounted for most of the episodes. Two thirds of the events occurred during the first 72 hours of admission and 33% happened during the morning shift. The most frequent diagnoses were schizophrenia (26%), schizoaffective disorder (11.3%), and bipolar disorder (22.6%).

*Conclusion:* This study demonstrates a preponderance of using seclusion and restraint in recently admitted, younger, male involuntary patients with the diagnoses of schizophrenia, schizaffective disorder, and bipolar disorder. The frequency of these interventions was

higher during morning shift, possibly due to higher level of interactions and more demands.

## REFERENCES:

1. Altenor A: Seclusion and restraints. Psychiatric Services 2000; 51(10):1318.
2. Fisher W A: Restraint and seclusion: a review of literature. American Journal of Psychiatry 1994; 151:1584–1591.

**Poster 144** **Saturday, October 8**
**8:30 a.m.-10:00 a.m.**

## AN INTERVENTION TO REDUCE SECLUSION AND RESTRAINT ON A CHILDREN'S INPATIENT UNIT

Michael A.B. Bogrov, M.D., *Service Chief, Children's Inpatient Unit, Sheppard Pratt Health Services, 6501 North Charles Street, Baltimore, MD 21285*; Marty Spence, R.N., *Unit Manager, Children's Inpatient Unit, Sheppard Pratt Health Services, 6501 North Charles Street, Baltimore, MD 21285*

## EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to formulate a child-centered plan for reduction of seclusion and restraint in a residential program; recognize the importance of promoting autonomy as an intervention in reducing seclusion and restraint in a residential program.

## SUMMARY:

Over a three-year period, a concerted effort to reduce the number of seclusion and restraint incidents on a children's inpatient unit resulted in an 83% reduction in events. In addition, there has also been a similar reduction in staff injuries. The designed intervention focused on four areas: modifications to the physical structure of the unit, reallocation of staff to target critical areas and times, modification of the milieu program to emphasize self-control for patients experiencing emotional crises, and training of staff in preventive approaches. A subsequent protocol uses specific interventions and outcome data to identify more proactive strategies. This includes development of a children's scale to identify children at risk for escalated behavior, an individualized intervention to help children reduce their risk of escalation, a parenting component to complement and continue the hospital-based intervention, and an affective education intervention for both children and caregivers. The outcome measures are designed to pull for autonomy and competence in managing affective lability, objective demonstration of affective stability, and a sense of hopefulness in managing affective instability. These measures are for children and caregivers involved in the program.

## REFERENCES:

1. Master KJ, Bellonci C, and the Work Group on Quality Issues. Practice Parameter for the Prevention and Management of Aggressive Behavior in Child and Adolescent Psychiatric Institutions, With Reference to Seclusion and Restraint, Journal American Academy Child and Adolescent Psychiatry 2002; 41(2):45–255.
2. Strayhorn JM Jr: Self-control: toward systematic training programs. Journal American Academy Child and Adolescent Psychiatry 2002; 41:1.

**Poster 145** **Saturday, October 8**
**8:30 a.m.-10:00 a.m.**

## BOARDING HOME PLACEMENT IN PATIENTS WITH SCHIZOPHRENIA

Robert G. Bota, M.D., *Resident, Department of Psychiatry, University of Missouri, 7638 Goddard Drive, Shawnee, KS 66214*; John S. Munro, M.D.; Kemal Sagduyu, M.D.

## EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to explain how boarding home placement decreases the need for inpatient hospitalization in people who are diagnosed with schizophrenia.

## SUMMARY:

*Objective:* To determine if boarding home placement of patients with schizophrenia decreases the need for acute inpatient treatment, during and after the placement.

*Method:* Data were collected from the medical records of the 74 patients initially diagnosed with schizophrenia in our hospital from July 2001 to June 2002. The progress of these patients was then tracked until February 2005.

*Results:* From this patient cohort, 35 had no boarding home (BH) placement and used our inpatient services with a frequency of 1.1 days a month on average. Another 20 patients were placed in a BH after an average period of ten months without placement in a BH. During the pre-BH period they needed more acute inpatient care (3.3 vs. 1.1 days/month) than patients that did not received BH services ($p<0.0003$). Following BH placement these 20 patients spent an average of 14 months in a BH, requiring only 0.34 days/month inpatient treatment. On discharge from BH, for the next 11 months they needed only 0.22 days/month of inpatient services. Remaining patients were lost at follow up.

*Conclusion:* Referral to BH was done as result of frequent need for acute inpatient stabilization. BH place-

ment resulted in a persistent decrease in the need for inpatient hospitalization.

No funding sources were used.

## TARGET AUDIENCE:

Psychiatrists, social workers, MHCP.

## REFERENCES:

1. Parker G, Barr R: The exodus of long-stay psychiatric patients. Med J. 1978; 1:801–3.
2. Dubin WR: A positive look at BH. Hosp Comunity psychiatry 1978; 29:593–5.

**Poster 146** **Saturday, October 8**
**8:30 a.m.-10:00 a.m.**

## PSYCHOSOCIAL TREATMENT IN SPANISH FOR OLDER LATINOS WITH SCHIZOPHRENIA

*Supported by the National Institute of Mental Health*

Jesus A. Bucardo, M.D., *Assistant Clinical Professor of Psychiatry, University of California at San Diego, P.O. Box 337, Bonita, CA 91908*; Brent T. Mausbach, Ph.D.; Conception Barrio, Ph.D.; Christine L. McKibbin, Ph.D.; Sherrill R. Goldman, M.A.; Dilip V. Jeste, M.D.; Thomas L. Patterson, Ph.D.

## EDUCATIONAL OBJECTIVES:

At the conclusion of this session the participant should be able to (1) recognize cultural scripts and roles that influence treatment acceptance and adherence among Latinos; (2) discuss cultural and language issues relevant to the adaptation of interventions for Latino patients; and (3) recognize the importance of family participation in treatment of Latino patients.

## SUMMARY:

There are growing numbers of Latino patients with psychoses living into old age in the U.S. There is a need for culturally appropriate behavioral interventions designed to improve their functioning. We describe the development of a community-based intervention, PEDAL (Programa de Entrenamiento para el Desarrollo de Aptitudes para Latinos), designed to enhance functioning of Latinos with schizophrenia. Initially, we translated and adapted an Anglo-oriented manualized psychosocial intervention. We then conducted a pilot test at three psychiatric clinics in San Diego County specializing in care of Latinos. First we compared participants randomly assigned to: (1) the 24-session PEDAL group therapy (n=21); or (2) a support group (SG; n=8). Compared with the patients randomized to SG, PEDAL-treated patients' everyday living skills improved significantly. We also compared the 21 PEDAL-treated patients with Latinos (n=15) who indicated they spoke English and were treated with the original non-adapted intervention in English. PEDAL participants demonstrated significant improvement in living skills compared with those treated in the English version. Results suggest that participation in a program designed specifically for older Latino patients with psychotic disorders, has the potential to significantly increase the patients' independence and improve functional skills.

The funding source for this study is the National Institute of Health.

## TARGET AUDIENCE:

Psychiatrists, nurses, social workers, counselors and other allied mental health practitioners that care for Latino patients with schizophrenia and their families.

## REFERENCES:

1. Kopelowicz A, Zarate R, Gonzalez Smith V et al: Disease management in Latinos with schizophrenia: a family-assisted, skills training approach. Schizophr Bull 2003; 29:211–217.
2. Patterson TL, McKibbin CL, Taylor MJ, et al: Functional Adaptation Skills Training (FAST): A pilot psychosocial intervention study in meddle-aged and older patients with chronic psychotic disorders. Am J Geriatr Psychiatry 2003; 11:17–23.

**Poster 147** **Saturday, October 8**
**8:30 a.m.-10:00 a.m.**

## IMPACT OF USE OF SECLUSION AND RESTRAINT ON HOSPITAL MILIEU

Satyanarayana Chandragiri, M.D., *Chief Medical Officer, Department of Psychiatry, East Oregon University; and Former APA/Bristol-Myers Squibb and APIRE/Janssen Fellow, 2600 Westgate, Pendelton, OR 97801*; Kanakalatha Abbagani, M.S.W., *Psychiatric Social Worker, Osmania University, Plot #10 Parkview Enclave Manovikasnagar, Secunderabad, India 500009*

## EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize the indirect impact of the use of seclusion and restraint on all the staff and patients in the unit milieu and help take steps to minimize the negative impact on all.

## SUMMARY:

Trauma-informed systems of care should not traumatize or re-traumatize service recipients or the staff that serve them. Physical restraint and seclusion is an extremely intrusive intervention involving significant risks for psychological and physical injury and even death.

Individuals who have been restrained consistently report that the experience violates personal autonomy and basic human dignity, in addition to the negative impact on physical and mental health. Individuals with histories of abuse face even more risks. Staff are also at risk of injury when trying to place agitated individuals into restraint, and many express ethical discomfort with the practice. In this study the staff and persons served in Eastern Oregon Psychiatric Center were surveyed about their perception of the event of restraints and seclusion after they occurred in the unit. The impact of Event scale measured the psychological response to the event. Other significant events occurring in the hospital surrounding the occurrence of seclusion and restraint were also measured by the incident reports. In conclusion, it is felt that events of seclusion and restraint have significant effect on persons in the unit. In designing systems of care that are person centered, it is essential to consider these findings and find ways to mitigate the negative impact on all the members of the community.

No external source of funding used.

## TARGET AUDIENCE:

Psychiatrists, administrators, mental health nurses.

## REFERENCES:

1. National Association of State Mental Health Program Directors: Reducing the use of seclusion and restraint: Part II. March 2001 http://www.nasmbpd.org
2. Horowitz MJ, Wilner N, Alvarez W: Impact of Event scale: a measure of subjective distress. Psychosomatic Medicine 1979; 41:209–218.

**Poster 148** **Saturday, October 7**
**8:30 p.m.-10:00 a.m.**

## SUPPORTED EMPLOYMENT IMPLEMENTATION IN CANADA AND THE U.S.: A FIDELITY EVALUATION

Marc Corbiere, Ph.D., *Assistant Professor, University of British Columbia Health Promotion Research, 2206 East Mall-Room 414, Vancouver, BC, Canada V6T1Z3*; Gary Bond, Ph.D.; Elliot M. Goldner, M.D.; Tasha Ptasinski, B.S.C.; Genevieve Carriere, B.S.C.

## EDUCATIONAL OBJECTIVES:

At the conclusion of this session, participants should be able to distinguish between supported employment programs (an evidence-based practice) and other vocational programs in terms of programmatic components (fidelity and quality). Participants will learn about supported employment programs implementation in Canada and the U.S.

## SUMMARY:

*Objective:* Supported employment (SE) has been documented in the United States as an evidence-based practice that aims to assist people with severe mental illness obtain and maintain employment. The evidence is strongest for the programs following the Individual Placement and Support (IPS) model of SE. This poster examines the degree to which supported employment programs in Canada for individuals with severe mental illness are similar to those being implemented under the American model of SE.

*Methods:* The Quality of Supported Employment Implementation Scale (QSEIS) is a 33-item fidelity scale that measures the extent to which vocational programs follow the evidence-based principles of SE. Data gathered using this scale were compiled for ten supported employment programs from five different vocational agencies in Canada, and compared with U.S. SE (N= 106) and non-SE programs (N=38).

*Results:* Results obtained from these interviews are presented as inter-agency comparisons of both Canadian and American vocational programs. The QSEIS allows us to observe significant differences between SE programs offered through a comprehensive rehabilitation center, SE programs following the IPS model, and non-SE programs. Overall, the Canadian SE programs following the IPS model had the highest fidelity.

*Conclusion:* Implementation of high-fidelity supported employment is possible in Canada.

This study is funded by the Canadian Psychiatric Research Foundation (2003-2005)

## TARGET AUDIENCE:

Researchers and mental health professionals (Psychiatrists, Occupational Therapists, Employment Specialists, & Case Managers) interested in the evaluation of Community Services.

## REFERENCES:

1. Bond GR: Supported employment: evidence for an evidence-based practice. Psychiatric Rehabilitation Journal 2004: 27:345–359.
2. Twamley EW, Jeste DV, Lehman AF: Vocational rehabilitation in schizophrenia and other psychotic disorders-a literature review and meta-analysis of randomized, controlled trials. Journal of Nervous and Mental Disease 2003; 191:515–523.

**Poster 149** **Saturday, October 7**
**8:30 p.m.-10:00 a.m.**

## ECONOMIC REALITIES OF MENTALLY ILL WOMEN: CHALLENGES FOR INTERVENTION

*Supported by the MacArthur Foundation*

Natalie D. Crawford, B.A., *Department of Epidemiology, Columbia University, 722 West 168th Street, Room*

*1714, New York, NY 10032*; Stephanie LeMelle, M.D.; Pamela Y. Collins, M.D.

## EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize the magnitude of poverty among women with severe mental illness (SMI) and describe the content of a money management intervention.

## SUMMARY:

*Objective:* Most women with severe mental illness (SMI) are impoverished. Poverty increases their vulnerability to physical and financial coercion as well as exchange of sex for money. Women with SMI may engage in exchange of sex for money, housing, and other goods. We evaluated a money management intervention that addressed these financial challenges. We present the baseline data.

*Methods:* We assessed money management practices of 98 women with SMI in community mental health settings in New York City.

*Results:* The mean age was 41. Fifty-three (54.1%) women were diagnosed with schizophrenia, 42 (42.9%) carned below the 2004 poverty level 79 (80.6%) received checks from SSI/SSD, and 27 (27.6%) were evicted due to unpaid rent in their lifetime. Although 52 (53.1%) women made a budget for their money in the past three months. 34 (34.7%) women had to borrow money to cover their expenses. Eight (8.2%) had not paid rent on time and 49 (50%) had no money at the month's end.

*Conclusion:* Women in this sample lived below the poverty level and lacked adequate resources at the end of each month. The data support the need for income-generating and money-management interventions that enable women to safely meet their basic needs.

This study was supported in part by NIMII KO1 MH01691 and the MacArthur Foundation.

## TARGET AUDIENCE:

All mental health care providers.

## REFERENCES:

1. Ruesch P, Meyer GJ, et al: Occupation, social support and quality of life in persons with schizophrenia or affective disorders. Social Psychiatry & Psychiatric Epidemiology 686-694.
2. Weinhardt, LS, Carey MP, & Carey KB: IIIV-risk behavior and the public health context of HIV-AIDS among women living with a severe and persistent mental illness Journal of Nervous and Mental Disorders 1998; 276–282.

**Poster 150** **Saturday, October 7**
**8:30 p.m.-10:00 a.m.**

# VIOLENCE RISK ASSESSMENT OF HATE CRIME OFFENDERS

Desiree A. Crevecoeur, Ph.D., *Project Director, Department of Psychiatry, University of California at Los Angeles, 1640 South Sepulveda Boulevard, #200, Los Angeles, CA 90025*; Edward W. Dunbar, Ed.D., *Department of Psychiatry, University of California at Los Angeles, Franz Hall, Los Angeles, CA 90024*; Gary Quinones, Ph.D.

## EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should recognize instruments that can be used to assess the violence risk for hate crime perpetrators.

## SUMMARY:

This study examined the relationship between criminal history and current criminal activity (specifically, target and crime severity) for hate crime offenders. The criminal histories and violence risk of a sample of 204 hate crime offenders are examined. Record review of the offender's criminal history was rated on two violence risk assessment systems, the HCR-20 and Cormier-Lang scale. Crime reports were rated for the severity of the offense and the offender's targeting of outgroup victims. Over half of the offenders had prior criminal convictions. HCR-20 ratings were comparable to those found in other offender groups and were correlated with the severity of the hate crime. According to the Cormier-Lang scale, the number of prior arrests and number of criminal convictions were significantly greater for offenders who targeted racial minority victims. Offenders who belonged to bias-oriented groups had more extensive and violent criminal histories and committed more violent hate crimes. Findings are considered in terms of clinical intervention and risk assessment practices with hate crime offenders. The audience for this study would include anyone engaged in the assessment or treatment of criminal offenders.

## TARGET AUDIENCE:

Psychiatrists and forensics experts who deal with hate crimes.

## REFERENCES:

1. Harris GT., Rice, M.E., Cormier, G.A.: Psychopathy and violent recidivism. Law and Human Behavior 1995; 15:625–637.
2. American Psychiatric Association: Diagnostic and Statistical Manual of Mental Third Edition-Revised. American Psychiatric Association Press, Washington D.C., 1988.

**Poster 151** **Saturday, October 8 8:30 a.m.-10:00 a.m.**

## HATE CRIME PROFILING: DOES AGE AND HISTORY PREDICT TO VIOLENT CRIMES?

Desiree A. Crevecoeur, Ph.D., *Project Director, Department of Psychiatry, University of California at Los Angeles, 1640 South Sepulveda Boulevard, #200, Los Angeles, CA 90025*; Lindsay Cameron, B.A., *Department of Psychiatry, University of California at Los Angeles, 27465 Paseo Sienna, San Juan Capistrano, CA 92675*; Lindsay Mathews, B.A.; Rachel Cesar, B.A.

### EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to identify which perpetrators are more likely to commit violent crimes and have some impression of the usefulness of treatment.

### SUMMARY:

Hate crimes, due to their nature, are not simply destructive and debilitating to the individual victim, but are damaging to the entire community to which the victim belongs. Furthermore, because these crimes appear to be increasing, it is likely that treatment in addition to incarceration for some perpetrators will be necessary. As such, it is important to determine, who will likely benefit from treatment and who may show no benefit from treatment and may require incarceration. The current study compared hate crime perpetrators with no prior criminal history with those who had at least one prior crime (violent or nonviolent). Specific variables examine included age at first offense, total number of convictions, severity of violent crimes, severity of nonviolent crimes, and the victim group. Instruments used included the HCR-20, which assess an individual's potential for future violence. Prior research in other areas of violence and criminal activity has shown that individuals who begin their criminal career at a young age may also go on to commit violent crimes as they age. Findings indicate that prior violence and young age at first violent offense predicts to greater violence in future hate crimes, but only with specific victim groups. The findings are discussed as they relate to the treatment amenability of this population of offenders.

### TARGET AUDIENCE:

Psychiatrists and forensic experts who assess on treat violent offenders.

### REFERENCES:

1. Monahan J: Predicting violent behavior: An assessment of clinical techniques. Beverly Hills, CA: Sage, 1981.
2. Salfati CG, Canter DV: Differentiating stranger murders: profiling offender characteristics from behavioral styles. Behavioral Sciences and the Law 1999; 17:392–434.

**Poster 152** **Saturday, October 8 8:30 a.m.-10:00 a.m.**

## FIRST OUTPATIENT PSYCHIATRIC CONTACT FOLLOWING DISCHARGE FROM AN ACUTE PSYCHIATRIC UNIT

Mohamed H. Eldefrawi, M.D., *Resident, Department of Psychiatry, Southern Illinois University, P.O. Box 19642, Springfield, IL 62794-9642*; Gautam Rajendran, M.D., *Resident, Department of Psychiatry, Southern Illinois University, P.O. Box 19642, Springfield, IL 62794-9642*; Imran A. Khan, M.D.; Jill Toepfer, M.A.

### EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to demonstrate rates of first attendance at follow up after discharge from acute psychiatry unit, (2) describe clinical characteristic of lost at follow up subgroup.

### SUMMARY:

A retrospective review of referral notes and follow-up phone contact of 51 psychiatric patients discharged from two acute midwest university-affiliated units were evaluated for compliance with first outpatient (OP) follow-up appointments during a six-month period. 62.7% of patients (n=32) complied with their first follow-up appointment. Almost half of those who missed their first follow-up OP contact, 19.6% (n=10), showed at a second rescheduled appointment. Only 5.9% (n=3) showed up for their first OP contact when rescheduled for a third appointment. By the end of the six-month period. 11.8% (n=6) of the psychiatrically discharged patients were considered lost at follow up. Psychiatric characteristics of those lost at follow up suggest that 5.9% (n=3) were receiving other mental health services and 5.9% (n=3) had a comorbid substance abuse diagnosis. Our results suggest that most psychiatrically discharged patients (88.2%, n=45) showed for their first OP psychiatric follow-up contact when given at least two rescheduled appointments.

### TARGET AUDIENCE:

Psychiatry residents, inpatient/outpatient liaison and administrative staff.

### REFERENCES:

1. El-Mallakh RS, James T, Katz M, McGovern B, Nair S, Tallent S, Williams G: Follow up after inpatient

psychiatric hospitalization with partial control of the system responsiveness variable. Psychiatry 2004; 67:294–298.
2. Kruse CR, Rouland BM: Factors associated with attendance at 1st appointment after discharge from a psychiatric hospital. Psychiatr Serv 2002; 53:473–476.

**Poster 153** **Saturday, October 8 8:30 a.m.-10:00 a.m.**

## LAYPERSON'S CHOICES AND DELIBERATIONS FOR MENTAL HEALTH COVERAGE

Sara E. Evans, M.H.S., *Doctoral Student, Department of Health Policy, Johns Hopkins University, 624 North Broadway, Room 660, Baltimore, MD 21202*; Susan D. Goold, M.D.; Nancy Baum, M.H.S.

### EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to apply various strategies to help individuals choose mental health care insurance coverage.

### SUMMARY:

In this study, we used a simulation exercise in which groups of laypersons deliberate about health care tradeoffs, to learn about public values and preferences for mental health services. Five hundred and sixty-two individuals participated in Choosing Healthplans All Together (CHAT), a simulation exercise in which participants choose whether and how extensively to cover different types of health services in a hypothetical health plan constrained by limited resources. We describe individual and group decisions and group dialogue concerning how to make benefit selections and whether to choose mental health coverage. Qualitative and quantitative analysis were used to analyze choices and dialogue among participants. Qualitative analysis examined arguments presented including the main themes of social relevance, treatment efficacy, perceptions of personal risk, and community benefit. Group selection for mental health coverage was more favorable than individual selection. Individual's selection of mental health coverage, however, tended to increase after group discussion. Individual reasoning may change based on new perceptions or engagement in activities and it is important to make an effort to understand citizens reasoning. Mental health parity has continued to be an important issue and insights gained from this and other studies of layperson deliberations may help enlighten this debate.

### TARGET AUDIENCE:

Mental Health Services, Decision Making, Qualitative Research.

### REFERENCES:

1. Hanson K: Public opinion and the mental health parity debate: lessons from the survey literature. Psychiatric Services 49: 1059–1066.
2. Goold SD, Biddle AK, Klipp G, Hali, C. Denis M: Choosing Healthplans All Together: A Game in Which Consumers Design Their Own Healthplan. JHPPL 2005.

**Poster 154** **Saturday, October 8 8:30 a.m.-10:00 a.m.**

## EFFECTS OF DUAL DIAGNOSIS AND HOMELESSNESS ON UTILIZATION OF MENTAL HEALTH SERVICES

*Supported by the National Institute of Mental Health*

David P. Folsom, M.D., *200 West Arbor Drive, #MC8809, San Diego, CA 92103*; Laurie Lindamer, Ph.D.; Dilip V. Jeste, M.D.; Todd Gilmer, Ph.D.; Piadad Garcia, Ed.D.; William B. Hawthorne, Ph.D.

### EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to choose the appropriate mental health care services for both substance abusing and non-substance abusing homeless persons.

### SUMMARY:

*Objective:* This investigation compared the effects of homelessness and substance abuse, both separately and together, on the utilization of mental health services.

*Methods:* Data on 14,299 persons with schizophrenia, bipolar disorder, or major depression treated in the San Diego County public mental health system in 2003–04 were used. Four groups were compared on demographic and clinical variables: non-homeless non-substance abusers, non-homeless substance abusers, homeless non-substance abusers, and homeless substance abusers. Multivariate logistic regression analyses were used to calculate odds ratios for utilization of eight mental health services, adjusting for demographic and clinical factors.

*Results:* There were a total of 2,393 homeless persons (16.7% of sample). Homeless were more likely to be substance abusers than non-homeless (59.8% versus 22.0%, P<.001). Homelessness and substance abuse had the largest effect on use of crisis residential treatment (OR 51.6 for homeless substance abusers, 10.9 for homeless, and 6.6 for substance abusers, all p <.001), and

jail (OR 13.5 for homeless substance abusers, 2.6 for homeless, and 6.8 for substance abusers, all p <.001).

*Discussion:* Homelessness and substance abuse have large effects on some, but not all, types of mental health treatment. Further research is needed to improve the outcomes of this vulnerable population.

*Funding:* NIMH grants MH67895 and MH066248.

## TARGET AUDIENCE:

Mental health services researchers.

## REFERENCES:

1. Gonzales G, Rosenheck RA: Psychiatric Services 2002; 53:437–446.
2. Drake RE, et. al: American Psychologist 1991; 46:1149–58.

**Poster 155** **Saturday, October 8 8:30 a.m.-10:00 a.m.**

## TREATMENT ADHERENCE WITH ANTIPSYCHOTICS AMONG BIPOLAR AND MANIC PATIENTS

*Supported by AstraZeneca Pharmaceuticals*

Frank D. Gianfrancesco, Ph.D., *President, HECON Associates, Inc., 9833 Whetstone Drive, Montgomery Village, MD 20886*; Kitty Rajagopalan, Ph.D.

## EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to (1) describe the components of antipsychotic treatment adherence and their measurement with prescription claims data; (2) compare antipsychotics with respect to treatment compliance and treatment duration; and (3) identify patient and antipsychotic-related factors associated with poor treatment compliance and shorter treatment duration.

## SUMMARY:

*Objective:* To assess adherence to antipsychotic monotherapy in bipolar/manic disorder.

*Methods:* 18,158 antipsychotic monotherapy treatment episodes for bipolar/manic disorders were identified from a claims database (1999–2003) representing 50 million U.S. insured patients. Overall adherence was measured by treatment compliance (medication possession ratio [MPR]) and treatment duration. Atypicals included risperidone, olanzapine, quetiapine, and ziprasidone; conventional agents included haloperidol, perphenazine, thioridazine, and thiothixene. Multiple regression adjusted for patient characteristics.

*Results:* Quetiapine alone had significantly greater compliance (MPR) than conventional agents (P<0.05) and the highest compliance among the atypicals, which was significantly greater than risperidone or olanzapine. Olanzapine and ziprasidone demonstrated significantly greater compliance than risperidone. Daily dose was negatively associated with compliance for all agents except quetiapine (P<0.05 for risperidone and conventional agents), which had a positive, but nonsignificant association (P=0.074). Quetiapine and risperidone had significantly longer treatment durations than olanzapine, ziprasidone, and conventional agents. All atypicals, except ziprasidone, had significantly lower odds of switching to another psychotropic compared with conventional agents; quetiapine had the lowest estimated odds ratio.

*Conclusion:* According to claims data, treatment adherence for quetiapine appears higher than for other agents commonly prescribed for bipolar/manic disorder, possibly due to more favorable tolerability.

Supported by funding from AstraZeneca Pharmaceuticals LP.

## TARGET AUDIENCE:

Psychiatrists, managed care providers.

## REFERENCES:

1. Keck PE Jr, McElroy SL, Strakowski SM, et al: J Clin Psychiatry 1996; 57:292–297.
2. Al-Zakwani IS, Barron JJ, Bullano MF, et al: Curr Med Res Opin 2003; 19:619–626.

**Poster 156** **Saturday, October 8 8:30 a.m.-10:00 a.m.**

## EVOLVING A PSYCHOSOCIAL REHABILITATION PROGRAM IN A STATE OPERATED PSYCHIATRIC HOSPITAL

John T. Hopkins, M.D., M.P.H., *Psychiatrist, Georgia Regional Hospital, 370 Triple Creek Drive, Fairburn, GA 30213-3252*

## EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to recognize the basic premise of psychosocial rehabilitation, the degree of medical intervention, and how this differs from the classic medical model. The participant should also be able to appreciate the role of the physician/psychiatrist as both a clinician and an employee of a state psychiatric hospital.

## SUMMARY:

The psychosocial rehabilitation model has been incorporated into state psychiatric hospitals with varying degrees of success. Here, an effort has been made to institute such a program, but with variations on the recovery elements of the rehabilitation model and increased medi-

cal intervention. This program is in a mixed clinical environment on an inpatient setting. Criteria were developed for referral to the Psychosocial Rehabilitation Unit (PSRU). There are those who have been referred and accepted versus those patients recommended for transfer, administratively. Increases in the census of the hospitals' two other adult mental health Units warranted transfer to the PSRU, with many of these outside the original criteria for acceptance to this unit. The premise here is that any patient admitted to a state psychiatric hospital can benefit from some element of a psychosocial rehabilitation program. In order to facilitate the needs of all patients involved in varying stages of recovery towards community re-integration, there necessitated the blending of two distinct models of treatment, on an inpatient basis, the classic Medical Model and that of the Psychosocial Rehabilitation Model. What we have evolved is a new and distinct model for treatment, for patients focusing on their recovery, seeking support in community re-intergration.

## TARGET AUDIENCE:

Physicians, psychiatrists, mental health clinicians, all stakeholders in mental health services, state hospital executives/administrators.

## REFERENCES:

1. Mental Health: A Report of the Surgeon General 1999; 4:1–8.
2. The road to recovery: balancing new adult behavioral health community supports: Psychosocial Rehabilitation Journal 2004; 12(3):9–26.

**Poster 157** **Saturday, October 8**
**8:30 a.m.-10:00 a.m.**

## ASSOCIATION BETWEEN MEDICAL RECORDS TRAINING AND INPATIENT VIOLENCE

Ali Khadivi, Ph.D., *Associate Director of Psychology, Department of Psychiatry, Bronx-Lebanon Hospital, 1276 Fulton Avenue, 6th Floor, Bronx, NY 10456*; Ramanbhai C. Patel, M.D., *Director, Adult Psychiatry Services, Bronx-Lebanon Hospital, 1276 Fulton Avenue, Bronx, NY 10456*; Andreas Evdokas, Ph.D.; Jane Lederer, Ed.D., R.N.; Jeffrey M. Levine, M.D.

## EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should recognize the impact of electronic medical records training on psychiatric care of inpatients.

## SUMMARY:

Electronic medical records (EMR) have become more common in psychiatric settings. Learning to use EMR requires training and often involves time away from clinical work. To date, little is known about the impact of learning EMR on care of inpatient psychiatric patients. The objective of this study is to see if there is any association between training on EMR and increased inpatient agitation and violence. The rationale is that the EMR training period could be a distracting time for clinician and as a result patients may feel not attended to, which in turn may make them agitated and more prone to violence.

*Method:* The study was conducted on three adult inpatient psychiatric units in an inner-city hospital. EMR training began on January 2005, and was completed by the end of March 2005. The total number of episodes of seclusion/restraint as well as patient-related violence for the three-month training period was compared with the same period during the last year.

*Results:* despite no changes in staff to patient ratio, the total number of episodes of violence doubled compared with the previous year (from 10 to 20 episodes). Patient assaults on staff accounted for most of the total increase (from two to seven episodes).

*Conclusion:* EMR Training in inpatient psychiatric settings may be associated with increased patient-related violence.

No funding source for this project.

## TARGET AUDIENCE:

General and administrative psychiatrist, psychiatric, nurse clinician and psychologist.

## REFERENCES:

1. Khadivi A, Patel RC, Atkinson AR, Levine JM: Association between seclusion and restraint and patient-related violence. Psychiatric Services 2004; 55:1311–1312.
2. Kaufman, KR, Steven Hyler: Problem with electronic medical record in clinical psychiatry: a hidden cost. Journal of Psychiatric Practice 2005; 11:200–204.

**Poster 158** **Saturday, October 8**
**8:30 a.m.-10:00 a.m.**

## THE LONG-TERM IMPACT OF STAFF TRAINING ON REDUCING PATIENT RELATED VIOLENCE

Ali Khadivi, Ph.D., *Associate Director of Psychology, Department of Psychiatry, Bronx-Lebanon Hospital, 1276 Fulton Avenue, Sixth Floor, Bronx, NY 10456*; Andreas Evdokas, Ph.D., *Department of Psychiatry, Bronx-Lebanon Hospital, 1276 Fulton Avenue, 6th*

*Floor, Bronx, NY 10456*; Mario Rendon, M.D.; Rosa R. Cifre, L.C.S.W.; Jeffrey M. Levine, M.D.

## EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should recognize how an interdisciplinary staff training in management of violence and use of seclusion/restraints is associated with long-term reduction in patient related violence in a child-adolescent impatient psychiatry service.

## SUMMARY:

*Objective:* Few studies have examined the long-term impact of staff training on reducing inpatient-related violence. The study assessed the effect of an intervention that was designed to reduce seclusion/restraint and violence in an inner-city acute child and adolescent inpatient psychiatric unit.

*Method:* The total number of episodes of seclusion and restraint in 12 months before and three years after the intervention was determined by examining the nursing logs for 2001 to 2004. Episodes of violence against patients and staff and of self-destructive behavior were determined from incident report files. The intervention that began in 2002 was compatible with mandates of JCAHO and included staff education on the use of seclusion/restraints, early recognition of signs of agitation, specialized training on violence de-escalation, and rapid stabilization.

*Results:* A significant decrease was seen in total number of episodes of seclusion/restraints (58% reduction) and patient-related violence (34% reduction) two months after the intervention. By the third year, there was 70% reduction in total episodes of violence and 68% reduction in total number of episodes of seclusion/restraint. The number of admissions and total patient days were not significantly different between the pre-intervention and post-intervention periods.

*Conclusion:* Interdisciplinary staff training in management of violence and use of seclusion/restraints is associated with long-term reduction in patient-related violence in a chid-adolescent inpatient psychiatry service.

No funding source for this project.

## TARGET AUDIENCE:

Child and forensic psychiatrist, psychologist, nurse clinicians and administrators.

## REFERENCES:

1. Bower, FL, McCullough, CS, & Timmons, ME: A synthesis of what we know about the use of physical Restraints and seclusion with patients in psychiatric and acute care settings. The Online Journal of Knowledge Synthesis for Nursing 2003; 10:1–46.
2. Khadivi, A, Patel, RC, Atkinson AR, Levine JM: Association between seclusion and restraint and patient-related violence. Psychiatric Services 2004; 55:1311–1312.

**Poster 159** **Saturday, October 8**
**8:30 a.m.-10:00 a.m.**

# GHARROO PROJECT: MENTAL HEALTH CARE INTEGRATION INTO EXISTING HEALTH SYSTEM

Aliya A. Khan, M.D., *House Physician, Baqai Hospital, 10-C, 17th Comm Street, Phase 2, EXT DHA, Karachi, Pakistan 75500*; Khurshid A. Khurshid, M.D., *Department of Psychiatry, Southern Illinois University, 1521 South Eighth Street, Springfield, IL 62703*

## EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to 1. To recognize the importance of integration and incorporation of mental health care into existing health care system and into the community. 2. To recognize the importance of models and methodologies that are accessible, affordable, and acceptable to the community.

## SUMMARY:

Gharroo, a rural town in Interior Sindh, is of paramount social and cultural importance to Pakistan. It has a population of fifty thousand. Mental health care system of Gharroo is nonexistent and establishing one has been beset with the problems of ignorance, illiteracy, poverty, unemployment, poor health system, misconception of mental health, and lack of resources. To improve these problems and mental health status, Baqal Institute of Psychiatry has launched a project in Gharroo. The emphasis is to create awareness in the community about the mental health, to incorporate mental health care services into the existing health care system, to train primary health care physicians and other allied health care providers, to support community participation, and to partnership with traditional health care providers. This project has short-term and long-term goals. In a short term, the project targets high priority conditions like epilepsy, psychosis, and drug-induced problems. This innovative approach of increasing the accessibility and acceptability of mental health system has been well received. Gharroo context offers an opportunity to integrate and incooperate mental health services within the existing health care system.

## TARGET AUDIENCE:

Psychiatrists, Primary Health Care Physicians, Social Workers.

**REFERENCES:**

1. Gadit AA: Community Mental Health.
2. Jacob KS: Community Care for People With Mental Disorders in Developing Countries.

**Poster 160** **Saturday, October 8**
**8:30 a.m.-10:00 a.m.**

## RELATIONSHIP OF PERCEIVED CULTURAL COMPETENCE TO PATIENT SATISFACTION

Isabel T. Lagomasino, M.D., M.S.H.S., *Assistant Professor of Psychiatry, University of Southern California, 1520 San Pablo Avenue, Suite 4102, Los Angeles, CA 90041*; Megan M. Dwight-Johnson, M.D., M.P.H., *Assistant Professor of Psychiatry, University of Washington, Box 356560, Seattle, WA 98195*; Francisco Velarde, M.D.; Jeanne Miranda, Ph.D.

### EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize the importance of perceived cultural sensitivity to overall satisfaction with health care and the specific care components that might be targets for interventions to improve both cultural sensitivity and satisfaction.

### SUMMARY:

*Objective:* To examine the relationship of perceived cultural competence to satisfaction with care among depressed primary care patients.

*Methods:* Funded by AHRQ, Partners in Care randomized 46 primary care practices to quality improvement interventions for depression vs. usual care. 1,356 depressed patients (including 778 whites, 398 Latinos, 93 African Americans) and 181 primary care providers participated. At 18 months, patients were asked their perceptions regarding providers' cultural sensitivity and bias and satisfaction with care. Multivariate logistic regressions will test associations between perceived cultural competence and satisfaction, adjusting for covariates and clustering effects.

*Results:* Initial results indicate that patients' satisfaction with their overall and mental health care were both significantly related to perceptions of providers' cultural sensitivity and cultural bias. We will explore the mediating effects of sociodemographic and clinical variables (including patient ethnicity, depressive severity, intervention status) and will examine associations between cultural competency and satisfaction with specific care components (health explanations, choice of treatments, shared decision making, access to mental health care).

*Conclusions:* Patient perceptions of the cultural competence of their care may play a significant role in overall satisfaction. Study results may indicate which care components may be made more culturally relevant with the aim of improving patient satisfaction.

### TARGET AUDIENCE:

Health Services Researchers.

**REFERENCES:**

1. Saha S, et al: Patient-physician relationships and racial disparities in the quality of health care. Am J Public Health 2003; 93:1713–1719.
2. Miranda J, et al: Improving care for minorities: can quality improvement Interventions improve care and outcomes for depressed minorities. Results of a randomized controlled trial. Health Serv Res. 2003; 38(2):613–630.

**Poster 161** **Saturday, October 8**
**8:30 a.m.-10:00 a.m.**

## PERCEPTIONS OF CULTURAL COMPETENCE AMONG DEPRESSED PRIMARY CARE PATIENTS

Francisco Velarde, M.D., *Post-Graduate Physician, University of Southern California, 1520 San Pablo Avenue, Suite 4102, Los Angeles, CA 90041*; Isabel T. Lagomasino, M.D., M.S.H.S., *Assistant Professor of Psychiatry, University of Southern California, 1520 San Pablo Avenue, Suite 4102, Los Angeles, CA 90041*; Megan M. Dwight-Johnson, M.D., M.P.H.; Jeanne Miranda, Ph.D.

### EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to understand how perceptions of culturally competent care may differ among ethnic groups and to recognize patient factors associated with these perceptions.

### SUMMARY:

*Objective:* To examine perceptions of provider cultural competence and bias among depressed primary care.

*Methods:* Funded by AHRQ, Partners in Care randomized 46 primary care practices to quality improvement interventions for depression vs. usual care. 1356 depressed patients (including 778 whites, 398 Latinos, 93 African Americans) and 181 primary care providers participated. At 18 months, patients were asked their perceptions regarding their providers' cultural sensitivity and bias. Multivariate logistic regressions will test associations between patient perceptions and sociodemographic and clinical characteristics, adjusting for covariates and clustering effects.

*Results:* Initial results indicate that Latinos were less likely than whites and African Americans to perceive providers as culturally sensitive; both Latinos and African Americans were more likely than whites to report they would have received better care if they belonged to a different ethnic group. We will explore the independent effects of intervention status and patient age, gender, education, wealth, insurance status, physical health, and depression severity on each cultural competence variable and examine significant interactions.

*Conclusions:* There appear to be ethnic differences in patient perceptions of cultural competence and bias. Further analyses will explore whether these differences are accounted for by sociodemographic or clinical characteristics and may suggest potential targets for cultural competence interventions.

## REFERENCES:

1. Johnson R, et al: Racial and ethnic differences in patient perceptions of bias and cultural competence in health care J Gen Intern Med 2004;19: 101-110.
2. Miranda J, et al: Improving care for minorities: Can quality improvement interventions improve care and outcomes for depressed minorities. Results of a randomized controlled trial. Health Serv Res 2003;38 (2): 613-630.

## TARGET AUDIENCE:

Health Services Researchers.

**Poster 162 WITHDRAWN**

**Poster 163** **Saturday, October 8**
**8:30 a.m.-10:00 a.m.**

## PSYCHOTIC VARIANTS OF GENDER IDENTITY DISORDERS

N. Stepan Matevossian, M.D., *Psychiatrist, Moscow State Psychoendocrinological Centre, ARBAT25, Moscow, Russia 11902*

## EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to identify the differential diagnostic criteria in gender identity disorder that is associated with schizophrenia-spectrum disorder.

## SUMMARY:

*Objective:* Description of clinical-phenomenological characteristics of the GID syndrome in schizophrenia-spectrum disorders and identifying its differential-diagnostic criteria.

*Material and methods:* Subjects of investigation were 21 persons with psychotic forms of GID (18 male and three female); seven of them were diagnosed as paranoid schizophrenia, three as simple form of schizophrenia, nine as schizotypical disorder, one as nonspecified schizophrenia and one as chronic delusional disorder. Their age varied from 18 to 40 years. All of them sought medical assistance on the matter of changing their sex. Of the total 118 persons that sought assistance, the group of schizophrenia-spectrum disorders constituted 18%, which is much higher than the percentage mentioned in literature.

*Methods used:* clinical-psychopathological, sexological, with evaluation of sexual development characteristics before, during and after puberty, and in adulthood, pathopsychological and statistical methods.

*Results and conclusions:* The clinical picture of GID in psychosis is variable and presents a mixture of interpretative delusions, paranoiac delusions of changing into a person of opposite sex as well as dysmorphophobic, depersonalization and affective disorders. Presence of morphological ground, i.e., organic insufficiency (62%), inborn urogenital pathology (50%), sexual dysontogenesis manifestations (85%), peculiarities of sex drive development in childhood and adolescence (43%), and the upbringing characteristics including sexual education (66%) seem to be pathoplastic factors involved in development of delusions.

## REFERENCES:

1. Warner P, Bancroft J: A regional service for sexual problems: A three-year study. Sexual and Marital Therapy 1997; 8:1016–1029.
2. Uguz S, Soylu L, Diler RS, Evlice YE: Psychological factors and sexual dysfunctions: A descriptive study in Russian males. Psychopathology 2003; (2):111–131.

**Poster 164** **Saturday, October 8**
**8:30 a.m.-10:00 a.m.**

## BEST PRACTICE IN SUICIDE RISK ASSESSMENT

Nora McAuliffe, O.T., *Mental Health System Manager, Trillium Health Centre/Mental Health, 100 Queensway, West, Mississauga, ON, Canada L5b 1B8*; Margaret J. Bickerton, M.H.Sc., *Director, Mental Health System Manager, Trillium Health Centre/Patient Services, 100 Queensway, West, Mississauga, ON, Canada L5B 1B8*

## EDUCATIONAL OBJECTIVES:

At the conclusion of the session, the participant should be able to: (1) demonstrate understanding of issues surrounding suicide risk assessment, and (2) recognize strategies to develop systemic approach to developing and

sustaining suicide risk assessment programs across different mental health services.

## SUMMARY:

Although it is not possible to predict suicide, suicide risk assessment places a person along a risk continuum to appreciate the bases of suicidality and allows for more informed intervention. In 2003, Trillium Health Centre initiated a quality improvement project with the aim of implementing standardized suicide risk assessments and developing risk based protocols in all programs. Our learnings will be of interested to clinicians and administrators in Mental Health.

Project included:

- Literature review
- Clients and families perspective on suicide risk assessment
- Staff survey to determine skill and comfort with suicide risk assessment

Initial findings:

- Lots of literature about risk factors, little on developing common risk reduction practices
- Staff comfortable assessing risk, but wanted more training in risk assessment
- Families and patients wanted family more involved in care
- Patients indicated positive relationships with staff of paramount importance in risk reduction

Program developed

- Staff received two day risk assessment training
- Increased family involvement in development of client safety plans
- Protocols developed outlining interventions based on assessment findings

Two years later

- Staff now less comfortable with risk assessment, but feel they have adequate training

Future Plans

- Developing culturally sensitive assessments and interventions

## REFERENCES:

1. Suicide Intervention Handbook, Living Works Education Inc.
2. Overcoming Barriers to Suicide Risk Management Valente S: J of Psychological Nursing Vol 40, No. 7.

**Poster 165** **Saturday, October 8**
**8:30 a.m.-10:00 a.m.**

# SKYLAND TRAIL: AN INNOVATIVE RECOVERY MODEL FOR ADULTS WITH MENTAL ILLNESS

John S. McDaniel, M.D., *Medical Director, Skyland Trail, 1903 North Druid Hills Road, Atlanta, GA 30319*; Elizabeth E. Finnerty, M.B.A., M.H.A., *Executive Director, Skyland Trail, 1903 North Druid Hills Road, Atlanta, GA 30319;* Julie Dudkowski, LPC

## EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize an innovative recovery model for the community based treatment of persons with serious mental illness. Content will focus on client demographics including diagnoses, various treatment modalities, and outcomes (e.g., symptom reduction, satisfaction inventories, and functional outcomes).

## SUMMARY:

Skyland Trail, winner of APA's 2004 Gold Achievement Award, is a community-based, nonprofit, adult residential/outpatient treatment program for persons with serious mental illness fostering community reintegration and empowerment through an innovative recovery model. Treatment focuses on groups promoting education, coping skills (cognitive-behavioral therapy, dialectical behavior therapy,) life skills training, adjunctive therapies (horticultural therapy), vocational services, family involvement, and community reintegration. This poster describes Skyland Trail's recovery model, funding sources, and long-term community success. Data focuses on demographics, treatment modalities, and outcomes. In the 12 months prior to June 2005, 192 individual clients were served (60% male [mean age = 35] and 40% female [mean age = 36]. Primary diagnoses represented 30% schizophrenia, 17% schizoaffective disorder, 30% bipolar disorder, 18% unipolar major depression, and 5% other. All symptom reduction inventories (BASIS-32, Beck Hopelessness Scale, Medication Attitudes Inventory, McMullin Addiction Thought Scale) showed improvement as did measures of overall functioning (Vocational Outcomes—independent living, volunteerism, paid employment, Global Assessment of Functioning, Multnomah Community Ability Scale). Similar positive outcomes were reported on all measures of client, family, and clinician satisfaction. All outcome statistics reported reached statistical significance with a p value $\leq 0.5$.

## TARGET AUDIENCE:

Community-based clinicians providing recovery sources for persons with serious mental illness.

## REFERENCES:

1. Skyland Trail, Atlanta, Georgia. 2004 APA Gold Award: Involving the community in the rehabilitation of persons with serious mental illness. Psychiatric Services 55:1164–1167, 2004.
2. Rosenheck RA, Seibyl CL: Longitudinal perspective on monitoring outcomes of an innovative program. Psychiatric Services 56:301–307, 2005.

**Poster 166** **Saturday, October 8 8:30 a.m.-10:00 a.m.**

## NEW YORK CITY MOBILE CRISIS TEAM: SURVEY AND RECOMMENDATIONS

Hunter L. McQuistion, M.D., *Chief Medical Officer, Division of Mental Hygiene, City of New York, Department of Health and Mental Hygiene, and Former APA/Bristol-Myers Squibb Fellow, 93 Worth Street, Room 413, New York, NY 10013*; Monika Eros-Sarnyai, M.D., *Best Practice Specialist, New York City Department of Mental Health and Mental Hygiene, 43 Worth Street, New York, NY 10013*; Lloyd I. Sederer, M.D.

### EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to recognize the importance of formally assessing mobile crisis services to identify priorities to improve services and to acknowledge the need for establishing best practices for in mobile crisis.

### SUMMARY:

*Objectives:* As a first step toward optimizing the effectiveness of mental health mobile crisis response in our community, we assessed mobile crisis services in New York City.

*Methods:* We surveyed eight mobile crisis team (MCT) directors about team operations and service delivery challenges. We also randomly reviewed the charts of 104 referred clients.

*Results:* Prominent findings include the following: 68% of surveyed referrals to MCTs were solely motivated by missed clinic appointments. Fifteen percent of referrals were from family members though 52% of clients lived with their families. Sixty percent of cases were documented as linked to follow-up services. MCT operating hours averaged 62 hours per week, taking an average of two working days from referral to client face-to-face contact.

*Conclusions:* Our survey is key to initiating systems change. Through it, we identified four priorities: focusing MCT services on those in acute distress educating the public about mobile crisis, ensuring successful linkage by MCTs, and enabling rapid response time. All identified needs fell into three descriptive domains (outcome, utilization, and quality of service) that are important in designing the next step in systems reform: the development of a formal mobile crisis best practices document.

### TARGET AUDIENCE:

Mental Health Services, Mobile Crisis Intervention.

### REFERENCES:

1. Geller JL, Fisher WH, McDermeit M: National survey of mobile crisis services and their evaluation. Psychiatric Services 1995; 46(9):893–897.
2. Scott L: Evaluation of a Mobile Crisis Program: Effectiveness, efficiency, and consumer satisfaction. Psychiatric Services 2000; 51:(9):1153–1156.

**Poster 167** **Saturday, October 8 8:30 a.m.-10:00 a.m.**

## MORTALITY AND MEDICAL COMORBIDITY IN PATIENTS WITH SERIOUS MENTAL ILLNESS

Brian J. Miller, M.D., M.P.H., *Resident Physician, Medical College of Georgia, 1961 Long Creek Falls, Grovetown, GA 30813*; C. Bayard Paschall, Ph.D.; Dale P. Svendsen, M.D.

### EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to gain an improved understanding of the leading causes of death and medical comorbidities among SMI patients discharged from an Ohio public psychiatric hospital and the need to target interventions that improve quality of life outcomes for this population.

### SUMMARY:

*Objectives:* Numerous studies have documented excess mortality in patients with serious mental illness (SMI). The purpose of our study was to gain an improved understanding of the leading causes of death and medical comorbidities among patients with SMI.

*Methods:* Ohio Department of Mental Health (ODMH) records for 2,0018 patients discharged from an Ohio public psychiatric hospital between 1998 and 2002 were matched against Ohio Department of Health death records for corresponding years, identifying 608 deaths. Leading causes of death and medical comorbidities, age-adjusted mortality, years of potential life lost (YPLL), and standardized mortality ratios (SMR) were calculated for this population.

*Results:* Age-adjusted mortality was higher among ODMH decedents than for either the Ohio or U.S. general populations. Heart disease (21%) and suicides (18%) were the leading causes of death. The most prevalent medical comorbidities included obesity (24%) and hypertension (22%). ODMH decedents had a mean YPLL of 32 years. The overall SMR was 3.2 ($p<0.001$), corresponding to 417 excess deaths.

*Conclusions:* Our study demonstrated excess mortality among patients with SMI. This study highlights the need to integrate the delivery of currently fragmented mental and physical health services and to target interventions that improve quality of life outcomes for this population.

**REFERENCES:**

1. Felker B, Yazel JJ, Short D: Mortality and medical comorbidity among psychiatric patients: a review. Psychiatric Services 1996; 1356–1363.
2. Dembling BP, Chen DT, Vachon L: Life expectancy and causes of death in a population treated for serious mental illness. Psychiatric Services 1999; 50:1036–1042.

**Poster 168** **Saturday, October 8**
**8:30 a.m.-10:00 a.m.**

## REHOSPITALIZATION RATES OF PATIENTS DISCHARGED ON LONG-ACTING RISPERIDONE AND HALOPERIDOL DECANOATE

Meera Narasimhan, M.D., *Associate Professor, Department of Neuropsychiatry and Behavioral Sciences, University of South Carolina School of Medicine, 3555 Harden Street Extension, Columbia, SC 29203*; Ronald E. Prier, M.D., M.P.H.; Richard K. Harding, M.D.

### EDUCATIONAL OBJECTIVES:

At the conclusion to examine the rehospitalization rates for long-acting risperidone or haloperidol decanoate in patients discharged from a state psychiatric hospital.

### SUMMARY:

*Background:* Schizophrenia, an illness with devastating sequale, carries a 10% risk of suicide and poor functional outcome. Rates of rehospitalization between 28% and 50% in the first year of follow up. Preventing relapse and neurodegenerative changes has been the focus of newer treatments.

*Method:* A retrospective chart review of 215 charts examining the rehospitalization rate for all patients either on long-acting risperidone and haloperidol decanoate between December 2003 and April 2005 was conducted. Data were retrieved from the South Carolina Department of Mental Health inpatient database. Patient demographic information was de-identified in compliance with HIPPA and confidentiality laws of SCDMH.

*Results:* Rehospitalization on haloperidol decanoate and long-acting risperidone was 25% and 20%, respectively (p-value of .2697). Majority of patients in either groups were also on concomitant medications including atypical antipsychotics, typical antipsychotics and/or mood stabilizers. Rates of rehospitalization were higher in men (OR=1.32), African Americans (26% vs 21%), and in adults 18–45 yrs (OR=1.01) in both groups. Rates of rehospitalization were lower on long-acting risperidone when compared with haloperidol decanoate, although not statistically significant.

**REFERENCES:**

1. Conley RR, Kelly DL, Love RC, et al: Rehospitalization risk with second-generation and depot antipsychotics. Ann of Clin Psychiatry 2003; 15(1):23–31.
2. Lauriello J, McEvoy JP, Rodriguez S, et al: Long-acting risperidone vs placebo in the treatment of hospital inpatients with schizophrenia. Schizo Res 2005; 72(2–3):249–258.

**Poster 169** **Saturday, October 8**
**8:30 a.m.-10:00 a.m.**

## THE AWARENESS OF COMPLEMENTARY AND ALTERNATIVE MEDICINE AMONGST PHYSICIANS IN UPSTATE NEW YORK

Nikhil D. Nihalani, M.D., *Resident, Department of Psychiatry, Strong Memorial Hospital, 746 Spencerport Road, Rochester, NY 14606*; James L. Megna, M.D., Ph.D., *Assistant Professor of Psychiatry, State University of New York Upstate Medical University, 750 East Adams Street, Syracuse, NY 13210*

### EDUCATIONAL OBJECTIVES:

At the end of the presentation, the participant should be able to understand the extent and quality of awareness of complementary and alternative medication use by consumers amongst physicians in upstate New York.

### SUMMARY:

*Introduction:* In 1990, one in four Americans used alternative therapies for treatment; this has increased to 69% as per recent statistics in 1998. 67% of the health maintenance organizations offer at least one modality of CAM. The current marketplace for CAM is close to 24 billion dollars and is expected to increase at 15% per year.

*Aim:* A survey was conducted to understand the extent of awareness of the use of complementary and alternative medications amongst physicians in upstate New York.

*Method:* A voluntary/anonymous institutional review board approved survey consisting of nine questions was offered to 354 allopathic physicians from January to March 2004.

*Results:* 141 surveys were completed and returned to the study team. All were included in the final analysis. The results are discussed in detail in the paper.

*Conclusion:* The awareness of physicians regarding the use of CAM amongst their patients is increasing. The attitude of physicians toward CAM is becoming more critical. Reassuring, almost all the physicians who were surveyed were aware of the potential of CAM therapies to cause side effects and pharmacokinetic interactions with prescribed medications.

**REFERENCES:**

1. Boon H, Westlake K, Stewart M, Gray R, Fleshner N, Gavin A, Brown JB, Goel V: Use of complementary/alternative medicine by men diagnosed with prostate cancer: prevalence and characteristics. Urology 2003; 62(5):849–53.
2. Himmel W, Schulte M, Kochen MM: Complementary medicine: are patients' expectations being met by their general practitioners? Br J Gen Pract 1993; 43:232–235.

**Poster 170** **Saturday, October 8**
**8:30 a.m.-10:00 a.m.**

## DEFINING HIGH UTILIZATION OF PSYCHIATRIC EMERGENCY SERVICES

Jagoda Pasic, M.D., Ph.D., *Medical Director, CTU, and Assistant Professor, Department of Psychiatry, Harborview Medical Center, 325 Ninth Avenue, Box 359396, Seattle, WA 98104-2499*; Joan E. Russo, Ph.D.; Peter P. Roy-Byrne, M.D.

### EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize the value of using different definitions of high utilization in the psychiatric emergency services.

### SUMMARY:

The study objective was to formulate different definitions for high utilization of psychiatric emergency services (PES) and determine their clinical utility.

*Methods:* Three definitions of high utilization (HU) (557 = 2SD above the mean visit number, 419 = 6-visits per year (YR6), and 520 = 4-visits per quarter (Q4)) yielded seven combinations. Regression models determined the group differences. Data were collected over four years.

*Results:* Seven HU combinations were collapsed into three groups: HU by all definitions, HU by 2SD and, HU by Q4. After eliminating and/or combining the overlapping groups, HU2SD and HUQ4 definitions emerged and identified two distinct patient populations. Compared with HUQ4, the HU2SD patients had more visits, were more likely to have history of incarceration and psychiatric hospitalization, be enrolled in a mental health plan, and were less likely to be homeless.

*Conclusions:* HU2SD definition captured chronically-severely mentally ill patients and HUQ4 definition captured acutely sick patients with visit clusters. From a clinical standpoint, these two definitions may be useful in guiding clinical interventions and mental health policies. From a methodological standpoint, HUYR6 definition may be appropriate for future research due to its overlap with HU2SD, which is otherwise limited by the patient sample size.

### TARGET AUDIENCE:

Emergency Psychiatrists.

**REFERENCES:**

1. Arfken C, Zeman L, Yeager L, et al.: Case-control study of frequent visitors to an urban psychiatric emergency service. Psychiatric Services 2004; 55:295–301.
2. Sullivan P, Bulik C, Forman S, et al.: Characteristics of repeat users of a psychiatric emergency service. Hospital and Community Psychiatry 1993; 44:376–380.

**Poster 171** **Saturday, October 8**
**8:30 a.m.-10:00 a.m.**

## COMORBIDITY, GENDER, AND ETHNICITY: A PILOT STUDY OF ANTIDEPRESSANT RESPONSE

Katherine G. Ruiz-Mellott, M.D., *Department of Psychiatry, Cedars Sinai Medical Center, 8730 Alden Drive, W101, Los Angeles, CA 90048*; Russell Poland, Ph.D.

### EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize the effect of antidepressant treatment as alcohol intake.

### SUMMARY:

*Background:* Gender and ethnic influences on treatment outcome in co-occurring disorders are understudied. Studies have investigated SSRI treatment of comorbid disorders, without assessing these factors. We designed an open label, pilot study to investigate the influence of ethnicity and gender on citalopram response in subjects with depression and an alcohol use disorder.

*Methods:* Inclusion criteria: DSM-IV current MDD and alcohol-use disorder, ethnicity Caucasian or African American, and HAM-D > or = 17. Subjects were treated for eight weeks with citalopram and had weekly assessments using HAM-D and Time Line Follow Back of alcohol intake.

*Results:* In 18 completers the antidepressant response rate was 38%. There was a trend toward reduction of HAM-D score from baseline to week 8, but improvement in depressive measures was not correlated with decreased alcohol intake. There was a trend toward *increased* alcohol intake in African-American subjects, and decreased alcohol intake in female subjects.

*Conclusions:* Subjects continued to drink an equal amount of alcohol during the study. We demonstrate an

intriguing relationship between ethnicity, gender, and treatment response. Female subjects showed a *decrease* in alcohol intake from baseline to week 8. Further analysis of biological and genetic factors mediating citalopram response are ongoing.

## TARGET AUDIENCE:

Clinicians and researchers involved in dual diagnosis treatment.

## REFERENCES:

1. McGrath PJ, Nunes EV, et al: Imipramine treatment of alcoholics. Archives 1996; 53:232–240.
2. Cornelius JR, Salloan JM, Ehler, et al: Fluoxetine is depressed alcoholics. Archives 1987; 54:700–705.

**Poster 172** **Saturday, October 8**
**8:30 a.m.-10:00 a.m.**

## PTSD AND BODY MASS INDEX IN MILITARY VETERANS: THE RICHMOND EXPERIENCE

Lynn Satterwhite, A.N.P., *Adult Nurse Practitioner, McGuire Veterans Affairs Medical Center, Box 116 A, 1201 Broad Rock Boulevard, Richmond, VA 23249*; Antony Fernandez, M.D., Director, Mental Health Clinics, McGuire Veterans Affairs Medical Center, 1201 Broad Rock Boulevard, Richmond, VA 23249

## EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize comorbid obesity in military veterans with posttraumatic stress disorder.

## SUMMARY:

Psychiatric and medical comorbidity including obesity commonly attend military veterans with posttraumatic stress disorder (PTSD). Body mass index (BMI) is a useful parameter to estimate the prevalence of overweight and obesity. The PTSD program database was reviewed. Variables assessed included (1) age, (2) decade of life, (3) height, (4) weight, (5) sex, (6) race, (7) employment status, (8) presence or absence of comorbid psychiatric conditions, (9) presence or absence of comorbid medical conditions, and (10) degree of disability. We calculated BMI. Of the 247 veterans, 164 (66.4%) were in the age range of 50 to 60 years. The mean BMI of all veterans was 30.3 $\pm$ 5.7 kg/m$^2$. Far exceeding current U.S. population findings, 83.8% of our study population was either overweight or obese. Veterans with 30% to 59%, 60% to 79%, and 80% to 100% SCD had mean BMI values of 32.1 $\pm$ 6.8 kg/m$^2$, 30.4 $\pm$ 4.9 kg/m$^2$, and 31.2 + 60 kg/m$^2$, respectively. Analysis of variance (ANOVA) revealed statistically significant differences ($df = 4$, $F = 2.285$, $p = 0.888$) among these five categories of SCD suggesting a threshold effect. Clearly, more definitive studies are needed with much larger study populations.

There was no commercial support funding for this poster presentation.

## TARGET AUDIENCE:

Psychiatrists, Nurse Practitioners, Primary Care Physicians.

## REFERENCES:

1. Flegal KM, Carroll MD, Ogden CL, Johnson CL: Prevalence and trends in obesity among US adults 1999–2000. JAMA 2002; 288:1723–7.
2. Magruder KM, Frueh BC, Knapp RG et al: PTSD symptoms, demographic characteristics, and functional status among veterans treated in VA primary care clinics. J Traum Stress 2004; 17:293–301.

**Poster 173** **Saturday, October 8**
**8:30 a.m.-10:00 a.m.**

## CORRELATES OF BURDEN IN CAREGIVERS OF PATIENTS WITH SCHIZOPHRENIA

*Supported by Janssen Pharmaceutica*

Vanja Sikirica, Pharm.D., *Outcomes Research Fellow, Health Policy Department, Thomas Jefferson, University, 2001 Hamilton Street, Suite 1619, Philadelphia, PA 19130*; Jeffrey S. Markowitz, Ph.D. *President, Health Data Analytics, 35 Arnold Drive, Princetown Junction, NJ 08550; Luella M. Engelhart, M.P.A.*

## EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize the burden caregivers of schizophrenia patients may face.

## SUMMARY:

To describe correlates of caregiver burden in a large sample of caregivers of schizophrenia patients. (Objective) Consumer Health Sciences Schizophrenia Project Data for 2002 were analyzed. Adult caregivers were contacted through a schizophrenia national advocacy group. Caregivers self-reported on caregiver and patient demography (e.g. age, patient education), caregiver burden (Oberst Caregiver Burden Scale (OCBS), comprised of caregiver demand and difficulty subscales; the dependent variable), caregiver quality of life (SF-8 scale, comprised of MCS and PCS), and patient health care utilization. Analyses of covariance were used to assess correlates of caregiver burden. Of 653 Questionnaires analyzed, five and six variables were significant inde-

pendent correlates for OCBs demand and difficulty subscales, respectively. Providing care for a significant other, having lower caregiver MCS score, spending more hours providing care and more days missed leisure activities were correlates in both subscales. Caregiver unemployment was a significant predictor of demand; being non-white and having lower PCS score were significant difficulty correlates. The strongest predictor of burden was number of hours spent providing care (25.6 hrs/week). Caregivers Burden in schizophrenia is substantial; health providers should consider this.

Funding for research is from Janssen Medical Affairs L.L.C.

## TARGET AUDIENCE:

Health care providers, policy makers and families of patients.

## REFERENCES:

1. McDonell MG, Short RA, Berry CM et al: Burden in schizophrenia caregivers impact of family psychoeducation and awareness of patient suicidality. Family Process, 2003; 42(1):91–103.
2. Wolthaus JE, Dingemans PM, et al: Caregiver burden in recent onset schizophrenia and spectrum disorders: Influence of symptoms and personality traits. J of Nervous & Ment Dis 2002:140(4):241.

**Poster 174** **Saturday, October 8**
**8:30 a.m.-10:00 a.m.**

# PSYCHIATRIC USE OF UNSCHEDULED MEDICATIONS IN A STATE HOSPITAL SYSTEM

Gregory M. Smith, M.S., *Chief Executive Officer, Department of Administration, Allentown State Hospital, 1600 Hanover Avenue, Allentown, PA 18109*; Robert H. Davis, M.D., *Associate Medical Director, Department of Public Welfare, Pennsylvania Office of Mental Health and Substance Abuse Services, Building 32, Harrisburg, PA 17105*; Aidan Altenor, Ph.D.; Karen L. Wolfe, R.N., M.S.

## EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize the large amount of psychotropic medications patients with severe mental illnesses are exposed to in hospitals that permit the use of PRN orders and that efforts to reduce their use can have a positive effect on falls, aggression assaults with injury, seclusion, and restraint.

## SUMMARY:

*Objective:* An October 2004 published study involving the psychiatric use of PRN medication orders at Arkansas State Hospital concluded that PRN orders may expose psychiatric patients to unnecessary psychotropic medications. Starting March 2004, the nine hospitals that comprise the Pennsylvania State Hospital system, with an average monthly census of 2,000 people, began a year-long study to measure the amount of unscheduled psychiatric medications being administered and reduce its use. The hospital system serves people with severe mental illnesses and provides 60,000 days of care each month.

*Method:* Each hospital's 24-hour nursing report was modified to record the unscheduled use of psychiatric medications administered via PRN and STAT physician order. Patient demographics including the specific medication administered, its dose, route, and the reason for the medication was part of the uniform dataset used in all nine hospitals. Monthly statistical reports were issued to the hospital system that identified patients who were the highest users of unscheduled psychiatric medications. This information was compared with incident reports of falls, aggression, medication errors, adverse drug reactions, assaults with injury, physical and mechanical restraint use, and seclusion.

*Results:* The psychiatric use of unscheduled medications in the nine-hospital system decreased from 88 per 1,000 days of care in March 2004 to 18 per 1,000 days of care in March 2005. Control measures, including incidents of patient falls, aggression, adverse drug reaction, assaults with injury, seclusion, and restraint all decreased by at least 10% during this study period. Medication errors showed a slight increase during this same period.

*Conclusion:* Increasing the quality of the decision making regarding the need to use unscheduled psychiatric medication by requiring a physician's STAT order can have a positive effect on most measures of patient care and decrease patient exposure to unnecessary psychotropic medications.

## TARGET AUDIENCE:

Clinicians who work within any inpatient hospital setting.

## REFERENCES:

1. Thapa P et al: PRN orders and exposure of psychiatric inpatients to unnecessary psychotropic medications. Psych Services Journal.
2. Szczesny S, Miller M: PRN medication use in inpatient psychiatry. Journal of Psychosocial Nursing & Mental Health Services January 2003.

**Poster 175** **Saturday, October 8**
**8:30 a.m.-10:00 a.m.**

## ANTI-SMOKING INTERVENTION IN A RESIDENTIAL SUBSTANCE ABUSE TREATMENT PROGRAM

Kathleen M. Stack, M.D., *Assistant Professor, Extended Care Department, Veterans Affairs Hospital, 100 Emancipation Drive, #18, Hampton, VA 23667*; Eric Bradshaw, M.D.; James Goalder, M.D.

### EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize the possibility of positive outcomes in addressing smoking during addiction treatment.

### SUMMARY:

The effects of a structured anti-smoking program on the number of cigarettes smoked by veterans in a residential substance abuse treatment program are evaluated. The number smoked was obtained by self-report at admission and discharge. Attendance of voluntary smoking cessation classes will be noted to determine if it is related to changes in smoking at discharge. The smoking habits of staff will also be obtained as it has been reported to affect smoking outcomes.

A total of 241 veterans were treated in 2003. Forty-seven (20%) were non-smokers, 194 (80%) smoked, 78 (40%) participated in the smoking cessation classes, and 116 (60%) did not. Of the 78 who attended, 12 (15%) quit smoking, 41 (53%) cut back an average of 10 cigarettes daily from 16 to six cigarettes at discharge, and 25 (32%) had no change in their smoking.

Of the 116 who did not attend five (4%) quit smoking, 15 (13%) cut back, and 96 (83%) had no change in their smoking.

Of the 13 staff, none were current smokers, seven (54%) were lifetime non-smokers, four (31%) were former smokers, and two (15%) were intermittent smokers.

*Discussion:* This pilot does show that treating smoking during addiction treatment can have a positive outcome. Further study is planned to increase motivation to quit smoking in this population.

### TARGET AUDIENCE:

Mental health providers who treat patients with addiction who also smoke.

### REFERENCES:

1. Asher MK, Martin RA: Perceived barriers to quitting smoking among alcohol dependent patients in treatment. Journal of Substance Abuse Treatment 2003; 24:169–74.
2. Stotts AL, Schmitz JM: Concurrent treatment for alcohol and tobacco dependence: are patients ready to quit both? Drug and Alcohol Dependence 2003; 69:1–7.

**Poster 176** **Saturday, October 8**
**8:30 a.m.-10:00 a.m.**

## TRANSITIONING PATIENTS FROM ASSERTIVE COMMUNITY TREATMENT

Keith R. Stowell, M.D., *Resident, Department of Psychiatry, University of Pittsburgh, 3811 O'Hara Street, Pittsburgh, PA 15213*; Ann L. Hackman, M.D.

### EDUCATIONAL OBJECTIVES:

At the conclusion of the presentation, the participant should be able to identify recent changes in thought on the duration of Assertive Community Treatment (ACT) and recognize factors that might play a role in the success of a transition from ACT to a lower level of care.

### SUMMARY:

*Background:* Until recently, it was generally accepted that persons in an Assertive Community Treatment (ACT) program would remain within this intensive level of care for an indefinite period of time. Newer research suggets that patients who have improved in ACT might be candidates for transition to a lower level of care.

*Methods:* A retrospective medical record review was undertaken to assess whether certain patient characteristics were associated with the success of such a transition. The charts of patients transitioned from the University of Maryland's ACT program to traditional community mental health services between 1995 and 2003 were reviewed.

*Results:* Sixty-seven patients were transitioned during the review period. Of these patients, 48 remained at a lower level of care. Nineteen patients required a return to ACT services or were lost to follow up. Survival analysis showed no significant difference in survival based on diagnosis, comorbid substance use, sex, race, or housing.

*Conclusions:* Though the relatively small size of the study population limited the statistical significance of the results, it is noteworthy that the overwhelming majority of patients in the group remained at a lower level of care. Further research might focus additional attention on assessing factors that predict a successful transition.

### TARGET AUDIENCE:

Psychiatrists, Nurses, Social Workers, and other personnel involved with Assertive Community Treatment Teams.

**REFERENCES:**

1. Rosenheck RA, Dennis D: Time-limited assertive community treatment for homeless persons with severe mental illness. Arch Gen Psychiatry 2001; 58:1073–1080.
2. Salyers MP, Masterton TW, Fekete DM: Transferring clients from intensive case management: impact on client functioning. Am J Orthopsychiatry 1998; 68:223–245.

**Poster 177** **Saturday, October 8 8:30 a.m.-10:00 a.m.**

## IDENTIFICATION OF SCHIZOPHRENIA AT RISK FOR HIGH FUTURE HEALTH CARE COSTS

Richard C. Surles, Ph.D., *Senior Vice President, Comprensive NeuroScience, Inc., 2 Tree Farm Road, Suite B210, Pennington, NJ 08534*; John Byrd, R. Ph., M.B.A., *Director, Outcomes Research and Pharmacy Services, Comprehensive NeuroScience, Inc., 1 Copley Parkway, Suite 534, Morrisville, NC 27560*; Joseph J. Parks, M.D.; George Oestereich, M.P.A.; John P. Docherty, M.D.; Kit N. Simpson, D.P.H.

### EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize the importance to early identification and proper treatment of co-occurring medical conditions in persons diagnosed with schizophrenia.

### SUMMARY:

*Background:* Schizophrenia is a heterogenous illness with great variation in course and outcome and associated health care costs. In the Missouri Medicaid plan, the most costly 10% of schizophrenic patients had combined Medicaid costs ten times that of the average Medicaid recipient. Current methods of selecting patients who would benefit most by special management have not yet proven effective in identifying those patients most likely to incur the highest annual Medicaid costs in the future.

*Methods:* We used a predictive algorithm model to identify schizophrenic patients at greatest risk of adverse health outcomes and higher services costs than other Medicaid recipients.

*Results:* A combination of prior spending on care and other co-occuring conditions was the primary predictor for high future costs. On average, patients identified at risk for high future costs had over three other chronic medical conditions. The most common medical conditions were asthma (39%), obesity (47%), substance abuse (61%), cardiovascular disease (71%), and hypertension (71%).

*Conclusion:* The most complex patients diagnosed with schizophrenia have severe medical and psychiatric illnesses. When caring for them, it is critical to understand and treat all of the medical conditions that result in their complex utilization patterns.

### TARGET AUDIENCE:

Clinicians, service researchers and policy making positions.

**REFERENCES:**

1. Parks J, Surles R: Using best practices to manage psychiatric medications under Medicaid. Psych Services 2004 55(11): 1227–9.
2. Marder SR, Essock SM, Miller AL et al: Physical health monitoring of patients with schizophrenia. Am J Psychiatry 2004; 161:1334–1349.

**Poster 178** **Saturday, October 8 8:30 a.m.-10:00 a.m.**

## IMPROVING QUALITY OF PSYCHOTROPIC PRESCRIBING REDUCES HOSPITAL UTILIZATION

Richard C. Surles, Ph.D., *Senior Vice President, Comprensive NeuroScience, Inc., 2 Tree Farm Road, Suite B210, Pennington, NJ 08534*; John Byrd, R.Ph., M.B.A., *Director, Outcomes Research and Pharmacy Services, Comprehensive NeuroScience, Inc., 1 Copley Parkway, Suite 534, Morrisville, NC 27560*; Kit N. Simpson, D.P.H.; Joseph J. Parks, M.D.; George Oestereich, M.P.A.; Annie C.N. Simpson, M.S.; John P. Docherty, M.D.

### EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize the importance of physician education and proper informed prescribing in serious mental illness.

### SUMMARY:

*Background:* The rising cost of psychotropic medications and their central role in behavioral health have generated national concern regarding the cost-effectiveness of psychotropic prescribing practices. To address this problem a computerized program was implemented in the Missouri Medicaid plan to improve the quality and cost-effectiveness of physician prescribing of psychotropic medications.

*Methods:* Targeted educational messages were sent to physicians if a prescription possibly deviating from best practice was identified. Medicaid recipients whose physician received a mailing during January and March 2004 were used as cases (n=1,911). A pre-post design

was used and compared with a matched control group using propensity scoring.

*Results:* The rate of hospitalization decreased from 16.8% to 9.5%. The mean number of hospital admissions decreased from 0.31 to 0.16 admissions per recipient. There were 1,813 fewer total hospital days in the post-exposure period (1681) compared with the pre-exposure period (3494). There was a reduction in non-pharmacy medical costs of $1,239 with an average six-month cost total of $5,109 in the post-exposure period compared with $6,347 in the pre-exposure period. All findings were significant at $p<0.01$.

*Conclusion:* The intervention appears to be associated with a decrease in hospital utilization and total non-pharmacy cost of care.

## TARGET AUDIENCE:

Clinicians, service researchers and policy making positions.

## REFERENCES:

1. Parks J, Surles R. Using best practices to manage psychiatric medications under Medicaid. Psych Services 2004; 55(11):1227–9.
2. Centorrino F, Goren JL, Hennen J et al. Multiple versus single antipsychotic agents for hospitalized psychiatric patients: case-control study of risks versus benefits. Am J Psychiatry 2004; 161(4):700–6.

**Poster 179** **Saturday, October 8**
**8:30 a.m.-10:00 a.m.**

## DOES ASSERTIVE COMMUNITY TREATMENT WORK IN JAPAN? A RADOMIZED, CONTROLLED TRIAL TO EVALUATE ITS EFFECTIVENESS

*Supported by the Ministry of Health, Labor, and Welfare of Japan*

Yuriko Suzuki, M.D., *Section Chief, Department of Psychiatric Rehabilitation, National Institute of Mental Health, NCNP Kohnodai Hospital, ACT-J, 1-7-1, Kohnodai Ichikawa, Japan 2728516*; Junichiro Ito, M.D.; Iwao Oshima, Ph.D.

## EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize the outline of research protocol to evaluate the effectiveness of ACT-J program, and its socioculturally unique aspects, with emphasis on supports to clients' family members as well as clients themselves.

## SUMMARY:

This presentation will describe a research protocol to evaluate the effectiveness of assertive community treatment in Japan (ACT-J) with preliminary baseline characteristics of its participants. A randomized controlled trial was conducted with intervention group receiving ACT services, and with a comparison group receiving conventional hospital-based care. Newly admitted patients to the K hospital who met the following criteria were eligible for the study: (1) resident (I. F. or M city), (2) age (18 to 60 years old), (3) primary diagnoses (schizophrenia, mood disorder, and other disorders, excluding mental retardation, personality disorder, substance abuse, dementia using ICD-10), (4) high utilization of psychiatric services, (5) lower level of functioning in the previous year. As a primary outcome index, hospital days were calculated, and additionally, psychiatric symptoms, social functioning, and quality of life were evaluated. Currently, the intervention group is comprised of 32 patients and the comparison group with 24 patients. There was no statically significant difference in sociodemographic indices at baseline. Most notably, about 70% of clients in both groups live with their family members. In conclusion, with a high percentage of patients living with their families, services would be modified to fit the needs of families as well as clients themselves.

This program is funded by the Ministry of Health and Welfare, Japan.

## TARGET AUDIENCE:

Mental health service researchers, practitioners.

## REFERENCES:

1. Ito J, Oshima J, Nishio M: Potentialities in developing assertive community treatment in Japan. Hosp Comm Psychiatry 2003; 45:36–41 (In Japanese).
2. Muser KT, Bond GR, Drake RE, et al: Model of community care for severe mental illness: A review of research on case management. Schizophrenia Bulletin 1998; 24:37–74.

**Poster 180** **Saturday, October 8**
**8:30 a.m.-10:00 a.m.**

## THE ROLE OF PATIENT MEDICATION EXPERIENCE IN ANTIPSYCHOTIC ADHERENCE

*Supported by Adheris, Inc.*

Mark R. Vanelli, M.D., *Chief Medical Officer, Adheris, Inc., 26 Bartlett Avenue, Arlington, MA 02174-6418*; Amy Dorgan, M.P.H., *Research Analyst, Adheris, Inc., One Van De Graaff Drive, Burlington, MA 01803*; Marcelo Perraillon-Coca, M.A.; Alex Pedan, Ph.D.

## EDUCATIONAL OBJECTIVES:

At the conclusion of this session, participants should be able to recognize that patients prescribed an antipsychotic for the first time face the greatest likelihood of medication discontinuation 30 to 45 days after filling their initial prescription. Routine follow-up and educational efforts at the time may improve antipsychotic adherence and quality of care.

## SUMMARY:

*Objective:* As the duration of psychiatric hospitalizations have decreased in length—from 25 days in 1990 to nine days in 2001—outpatient pharmacotherapy has increased in importance as a basis for treatment success. This prompted us to examine how long outpatients prescribed oral second-generation antipsychotics (SGAs) remained at least 50% of their prescribed medication and what role prior antipsychotic use played in adherence. APA guidelines recommend a year of antipsychoptic therapy for patients with a single episode of psychosis and perhaps longer for patients with multiple episodes.

*Method:* Kaplan-Meier survival analysis was applied to 259,422 patients who filled a new prescription for an SGA via retail pharmacy. Survival probabilities for patients who continued on 50% or more of prescribed antipsychotic were calculated for patients new to SGA therapy (''rookies'') and those continuing therapy (''veterans).

*Results:* After 3 months, survival probabilities for veterans ranged from 57–62% for rookies, from 27–31%. After 6 months, survival for veterans ranged from 39–43%; for rookies 14–17%.

*Conclusions:* Educational interventions and routine face-to-face follow-up are especially needed for SGA patients new to therapy, typically 30–45 days after starting therapy, when the risk of discontinuation is greatest.

## TARGET AUDIENCE:

Psychiatrists, case managers, psychiatric nurses and outreach workers, health care administrators, medication benefits administrators, patients and family members.

## REFERENCES:

1. World Health Organization: Adherence to long-term therapies: Evidence for action. 2003.
2. Vanelli M, Burstein P, Cramer J: Refill patterns of atypical and conventional antipsychotic medications at a national retail pharmacy chain. Psychiatric Services 2001; 52(9):1248–1250.

**Poster 181** **Saturday, October 8**
**8:30 a.m.-10:00 a.m.**

# MEDICATION NONCOMPLIANCE AMONG ASIAN PATIENTS WITH SCHIZOPHRENIA

Swapna Verma, M.D., *Associate Consultant Psychiatrist, Institute on Mental Health, 10 Buangkok View, Singapore 539747*; Siow A. Chong, M.D., *Senior Consultant Psychiatrist, Institute on Mental Health, 10 Buangkok View, Singapore 539747*; Calvin Fones, M.D.; David Chia, M.D.; Gwen Sin, M.D.; Christopher Cheok, M.D.; C. Escandelor, M.D.

## EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to better understand the prevalence and causes of medication noncompliance in schizophrenia from the point of view of patients as well as their caregivers in an Asian setting.

## SUMMARY:

*Introduction:* Antipsychotic medications represent the cornerstone of the pharmacological treatment for patients with schizophrenia. However, noncompliance to medications continues to be a major problem and is associated with greater number of relapses and hospitalizations. This study was carried out with the aim to examine the prevalence of therapeutic non-adherence in patients with schizophrenia who are on regular follow-up care at large teaching hospitals in Singapore.

*Methods:* Patients included in this study had diagnosis of schizophrenia based on DSM-IV criteria and were being treated with an antipsychotic medication for at least six weeks prior to the survey. Questionnaires were given to patients and patients' family members prior to seeing doctor for consultation.

*Results:* 239 patients and 145 relatives participated in the study. Although 93% of patients stated that they take their medication regularly, 44% also admitted that they had forgotten to take it at any time. Although 88% of the patients viewed the medication as being beneficial to them, almost half of the patients (49%) expressed feeling upset at having to take medication every day. There were no significant differences between patients' and relatives' perceptions about medication compliance.

*Conclusion:* Partial compliance remains a problem in almost half of schizophrenia patients. Lack of insight and stigma may be contributing to poor compliance.

## TARGET AUDIENCE:

Psychiatrist, Psychologist and Case Manager

## REFERENCES:

1. Glimer TP, Dolder CR, Lacro JP, et al: Adherence to treatment with antipsychotic medication and health

care costs among Medicaid benefeciaries with schizophrenia. Am J Psychiatry 2004; 161:692–699.
2. Rittmannsberger H, Pachinger T, Keppelmuller P, et al: Medication adherence among psychotic patients before admission to inpatient treatment. Psychiatric Services 2004; 55:174–179.

**Poster 182** **Saturday, October 8**
**8:30 a.m.-10:00 a.m.**

## INTRODUCING A TREATMENT MALL AT A STATE HOSPITAL: PROCESS AND INITIAL RESULTS

Steven L. Webster, M.Dir., *Psychosocial Rehabilitation Director, Dorothea Dix Hospital, 3601 MSC Center, Raleigh, NC 27699*; Susan Harmon, OTR/L, *Assistant Director of Psychosocial Rehabilitation, Dorothea Dix Hospital, 3601 MSC Center, Raleigh, NC 27699*

### EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to (1) become familiar with the key steps involved in the process of designing and implementing a treatment mall program. (2) recognize the potential benefits of the treatment mall model.

### SUMMARY:

Treatment malls are centralized programming areas, away from a hospital's residential wards, where patients and staff from multiple residential wards meet for a significant portion of the day. All ward functions are transferred to the mall during this time. The facility's physical and staff resources are pooled and integrated at the mall for efficiency and to ensure that everyone at the hospital has access to a full range of treatment and rehabilitation services. The limited literature suggests that effective treatment malls facilitate integrated, community relevant environments in which participants are more likely, than in ward-based programs, to become actively engaged in rehabilitation and recovery. Dorothea Dix Hospital, a public inpatient facility, introduced a treatment mall in August of 2003. This presentation describes the step-by-step process the facility used to design and implement its mall. Results include an increase in rehabilitative group offerings from 30 to 100 per day, with 83% of 248 adult inpatients enrolled in at least four daily groups. The current participant program satisfaction level in relation to personal goal attainment is 78%. Person centered curriculums and mall activities are increasing as patients partner with hospital managers to develop a recovery-oriented program within the mall.

Funding source: State of North Carolina.

### TARGET AUDIENCE:

Inpatient psychiatric hospital managers and practitioners.

### REFERENCES:

1. Bopp, Ribble, Cassidy, Markoff: Psychiatric Services 1996; 47 (7):697–698, 701.
2. Webster, Harmon Paesler: The Behavior Therapist 2005; 28(3):71–77.

**Poster 183** **Saturday, October 8**
**8:30 a.m.-10:00 a.m.**

## DO INPATIENT STAFF FEEL SAFE WHEN SECLUSION AND RESTRAINT ARE ELIMINATED?

Julia Dearmond, M.S., *Psychiatric Mental Health Nurse Practitioner, Department of Nursing, Oregon Health Science University, 3181 S.W. Sam Jackson Park Road, Portland, OR 97239*; William H. Wilson, M.D., *Professor of Psychiatry, Oregon Health Science University, 3181 S.W. Sam Jackson Park Road, UHN-80, Portland, OR 97231*

### EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to discuss staff perceptions of safety on three inpatient psychiatric units that have reduced the use of seclusion and restraint.

### SUMMARY:

*Background:* Historically, psychiatric inpatient units used seclusion and restraint to manage agitated and aggressive behavior. In 2000, new federal regulations mandated that seclusion and restraint only be used in the presence of imminent dangerousness. This study assessed staff perception of changes in professional practice and in their perception of personal and patient safety in the wake of these regulations.

*Methods:* In 2004, direct care staff of three psychiatric inpatient units in Oregon were surveyed using a questionnaire developed for this study. The units were (1) an acute unit in a private hospital, (2) an acute unit in a university hospital, and (3) a longer-stay unit in a state hospital.

*Results:* Staff from all units indicated that their practices had changed to reduce seclusion and restraint. Staff felt that they and their patients were as safe currently as they had been before use of seclusion and restraint was reduced.

*Conclusions:* Reduction of the use of seclusion and restraint did not aversely affect staff perceptions of personal and patient safety in three inpatient psychiatric units. Non-coercive measures for the control of agitation

can be introduced into psychiatric inpatient units without causing staff to feel unsafe in the workplace.

*Funding Source:* No commercial or external funding.

## TARGET AUDIENCE:

Psychiatrists, nurses, Inpatient unit staff, system planners, consumer advocates.

## REFERENCES:

1. Medical Directors Council: Reducing the use of seclusion and restraint. Alexandria VA: National Association of State Mental Health Program Directors, 1999.
2. Lee S et al: Views of nursing staff on the use of physical restraint. Journal of Psychiatric and Mental Health Nursing 2003; 10:425–430.

**Poster 184** **Saturday, October 8 8:30 a.m.-10:00 a.m.**

## INVOLVING RESIDENTS IN PERSON-CENTERED CULTURE CHANGE

William H. Wilson, M.D., *Professor of Psychiatry, Oregon Health Science University, 3181 S.W. Sam Jackson Park Road, UHN-80, Portland, OR 97231*; Cindy M. Scherba, R.N., *Program Director, Department of Nursing, Oregon Health Science University, 3181 S.W. Sam Jackson Park Road, Portland, OR 97239*; David A. Harrison, M.D.; Melissa B. Buboltz, M.D.

## EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to (1) discuss person-centered culture as an overriding value, and (2) describe involvement of psychiatric residents in patient centered unit culture.

## SUMMARY:

The acute inpatient psychiatric service at Oregon Health & Science University adopted the value of person-centered care several years ago. Participation in the ''Creating Violence Free and Coercion Free Mental Health Treatment Environments Project'' sponsored by the National Association of State Mental Health Program Directors gave additional impetus to change the unit culture and practice, resulting in further reductions, and near elimination, of seclusion and restraint. Psychiatric residents at various levels of training have been integral members of the interdisciplinary process that has been bringing about these changes. This poster outlines the ways that junior and senior level residents have been involved in the process both as learners and as active participates in culture change. Data are presented regarding changes in objective measures of change as rates of seclusion. Educational objectives and methods are presented from the perspective of the unit's medical director and program director. Psychiatric residents present case vignettes that clearly represent their experience with patient-centered culture change. Involving residents in the process of culture change has educational benefits as well as contributing to advances in clinical care.

## TARGET AUDIENCE:

Psychiatrists, psychiatric nurses, social workers, hospital service planners.

## REFERENCES:

1. Hagenow NR: Why not person-centered care? Nursing Admin Quart 2004; 27(3):203–207.
2. NASMHPD Medical Directors Council: Reducing the use of seclusion and restraint. Alexandria VA: National Association of State Mental Health Program Directors, 1999.

**Poster 185** **Saturday, October 8 8:30 a.m.-10:00 a.m.**

## ANTIPSYCHOTICS AND DIABETES AT A COMMUNITY MENTAL HEALTH CENTER

*Supported by Janssen Pharmaceutica*

Scott W. Woods, M.D., *Professor of Psychiatry, Yale School of Medicine, 38 Avon Street, #1, New Haven, CT 06511-2523*

## EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to better diagnose and treat diabetic patients maintained on antipsychotic medications.

## SUMMARY:

Diabetes mellitus (DM) is increasingly recognized as a complication of antipsychotic therapy. We estimated the diagnosed prevalence and undiagnosed prevalence of DM among antipsychotic-maintained patients at our community mental health center (CMHC) 2000–2002. We also measured glycemic control among diagnosed DM cases.

*Method:* Diagnosed prevalence was established by patient history. Undiagnosed prevalence was determined by early morning fasting plasma glucose (FPG) measurement. Hemoglobin Alc levels were employed as an index of glycemic control.

*Results:* Diagnosed prevalence of DM was 16.8% (83/494 patients 95% CI 13.6% to 20.4%). Diagnosed DM prevalence rates were higher in patients currently treated with risperidone (20.9%) than with olanzapine (8.4%). Many patients were switched to risperidone after receiving a DM diagnosis. FPG was ≥126 ng/dL on single determination in only 3/108 patients with no DM history.

Hemoglobin Alc levels met ADA guidelines (<7.0) in 37/55 diagnosed DM cases (67.3%).

*Discussion:* Cross-sectional prevalence data cannot be used to infer cause and effect and can be influenced by adverse selection. DM was common in antipsychotic-maintained patients at our CMHC; however, it was only rarely undetected and generally well managed. CMHC care may benefit disease management efforts for DM.

Funded by an investigator-initiated grant from Janssen Pharmaceutica and NIMH grant R01-MH61008.

## TARGET AUDIENCE:

Psychiatrists, medical students, psychiatric nurses.

## REFERENCES:

1. Leslie DL, Rosenheck RA: Incidence of newly diagnosed diabetes attributable to atypical antipsychotic medications. Am J Psychiatry 2004; 161:1709–1711.
2. Woods SW, et al: Best practices: racial and ethnic effects on antipsychotic prescribing practices in a community mental health center. Psychiatric Services 2003; 54:177–179.

**Symposium 1** **Wednesday, October 5**
**8:30 a.m.-11:30 a.m.**

## EVOLVING PERSPECTIVES OF COGNITIVE-BASED PSYCHOTHERAPIES FOR SCHIZOPHRENIA

Paul Lysaker, Ph.D., *Clinical Psychologist, Roudebush Veterans Administration, 1481 West 10th Street, 116A, Indianapolis, IN 46202;* Louanne W. Davis, Psy.D., *Clinical Psychologist, Roudebush Veterans Administration, 1481 West 10th Street, 116A, Indianapolis, IN 46202*

### EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant will be able to recognize how the basic principles of cognitive-behavior therapy can be modified and applied to assist persons with schizophrenia to function in the community.

### SUMMARY:

In light of controlled trials indicating cognitive-behavioral therapy (CBT) can lead to symptom reduction and increased community tenure in schizophrenia, many have begun to explore further uses of CBT for this group that might enhance participation in realistic life tasks and quality of life. This symposium will present detailed descriptions of four such recent adaptations of CBT. These include adaptations for (1) persons with first break schizophrenia, and adaptations that focus uniquely on (2) enhancing work outcomes, (3) metacognition and narrative, and (4) recovery of an enriched sense of self. Presentations will include technical material about how the interventions are implemented as well as methods for formal assessment. In additional, data will be presented from controlled trials and qualitative case analysis supporting the validity of each view. Cognitively based psychotherapies have been shown to assist even the more recalcitrant cases of schizophrenia. This symposium will present participants with both the basic principles of CBT as well as means to apply these principles with the scope of their own research and practice.

### TARGET AUDIENCE(S):

Skilled and novice practitioners and researchers working with persons with severe mental illness.

## No. 1A
## GROUP COGNITIVE-BEHAVIORAL THERAPY FOR FIRST EPISODE PSYCHOSIS: PRELIMINARY RESULTS OF A RANDOM CONTROL TRIAL

Tania Lecomte, Ph.D., *Assistant Professor of Psychiatry, University of British Columbia, 214-828 West 10th Avenue, Vancouver, BC, Canada V5Z 1L8;* Claude Leclerc, Ph.D.; Til Wykes, Ph.D.; Charles J. Wallace, Ph.D.; Alicia Spidel, M.A.

### SUMMARY:

*Objective:* Recent studies have demonstrated the efficacy of cognitive-behavioral therapy (CBT) in treating psychotic symptoms such as delusions and hallucinations of individuals with schizophrenia. CBT has been compared with supportive therapy or befriending, but has not before been compared with another treatment also aiming at improving symptoms and coping. Our study evaluates and compares the effects of a group CBT approach, adapted to the needs of first-episode clients with those of a skills training, symptom management approach and with a waiting list control group.

*Method:* This study is a single-blind, randomized, controlled trial. Both group treatments hold the same number of meetings and use identical formats, duration, and operational structure (both use a detailed intervention manual).

*Results:* Preliminary results with comparisons of the pre-post treatment effects as well as inter-group comparisons will be presented for the following measures: medication; Brief Psychiatric Rating Scale (BPRS); Birchwood Insight Scale; Maudsley Assessment of Delusions Scale (MADS); Belief About Voices Questionnaire, Self-Esteem Rating Scale; Cybernetic Coping Scale; and satisfaction with treatment.

*Conclusion:* Results suggest CBT can be successfully adapted to assist persons with first-break schizophrenia.

## No. 1B
## COGNITIVE BEHAVIOR THERAPY MODIFIED TO TARGET WORK OUTCOME IN SCHIZOPHRENIA

Louanne W. Davis, Psy.D., *Clinical Psychologist, Roudebush Veterans Administration, 1481 West 10th Street, 116A, Indianapolis, IN 46202;* Paul Lysaker, Ph.D.

### SUMMARY:

*Objective:* Many with schizophrenia wish to work, yet expect failure. These beliefs represent a barrier to desired levels of function. Cognitive-behavior therapy (CBT) has proven to be useful to persons with schizophrenia and could be adapted to enhance vocational outcomes.

*Method:* A total of 50 participants with schizophrenia or schizoaffective disorder were offered a six-month work placement and randomly assigned to receive six months of standard support services or a form of group and individual CBT adapted to target vocational function. Hours of work were assessed weekly and work

performance was assessed biweekly using the Work Behavior Inventory. Beliefs about self were assessed at baseline and after five months of treatment using the Beck Hopelessness Scale and Rosenberg Self-esteem schedule.

*Results:* ANOVA revealed the CBT group worked significantly more weeks and had significantly better average work performance than the support group. ANVOCA controlling for baseline indicated that the IVIP group sustained initial levels of hope and self-esteem through follow up, while the support group experienced declines. An illustrative case report will be presented with details allowing participants to understand the procedures and adaptations made.

*Conclusion:* Results suggest CBT may be modified to assist some with schizophrenia to achieve better work outcomes.

## No. 1C
## EFFECTS OF COGNITIVE PSYCHOTHERAPY FOR METACOGNITION AND COPING IN SCHIZOPHRENIA

Paul Lysaker, Ph.D., *Clinical Psychologist, Roudebush Veterans Administration, 1481 West 10th Street 116A, Indianapolis, IN 46202;* Louanne W. Davis, Psy.D.

### SUMMARY:

*Objective:* Controlled trials have indicated cognitive-behavioral therapy (CBT) can lead to symptom reduction and increased community tenure in schizophrenia. Less clear is whether these interventions can be adapted to facilitate improvements in actual cognitive processes such as metacognition and coping preference.

*Method:* A total of 50 participants with schizophrenia or schizoaffective disorder were offered a six-month work placement and randomly assigned to receive six months of standard support services or a form of group and individual CBT adapted to target function. Metacognition was assessed by having participants relate the narratives of their lives and illnesses at baseline and five-month follow up, after which raters evaluated the metacognition within those transcribed narratives using the Metacognition Assessment Scale. Coping style was assessed using baseline and follow-up assessments using the Ways of Coping Questionnaire.

*Results:* ANCOVA controlling scores at baseline revealed the CBT group showed greater improvement in overall metacognition and preference for active problem solving. An illustrative case report with repeated measures analyses will be used to supplement these findings and explore the interrelationship between growth of metacognition and personal narrative in long-term psychotherapy.

*Conclusion:* Results suggest CBT may be modified to assist some with schizophrenia to achieve better metacognition and coping.

## No. 1D
## USE OF JUNGIAN PSYCHOTHERAPY STRATEGIES IN THE COGNITIVE-BEHAVIORAL THERAPY OF SCHIZOPHRENIA

Steven M. Silverstein, Ph.D., *Associate Professor of Psychiatry, University of Illinois at Chicago, 912 South Wood Street, Chicago, IL 60612*

### SUMMARY:

Chadwick, Birchwood, and Trower (1994) suggested that future developments in cognitive-behavioral therapy (CBT) for schizophrenia will involve moving from a symptom model to a person model. In particular, they suggested that this paradigm shift will involve an increased focus on the construction of a sense of self. In working toward this goal, integration of selected concepts and techniques from psychotherapies that have focused on self issues may be useful. This presentation describes the integration of analytical (Jungian) techniques within CBT of schizophrenia, using case examples. In one example, initial attempts at CBT were unsuccessful as the patient refused to consider any possibility that his beliefs could be untrue or problematic. In subsequent work, the Jungian technique of amplification was used to normalize and explore cultural and historical meanings of the anomalous experience on which his delusional belief was based. This material served as evidence against his delusional explanation of the experience and provided concepts for a more realistic self-understanding. Other case examples will explore the use of behavioral strategies to foster awareness of persona-self differences, again with the goal of increasing awareness of previously under-appreciated tendencies, and the development of a more resilient sense of self.

### REFERENCES:

1. Lecomte T, Leclerc C, Wykes T, Lecomte J: Group CBT for clients with a first episode of psychosis. Journal of Cognitive Psychotherapy: An International Quarterly 2003; 17(4):375–384.
2. Sensky T, Turkington D, Kingdon D, Scott JL, Scott J, Siddle R, O'Carroll M, Barnes TRE: A randomized, controlled trial of cognitive-behavioral therapy for persistent symptoms in schizophrenia resistant to medication. Arch Gen Psychiatry 2000; 57:165–172.
3. Davis LW, Lysaker PH, Lancaster RS, Bell MD, Bryson GJ: The Indianapolis Vocational Intervention Program: a cognitive behavioral approach to addressing rehabilitation issues in schizophrenia. Jour-

nal of Rehabilitation Research and Development, in press.
4. Lysaker, PH, Lancaster, RS, Nees MA, Davis LW: Attributional style and symptoms as predictors of social function in schizophrenia. Journal of Rehabilitation Research and Development, 2004.
5. Chadwick P, Birchwood M, Trower P: Cognitive Therapy for Delusions, Voices and Paranoia. New York, Wiley, 1994.

**Symposium 2** **Wednesday, October 5**
**2:00 p.m.-5:00 p.m.**

## FAMILY DRIVEN APPROACHES TO SERVICES, SUPPORTS, AND RESEARCH

*Substance Abuse and Mental Health Services Administration*

Gary M. Blau, Ph.D., *Chief of the Child, Adolescent and Family Branch, Substance Abuse and Mental Health Services Administration, 1 Choke Cherry Road, Rockville, MD 20857*

### EDUCATIONAL OBJECTIVES:

At the conclusion of this session, participants will be able to: (1) articulate the definition of family driven care; (2) identify how family driven approaches to services and system planning can be realized; and (3) identify strategies for how to incorporate family driven care into practice and planning activities.

### SUMMARY:

Traditional approaches to service delivery have been professional and agency driven. Newer approaches are family driven, where families are active partners in developing, implementing, monitoring, and evaluating services and supports. These approaches extend the family focused conceptualizations of the earlier literature on systems of care (Stroul & Friedman, 1986). Family-driven approaches establish goals in true partnership with families and are grounded in the experiences, expertise, strengths, hopes, dreams, desires, and needs of the individual children, youth, and families that are being served.

During the 1990s children's mental health underwent a paradigm shift from provider-driven approaches, which focused on families to family-driven approaches (Osher and Osher, 2002). The family movement in children's mental health called for family-professional collaboration in service delivery activities (Dunst, 1997). The President's New Freedom Commission recognized this shift when it called for family and consumer-driven services as an overarching goal. To promote the transformation of children's mental health care called for by Achieving the Promise: Transforming Mental Health Care in America, the Center for Mental Health Services commissioned the Federation of Families for Children's Mental Health to develop an operational definition of family driven care. This symposium will present the definition, the method used to develop the definition, and the literature that supports the utilization of a family driven approach to care. This symposium will also describe the guiding principles of family-driven care and the conditions that exist in a family-driven care model. Practical applications and vignettes will also be used to identify specific strategies for implementing a family-driven care approach in clinical settings.

## No. 2A
## WRAPAROUND SERVICES AS A CLINICAL PARADIGM FOR FAMILY DRIVEN CARE

Ira S. Lourie, M.D., *Partner, Human Services Collaborative, 18902 Preston Road, Hagerstown, MD 26742*

### SUMMARY:

Early in the development of the System of Care Concept of providing services for children and adolescents with serious emotional disturbances, wraparound emerged as the service delivery approach that best fit the System of Care's core principles of services being community based, family driven, and culturally competent. Within a wraparound process, families are aided to gather around them a team consisting of family members along with a group of professionals, community service providers, public agency staff, friends, relatives, and other community resources that best represent those who are interested in the welfare of the child and family and who can provide the best resources for them.

This presentation will describe how the principles of wraparound services are applied in family driven manner and how these principles (unconditional care, individualized, community-based, strength-based, cultural competence, family-driven, cost-effectiveness, accountability and interagency) work together to insure family involvement at the highest levels. Dr. Lourie will further discuss how the practice of creating child and family wraparound teams works to develop truly individualized interventions. Dr. Lourie will demonstrate how the flexibility offered by the child and family team process allows for an intervention that can change at moment's notice to meet the changing needs of the child and family.

## No. 2B
## SERVICE DELIVERY: LET'S ALL WORK TOGETHER

David M. Osher, Ph.D., *Managing Research Scientist, American Institutes for Research, 1000 Thomas Jefferson Street, N.W., Washington, DC 20007-3835*

**SUMMARY:**

Service delivery involves a multiplicity of transactions between families, youths, and providers, mediated by how participants view each others role as well as by the needs, policies, procedures, organizational culture, and resources of providers and the agencies in which they work. The ways in which family-professional relationships are conceptualized help frame service delivery and policy development as well as services research. Typically, professionalized services are limited and determined by agency needs and evaluated on the basis of agency-defined outcomes. Alternatively families and youth can be viewed as allies who can implement and support professionally-driven approaches. Still further from agency-driven approaches, families can be treated as active agents in the development, implementation, and evaluation of interventions. When this happens, families are viewed and treated as having important and even expert knowledge, gained from experience and/or training and are expected to contribute to defining the nature of the presenting problems, the various factors contributing to it, and the range of strategies that could effectively resolve these problems. In these settings and communities, service planning and access are truly based on how the needs of a specific child or group of children and their families can best be met.

## No. 2C
## FAMILY-DRIVEN APPROACHES FOR CHILDREN'S MENTAL HEALTH

Sandra Spencer, *Executive Director, Federation of Families for Children's Mental Health, 1101 King Street, Suite 420, Alexandria, VA 22314;* Trina W. Osher, M.A.

**SUMMARY:**

During the 1990s children's mental health underwent a paradigm shift from provider-driven to family-driven approaches. This paradigm shift moved from viewing families as the passive receivers of services who were expected to carry out professional prescriptions to partners in the development, monitoring, and evaluation of services. The family movement in children's mental health, the roles played by families in systems of care, calls for family-professional collaboration in the education of children with emotional disturbance, and the conceptualization of family-centered approaches in early intervention work contributed to this paradigm shift. The President's New Freedom Commission recognized this shift when it developed Goal 2, calling for family and consumer driven services. The Center for Mental Health Services continued this process by commissioning the Federation of Families for Children's Mental Health to lead an effort to define and conceptualize family-driven care. This process has been informed by an expert panel, open forum discussions, feedback from stakeholders, and a literature review. This paper will present the definition, method used to develop it, and literature that supports it. The session will also describe the guiding principles of family-driven care and the conditions that exist in a family driven care model.

**REFERENCES:**

1. Dunst CJ: Conceptual and empirical foundations of family-centered practice, in Illback R, Cobb C, and Joseph H, HR. (Eds.). Integrated services for children and families: Opportunities for psychological practice. Washington, DC: American Psychological Association, 1997,pp 75–91.
2. Osher TW, Osher D: The paradigm shift to true collaboration with families. Journal of Child and Family Studies 2002; 11:1, 47–60.
3. Stroul BA, Friedman RM: A system of care for children and youth with severe emotional disturbances. Washington, DC: National Technical Assistance Center for Children's Mental Health, 1986 rev.
4. New Freedom Commission on Mental Health, Achieving the Promise: Transforming Mental Health Care in America. Final Report. DHHS Pub. No. SMA-03-3832. Rockville, MD, 2003.
5. Lourie I, Katz-Leavy J, Stroul B: Individualized Services in a System of Care, in Children's Mental Health: Creating Systems of Care in a Changing Society. Edited by Stroul B. Baltimore, MD: Brookes, 1996.

**Symposium 3** **Wednesday, October 5**
**2:00 p.m.-5:00 a.m.**

## USERS' PERSPECTIVE ON SERVICES RELATED TO RECOVERY: A CANADIAN EXPERIENCE

Myra Piat, Ph.D., *Assistant Professor of Psychiatry, Douglas Hospital, 6875 La Salle Boulevard, Verdun, PQ, Canada H4H 1R3;* Michel Perreault, Ph.D., *Psychologist and Researcher, Department of Psychiatry, Douglas Hospital, 6875 La Salle Boulevard, Montreal, PQ, Canada H4H 1R3*

**EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be (1) sensitized on users' perspective of different services designed for persons with severe mental health and substance abuse disorders, (2) informed about communalities emerging around users' opinions of services, (3) aware of different service organization models and how they are adapted to meet consumers' needs in a recovery context.

## SUMMARY:

*Context:* Over the past 20 years, numerous consumer satisfaction studies on mental health services have been conducted in North America. However, these studies focus on specific aspects and rarely provide and overview of services targeted for the recovery.

*Objectives:* This symposium will report findings from five different studies on consumer evaluation of services in mental health and substance abuse throughout the province of Québec, Canada.

*Methods:* Questionnaires, focus groups, and key informant interviews were conducted with persons with severe and persistent disorders and marginalized persons. Accessibility, perceived needs, and satisfaction were evaluated in the following areas: organization of mental health services, housing and employment, and substance abuse treatment.

*Results:* Findings demonstrate: (1) consumers receiving services are generally satisfied with service providers but less satisfied with the organization of services, (2) the perspective of marginalized consumers is different as they are confronted with poor accessibility and services that are not sufficiently adapted to their needs, (3) organization of service networks which optimizes the match between users' and mental health workers' perception of needs are the most efficient.

*Conclusion:* In order to promote full participation of consumers in recovery oriented services it is essential to consider consumers' preferences and assessment of services.


## TARGET AUDIENCE(S):

Mental health and addiction professionals, program managers, consumers.

## No. 3A
## ACCESSIBILITY TO A LOW THRESHOLD METHADONE TREATMENT: USERS' PERSPECTIVE ON A MONTREAL PROGRAM


Michel Perreault, Ph.D., *Psychologist and Researcher, Department of Psychiatry, Douglas Hospital, 6875 La Salle Boulevard, Montreal, PQ, Canada H4H 1R3;* Marie-Christine Heroux, M.S.C.; Isabelle Tremblay, M.P.S.; Pierre Lauzon, M.D.



## SUMMARY:

*Statement of Problem:* Access to health services has been a major challenge for marginalized persons with substance-abuse disorders. This clientele, addicted to heroin, does not have easy access to conventional methadone treatment. In order to reach this disaffiliated clientele, a low threshold program was initiated in Montreal. The clientele's perspective was assessed to orient its development.

*Objectives:* To describe the client's opinion at the beginning, during treatment, and after drop out.

*Methods:* (1) a survey based on personal interviews with 87 clients conducted three months after admission with a 31-item validated questionnaire; (2) a survey based on self-administered questionnaire to 88 clients during treatment, and (3) three focus groups with clients and persons who dropped out of the program.

*Results:* The main sources of satisfaction are program reception, staff's openness and acceptance, flexible appointment times, and the ability to return to treatment after dropping out. Improvements suggested are related to treatment modalities, the most frequently mentioned being the possibility to have take-home dosages of methadone.

*Conclusion:* Even though the availability of methadone is the primary reason for attending the program, staff acceptance appears to be the most important reason for staying and returning to treatment.


## No. 3B
## PERCEPTION OF HOMELESS MENTALLY ILL ABOUT THEIR NEEDS AND ACCESSIBILITY


Jean-Pierre Bonin, Ph.D., *Adjunct Professor, Faculty of Nursing, University of Montreal, and Post Doctoral Fellowship in Psychiatry, McGill University, C. P. 6128 Succ. Centre-Ville, Montreal, PQ, Canada H3C 3J7;* Louise Fournier, Ph.D.; Regis Blais, Ph.D.



## SUMMARY:

*Statement of Problem:* Homeless mentally ill persons seek less assistance or do not obtain mental health services (Breaky, 1992). They do not trust authority figures or service dispensers, and professionals are often reluctant to treat their very complex problems. Thus, it is important to have a better understanding of the perception of homeless mentally ill persons about their service needs and accessibility to these services.

*Objectives:* To describe the perception of homeless mentally ill persons about their overall need for services and specific mental health services.

*Methods:* This study used data from a health survey of the homeless (Fournier, 2001), in Montreal, Canada (N=757). Subjects included in the study suffered from depression, bipolar disorders, or psychosis during their lifetime.

*Results:* Respondents identified the need to have a place to stay as their primary need. Only 40% said that they needed mental health treatment, and 24% talked about substance abuse treatment. Respondents stated that the main reason for not receiving services was because

they wanted to resolve their problems by themselves. Two thirds said that their last inpatient treatment was useful.

*Conclusion:* We have to find innovative ways to help homeless mentally ill persons receive services they need.

## No. 3C
## THE ROLE OF WORK STATUS AND MEANING OF WORK IN RECOVERING FROM PSYCHIATRIC DISABILITIES

Helene Provencher, Ph.D., *Professor of Nursing, University of Laual, Pauilion Paul-Comptois, Quebec City, PQ, Canada G1K 7P4;* Myreille St.-Onge, Ph.D.; Michele Clement, Ph.D.; Myra Piat, Ph.D.

### SUMMARY:

*Statement of Problem:* In the domain of vocational rehabilitation, the benefits of work to non-vocational domains, such as symptoms, life satisfaction, and empowerment remain an unresolved issue. The subjective experience of work in recovery also is poorly understood.

*Objective:* To explore the role of work in recovery among employed and unemployed persons with psychiatric disabilities.

*Methods:* Sixty-five persons with schizophrenia and affective disorders participated in semi-structured interviews and completed self-report measures on symptoms, life satisfaction, and empowerment. Participants were divided into five groups: competitively employed persons, those involved in pre-vocational training and sheltered work settings, volunteers, and unemployed persons.

*Results:* Preliminary results demonstrate the linkages between work status and quantitative indicators of recovery, that is perceived symptoms, life satisfaction, empowerment, as well as qualitative ones, such as meaning of work, meaning of recovery, and quality of life. These results will be presented while taking into account the motivation to get future competitive jobs for those involved in non competitive settings or being unemployed.

*Conclusion:* The recovery approach brings an enlarged vision about the experience of work in the lives of persons with psychiatric disabilities.

## No. 3D
## EVALUATION SERVICES IN FOSTER HOMES IN MONTREAL, CANADA: A CONSUMER PERSPECTIVE

Myra Piat, Ph.D., *Assistant Professor of Psychiatry, Douglas Hospital, 6875 La Salle Boulevard, Verdun, PQ, Canada H4H 1R3;* Michel Perreault, Ph.D.; David Bloom, M.D.

### SUMMARY:

*Objectives:* This presentation will report findings of a study on consumer evaluation of services in foster homes in Montreal, Canada. Over the past four decades, mental health professionals have placed thousands of deinstitutionalized persons into foster homes. Although current policies identify access to suitable housing as a priority for integrating persons with serious mental illness, little is known about this housing network. The majority of consumers have lived in these homes for many years, and are heavy users of services; however, their opinions have not been considered.

*Method:* This study focused on the consumer's perspective. Client satisfaction with services in foster homes was evaluated by 146 consumers. A satisfaction protocol developed from eight focus groups, evaluated seven dimensions of life in a foster home: (1) physical environment, (2) foster home services, (3) organization of foster home, (4) relationship with caregiver, (5) treatment, (6) relationship with other residents and the community, and (7) overall ambiance.

*Results:* Consumers identify areas of satisfaction and dissatisfaction. Challenges in implementing a consumer satisfaction study will be examined.

*Conclusion:* For the first time consumers evaluated services in foster homes. Findings have important implications for service providers and the overall quality of services.

## No. 3E
## APPROPRIATENESS BETWEEN NEEDS AND SERVICES IN MENTAL HEALTH: THE PERCEPTION OF USERS AND THEIR PRIMARY MENTAL HEALTH WORKER

Marie-Josee Fleury, Ph.D., *Assistant Professor, McGill University Research Center, Douglas Hospital, 6875 La Salle Boulevard, Montreal, PQ, Canada H4H 1R3;* Alaih Lesage, M.D.; Youcef Ouadahi, M.B.A.; Guy Grenier, Ph.D.

### SUMMARY:

*Statement of the problem:* Important differences exist between users and mental health professionals concerning the appropriateness of services to answer the consumer's needs.

*Objectives:* To compare the perception of users with severe mental health problems with those of their primary mental health professional, in order to identify the main factors of divergence between these two groups.

*Methods:* (1) 186 mental health service users, from six territories in Quebec (Canada), answered the Cam-

berwell Assessment of Needs (CAN) and another questionnaire developed from their clinical dossiers and short interviews; (2) the users responses were compared with those of their primary mental health worker (N=165).

*Results:* The local networks responding best to the users' needs are those where a maximum of similarities are observed between the users' and their primary mental health workers' answers. They are also those in which the users make the greatest use of the available resources.

*Conclusion:* Mental health workers must take into consideration the users' point of view, particularly in the field of social relations, daily activities and information on the disease and its treatment, which are the needs that are the least well taken care of.

## REFERENCES:

1. Perreault M, Rousseau M, Mercier C, Lauzon P, Gagnon C, Côté P: Accessibilité aux traitements de substitution à la méthadone et réduction des méfaits: le rôle d'un programme à exigences peu elevées. Revue Canadienne de Santé Publique 2003; 94(3), 197–200.
2. Bonin JP, Fournler L: Enquéte auprès de la clientèle des ressources pour personnes itinérantes des régions de Montréal-Centre et de Québec (Tome 2): Soutien social. Québec: Institut de la statistique du Québec, 2003.
3. Provencher HL, Gregg R, Mead S, Mueser KT: The role of work in the recovery of persons with psychiatric disabilities. Psychiatric Rehabilitation Journal 2002; 26:132–144.
4. Piat M, Perreault M, et al: Stakeholder Perspectives On Psychiatric Foster Homes: Consumers, Families, Caregivers, and Professionals. Psychiatric Rehabilitation Journal 2004; 27(3):228–234.
5. Fleury MJ, Lesage A, Ouadahi Y, Grenier G, Aubé D, Perreault M, Poirier LR: Integrated Network Services and Responses to Needs, Research report transmitted to the Canadian Research Foundation on Health Services, 2004.
6. Foundation on Health Services, 2004.

**Symposium 4** **Thursday, October 6**
**8:30 a.m.-11:30 a.m.**

# MENTAL HEALTH SERVICE UTILIZATION FOR MOOD DISORDERS: AN INTERNATIONAL COMPARISON

Paula Goering, Ph.D., *Professor, Department of Psychiatry, University of Toronto, 33 Russell Street, 3rd Floor Tower, Toronto, ON Canada M5S 2S1;* Sergio Aguilar-Gaxiola, M.D., Ph.D., *Professor, Department of Psychiatry, California State University, 531 On Campus Drive, M/S 11, Fresno, CA 93740*

## EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to (1) understand the important factors that influence mental health service utilization for mood disorders, (2) be aware of age-specific determinants of service use among individuals with mood disorders, and (3) be mindful of international variability in factors influencing mental health service utilization.

## SUMMARY:

This symposium will examine recent data on mental health service utilization for mood disorders and provide an international comparison of findings. Data from the Canadian Community Health Survey-Mental Health and Well Being (CCHS 1.2) will be reviewed and compared with emerging data from the World Health Organization's World Mental Health Initiative, of which Dr. Aguilar-Gaxiola is coordinator for Latin America and the Caribbean. Dr Goering will provide her unique insights derived from her leadership role in mental health systems research in Canada. Individual presentations will focus on specific age groups, including adolescents, adults, and the elderly, and identify unique factors influencing service utilization in each age category. Specifically, new information on the effect of gender and other variables on service utilization among depressed adolescents, adults with bipolar disorder, and older adults with various psychiatric conditions will be explored. The findings will be discussed in terms of clinical relevance, policy implications, and future research. The target audience for this symposium includes clinicians, researchers, and health system administrators. There are no specific background requirements.

**No. 4A**

# MENTAL HEALTH SERVICE USE AMONG ADOLESCENTS AGED 15–18 WITH DEPRESSION

Amy H. Cheung, M.D., *Assistant Professor, Department of Psychiatry, University of Toronto, 33 Russell Street, 3rd Floor Tower, Toronto, ON, Canada M5S 2S1;* Carolyn Dewa, Ph.D.; Anthony J. Levitt, M.D.

## SUMMARY:

*Objective:* This study examined the 12-month service use rates in youth aged 15–18 who met diagnostic criteria for major depression as part of a Canada-wide community survey.

*Method:* Data from the Canadian Community Health Survey Cycle 1.2 (CCHS) were used to examine the 12-month service use rate of youth who met criteria for major depression in the 12 months preceding the interview. The sample size for subjects aged 15–18 was

2,886. Odds ratios were calculated to examine possible gender differences.

*Results:* Fifty-five percent of adolescents with depression (95%CI 40.7–71.1) reported mental health service use in the previous 12 months. Females with depression were significantly more likely to see social workers as compared with males (male = 10.8%, female = 39.9%, OR = 0.18, 95% CI 0.18–0.19). As compared with females, males were significantly more likely to see psychiatrists (male = 45.5%, female = 21.4%, OR = 4.39, 95% CI 4.26–4.52) and psychologists (male = 25.2%, female = 16.7%, OR = 1.67, 95% CI 1.62–1.73).

*Conclusions:* A significant portion of adolescents who met diagnosis for depression in the past 12 months was not receiving mental health services. There were also gender differences in the type of providers that were seen. Issues that impact this pattern of utilization include identification of those at risk, and access to, and availability of, services.

*Funding:* Ministry of Health, Ontario, and the Ontario Mental Health Research Foundation.

## No. 4B
## GENDER DIFFERENCES IN SERVICE UTILIZATION FOR BIPOLAR DISORDER

Ayal Schaffer, M.D., *Assistant Professor, Department of Psychiatry, University of Toronto, 2075 Bayview Avenue, Room FG29, Toronto, ON, Canada M4N 3M5;* John Cairney, Ph.D.; Amy H. Cheung, M.D.; Scott Veldhuizen, B.A.; Anthony J. Levitt, M.D.

### SUMMARY:

*Objective:* To determine the effect of gender on service utilization in a community sample of individuals with bipolar disorder (BD).

*Methods:* This study utilized data from the Canadian Community Health Survey Cycle 1.2 on Mental Health and Well-Being (CCHS 1.2). This survey, conducted by Statistics Canada between May and December 2002, involved 36,984 respondents aged 15 or older who were primarily interviewed in person. The overall response rate was 77.0%. For individuals diagnosed with BD, we determined the effect of gender on illness history, service utilization, and medication use.

*Results:* Men and women with BD had similar numbers of lifetime manic or depressive episodes, yet men with BD were significantly less likely than women with BD to have ever accessed mental health resources of any type ($p = 0.02$). There were no gender differences in likelihood of having experienced a depression in the past 12 months, but women were significantly more likely to have been prescribed an antidepressant medication during this time period ($p = 0.02$).

*Discussion:* Gender appears to play an important role in service utilization and medication use among this community sample of bipolar patients.

*Funding:* Ministry of Health and Long-Term Care, Province of Ontario, Canada.

## No. 4C
## MENTAL HEALTH CARE USE IN OLDER CANADIANS

John Cairney, Ph.D., *Research Scientist, Department of Psychiatry, University of Toronto, 33 Russell Street, Toronto, ON, Canada M5S 2S1*

### SUMMARY:

*Objective:* To examine the pattern of mental health care use among older adults in Canadia using the socio-behavioral model of help seeking.

*Methods:* This study utilized data from the Canadian Community Health Survey Cycle 1.2 on Mental Health and Well-Being (CCHS 1.2). This survey, conducted by Statistics Canada between May and December 2002, involved 36,984 respondents aged 15 or older who were primarily interviewed in person. The overall response rate was 77.0%. In this study, only those individuals ages 64 and older are selected for analyses (n=7736).

*Results:* Gender, age, and socio-economic status are all significantly related to help seeking in older adults, even after adjustment for depression, anxiety, suicidal ideation, and physical health status (count of chronic conditions and limitations in physical activity). Older adults who had suffered from major depression, anxiety disorders, and those who had physical health problems were also more likely to have had a mental health contact.

*Discussion:* Independent of need, older men and those with low levels of income and education were less likely to have sought care for mental health reasons. These findings are discussed in terms of policy implications and future research.

*Funding:* Canadian Institute for Health Research.

### REFERENCES:

1. Wu P, Hoven CW, Cohen P, et al: Factors associated with use of mental health services for depression by children and adolescents. Psychiatr Serv 2001; 52:189–95.
2. Rushton JL, Forcier M, Schectman RM: Epidemiology of depressive symptoms in the National Longitudinal Study of Adolescent Health. J Am Acad Child Adolesc Psychiatry 2002; 41:199–205.
3. Robb JC, Young LT, Cooke RG, et al: Gender differences in patients with bipolar disorder influence outcome in the medical outcome survey (SF-20) subscale scores. J Affect Disord 1998; 49:189–193.

4. Shulman KI, Schaffer A, Levitt A, et al: Effects of gender and age on the phenomenology and management of bipolar disorder. World Psychiatric Association Series Evidence and Experience in Psychiatry: Volume 5 Bipolar Disorder. Edited by Maj M, Akiskal HS, Lopez-Ibor JJ, Sartorius N. Wiley Publication, 2002.
5. Beekman ATF, de Beurs E, Van Balkom AJLM, Deeg DJH, et al: Anxiety and depression in later life: co-occurrence and communality of risk factors. American Journal of Psychiatry 2000; 157:89–95.
6. Anderson R: Revisiting the behavioral model and access to medical care: Does it matter? Journal of Health and Social Behavior 1995; 36:1–10.

**Symposium 5** **Thursday, October 6**
**8:30 a.m.-11:30 a.m.**

## RECOVERY SYSTEM TRANSFORMATION IN CALIFORNIA

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

### EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant will have a detailed understanding of the efforts to transform California's mental health system on multiple levels to apply to their own efforts.

### SUMMARY:

Forty years ago California led the nation during deinstitutionalization. Now mental health is attempting a nationwide transformation into a recovery oriented system of care. The passage of Proposition 63 brought approximately $600 million to $800 million a year to California's mental health system, potentially thrusting us again into a leadership role. System transformation, to be successful, requires transformation at multiple levels. This symposium discusses in detail five levels: (1) political and economic aspects of transformation, (2) systems and administrative aspects of transformation, (3) program leadership and culture aspects of transformation, (4) staff (personal and practice) aspects of transformation, and (5) outcomes (accountability and incentivizing) aspects of transformation. The faculty for this symposium has been actively working within California to promote transformation in these areas. We will give an ''insiders'' view of the process as it unfolds.

### TARGET AUDIENCE(S):

Persons involved in recovery-based personal, programmatic, or system transformation.

## No. 5A
## TRANSFORMATION AS A POLITICAL EXERCISE

Richard S. Van Horn, *President and Chief Executive Officer, National Mental Health Association of Greater Los Angeles, 320 Pine Avenue, Suite 610, Long Beach, CA 90802*

### SUMMARY:

Five major events have brought the mental health system to a new transformation boundary: the Community Mental Health Act of 1956, the Mental Health Center Act of 1963, Mental Patients Bill of Rights (1967), Adult System of Care (1988), and the Outreach and Treatment Program for Homeless Mentally Ill of 1999. These five events and processes, along with all the activity around them, have led California to the Mental Health Services Act (Proposition 63) of November 2004. This is a half-century journey toward transformation. Bluntly, the California mental health constituency is truly the dog that caught the car.

The politics of success will be explicated in this presentation.

## No. 5B
## SYSTEMS AND ADMINISTRATION ASPECTS OF TRANSFORMATION

Martha Long, *Director, Village Integrated Services, 456 Elm Avenue, Long Beach, CA 90802*

### SUMMARY:

The passing of the Mental Health Services Act (Proposition 63) provides many challenges to the mental health community in California. Among the most dramatic is the idea that this act was designed with the notion of not just system change, but rather system transformation altogether. This presentation looks at what is required to ''ramp up'' the idea of change to that of transformation.

A total revamping of our mental health delivery system requires a cogent and understandable philosophy underpinning the many necessary changes, a set of measurable goals and a built-in accountability process that regularly and reliably checks on progress toward achieving these goals. Administrative attitudes must be geared toward assisting providers in achieving these goals, and providing tools, training, flexible funds, and other supports. Probably most importantly, it is critical to articulate that the goal of mental health treatment is not symptom reduction, but rather a better life for the people we serve.

## No. 5C
## LEADERSHIP AND CULTURAL ASPECTS OF TRANSFORMATION

Wayne Munchel, *Director of Training and Consultation, Village Integrated Services, 456 Elm Street, Long Beach, CA 90802*

### SUMMARY:

This segment of the program will focus on the essential role that leaders, psychiatrists, and supervisors must adopt to ensure that a ''culture of recovery'' is adopted and sustained. Psychiatrists and administrators will be invited to examine their personal impact on clients, colleagues, and staff that can either serve to nurture recovery or stifle it. The strategies that recovery-oriented leaders may utilize revolve around four basic principles of the recovery movement. The first area is hope. What actions do recovery-oriented leaders take that nurtures hope in themselves, their staff, and reflects it in their organizational structures and procedures? The next principle is healing. How do leaders conceptualize and articulate this happening in their organizations? The third principle is community engagement—how do recovery oriented leaders move their organizations beyond the stigmatized confines of the mental health system? The fourth principle is authority—what actions do leaders take that is based on genuine authority vs. positional authority; how is empowerment and self-responsibility fostered in mental health agencies?

## No. 5D
## STAFF ASPECTS OF RECOVERY TRANSFORMATION

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

### SUMMARY:

There is a lot of talk about transforming our mental health system into a consumer-driven, recovery-based system, but very little talk about transforming staff to work successfully in this new system. Recovery programs, to this point, tend to rely on creating small countercultures with dynamic leadership, staff that are different or want to change, and new non-professional and consumer staff. Transforming existing programs with existing staff will require a proactively guided process of staff transformation to succeed. Staff training and retraining efforts need to focus on the following areas: (1) looking inward and rebuilding passion for the work, (2) building inspiration and belief in recovery, (3) changing from treating illnesses to helping people with illnesses have better lives, (4) moving from caretaking to empowering, sharing power and control, (5) gaining comfort with mentally ill co-staff and multiple roles, (6) valuing the patient's subjective experience, (7) creating therapeutic relationships, (8) lowering emotional walls and becoming a guiding partner, (9) understanding the process of recovery, (10) becoming involved in the community, (11) reaching out to the rejected, and (12) living recovery values. Changing most of these areas will require clinical experiences working in recovery, rather than didactics.

## No. 5E
## MEASURING RECOVERY: CALIFORNIA'S INTEGRATED SERVICES FOR THE HOMELESS

David A. Pilon, Ph.D., *Director of Outcomes and Research, National Mental Health Association of Greater Los Angeles, 320 West Pine Avenue, Suite 601, Long Beach, CA 90802*

### SUMMARY:

In 1999, the California state legislature enacted Assembly Bill 34, designed to provide services to people who were mentally ill and were also homeless and/or incarcerated. Now in its fifth year, this program has achieved remarkable success in reducing hospitalizations, homelessness, and incarcerations among the mentally ill individuals it serves. Specifically, the following outcomes were obtained:

- The number of days of psychiatric hospitalization since enrollment dropped 60.6%.
- The number of days of incarceration dropped 75.4%.
- The number of days spent homeless dropped 71.5%.
- The number of days of full-time employment increased 55.9%.
- The number of days of part-time employment increased 91.8%.

This paper will describe how an evaluation system focused on quality-of-life outcomes can enhance the possibility for recovery from psychiatric disabilities. In addition, it will describe how California has adopted the type of outcome system created by the AB 2034 system and adapted it to its entire system of care.

### REFERENCES:

1. New Freedom Commission on Mental Health, Achieving the Promise: Transforming Mental Health Care in America. Final Report. DHHS Pub No SMA-03-3832, Rockville, MD: 2003.
2. Anthony W: Recovery-oriented service systems: Setting system level standards. Psych Rehab Journal 2000; 24(2):159–168.

3. Golornan D: Pilmal Leadership: Realizing the Power of Emotional Intelligence. Harvard Business School Pross, 2002.
4. Deegan P: Recovery as a journey of the heart. Psych Rehab Journal 1996; 19(3):91–97.
5. Effectiveness of Integrated Services for Homeless Adults with Serious Mental Illness: A Report to the Legislature as Required by Division 5, Section 5814 of the California Welfare and Institutions Code. CA State Department of Mental Health, May, 2003.

**Symposium 6** **Friday, October 7**
**2:00 p.m.-5:00 p.m.**

## WHAT DO WE KNOW ABOUT THE IMPACT OF ATYPICAL ANTIPSYCHOTICS ON QUALITY OF LIFE?

Ronald J. Diamond, M.D., *Clinical Professor, Department of Psychiatry, University of Wisconsin Mental Health Center of Dane County, 6001 Research Park Boulevard, Madison, WI 53719;* Peter J. Weiden, M.D.

### EDUCATIONAL OBJECTIVES:

By the end of the symposium, participants will have a better understanding of what is known, and what is not known, about the functional outcomes of patients taking traditional vs. atypical antipsychotic medications. New data from two Medicaid data sets will be presented, along with a discussion of the advantage and limits of this kind of data analysis.

### SUMMARY:

Despite acceptance as first-line therapy and huge outlay of public money, there is relatively little research support demonstrating any clear increased efficacy of the newer atypical antipsychotic medications, other than clozapine, over the older, much less expensive medications that they have largely replaced. It is extremely difficult and expensive to conduct long-term, double-blind controlled studies. Recent analysis of long-term Medicaid data shows an apparent advantage of the atypical medications on function, rehospitalization, criminal justice contacts, and cost. It is less clear that we fully understand the mediators of this apparent advantage. While other studies have suggested little change in adherence, these recent data have suggested that this increased adherence with the newer medications may be an important contributor to the observed functional improvement. This symposium will review the research evidence on difference in efficacy for atypical antipsychotics, and present data from this Medicaid project on the apparent long term differences in adherence and function outcomes in patients prescribed atypical or traditional antipsychotic medication. The limitations of using these kind of data will be discussed, along with the limitations of available more controlled research.

## No. 6A
## ARE ATYPICAL ANTIPSYCHOTICS REALLY BETTER?

Ronald J. Diamond, M.D., *Clinical Professor, Department of Psychiatry, University of Wisconsin Mental Health Center of Dane County, 6001 Research Park Boulevard, Madison, WI 53719*

### SUMMARY:

While many clinicians now believe that atypical antipsychotic medications have significant advantage of traditional antipsychotic medications, it has been difficult to find research support for this advantage for medications other than clozapine. This has been recently highlighted by several meta-analysis that have suggested little advantage for the newer medications. This discrepancy between the beliefs of experienced practitioners and the limited research evidence is particularly troubling because of the enormous cost difference between the older and the newer medications. A significant and growing portion of public mental health dollars are going for antipsychotic medications. This paper will review what is known about the effects of the atypical antipsychotic medications on quality of life, function, adherence, rehospitalization rates, and other outcome measures. It will also discuss the limitations in most of the available research, and some of the reasons why the views of the clinicians and the researchers are so discrepant. Key to the issue of impact, is how we conceptualize and measure improvement. What kinds of measures are most important, for what purpose, to whom, over what period of time?

## No. 6B
## IMPACT OF ANTIPSYCHOTIC MEDICATION ON QUALITY OF LIFE IN PERSONS WITH SCHIZOPHRENIA

Marion Becker, Ph.D., *Professor, Department of Psychiatry, University of South Florida, 13301 Bruce B Downs Boulevard, Tampa, FL 33612;* Nancy Lemron, M.S.; Carlos A. Santana, M.D.

### SUMMARY:

*Rationale:* The cost-effectiveness of atypical antipsychotics for persons with schizophrenia relative to typical antipsychotic medications has often been researched; however, patients with different levels of medication adherence may differ, and the impact of different levels

of drug adherence on outcomes has received much less attention. Benefits from atypical antipsychotic medications include increased adherence to medication prescribed, and higher levels of adherence may be associated with increased QoL.

*Objective:* This study's objective was to understand the relationship between four levels of antipsychotic medication adherence (<25%, 25%–49%, 50%–74%, or 75%–100%) among persons with schizophrenia and QOL outcomes including, behavioral health hospitalizations, number of involuntary examinations, criminal justice contacts, days employed, and days in the community.

*Methods:* Study sample included 10,330 Florida Medicaid beneficiaries during FY01–03. Using an intent-to-treat model, study subjects were divided into four medication groups based upon their antipsychotic medication use patterns: atypical antipsychotics only, conventional antipsychotics only, both atypical and typical, combination antipsychotics.

*Results:* In both the atypical antipsychotics only and conventional antipsychotics only groups, QoL outcomes improved with increasing levels of medication adherence. Individuals who received atypical antipsychotic medications had higher levels of employment compared with those on typical medications.

## No. 6C
## THE SOCIETAL VALUE OF ATYPICAL ANTIPSYCHOTIC MEDICATIONS

Neil Jordan, Ph.D., *Research Assistant Professor of Behavioral Sciences, Department of Psychiatry, Northwestern University, 339 East Chicago Avenue, Room 717, Chicago, IL 60611;* Marion Becker, Ph.D.; Nancy Lemron, M.S.; Carlos A. Santana, M.D.; Paul Stiles, Ph.D.

### SUMMARY:

*Rationale:* Economic benefits from atypical antipsychotic medications include increased compliance, which may be associated with fewer civil/criminal justice episodes and increased probability of employment.

*Objective:* This study's objective was to understand the relationship between antipsychotic medication use and health service, civil/criminal justice, and employment outcomes, and the costs associated with those outcomes.

*Methodology:* Our sample included 12,953 Florida Medicaid beneficiaries with schizophrenia. Subjects were assigned to medication groups using a treatment episode approach. Administrative databases were used to identify demographic characteristics, health services use, involuntary psychiatric examinations, arrests, and employment status. Standard unit prices were used to calculate services costs.

*Results:* Individuals who had a treatment episode in which they received atypical and conventional antipsychotic medications had the highest average mental health costs. Individuals who had no antipsychotic claims had the highest civil/criminal justice costs.

*Conclusions:* Although these economic findings challenge the short-term cost-effectiveness of atypical antipsychotic medication compared with conventional antipsychotic agents, we cannot conclude that conventional agents are more appropriate for persons with schizophrenia. Our administrative data lacked measures of illness severity, health status functioning, and QoL Future studies should combine administrative data with such measures to improve our ability to assess the cost-effectiveness of atypical antipsychotic medication.

This research was supported by AstraZeneca Pharmaceuticals LP.

## No. 6D
## THE IMPACT OF ANTIPSYCHOTIC MEDICATION CLASS AND ADHERENCE ON SCHIZOPHRENIA COST OF CARE

M. Scott Young, Ph.D., *Coordinator of Statistical Research, Mental Health Law and Policy, University of South Florida, 13301 Bruce B Downs Boulevard, Tampa, FL 33612;* Marion Becker, Ph.D.; Nancy Lemron, M.S.

### SUMMARY:

*Rationale:* Much work has compared the cost-effectiveness of typical and atypical medications for treatment of persons with schizophrenia, but few of these investigations have considered the influence of patient antipsychotic medication adherence levels.

*Objective:* This presentation will describe the cost-effectiveness of antipsychotic medication class and adherence on the overall cost of care for persons with schizophrenia.

*Methods:* Using Florida Medicaid pharmacy claims from a sample of 10,330 Medicaid beneficiaries diagnosed with schizophrenia, two levels of antipsychotic medication class (atypical or typical) and four levels of medication adherence (<25%, 25%–49%, 50%–74%, or 75%–100%) were defined. Several agencies' administrative data were integrated to examine costs related to medications, physical health services, emergency room visits, involuntary examinations, behavioral health hospitalizations, outpatient mental health services, addiction services, residential treatment, and criminal justice involvement.

*Results:* Within each medication class, higher levels of antipsychotic medication adherence were associated

with significantly lower overall non-antipsychotic medication costs of care. Further, the lowest costs were observed among persons with maximal (75%–100%) adherence. With regard to medication class, results indicated that persons taking atypicals incurred significantly greater overall non-antipsychotic medication costs of care compared with persons taking typical antipsychotics. This pattern of findings was consistent across all four adherence levels.

## REFERENCES:

1. Corrigan PW, Reinke RR, Landsberger SA, Charate A, Toombs GA: The effects of atypical antipsychotic medications on psychosocial outcomes. Schizophrenia Research 2003; 63(1–2):97–101.
2. Becker M, Diamond R: Quality of life measurement in persons with schizophrenia: are we measuring what's important? in H. Katschnig & H. Freeman (Eds.), Quality of Life in Mental Disorders (2nd ed.), Chichester, England, Wiley, in press.
3. Gianfrancesco F, Durkin MB, Mahmoud R, Wang RH: Use of health care services by patients treated with risperidone versus conventional antipsychotic agents. Pharmacoeconomics 2002; 20:413–427.
4. Becker M, Diamond R: Wisconsin Quality of Life Index (W-QLI), in Rush AJ, et al. (Eds.) Handbook of Psychiatric Measures 141–142. Washington, DC, American Psychiatric Association, 2000, pp 141–142.

**Symposium 7** **Friday, October 7**
**2:00 p.m.-5:00 p.m.**

## THE IMPACT OF HIV ON THE BRAIN

*APA Committee on AIDS*

Francine Cournos, M.D., *Professor of Clinical Psychiatry, Columbia University College of Physicians and Surgeons, and Deputy Director, New York State Psychiatric Institute, 5355 Hudson Parkway, 9-F, Bronx, NY 10471*

## EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to (1) review clinical disorders and symptoms of HIV in the brain; (2) describe the effects of HIV disease on behavior and on cognitive functioning; (3) review basic treatment strategies; (4) illustrate common characteristics, diagnostic approaches, and management issues; and (5) provide strategies for evaluating mental status; and (6) review and discuss clinical cases.

## SUMMARY:

Mental health providers at every skill level need to be involved in the diagnosis and treatment of HIV-infected patients. Long-term patient well being will depend on the successful integration of complex assessment, diagnosis, treatment, and referral aspects of HIV on the part of providers. This symposium is composed of three sessions. Neuropsychiatric Aspects of HIV reviews the clinical involvement of HIV in the brain and describes the effects of HIV infection on behavior. Pharmacological and non-pharmacological treatment options will be presented. Clinical Intervention will provide information on treatment intervention and referral. The final session entitled Case Discussion, Parts 1 and 2 illustrates the complexity of issues involved in the management of HIV infection in patients. There will be two different case discussion formats including video cases. During this session, participants will also have the opportunity to introduce individual clinical cases and receive feedback from the presenters. A question and answer period will also be scheduled for further discussion. This symposium is intended for a diverse group of mental health providers.

## No. 7A
## NEUROPSYCHIATRIC ASPECTS OF HIV AND AIDS

Marshall Forstein, M.D., *Director of Psychiatric Residency Training, Department of Psychiatry, Cambridge Hospital, Harvard School of Medicine, 1493 Cambridge Street, Cambridge, MA 02139*

## SUMMARY:

The neuropsychiatric aspects of HIV presents a clear and concise overview of the conditions that are most prevalent and most likely to be seen by providers working in mental health settings with HIV infected patients. It provides a description of HIV's symptom producing actions in the brain, of the most common clinical disorders and symptoms, and of the effects of HIV disease on behavior and on cognitive functioning. It also summarizes other medical diagnoses with similar characteristics, and basic treatment strategies. Having a fundamental understanding of the impact that HIV can have on the brain is crucial for health care professionals to effectively assess, treat, or refer patients. By the end of the session, participants are expected to be able to describe the impact that HIV can have on the brain as well as list at least two clinical features of each brain disorder or syndrome.

## No. 7B
## CLINICAL INTERVENTION

Shahrad R. Amiri, M.D., *Chief Resident, Department of Psychiatry, Cedars Sinai Medical Center, 1926 Granville Avenue, Los Angeles, CA 90025*

**SUMMARY:**

During clinical intervention, slides and accompanying narratives are used to take mental health care providers through the clinical presentations of different neuropsychiatric conditions and through strategies for managing these as part of a team approach to assessment and intervention. This module discusses how CNS involvement may look in patients, various causes and origins of client complaints, strategies for evaluating clients' mental status, and treatment intervention and referral. Fundamental assessment and interpretation guidelines will be provided which will allow all mental health providers to better understand individual roles on a treatment team. In addition, common side effects of medications will be reviewed.

## No. 7C
## CASE DISCUSSION: PARTS 1 AND 2

Francine Cournos, M.D., *Professor of Clinical Psychiatry, Columbia University College of Physicians and Surgeons, and Deputy Director, New York State Psychiatric Institute, 5355 Hudson Parkway, 9-F, Bronx, NY 10471*

**SUMMARY:**

Case discussion, parts 1 and 2, reviews clinical cases that illustrate common characteristics, diagnostic approaches, and management issues in clients living with neuropsychiatric manifestations of HIV/AIDS. Case material is presented, and trainees formulate opinions and analyze a series of increasingly detailed scenarios in order to hone their problem-solving and critical thinking abilities, and group discussions are encouraged to maximize the capacity of mental health care providers to respond to ever-shifting patient needs within a structured framework.

The case discussion will reinforce knowledge gained from the first two sessions.

**REFERENCES:**

1. American Psychiatric Association. Practice Guideline for the Treatment of Patients with HIV/AIDS. Am J Psychiatry(suppl). 157:11, November 2000.
2. Anderson JR, Barret RL, (eds): Ethics and HIV/AIDS: Clinical Decision-making with complex cases. Washington, DC. American Psychological Association, 2001.
3. Boccellari A, Zeifert P: Management of neurobehavioral impairment in HIV-1 Infection, in Zegans L., Coates TJ (eds). Psychiatric Manifestations of HIV Disease. Psychiatric Clinic of North America 1994; 17(1): 183–204.
4. Heaton RK, et al: The impact of HIV-associated neuropsychological impairment on everyday functioning. J Int Neuropsychol Soc 2004; 10(3):317–31.
5. American Psychiatric Association: Practice Guideline for the Treatment of Patients with HIV/AIDS. Am J Psychiatry(suppl) 2000; 157:11.
6. Boccellari A, Zeifert P: Management of neurobehavioral impairment in HIV-1 Infection, in Zegans L, Coates TJ (eds). Psychiatric Manifestations of HIV Disease. Psychiatric Clinic of North America 1994; 17(1): 183–204.
7. Anderson JR, Barret RL (eds): Ethics and HIV/AIDS: Clinical Decision-Making With Complex Cases. Washington, DC. American Psychological Association, 2001.

**Symposium 8** **Friday, October 7**
**2:00 p.m.-5:00 p.m.**

## RECOVERY-ORIENTED PSYCHOEDUCATION: MODELS THAT WORK

*Therapeutic Education Association*

Karen A. Landwehr, M.C., *Clinician and Educator, Tacoma Comprehensive Mental Health Community Education Partnership, 514 South 13th Street, Tacoma, WA 98402*; Garry M. Vickar, M.D., *Chair, Department of Psychiatry, Christian Hospital, 11125 Dunn Road, Suite 213, St. Louis, MO 63136*

**EDUCATIONAL OBJECTIVES:**

The participant should be able to recognize the evidence-based nature of psychoeducation as a recovery-focused treatment approach. The participant should have specific information about four model programs and how these approaches can be implemented or adapted for use in a variety of treatment settings.

**SUMMARY:**

Successfully implementing the goals of recovery and reintegration requires a shift in understanding of mental illness by all stakeholders: those who have a mental illness and their family members as well as those psychiatric and anciliary services. A variety of programs exist that seek to promote this understanding. This symposium will present participants with an overview of the evidence demonstrating the effectiveness of psychoeducation as a recovery-oriented treatment modality and information about four innovative approaches to promoting recovery through psychoeducation. Social skills training developed at UCLA will be described along with ideas for implementation in other settings. A consumer-family-professional collaboration in psychoeducation currently in use at the Pacific Clinic in Pasadena will be profiled. Hospital-community outreach efforts by STEPSSM in St. Louis, MO., will be described and suggestions offered for collaboration with other commu-

nity resources in promoting the goals of recovery. The Hope and recovery conferences held in Pierce County, Washington, which bring together individuals with major mental disorders, their family members and mental health professionals to learn about mental illness and its treatment, will be profiled and suggestions offered for developing similar conferences in other areas.

## No. 8A
## DOES PSYCHOEDUCATION PROMOTE RECOVERY? A REVIEW OF THE EVIDENCE

Patricia L. Scheifler, M.S.W., *Director, Partnership for Recovery, 249 Lakewood Circle, Sylacauga, AL 35150*

### SUMMARY:

There continues to be significant emphasis on implementing services that are recovery oriented and evidence based. Many treatment providers are understandably reluctant to adopt practices and utilize services that fail to measure up to both standards. This presentation will summarize the psychoeducation research literature, take a more in-depth look at studies that focus on psychoeducation outcomes that promote recovery, and suggest directions for future psychoeducation research.

## No. 8B
## TRAINING SKILLS FOR DISEASE MANAGEMENT AND COMMUNITY RE-INTEGRATION

Robert Paul Liberman, M.D., *Professor of Psychiatry, University of California at Los Angeles, Neuropsychiatric Institute, 760 Westwood Plaza, Los Angeles, CA 90095-1759*

### SUMMARY:

Recovery-oriented programs for patients with serious and persisting mental disorders must surmount three challenges: (1) controlling, stabilizing, or eliminating symptoms that intrude on a person's life activities; (2) improving functional capacities for social and independent living; and (3) organizing social supports that will foster, sustain, and strengthen community adaptation. Symptom management by medication alone is achieved at the expense of poor adherence, frequent crises, dependence upon the psychiatrist, and unacceptably high relapse rates.

Teaching disease management and community re-integration skills requires instructional techniques that can compensate for the cognitive and learning disabilities that plague most individuals with severe mental disorders. Using customary classroom lecture and discussion formats, patients learn very little and remember less. The modules used by the UCLA Social & Independent Living Skills Program utilize specialized educational methods such as social modeling, repetition to criteria of mastery, behavioral rehearsal, training in problem-solving, and in vivo and community-based assignments. Disease management is taught through the Medication Management, Symptom Management, Substance Abuse Management and Involving Families modules. Community re-integration is taught through the Community Re-Entry, Basic Conversation Skills, Friendship & Intimacy, Recreation for Leisure, Workplace Fundamentals, and Personal Effectiveness modules. Research has validated the efficacy and effectiveness of the modules in many facilities around the U.S. as well as in 12 cultures here and abroad.

## No. 8C
## CONSUMER, FAMILY, AND PROFESSIONAL COLLABORATION

Christopher S. Amenson, Ph.D., *Faculty Chair, Pacific Clinics, 909 South Fair Oaks Avenue, Pasadena, CA 91105*; Jason West; Rita Murray

### SUMMARY:

A variety of models and curricula for patient and family education exist, some with demonstrated effectiveness. Most models use trainers who are professionals or patients or family members. A large body of research indicates that the patient-physician (patient-therapist) relationship and family cooperation are strong predictors of adherence to medication and psychiatric rehabilitation and of patient outcomes.

This paper presents a model for patient and family education provided by a team of patients, families, and professionals. This model uses a collaborative process that is congruent with the content of promoting the use of evidence-based therapies through shared commitment to rehabilitation goals and methods. A brief sample of a medication adherence course will be presented. The author's experience using this model for professional training and continuing education will be discussed.

## No. 8D
## WHEN PSYCHOEDUCATION IS NOT JUST PSYCHOEDUCATION

Garry M. Vickar, M.D., *Chair, Department of Psychiatry, Christian Hospital, 11125 Dunn Road, Suite 213, St. Louis, MO 63136*

## SUMMARY:

In this presentation the importance of reaching out to other community resources (NAMI, National Mental Health Association, state/private consortiums) will be discussed. Without the proper opportunity to advance the purposes and meaning of our psychoeducation programs, patients who otherwise could benefit are not being informed of what is in the community and available. Over the almost 20 years of its existence, STEPS[sm] has included as one of its agenda items outreach to the community as a major focus of attention. Patients from all sectors need to be encouraged to get as much information about their illness and therapeutic services available as possible. What has worked for us will be discussed in detail with suggestions for implementation elsewhere.

## No. 8E
## HOPE AND RECOVERY CONFERENCES: A COLLABORATIVE COMMUNITY EFFORT

Karen A. Landwehr, M.C., *Clinician and Educator, Tacoma Comprehensive Mental Health Community Education Partnership, 514 South 13th Street, Tacoma, WA 98402*; Larry S. Baker, M.Div.

## SUMMARY:

As treatment for major mental illness becomes increasingly effective, recovery from these disorders is often not only possible, but likely. Yet the general belief that being diagnosed with a major mental illness results in a life of declining functionality remains. Pierce County, Washington's Mental Health Regional Support Network, established an initiative to decrease this stigmatizing and false assumption by providing psychoeducation concerning the availability and effectiveness of treatment for these disorders. Recognizing that the goals of recovery rely as much on the consumer as on the treatment received, a series of conferences has been held, bringing together individuals with mental disorders, family members of those with mental illnesses, and professionals in mental health and associated agencies. Titled ''Hope and Recovery Conferences,'' these events provide an opportunity for participants to learn about issues relevant to recovery from psychiatric illnesses from nationally recognized authorities and local practitioners, and to establish a more collaborative approach to treatment. This presentation will offer a description of the Hope and Recovery Conferences, their goals, and the impact they have had on participants' perceptions of mental illness. Suggestions for implementing similar psychoeducation opportunities in other communities will be provided.

## TARGET AUDIENCE(S):

Clinical directors, ARNPs, Psychiatrists, direct-service clinicians and case managers.

## REFERENCES:

1. Mueser KT, et al: Illness management and recovery: a review of the research. Psych Svcs 2002; 53:1272–1284.
2. Heinssen RK, Liberman, RP, Kopelowicz A: Psychosocial skills training for schizophrenia: lessons from the laboratory. Schizophrenia Bulletin 2000; 26(1):21–46.
3. Amenson CS: Schizophrenia: Family Education Methods. Pasadena, CA, Pacific Clinics, 1998.
4. New Freedom Commission on Mental Health: Achieving the promise: Transforming mental health care in America. Final report. DHHS Pub. No SMA-03-3832, Rockville, MD, 2003.
5. Russinova Z: Providers' hopa-inspiring competence as a factor optimizing psychiatric rehabilitation outcomes. Journal of Rehabilitation 1999; 16(4):50–57.
6. Frankl VE: Man's Search for Meaning. New York, Washington Square, 1963.

**Symposium 9** **Friday, October 7**
**2:00 p.m.-5:00 p.m.**

## INNOVATIONS IN LEVEL OF CARE ASSESSMENT FOR PSYCHIATRIC AND SUBSTANCE DISORDERS

Kenneth M. Minkoff, M.D., *Clinical Assistant Professor of Psychiatry, Harvard Medical School, and Senior System Consultant, Zialogic, 100 Powdermill Road, #319, Acton, MA 01720*

## EDUCATIONAL OBJECTIVES:

At the conclusion of the session, the participant should be able to: (1) describe the concept of independent delinked dimensions of service intensity and identify four such dimensions; (2) discuss the concept of multidimensional service intensity assessment and identify six assessment dimensions commonly utilized for addiction and/or psychiatric patients; and (3) evaluate the current utility and validity of the ASAM PPC 2R and LOCUS 2.0 in application to real clinical situations for individuals with co-occurring disorders.

## SUMMARY:

Despite the fact that there has been extensive controversy regarding managed care, there has been surprisingly little available objective data on the clinical process of utilization management and level of care determination. Fortunately, in recent years, this has begun to change, as there has been increasing development and

investigation of more sophisticated instruments for assessment of level of care or service intensity requirements for individuals with mental health and/or substance use disorders.

This symposium attempts to bring together in a single forum a presentation of the most up to date level of care assessment tools available in the public domain. The symposium begins with a presentation of general principles of utilization management, including the description of independent dimensions of service intensity and the concept of multidimensional service intensity assessment.

The symposium continues with presentations by the major developers of the most well-known service intensity assessment tools for individuals with mental health and substance disorders: The ASAM Patient Placement Criteria, Second Edition Revised (2001), and the American Association of Community Psychiatrists Level of Care Utilization System (LOCUS 2.0) (2001). Each instrument will be described by its major author, along with information on validity and reliability studies, and instructions on use.

The final section of the symposium will emphasize audience participation in the level of care assessment process. A sample case illustrating a complex patient with co-occurring disorders in crisis will be distributed, along with copies of the tools, and the audience will participate in using each tool to evaluate level of care. The strengths and limitations of each instrument will then be discussed.

In total, the symposium will present the participant with an accurate portrayal of the current field of level of care assessment, and the directions for future research. This material will be valuable for anyone—clinician or manager—involved in the development of managed care evaluation systems, or in the delivery of clinical services that require such utilization management or assessment.

## No. 9A
## PRINCIPLE OF UTILIZATION MANAGEMENT AND LEVEL OF CARE ASSESSMENT

Kenneth M. Minkoff, M.D., *Clinical Assistant Professor of Psychiatry, Harvard Medical School, and Senior System Consultant, Zialogic, 100 Powdermill Road, #319, Acton, MA 01720*

### SUMMARY:

The presentation begins with an outline of basic principles of utilization management. This will include the concept of independent dimensions of service intensity, including biomedical, residential, treatment, and case management intensity, which lead in turn to the reconceptualization of ''levels of care'' as ''matrices of service intensity.'' In this model, the independent dimensions are ''de-linked'' so that program models can vary flexibly across dimensional categories.

The second key concept is that of multidimensional service intensity assessment. Level of care instruments are based on identifying these dimensions, and connecting ratings on each dimension, separately and together, to the identification of patient service intensity requirements. Later talks in this symposium will illustrate how this is currently being done for individuals with substance and/or psychiatric disorders (ASAM PPC 2R, LOCUS 2.0).

The goal of the presentation will be to provide a general framework for attendees to consider utilization management as a CLINICAL decision-making process, and to be able to objectively evaluate current methodology for objective service intensity assessment and decision making.

## No. 9B
## UNDERSTANDING AND USING THE PATIENT PLACEMENT CRITERIA OF THE AMERICAN SOCIETY OF ADDICTION MEDICINE

David Mee-Lee, M.D., *Chair, Coalition for National Clinical Criteria, 4228 Boxelder Place, Davis, CA 95616*

### SUMMARY:

Clinicians involved in planning and managing care often lack a common language and systematic assessment and treatment approach that allows for effective, individualized treatment plans and level of care placement. The Patient Placement Criteria for the Treatment of Substance-Related Disorders of the American Society of Addiction Medicine (ASAM) first published in 1991, provided common language to help the field develop a broader continuum of care. The revised second edition (ASAM PPC-2R) published in April 2001, added criteria for co-occurring mental and substance-related disorders, which made the ASAM PPC-2R even more applicable to behavioral health systems. We will review the underlying principles of the ASAM Patient Placement Criteria (PPC). Participants identify how recent revisions can assist mental health systems improve care for dual diagnosis patients, and understand how to use the criteria in clinical practice.

## No. 9C
## LEVEL OF CARE UTILIZATION SYSTEM: A SIMPLE METHOD FOR LEVEL OF CARE DECISIONS

Wesley E. Sowers, M.D., *President, American Association of Community Psychiatrists; and Medical Director,*

*Office of Behavioral Health Services, Allegheny County Department of Human Services, 304 Wood Street, Pittsburgh, PA 15222*

## SUMMARY:

The Level of Care Utilization System for Psychiatric and Addiction Services (LOCUS) was developed by the American Association of Community Psychiatrists in 1995, and updated to the current version (LOCUS 2.0) in 2001. The instrument attempts to assist in making level of care determinations for individuals with mental health and/or substance-use disorders to balance clinical quality with the need for efficient management of utilization of care. It is designed to be easily understood and used by clinicians. A number of principles were identified to guide the development of LOCUS: (1) integration of mental health and addiction variables; (2) dimensional and quantifiable assessment parameters; (3) levels of care defined flexibly in terms of resource intensity rather than rigidly defined program requirements; and (4) adaptable to the variety of circumstances encountered in behavioral health environments. LOCUS has been field tested over the past several years, and has been updated to accommodate suggestions from that process. Preliminary testing has demonstrated reliability and consistency with expert determinations for placement decisions. This workshop will provide an overview of how to use the LOCUS, discuss practical applications, and illustrate utility in relation to a specific case example.

## REFERENCES:

1. Minkoff and Regner: Innovations in dual diagnosis treatment in managed care: The Choate Dual-Diagnosis Case Rate Program: J Psychoactive Drugs, 1999.
2. Minkoff: Level of care determination for individuals with co-occurring disorders: Psychiatric Rehabilitation Skills, 2001.
3. Mee-Lee D, Shulman GD, Fishman M, Gastfriend DR, Griffith JH (eds): ASAM Patient Placement Criteria for the Treatment of Substance-Related Disorders, Second Edition-Revised (ASAM PPC-2R). Chevy Chase, Md, American Society of Addiction Medicine, Inc., 2001.
4. Mee-Lee D: Treatment planning for dual disorders. Psychiatric Rehabilitation Skills 2001; 5(1):52–79.
5. Sowers W: Level of care determinations in psychiatry. Harvard Rev Psychiatry 1998; 5:286–290.
6. Sowers W, George C, Thompson K: Level of Care Utilization System for Psychiatric and Addiction Services (LOCUS): a preliminary assessment of reliability and validity. CMHJ 1999; 35(6):545–563.

**Symposium 10** **Friday, October 7**
**2:00 p.m.-5:00 p.m.**

# DANGEROUS ONES: ASSESSING AND TREATING PSYCHOPATHS, PEDOPHILES, AND FIRESETTERS

Jeffrey L. Geller, M.D., M.P.H., *Professor of Psychiatry, University of Massachusetts Medical School, 55 Lake Avenue, North, Worcester, MA 01655-0002*

## EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to demonstrate an understanding of three cohorts of dangerous or malevolent individuals—psychopaths, pedophiles, and firesetters—and a knowledge of their phenomenology, assessment, and treatment.

## SUMMARY:

Throughout the history of organized psychiatry, there has been an ongoing debate about the dangerousness of persons with psychiatric disorders. Much of the focus has been on those with psychotic disorders. Receiving less notice throughout the twentieth century has been attention to psychiatric pathology that may best be described as characterized by malfeasance. While the demarcation between responsibility and lack thereof for dangerous acts by patients with psychotic disorders may be difficult, differentiating between malevolence and psychopathology is proving even more challenging in contemporary society. In this symposium, the presenters focus on three cohorts who have proven to be high risks for society at large, a challenge for clinicians, and an ever-increasing percentage of the longer stay institutional populations: psychopaths, pedophiles, and firesetters. Each speaker will focus on one group, discussing the phenomenology, assessments, and interventions for that group. A discussion of the general problems of such populations will follow.

## No. 10A
## PSYCHOPATHIC PERSONALITY DISORDER: ASSESSMENT AND RISK FOR VIOLENCE

Gina Vincent, Ph.D., *Assistant Professor of Psychiatry, University of Massachusetts Medical School, 55 Lake Avenue North, Worcester, MA 01655*

## SUMMARY:

Psychopathy has become widely accepted as a personality disorder marked by maladaptive patterns of behavior, affect, and cognition that are stable across situations and social interactions. Interpersonally, psychopathic individuals are arrogant and deceitful; affectively, they

are shallow and lacking in empathy; behaviorally, they are impulsive and irresponsible. Given the characteristics of this disorder, individuals with psychopathy are frequently in trouble with the law, especially with respect to violent activity.

The gold standard for assessing psychopathic personality disorder is the Psychopathy Checklist-Revised (PCL-R), now in its second edition. This clinical assessment tool measures psychopathy both dichotomously (as a diagnosis that is present or absent) and dimensionally (as a constellation of traits that can be scored from 0 to 40). Meta-analytic studies indicate that the association between PCL-R scores and future violence is around .35, just slightly lower than the association between cardiac bypass surgery and a reduction in angina pain (r = .38) and significantly higher than the association between bypass surgery and decreased mortality (r = .08).

The goals of this presentation are threefold. First, it will cover the best practices in the psychological assessment of psychopathy. Second, the presenter will discuss the occurrence and nature of violence among psychopaths, and will end with strategies for treatment and risk management.

## No. 10B
## PEDOPHILIA: DIAGNOSTIC AND TREATMENT CONSIDERATIONS

Fabian M. Saleh, M.D., *Assistant Professor of Psychiatry, University of Massachusetts Medical School, 55 Lake Avenue, North, Worcester, MA 01655*

### SUMMARY:

Sex offender treatment remains the subject of media attention and controversy. With the adoption of sex offender commitment statutes in many states, there is a pressing need to properly evaluate and provide evidence-based treatments for sex offenders who are amenable to treatment. This is particularly true for those sex offenders who are afflicted with paraphilic disorders, such as pedophilia. This presentation will review the literature on the phenomenology and etiology of sexual offending behavior, in particular as it relates to pedophilia. Strategies used to diagnose pedophilia will be reviewed. Differential diagnostic considerations will also be addressed. In addition, psychological and biological based treatment modalities used to treat this population will be examined. Finally, recommendations based on this presentation will be discussed.

## No. 10C
## THE BURNING ISSUE OF PATHOLOGICAL FIRESETTING

Jeffrey L. Geller, M.D., M.P.H., *Professor of Psychiatry, University of Massachusetts Medical School, 55 Lake Avenue, North, Worcester, MA 01655-0002*

### SUMMARY:

Fire setting is a frightening and expensive problem throughout the world. Arson is a leading cause of nonresidential fires, residential fires, and fire fatalities. There is no adequate description of the typical arsonist, for there is not now, nor has there ever been, such a character. Arson is a complex, multidetermined event that has its origins in everything from profit to pathology. Pathological firesetting has been associated with mental disorders (disorders of thought, perception, mood, judgment, impulse control) and medical or neurologic disorders, e.g., epilepsy, AIDS, hypoglycemia. Revenge, the most common motive for firesetting, while not generally considered in the pathological category, may be just that—for why does the revengeful person choose fire? What appears to unite all these forms of firesetting are the social skills deficits of those who set fires. This presentation provides the groundwork for understanding firesetting through a capability model that postulates firesetting avoids areas of conflict for the socially challenged person and becomes reinforcing through its successful outcome for persons with low levels of personal accomplishment. The treatment implications of this model are discussed, as are the societal implications.

### TARGET AUDIENCE(S):

This symposium is relevant for clinicians, policy makers, and researchers.

### REFERENCES:

1. Hare RD: The Hare PCL-R, 2nd Edition. Toronto, Ontario, Multi-Health Systems, 2003.
2. Hemphill JF, Hart SD: Forensic and clinical issues in the assessment of psychopathy, in A. E. Goldstein (Ed). Handbook of Psychology: Volume 11 Forensic Psychology. New York, John Wiley & Sons, 2003 pp 87–107.
3. Saleh FM, Berlin FS: Sexual deviancy: diagnostic and neurobiological considerations. Journal Child Sexual Abuse (Special Edition) 2003; 12(3/4):233–253.
4. Saleh FM, Guidry LL: Psychosocial and biological treatment considerations for the paraphilic and nonparaphilic sex offender. The Journal of the American Academy of Psychiatry and the Law 2003; 31:486–93.

5. Geller JL: Pathological firesetting in adults. International Journal of Law and Psychiatry 1992; 15:283–302.

**Symposium 11** **Saturday, October 8**
**8:30 a.m.-11:30 a.m.**

## RECOVERY-ORIENTED PSYCHOEDUCATION: DEFINING AND REFINING THE PRACTICE

*Therapeutic Education Association*

Garry M. Vickar, M.D., *Chair, Department of Psychiatry, Christian Hospital, 11125 Dunn Road, Suite 213, St. Louis, MO 63136*; Karen A. Landwehr, M.C., *Clinician and Educator, Tacoma Comprehensive Mental Health Community Education Partnership, 514 South 13th Street, Tacoma, WA 98402*

### EDUCATIONAL OBJECTIVES:

At the conclusion of the session, the participants should be able to define recovery from the standpoints of individuals who have mental disorders, of family members, and of psychiatric care providers. The participant will also be able to identify the key elements in effective recovery-oriented psychoeducation programs must change to help participants meet their goals of recovery.

### SUMMARY:

Recovery-oriented treatment is more than just the latest buzzword used to describe business as usual. It involves a change in mindset that in turn produces a change in other treatment modalities. Psychoeducation is not exempt from the need to change in order to provide programs that foster independence, self-advocacy, and realization of the personal goals of the consumers and families we serve. This symposium will focus on (1) identifying attitudinal and systemic changes necessary to progress from the maintenance goal prevalent in biopsychosocial treatment to a goal of maximum recovery for patients; (2) defining recovery and considering ways in which the understanding of recovery differs between care providers and consumers; (3) recognizing ways in which current psychoeducation approaches can be adapted to better promote recovery; and (4) identifying the critical components necessary to provide a diverse population effective psychoeducation that fosters the goals of recovery and reintegration.

## No. 11A
## ATTITUDINAL AND SYSTEMIC IMPERATIVES FOR RECOVERY

Larry S. Baker, M.Div., *Director of Training, Tacoma Comprehensive Mental Health Community Education Partnership, 514 South 13th Street, Tacoma, WA 98402*; Karen A. Landwehr, M.C.

### SUMMARY:

Public-sector mental health services have effectively dealt with psychiatric crises and stabilized individuals with severe, persistent disorders. In recent years, dissatisfaction has been growing with stopping there. Consumer and family groups, the President's New Hope Commission, the Center for Mental Health Services, and others have been envisioning transformation of our nation's mental health system.

The search for evidence-based best practices has accelerated the urgency of needed changes. Shifting funding patterns, and rules changes in state and federal programs necessitate more outcome-based evaluations of traditional and innovative treatment models. Designing and offering services that are consumer and family friendly is beginning to occur across the country and in other places in the world.

Those of us who have been in the field for a long time carry certain amounts of ''baggage'' from our initial education and training through to the exigencies and practicalities of our current work settings.

This portion of the workshop will look at the attitudinal and systemic changes that drive this ''transformation.'' Opportunities for discussion will be given at the close of the presentation and during the moderator's summation. It is suitable for all in attendance at the institute.

## No. 11B
## RECOVERY: WHAT ARE THE GOALS AND WHO SETS THEM?

Frederick J. Frese III, Ph.D., *Assistant Professor of Psychology in Clinical Psychiatry, Northeastern Ohio University College of of Medicine, and Coordinator, Summit County Recovery Project, Summit County Alcohol, Drug Addiction and Mental Health Services Board, 283 Hartford Drive, Hudson, OH 44236*

### SUMMARY:

With the advent of modern psychotropic medications and effective psychosocial treatments, persons diagnosed with schizophrenia and other forms of serious mental illness are experiencing recovery to a much greater degree than in the past. It is now becoming clear that the primary goal of persons with these conditions should be to integrate themselves into the everyday world of vocational and social activities. Increasingly, it is recognized that the principles of hope, empowerment, and dignity are major aspects of the journey to recovery.

In the light of the President's New Freedom Commission's report's call for transforming the mental health system to one that is consumer and family driven and recovery focused, these basic principles of recovery are taking on increased importance. This presentation will focus on developing approaches to recovery and how these approaches differ from traditional methods of treatment. This presentation is suitable for clinicians and administrators responsible for serving persons with serious mental illness.

## No. 11C
## OUTCOMES OF PSYCHOEDUCATION FOR DIVERSE PATIENTS

Christopher S. Amenson, Ph.D., *Faculty Chair, Pacific Clinics, 909 South Fair Oaks Avenue, Pasadena, CA 91105*

### SUMMARY:

This presentation will summarize the research on outcomes for a wide variety of patient and family education and psychoeducation interventions. The outcomes of increased knowledge, increased skill, generalization of skills to the community, symptom reduction, relapse reduction, improved role functioning, and reduction of caregiver burden will be described for interventions that vary in intensity and duration, type of methods used, and target population. Special emphasis will be placed on current knowledge about outcomes for diverse populations.

The critical components of each type of patient and family education and psychoeducation will be presented. The author's ISBEST model for matching interventions to patient and family needs will be discussed. Modifications of educational interventions to fit the needs of people from cultures that are reluctant to use psychiatric services or attend classes will be described.

## No. 11D
## THE CHALLENGES OF ADAPTING PSYCHOEDUCATION TO RECOVERY CULTURES

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

### SUMMARY:

Psychoeducational approaches (illness management, skills training, and family psychoeducation) have thrived in both medical and rehabilitation cultures. As we're working to transform to a recovery culture, psychoeducation faces serious obstacles despite its evidence-based designation: (1) While evidence-based practices and recovery are motivating to funders and administrators, they are not compelling to consumers. (2) The recovery model values highly individualistic, subjective journeys, rather than a prescribed, illness-oriented course. (3) The expert teacher and unsophisticated student roles traditionally used in psychoeducation work against recovery goals of empowerment and normalizing roles. (4) Recovery values family for its meaningful relationships rather than as a treatment environment. Major adaptations will be needed if a recovery culture is to be nurtured while attempting to preserve the wisdom and goals of psychoeducation. Examples include: More subjective, individualized medication collaboration; more ''in vivo'' coaching, including use of consumer ''life coaches''; more normalizing developmental approaches to families including acknowledgement of trauma; more use of motivational interviewing techniques applied to mental health insight and treatment; and more empowerment based planning like WRAP and advanced directives. This presentation will explore these issues and how they can be effectively addressed.

### TARGET AUDIENCE(S):

Clinical directors, ARNPs, psychiatrists, direct-service clinicians and case managers.

### REFERENCES:

1. Power AK: Transformations for Recovery. Presented at the Best Practices Conference: Midwest Oklahoma, November 4, 2004.
2. Anthony WA: A recovery-oriented service system: setting some system level standards. Psychiatric Rehabilitation Journal 2000; 24(2):159–65.
3. Frese FJ, Davis WW: The consumer-survivor movement, recovery, and consumer professionals. Professional Psychology: Research and Practice 1997; 28:243–245.
4. Amenson CS, Liberman RP: Dissemination of educational classes for families of adults with schizophrenia. Psych Svcs 2001; 52:589–592.
5. Frese F, et. al: Integrating evidence-based practices and the Recovery Model. Psych Services 2001; 52:1462–1468, and reply letter.
6. Fisher D, Ahern L: Evidence-based practice and recovery. Psych Services 2002; 53:632–633.

**Symposium 12** **Saturday, October 8**
**8:30 a.m.-11:30 a.m.**

## TREATING DEPRESSION IN THE COMMUNITY

Rodrigo A. Muñoz, M.D., *Past President, American Psychiatric Association, and Consultant, APA/IPS Scientific Program Committee, 3130 5th Avenue, San*

*Diego, CA 92103-5839*; John S. McIntyre, M.D., *Vice President for Behavioral Health; Chair, Department of Psychiatry and Behavioral Health, Unity Health System; and Past President, American Psychiatric Association, 81 Lake Avenue, Third Floor, Rochester, NY 14608*; Robert Popovian, Ph.D.

## EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participants should be able to understand the principles of evidence-based medicine relevant to the treatment of depressive disorders.

## SUMMARY:

Researchers and clinicians are exploring the meaning of demographic and clinical variables that may optimize the care of depressed patients. Dr. Szisook and his fellow researchers have found differences in clinical presentation according to age. Dr. Trivedi has found that variable levels of interest in algorithms in the part of the researcher and the clinician may facilitate or limit implementation. Clinical guidelines, quality indicators, and performance indicators are likely to shape the clinical practice of psychiatry.

## No. 12A
## PRE-ADULT VERSUS ADULT ONSET OF MAJOR DEPRESSIVE DISORDER: IS THERE A DIFFERENCE?

Sidney Zisook, M.D., *Professor of Psychiatry, University of California at San Diego, and Consultant, APA/IPS Scientific Program Committee, 9500 Gilman Drive, La Jolla, CA 92093-0603*

## SUMMARY:

*Abstract:* This report describes the relationship between age of onset (before age 18 or thereafter) and clinical features of major depression disorder (MDD) in a large series of 2,541 outpatients entering the STAR*D (Sequenced Treatment Alternatives to Relieve Depression) depression treatment protocol (*www.star-d.org*).

*Methods:* Age of onset was defined by asking participants to estimate the age at which they experienced their first major depressive episode. The population is divided in terms of pre-adult (before age 18) and adult (age 18 or later) onset.

*Results:* The mean age of onset was 25 (SD = 14.5) years and 38% had an onset of MDD before age 18. Although younger than the adult onset group, patients with pre-adult onset had a longer duration of illness and were more likely to be female. After correcting for present age, duration of illness, and gender, patients with a pre-adult onset of MDD were more likely to have family histories of mood and substance use disorders, had more and more severe episodes of depression, had more suicidality, more Axis I comorbidity, more atypical features and irritability, and were more likely to be unmarried.

*Conclusions:* Pre-adult onset MDD is a particularly severe and chronic condition.

## No. 12B
## THE USE OF ALGORITHMS IN CLINICAL PRACTICE

Madhukar H. Trivedi, M.D., *Professor of Psychiatry, University of Texas Southwestern Medical Center, 6363 Forest Park Road, #1300, Dallas, TX 75235*

## SUMMARY:

The author describes systems that are developed to assist in implementation of treatment algorithms. When there is an interest in adhering to an algorithm, in the absence of a well developed automated system, the algorithm adherence remains poor.

## No. 12C
## QUALITY INDICATORS IN THE TREATMENT OF DEPRESSION

Rodrigo A. Muñoz, M.D., *Past President, American Psychiatric Association, and Consultant, APA/IPS Scientific Program Committee, 3130 5th Avenue, San Diego, CA 92103-5839*; Britton A. Arey, M.D.

## SUMMARY:

The authors review the usefulness of clinical quality indicators in the admission, treatment, and discharge of depressed patients, and during their outpatient treatment. Quality indicators may improve the psychiatrist's insight about reasons for admission, choices in treatment, and optimal maintenance of patients recovering from depression.

## REFERENCES:

1. Fava M, et al: Background and rationale for the sequenced treatment alternatives to relieve depression (STAR*D) study. Psychiatr Clin North Am 2003; 26(2):457–494.
2. Tawny L, Baltinger M, et al: Clinicians adherence to an algorithm for pharmacotherapy of depression in the Texas public mental health sector. Psychiatr Serv 2004; 55:703–705.
3. APA: Quality Indicators, Final report, 1999.

**Symposium 13** **Saturday, October 8**
**8:30 a.m.-11:30 a.m.**

## CHANGING THE WORLD IN SAN DIEGO: IMPLEMENTATION OF THE COMPREHENSIVE, CONTINUOUS INTEGRATED SYSTEM OF CARE

Kenneth M. Minkoff, M.D., *Clinical Assistant Professor of Psychiatry, Harvard Medical School, and Senior System Consultant, Zialogic, 100 Powdermill Road, #319, Acton, MA 01720*; Christie A. Cline, M.D., M.B.A., *President, Zialogic, 12805 Calle Del Oso, Albuquerque, NM 87111*; John W. Allen, M.D.

### EDUCATIONAL OBJECTIVES:

Participants should be able to: (1) understand the eight CCISC principles and their application to system design within an integrated philosophy; (2) recognize the 12 steps of implementation of CCISC and their utilization in real-world systems; (3) understand top down, bottom up CQI strategies for building dual-diagnosis capability at a system, program, clinical practice, and clinician level; and (4) describe the real challenges of implementation in San Diego County, with regard to adult mental health, child mental health and alcohol and drug services, and the role of system administrators, program leaders, and trainers in the process.

### SUMMARY:

Individuals with co-occurring mental health and substance use disorders represent a population with poorer outcomes and higher costs in multiple domains, presenting with sufficient frequency in all systems and services that it is recognized that ''dual diagnosis is an expectation, not an exception.'' As a result, there has been increasing recognition of the need for developing a systemic approach to serving these individuals. Minkoff and Cline have developed an implementation process for a model termed Comprehensive Continuous Integrated System of Care, in which within existing resources in any system, all programs can be designed as dual diagnosis programs meeting minimal standards of dual diagnosis capability, but each program has a different job, to provide matched services to its existing cohort of cod clients based on a set of consensus best practice principles within an integrated disease and recovery philosophy. In this symposium they describe the model, and the 12-step implementation process and implementation toolkit, based on strategic planning and continuous quality improvement principles.

The remainder of the symposium is dedicated to describing the ongoing process of implementation in San Diego County that began in 2002 with the assistance of Minkoff and Cline and continues to evolve independently. This will include presentations by representatives from adult mental health, children's mental health, and alcohol/drug services, and by a representative program from the county train the trainer cadre that plays a significant role in the implementation proces. The goal of these presentations is to help the audience translate an abstract model into understanding the exigencies of real world implementation, and be able to recognize the contributors to success within the challenges and constraints of an actual system of care.

## No. 13A
## COMPREHENSIVE, CONTINUOUS INTEGRATED SYSTEMS OF CARE

Kenneth M. Minkoff, M.D., *Clinical Assistant Professor of Psychiatry, Harvard Medical School, and Senior System Consultant, Zialogic, 100 Powdermill Road, #319, Acton, MA 01720*; Christie A. Cline, M.D., M.B.A.

### SUMMARY:

Individuals with co-occurring disorders are an expectation, not an exception throughout the service system, associated with poor outcomes and high costs in multiple domains. To provide more welcoming, accessible, integrated, continuous, and comprehensive services in a system of care with scarce resources, the CCISC model organizes a framework for system design in which every program is a dual-diagnosis program meeting minimum standards of dual diagnosis capability (DDC) (along with some specialized program elements that are dual diagnosis enhanced) within the context of its existing resources, but each program has a different job, based first on what it is already designed to be doing, and the people with co-occurring disorders already there, but providing matched services based on a set of research derived integrated consensus best practice principles within the context of its existing resources. Similarly, each clinician is a dual-diagnosis clinician meeting minimal standards of dual competency regardless of licensure or job description, to provide properly matched services to the clients in his or her caseload.

This presentation summarizes the model, the eight principles, and the 12-step program of CCISC implementation involving a strategically planned CQI process that incorporates a ''top-down, bottom-up and back again'' interactive design, in which the system, programs, clinical practices, and clinician competencies all progress together building on existing system strengths and resources. The presentation will also discuss the CCISC toolkit, including system fidelity tool (CO-FIT), program self assessment for dual-diagnosis capability (COMPASS), and clinician self-assessment of attitudes and skills (CODECAT). Finally, application of the model will be discussed in a range of state and county

systems across the U.S. and Canada (currently in over 25 states and two provinces.)

## No. 13B
## COMPREHENSIVE, CONTINUOUS INTEGRATED SYSTEMS OF CARE IN SAN DIEGO: ADULT AND OLDER ADULT MENTAL HEALTH SYSTEMS

Piadad Garcia, Ed.D., *Director of Adult and Older Adult Mental Health Services Integration, San Diego Health and Human Services Administration, 3255 Camino del Rio South, San Diego, CA 92186*

### SUMMARY:

This presentation describes the origination of concern about co-occurring disorders in the adult mental health division in San Diego, and the development of a task force leading to the emergence of a strategic plan. Implementation of the plan involved a broad consensus to implementation of CCISC resulting in a county-wide charter document with specific priorities for clinical practice implementation, that subsequently became anchored in contracting and policy.

The presentation goes on to discuss the implementation process, including both successes and challenges in moving a comprehensive change process in a county system of 3.5 million people. Particular successes are described, including the development of the first policy in California outlining how the mental health agencies could welcome, assess, and provide integrated treatment to individuals with co-occurring disorders within the parameters of existing MediCal funding and billing requirements.

## No. 13C
## COMPREHENSIVE, CONTINUOUS INTEGRATED SYSTEMS OF CARE IN SAN DIEGO: CHILDREN'S MENTAL HEALTH SERVICES

Rosa Ana Lozada-Garcia, L.C.S.W., *Assistant Deputy Director, Children's Mental Health Services, San Diego Health and Human Services Administration, 3255 Camino del Rio South, San Diego, CA 92186*; Susan Wingfield-Ritter, M.S., M.F.T.; Anne Fitzgerald, L.C.S.W.

### SUMMARY:

Although the CCISC project originated in the adult mental health division, it incorporated consensus from the children's division as well, and the initial project included children's providers as well as a specific children's subcommittee. This presentation describes the evolution of the concept of dual diagnosis capability in the children's service system, and particularly the recognition of a complete alignment between CCISC implementation and the existing Children's Mental Health System of Care project, funded by SAMHSA in 1999, and its associated Wraparound Academy.

The presentation reviews some of the key challenges of children's services implementation, in particular the development of a definition of co-occurring, which evolved to include parents with co-occurring disorders as well, and the effort to re-design screening tools and training processes to accommodate integrated service as a core function within the system of care. Finally, the presentation will discuss the energy contributed by key stakeholders, namely the children and families themselves.

## No. 13D
## COMPREHENSIVE, CONTINUOUS INTEGRATED SYSTEMS OF CARE IN SAN DIEGO: ALCOHOL AND DRUG SERVICES

Connie Moreno-Peraza, A.C.S.W., *Director of Alcohol and Drug Services, San Diego Health and Human Services Administration, 3255 Camino del Rio South, San Diego, CA 92186*; Rosalind Corbett, C.A.D.C.; Richard Burtz, C.A.D.C.

### SUMMARY:

Alcohol and Drug Services (ADS) was incorporated as a full partner in the beginning of the initiative. This presentation emphasizes that the utilization of the CCISC model to develop integrated services does not require (and in fact may even be impeded by) the development of an integrated structure. The implementation of dual-diagnosis capability was pioneered by three addiction programs in the county, which engaged in the process of dual-diagnosis capability development and contributed trainers to the cadre. This enabled other programs to eventually join in. A major emphasis is on how mental health and addiction services could be re-positioned to work as partners, rather than as competitors, and helping addiction providers to be recognized as important customers for access to mental health services like crisis intervention and psychopharmacology.

The presentation concludes by discussing the impact of CCISC on the provider system, the response of the recovery community and other stakeholders, including the criminal justice system, and the evolution of CCISC into policy and contract.

## No. 13E
## THE ROLE OF THE TRAINER CADRE IN PROGRAM IMPLEMENTATION AND SYSTEM CHANGE

James D. Rogers, Psy.D., *Director of Program Operations, Community Research Foundation, 1202 Morena*

*Boulevard, #300, San Diego, CA 92110*; Debbie Tate, L.C.S.W.; Alicia Outcault, L.C.S.W.; Laura Rosenbluth, L.C.S.W.

**SUMMARY:**

This presentation describes the development of structures and processes to organize the implementation of CCISC at the program level, clinical practice level, and the clinician competency and training level at the same time. The presenter is both director of clinical operations for one of the largest agencies in San Diego (providing services in all three divisions) as well as co-chair of the first train-the-trainer cadre. The presentation describes the formation of the cadre, the evolution of the roles and responsibilities of its membership within the process of system change, and the continuing development of train-the-trainer groups throughout the service system to promote continuing dissemination of the model. In addition, the presentation describes how cadre members began to function not just as trainers but as critical system change agents, participating in the recognition of policy inconsistencies that impeded integrated service development, and working on committees that actually were empowered to develop new policies.

Further, this presentation also describes the role of cadre members in the internal development of dual-diagnosis capability in their own agencies, involving the use of the toolkit, the development of action plans, provision of internal training and technical assistance, and building teams of additional internal trainers and change agents to promote the process. The presenter's own agency will be used as an illustration of how this evolved.

**REFERENCES:**

1. Minkoff and Cline: Changing the World: Design and Implementation of Comprehensive Continuous Integrated Systems of Care. Psychiatric Clinics of North America, in press, 2005.
2. San Diego County: Welcoming Policy for Individuals with Co-Occurring Disorders, 2004.
3. San Diego County Children's Mental Health Services Business Plan, 2004.
4. Minkoff and Cline: The scope of practice of addiction counselors with co-occurring disorders. Counselor Magazine, 2004.
5. Cline and Minkoff: A Strength-based Systems Approach to Creating Integrated Services for Individuals with Co-occurring Psychiatric and Substance Use Disorders, SAMHSA Technical Assistance Document, *www.samhsa.gov*, 2002.

**Symposium 14** **Saturday, October 8**
**8:30 a.m.-11:30 a.m.**

## TWENTY-FIVE YEARS OF ASSERTIVE COMMUNITY TREATMENT: WHERE ARE WE NOW?

David C. Lindy, M.D., *Clinical Director and Chief Psychiatrist, Community Mental Health Services, Visiting Nurse Service of New York, and Associate Clinical Professor, Department of Psychiatry, Columbia University College of Physicians & Surgeons, 1250 Broadway, Third Floor, New York, NY 10001*; Neil Pessin, Ph.D., *Director, Community Mental Health Services, Visiting Nurse Service of New York, 1250 Broadway, Third Floor, New York, NY 10001*; Alan Rosen, M.D.

**EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be able to recognize important, current issues relating to implementation of ACT, Fidelity to the ACT model, and challenges with changing patient populations.

**SUMMARY:**

Over the past 25 years, assertive community treatment, or ACT, has become a well studied and widely implemented model for the community-based treatment of persons with severe and persistent mental illness. Research has demonstrated a significant relationship between fidelity to the ACT model and program efficacy. Consumers, families, payers, and providers have all endorsed ACT, and SAMHSA regards it as one of six evidence-based practices. ACT teams have been established in Europe and Australia, as well as throughout the United States. However, at this juncture in its history ACT faces some critical questions. As ACT becomes so widespread, how do we insure that programs are faithful to the model? At the same time, has fidelity to the model become so rigidly interpreted that teams cannot creatively and flexibly meet their own needs? Is stability for clients still the appropriate goal, or should it be recovery? As more ACT clients have substance abuse, forensic histories, and personality disorders, is ACT still evidence-based or do we need new models?

This symposium will survey the state of the art, 25 years later. Papers will include: Dr. Ronald Diamond on shifting the ACT treatment goal to a recovery model, Dr. Walter Rush on challenges in starting a new program today, Drs. David Lindy and Neil Pessin on comparisons of two ACT teams in two very different parts of New York City, and Dr. Gregory Teague on model fidelity and modification in relation to the Dartmouth assertive community treatment scale. Dr. Alan Rosen will be discussant, as well as provide an international perspective.

We hope to encourage a lively discussion among panelists and audience regarding these important issues.

## No. 14A
## RECOVERY ORIENTED ASSERTIVE COMMUNITY TREATMENT

Ronald J. Diamond, M.D., *Clinical Professor, Department of Psychiatry, University of Wisconsin Mental Health Center of Dane County, 6001 Research Park Boulevard, Madison, WI 53719*

**SUMMARY:**

ACT teams are very effective in helping people with schizophrenia live more stable lives in the community. Unfortunately, too often, ACT teams are perceived as paternalistic, controlling, and in conflict with a more recovery-oriented approach to treatment. The very power of the ACT team to intervene in the client's life increases the risk of control and paternalism. This is not inevitable. Recovery-oriented ACT teams must understand that their mission is recovery more than just stability, that consumers must be allowed to take calculated risks in how they want to live their own lives, and that the treatment planning process must really put the personal goals of the consumer at the forefront of the plan. Recovery from mental illness is the process of having more to life than just illness. It is the process of having life goals, and having the hope that one can achieve these goals. Treatment planning is how the person's own recovery goals get connected to the treatment process. Effective treatment planning is a collaborative process that includes the active involvement of both client and clinician. The goal for ACT teams is to make this collaborative process real.

## No. 14B
## CHALLENGES OF HIGH FIDELITY ASSERTIVE COMMUNITY TREATMENT IMPLEMENTATION: THE MINNESOTA EXPERIENCE

Walter K. Rush IV, M.D., *Professor of Psychiatry, University of Minnesota, 3112 James Avenue South, Minneapolis, MN 55408*; Steven G. Harker, M.D.; Kirk Fowler, L.I.C.S.W.

**SUMMARY:**

In Minnesota, we changed the service structure for people with severe and persistent mental illness once before. We are in the process of changing again, but this time with strict fidelity to the ACT model. Throughout the planning stage, we have encountered resistance from psychiatrists, case managers, and administrators and we may get resistance from patients once the program is implemented. Ultimately, the success of the program will be dependent on getting our skilled workers and the patients to believe in it. It is important to also build an understanding that ACT works if implemented with high fidelity. Significant deviations could result in our system revision falling short of its goals. This paper examines both the resistance and the importance of fidelity to the model.

## No. 14C
## A TALE OF TWO TEAMS: THE NEW YORK EXPERIENCE

David C. Lindy, M.D., *Clinical Director and Chief Psychiatrist, Community Mental Health Services, Visiting Nurse Service of New York, and Associate Clinical Professor, Department of Psychiatry, Columbia University College of Physicians & Surgeons, 1250 Broadway, Third Floor, New York, NY 10001*; Neil Pessin, Ph.D.

**SUMMARY:**

For the past ten years, the Visiting Nurse Service of New York's Community Mental Health Services has operated two ACT teams in New York City, each with a maximum of 68 clients. Both are licensed by the New York State Office of Mental Health, held accountable to the same auditing standards, and must meet the same fidelity measures. However, the teams function in very different settings and serve populations that have important differences. The Manhattan team operates primarily in the Chinatown, little Italy, and lower East Side neighborhoods of lower Manhattan. This is a dense, ethnically diverse area with multiple hospitals and ancillary services. Most clients are 35-64 years old, and Hispanic, non-Hispanic, white, or Asian. Most have family members or other involved collaterals. The Far Rockaway team operates in a very poor, less dense, isolated area of New York with only one hospital and fewer services. Its clients are mostly 18-34 years old, African American, and white. The team contacts far fewer collaterals. We will examine the implications of treatment setting and client population on model fidelity and optimal care for each group. We will also consider issues related to the payer's need to utilize ACT as the treatment of last resort for populations atypical for ACT.

## No. 14D
## ACTING IN GOOD FAITH: ISSUES IN FIDELITY TO ASSERTIVE COMMUNITY TREATMENT

Gregory Teague, Ph.D., *Associate Professor, Mental Health Law and Policy, University of South Florida,*

*13301 Bruce B Downs Boulevard, MHC2734, Tampa, FL 33612*

## SUMMARY:

There is considerable evidence that assertive community treatment (ACT) is an effective service model for persons with serious mental illness, and that practices must be implemented with sufficient fidelity to intended designs in order to obtain the expected outcomes. ACT has been implemented widely, typically in multiple sites through coordination by a central mental health authority. There exist both a measure of fidelity for the general ACT model and a detailed manual for its most definitive form (PACT), and many experienced consultants are available to help programs through the start-up process. Nonetheless, there is considerable variation in both the process and the products of implementation efforts.

Do differences in program requirements and resulting characteristics reflect variation in implicit ''program theory,'' i.e., differing views of critical program features, mechanisms of effect, and intended outcomes? Which program features are most crucial, and therefore how much adaptation of the theoretical ideal to local circumstance should be permitted or fostered? How might program specifications and fidelity measures be modified to more effectively inform implementation? The presenter, principal author of the most widely used ACT fidelity measure, the DACTS, will discuss these issues and describe proposed modifications to fidelity measurement for ACT.

## REFERENCES:

1. Diamond RJ: Coercion and tenacious treatment in the community applications to the real world, in Coercion and Aggressive Community Treatment: A New Frontier in Mental Health Law. Edited by Dennis D, Monahan J. New York, Plenum Press, 1996, pp 51–72.
2. Rosen A, Teeson M: Does case management work? The evidence and the abuse of evidence-based medicine. Australian and New Zealand Journal of Psychiatry 2001; 35:731–746.
3. Allness DJ, Knoedler WH: The PACT Model of Community-Based Treatment for Persons with Severe and Persistent Mental Illnesses: A Manual for PACT Start-Up, Arlington, Va, NAMI, 1999.
4. Teague GB, Bond GR, Drake RE: Program fidelity in assertive community treatment: development and use of a measure. American Journal Orthopsychiatry 1998; 68:216–232.

**Symposium 15** **Sunday, October 9**
**8:30 a.m.-11:30 a.m.**

# PLANNING NEW MENTAL HEALTH SYSTEMS: WHAT IS PSYCHIATRY'S ROLE?

Richard A. Shadoan, M.D., *Chair, CPA Implementation, Mental Health Services Administration, 2299 Post Street, Suite 308, San Francisco, CA 94115*

## EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to evaluate California's Mental Health Services Act and learn lessons that would be valuable for similar planning in other countries and states.

## SUMMARY:

Planning and implementation of California's Mental Health Services Act provides approximately $800 million per year for recovery-oriented services to California residents. Planning and implementation of these services in each California county has been undertaken via a unique stakeholders process that includes representation from many parts of the community, including providers, consumers, family members, and special populations. The role of psychiatrists and organized psychiatry in planning for these services in a number of California counties will be reviewed in light of the lessons that it may provide for similar planning in other counties and states.

## No. 15A
# A RESPONSE TO THE PRESIDENT'S FREEDOM COMMISSION ON MENTAL HEALTH REPORT

Marcia K. Goin, M.D., Ph.D., *Past President, American Psychiatric Association, and Clinical Professor of Psychiatry, University of Southern California, Keck School of Medicine, 1127 Wilshire Boulevard, Suite 1115, Los Angeles, CA 90068*

## SUMMARY:

The Passage of California's Mental Health Service Act in November of 2004 has given the leaders of mental health programs in California an opportunity to fulfill many of the goals outlined in the report by the President's Freedom Commission on Mental Health. The report describes the mental health delivery systems in the United States as fragmented and in disarray. With the amount of money that will be generated by the 1% tax on income of over $1,000,000 (estimated at $700,000 million per year), there is both an opportunity and a danger. If the money is not spent on cost effective, evidence-based

programs and does not have an effect in TRANSFORMING the mental health system mentioned in the Commission report, we will all lose, especially our patients. This presentation will focus on the process in addressing the major problems in access to mental health care.

## No. 15B
## MENTAL HEALTH SERVICES ACT PLANNING IN LOS ANGELES

Roderick Shaner, M.D., Medical *Director, Los Angeles County Department of Mental Health, 550 South Vermont Avenue, Los Angeles, CA 90020*

### SUMMARY:

Planning and implementation of California's Mental Health Services Act provides approximately $250 million per year for recovery-oriented services in Los Angeles County. Planning and implementation of these services has been undertaken via the required unique stakeholders process that includes representation from many parts of the community, including providers, consumers, family members, and special populations. The role of psychiatrists and organized psychiatry in planning for these services will be reviewed in light of the lessons that it may provide for similar planning in other counties and states.

## No. 15C
## JAILS AND PRISONS: THE OTHER REVOLVING DOOR

Ronald C. Thurston, M.D., *President, Southern Californis Psychiatric Society, 970 Petit Avenue, #A, Ventura, CA 93004-2215*

### SUMMARY:

When treatment programs decline, jail and prison time increase. Tax payers pay more, patients do worse. This presentation will discuss ways of reversing this trend: crisis intervention treatment, mental health courts, enhancing treatment programs while in custody, and strenthening discharge planning, including retaining mental health benefits.

## No. 15D
## THE IMPORTANCE OF HEARING CONSUMER AND FAMILY VOICES IN THE STAKEHOLDERS' PROCESS

Robert P. Cabaj, M.D., *Director, San Francisco Community Behavioral Health Services, and Associate Clinical Professor of Psychiatry, University of California at San Francisco, 1380 Howard Street, Fifth Floor, San Francisco, CA 94103*

### SUMMARY:

Consumers and families played a major role in the development and passage of California's Mental Health Service Act. As we now shift to the implementation phase of the act, they should play an equally important role. This presentation will discuss ways to encourage their input as important stakeholders and to make sure their experiences and ideas are incorporated in the decision-making process.

### REFERENCES:

1. Mental Health Services Act. Internet at *www.dmh.cahwnet.gov/MHSA/docs/meeting/12-17-2004*
2. Making Prop 63 work. Building a Bridge to Better Mental Health. Internet at *www.bettermentalhealth.org*.
3. Savela T, Robinson G, Crow S: Contracting for public mental health services. (DHHS Publication No. [SMA] 00-3438). Rockville, MD: Center for Mental Health Services Substance Abuse and Mental Health Services Administration, 2000.
4. California Department of Mental Health (2002). Effectiveness of integraled services in jails and prisons. Division 5, Section 5814, California Welfare and Institutions Code.

**Workshop 1** **Wednesday, October 5**
**10:00 a.m.-11:30 a.m.**

## VIOLENCE BY PSYCHIATRY INPATIENTS ON RESIDENTS: A CROSS-CULTURAL PERSPECTIVE

Jeffrey M. Levine, M.D., *Chair, Department of Psychiatry, Bronx Lebanon Hospital, 1276 Fulton Avenue, Fifth Floor, Bronx, NY 10456*; Ashokkumar Patel, M.D., *Department of Psychiatry, Bronx Lebanon Hospital, 1276 Fulton Avenue, 5th Floor, Bronx, NY 10456*; Muhammad A. Alam, M.D.; Eduardo R. Carmona, M.D.; Belinda A. Hara, M.D.

### EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, participants will understand the impact of patient-directed violence on psychiatric residents; improve understanding of how culture shapes the reactions of the residents to assaults by patients.

### SUMMARY:

Studies have indicated that during psychiatric residency 40% to 54% of psychiatric residents report being assauted. Although most assaults do not cause serious injuries, there may be psychological effects on the residents. Little is known about the impact of patient-directed violence on psychiatry residents. In addition, many psychiatric residents come from different cultural backgrounds and little is known about how the culture of psychiatric trainees mediates their reactions to violence. The purpose of this interactive workshop is to examine the perspectives and reactions of four psychiatric residents from four different nationalities. Each has been a victim of patient violence during the course of his or her training. The workshop will begin with a brief overview of the literature on violence by patients toward psychiatric residents. Each resident discusses how patient violence toward a physician is viewed in his/her culture. They then share their own reactions of being the victim of patient assaults. There will be three male and one female resident presenters. They will offer cultural perspective from India, Cuba, Pakistan, and the Philippines. The director of residency training will serve as moderator and will offer recommendations with regard to residency training and patient violence. The workshop will be highly interactive and participants will be asked to share points of view and experiences.

### TARGET AUDIENCE(S):

Psychiatry residents, general, administration and forensic psychiatry.

### REFERENCES:

1. Assaults by patients on psychiatric residents: A survey and training recommendation. Psychiatry Svcs 1999; 50:381–383.
2. Patients assaults on psychiatry resident: results of National Survey. Traumatology 2002; 8(4).

**Workshop 2** **Wednesday, October 5**
**10:00 a.m.-11:30 a.m.**

## PSYCHIATRIC AND PSYCHOSOCIAL ISSUES OF MINORITY ELDERLY IN THE 21ST CENTURY

*APA Committee of Representatives of Minority/ Underrepresented Groups*

Jagannathan Srinivasaraghavan, M.D., *Professor and Chief, Division of Community and Public Psychiatry, Department of Psychiatry, Southern Illinois University School of Medicine; and Medical Director, Choate Mental Health Center, 1000 North Main Street, Anna, IL 62906*; Dilip V. Jeste, M.D.; Rodrigo A. Muñoz, M.D.; Warachal E. Faison, M.D.; Mary H. Roessel, M.D.

### EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participants should be able to recognize the changing demographics of the minority elderly, understand the unique issues and concerns of each group, and list recommendations for addressing those issues including access and workforce.

### SUMMARY:

Persons 65 and older numbered 35 million in 2000, representing 12.4% of the U.S. population. Among them, 16.4% were minorities comprising 8% African Americans, 5.6% Hispanic Americans, 2.4% Asian Americans or Pacific Islanders, and less than 1% Native Americans and Native Alaskans. In 2000, only 6.6% of all minorities were elderly compared with 15% of whites. By 2030, the number of minority elderly is expected to more than double. Often, African Americans lack supplemental health insurance, suffer from at least one chronic condition, and forego buying at least one medication due to the cost. Elderly Hispanic Americans have a high rate of poverty, feel ''old'' early, leading to ''psychological death,'' and do not seek psychiatric help until advised by family or close friends. Asian Americans are a diverse group. Asian American elderly women have the highest rate of suicide, especially Chinese women. Asian Americans are also low utilizers of mental health services. Native Americans and Native Alaskans have shorter life expectancy and have a high rate of alcoholism, depression, and suicide. In this workshop, we will visit unique concerns of each group and address access and systems

of care for providing mental health services to the minority elderly.

## TARGET AUDIENCE(S):

Psychiatrists, psychologists and mental health professionals.

## REFERENCES:

1. Mental Health: Culture, Race and Ethnicity: A Supplement to Mental Health: A Report of the Surgeon General, 2001.
2. Cohen JJ, Gabriel B, Terrell C: The case for diversity in the health care workforce. Health Affairs 2002; 21(5):90–102.

**Workshop 3** **Wednesday, October 5**
**10:00 a.m.-11:30 a.m.**

## NATIONAL EFFORTS TO ADDRESS STIGMA AND DISCRIMINATION

*Substance Abuse and Mental Health Services Administration*

Christopher Marshall, *Consumer Affairs Specialist, Substance Abuse and Mental Health Services Administration, Community Mental Health Services, 1 Choke Cherry Road, Room 6-1071, Rockville, MD 20857*; Paolo Del Vecchio, M.S.W.; Carole Schauer, M.S.N.

## EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: (1) demonstrate understanding of the goals, objectives, activities, of the National Anti-Stigma Campaign; (2) demonstrate understanding of the goals, objectives, materials, activities, and results of the Elimination of Barriers Initiative; (3) describe resources and trainings available of the Resource Center to Address Stigma and Discrimination; and (4) demonstrate understanding of stigma research, public education models, recovery, strengths-based perspective, and the contact approach.

## SUMMARY:

The Substance Abuse and Mental Health Services Administration has initiated several national efforts to reduce discrimination and stigma including the National Anti-Stigma Campaign (NASC), the Elimination of Barriers Initiative (EBI), and the Resource Center to Address Discrimination and Stigma (ADS Center). Recently initiated, the NASC responds to the recommendation of the President's New Freedom Commission on Mental Health for a national education campaign to address stigma. The NASC will use social marketing techniques to develop national public education messages via television, radio, print PSAs, outdoor advertising, and the Internet. The NASC will also build community support for the campaign. The objectives include educating the general public about mental health, promoting recovery, and encouraging help-seeking behavior. The EBI, in its third year, is an eight-state demonstration that tests public education messages to reduce discrimination and stigma. The EBI developed television, radio, and print PSAs in English and Spanish that are receiving above average distribution. The ADS Center is a national technical assistance center and serves as a central source for extensive information on effective anti-stigma programs and resources. The ADS Center hosts multiple Web-based trainings on the impact on stigma on housing, employment, recovery, diversity, education, and more.

## TARGET AUDIENCE(S):

Psychiatrists, researchers, academicians, policy makers, state officials, consumers and family members.

## REFERENCES:

1. Achieving the Promise: Transforming Mental Health Care in America (2003) DHHS, New Freedom Commission on Mental Health.
2. Mental Health: A Report of the Surgeon General (1999) U.S. Dept. of HHS.

**Workshop 4** **Wednesday, October 5**
**1:30 p.m.-3:00 p.m.**

## REHABILITATION IN LIEU OF IMPRISONMENT FOR DRUG RELATED OFFENSES: THE CHALLENGES

Rodrigo A. Muñoz, M.D., *Past President, American Psychiatric Association, and Consultant, APA/IPS Scientific Program Committee, 3130 5th Avenue, San Diego, CA 92103-5839*; Gretchen Burns; Amanda Ruiz, M.D.; Claudio O. Cabrejos, M.D.

## EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participants should be able to identify the risks and opportunities in dealing with drug offenders by extending the option of entering a rehabilitation program, rather than serving prison sentences.

## SUMMARY:

California Proposition 36 permitting rehabilitation as an alternative to prison has been implemented since July 2001. Nearly 30,500 people chose rehabilitation during the first year. The number increased to 36,000 the following year.

Initial research shows that rehabilitation participants may be more likely to be rearrested than those in other criminal justice programs. We want to bring to IPS

several of the Proposition 36 advocates, psychiatrists seeing patients with drug addictions in the private sector, and critics that propose new financing and programs that may improve the effectiveness of rehabilitation. This is made more timely when Proposition 63 may enhance funds for rehabilitation.

## REFERENCES:

1. Blume SB: Drug and Alcohol Abuse: A Clinical Guide to Diagnosis and Treatment, 5th ed. Am J Psychiatry 2000; 157:1894–1895.
2. Barton GM: The chronic mental patient: five years later. Psychiatr Serv 2004; 55:1188–1189.
3. AH Mack Frances RJ: Substance-related disorders. Focus 2003; 1:125–145.

**Workshop 5** **Wednesday, October 5**
**1:30 p.m.-3:00 p.m.**

## MINORITY THERAPISTS AND MINORITY PATIENTS: EXPLORING THE MEANING OF A SHARED MINORITY STATUS IN PSYCHOTHERAPY

*APA AstraZeneca Minority Fellows*

Toya D. Clay, M.D., *Department of Psychiatry, Columbia University, 1051 Riverside Drive Box 104, New York, NY 10032*; Sherri M. Simpson, M.D.; Jennifer R. Lee, M.D.; Sreba Anam, M.D.; LaShondra T. Washington, M.D.; Yolanda Coleman, M.D.; Aliya Carmichael Jones, M.D.; Osvaldo Gaytan, M.D., Ph.D.

## EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to: (1) recognize that race and culture operate in every therapeutic situation, (2) recognize that race and culture are best conceptualized as fluid phenomena and that they are best utilized when patients and therapists can negotiate the meanings of race and culture within the therapeutic dyad; and (3) recognize the unique opportunities and the hidden obstacles of being a minority therapist treating same minority patients.

## SUMMARY:

In Tang and Gardner's paper, Race, Culture, and Psychotherapy, the authors point out that when therapist and patient share a racial identity (i.e. skin color and physical features), they are likely to share assumptions about their race and culture that inevitably influence the therapeutic process. As minority therapists in training, we are uniquely situated to observe this inevitable influence of race and culture.

This is not to say that majority (i.e. white) therapists can not or do not appreciate the impact of race on the therapeutic process, but they may not be as sensitized to its clues. Unfortunately, since being aware of and managing differences based on race and culture has largely been the domain of minorities, this often means that members of the majority culture, including majority therapists, feel that they are negligibly affected by race and culture, especially with their majority patients, as if that specific dyad were without the important influences of race and culture.

With minority patients being treated by majority therapists, neglect of race and culture early on in the therapeutic process may lead to minority patients holding onto concerns about the majority therapist's ability to fully understand the patient and empathize with his/her experience, which might jeopardize the therapeutic alliance and process. It is often gratifying then for minority patients (and minority therapists) to encounter therapists (and patients) who share their racial identity, with a main shared assumption being that understanding of the patient's problems and experiences will occur automatically.

This workshop will address these shared assumptions, which although they may lead to immediate comfort on the part of both patient and therapist because of the belief that they both inherently know something important about the other, can also lead to barriers and even unworkable situations in the therapy. We will explore these assumptions in same minority therapeutic dyads as a way of re-conceptualizing race and culture in psychodynamic psychotherapy, not as static and esoteric concepts but as fluid concepts that create *individualized* meaning for the patient *and* the therapeutic relationship/process. The workshop will focus on the ways in which the exploration of these shared assumptions can enhance the therapeutic process, as well as ways of recognizing when these shared assumptions are at play (over-identification) in the transferences, countertransferences and resistances that take form in the therapy.

## TARGET AUDIENCE(S):

All psychodynamic psychotherapists, particularly trainees and minority therapists.

## REFERENCES:

1. Tang NM, Gardner J: Race, culture, and psychotherapy: transference to minority therapists. Psychoanalytic Quarterly 1999; 68(1):1–20.
2. Leary: Interpreting in the dark: race and ethnicity in psychoanalytic psychotherapy. Psychoanalytic Psychology 12(1): pp. 127–140.

**Workshop 6** **Wednesday, October 5**
**3:30 p.m.-5:00 p.m.**

## BRIDGING THE GAP BETWEEN MENTAL HEALTH AND DENTAL HEALTH

Annelle B. Primm, M.D., M.P.H., *Director, Division of Minority and National Affairs, American Psychiatric*

*Association, 1000 Wilson Boulevard, Suite 1825, Arlington, VA 22209*; F. M. Baker, M.D., M.P.H.; Mario Cruz, M.D.; Gail Cherry-Peppers, D.D.S., M.A.

## EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to identify the most common types of dental problems among people with mental illness and substance-use disorders; and learn strategies for maximizing oral health in people with mental illness.

## SUMMARY:

Numerous reports in the psychiatric and dental scientific literature have documented that patients with psychiatric illness and substance-use disorders are at increased risk for poor dental health. Among the underlying factors associated with compromised oral health in people with mental disorders include neglect of self-care, depressive symptoms, anxiety, and suspiciousness. In addition, psychotropic medications can contribute to poor oral health due to side effects such as dry mouth due to decreased saliva production. Furthermore, people with mental illness have been found to have higher rates of edentulousness, which can interfere with self-esteem and employability. This workshop will profile the dental needs of people with mental illness. Perspectives of psychiatrists will be presented focusing on the topic of mental illness and dental disease as an unappreciated comorbidity as well as the resources required to satisfy unmet dental needs. A dentist will provide insights on the ways in which dentistry can best respond to the needs of dentally underserved populations with mental illness. The challenge of maximizing dental health in patients with mental illness and substance-use disorders will also be presented. The audience should benefit by achieving greater awareness of their patients' oral health as an important aspect of overall health.

## TARGET AUDIENCE(S):

Clinicians, trainees, primary care and dental professionals, policy makers and health service researchers.

## REFERENCES:

1. McCreadie RG, Stevens H, Henderson J, et al: The dental health of people with schizophrenia. Acta Psychiatrica Scandinavia 2004; 110(4):306–10.
2. Rosenheck R, Lam JA: Homeless mentally ill clients' and provders' perceptions of service needs and clients' use of services. Psychiatric Services 1997; 48(3):381–6.

**Workshop 7** **Wednesday, October 5**
**3:30 p.m.-5:00 p.m.**

# REMEMBER MY NAME: RESTORATION OF STATE HOSPITAL CEMETERIES AND THE EXPERIENCE OF AFRICAN AMERICANS

*Substance Abuse and Mental Health Services Administration*

Christopher Marshall, *Consumer Affairs Specialist, Substance Abuse and Mental Health Services Administration, Community Mental Health Services, 1 Choke Cherry Road, Room 6-1071, Rockville, MD 20857*; Larry Fricks, B.A.; Vanessa Jackson, L.C.S.W.

## EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to demonstrate understanding of the historical significance of individuals who lived and died in state hospitals, the importance of consumer-led efforts to restore dignity to state hospital graveyards depicting consumers as civic leaders, the specific experiential history of African Americans in state mental institutions, and the successful cemetery restoration efforts in Georgia.

## SUMMARY:

The Substance Abuse and Mental Health Services Administration has initiated a history project that examines efforts to restore abandoned and neglected patient cemeteries on state hospital grounds and reports on the history of the experiences of African Americans in state mental institutions. The project includes the development of a technical assistance manual that explains a process developed by civic-minded mental health consumers to engage state officials, legislators, corporate leaders, and community organizations in an effort to restore dignity and respect to the forgotten markers and graveyards of individuals who lived and died in state mental health hospitals. A video was also developed for this project that depicts the successful efforts of mental health consumers and former patients of Danvers State Hospital in Massachusetts to restore their neglected patient cemetery, and, as a result, to reduce stigma and create potential jobs and housing for consumers. As part of this history project, a paper was produced that reports on the experiential history of African Americans in mental institutions. The report provides an overview of the difficult conditions faced by African Americans and the slow march toward progress and equality within the institutional system. This workshop will also feature the efforts of mental health consumers in Georgia to restore state hospital patient cemeteries and their subsequent report on these activities.

## TARGET AUDIENCE(S):

Psychiatrists, clinicians, researchers, policymakers, state officials, consumers, and family members.

## REFERENCES:

1. NASMHPD position statement in state psychiatric hospital patient cemeteries, 2001.
2. Fricks L: The Georgia Story: How to Restore a State Hospital Cemetery, 2004.

**Workshop 8** **Wednesday, October 5**
**3:30 p.m.-5:00 p.m.**

## ASSURING SUCCESS IN THE COMMUNITY: VIABLE HOUSING OPTIONS FOR THE MENTALLY ILL

Marilyn Seide, Ph.D., *Division Chief, Los Angeles County Department of Mental Health, 1925 North Daly Street, Los Angeles, CA 90031*; Richard A. Miller, M.D.; Suzanne Wagner, M.A.; Dorene Houtant, M.S.W.

## EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to recognize what elements are essential in supportive housing—its development and implementation and clinical issues related to success.

## SUMMARY:

With the increase in the number of chronically mentally ill persons discharged from hospitals and other residential placements due to budget constraints around the country, it has become imperative that new, innovative, and appropriate community-based settings be developed and implemented. This workshop will look at some of these settings and assess their ability to successfully maintain people of varying degrees of mental illness in the community. Participants will address some of the issues faced in these less restrictive settings, such as what clinical and other supportive elements should be present to ensure the ability of clients to adapt to more independent living? Examples will be given of successful models and how they can be replicated.

## TARGET AUDIENCE(S):

Those involved in evaluating, placing and maintaining clients in supportive housing.

## REFERENCES:

1. Corp for Supportive Housing: Developing the Supportive Housing Program. U.S. Dept. of Housing and Urban Development, 2003.
2. Ford J, Young D, Perez B, Obermeyer R, Rohner D: Needs assessment for persons with severe mental illness: what services are needed for successful community living? Com Mental Health Journal 1992; 28(6).

**Workshop 9** **Thursday, October 6**
**8:00 a.m.-9:30 a.m.**

## FEDERAL AND LOCAL EFFORTS TO REDUCE AND ELIMINATE SECLUSION AND RESTRAINT

*Substance Abuse and Mental Health Services Administration*

Paolo Del Vecchio, M.S.W., *Associate Director for Consumer Affairs, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services, 1 Choke Cherry Road, Rockville, MD 20857*; Anita S. Everett, M.D., *Member, APA/IPS Scientific Program Committee, and Senior Medical Advisor, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services, 1 Choke Cherry Road #81053, Rockville, MD 20857*; Maggie Bennington-Davis, M.D.

## EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to recognize the importance of addressing seclusion and restraint and utilize alternatives to such interventions.

## SUMMARY:

Seclusion and restraint is one of the critical practice and policy issues for public and community psychiatry. Such interventions have resulted in deaths and serious physical injury and psychological trauma. The Harvard Center for Risk Analysis estimated deaths due to these practices at 150 per annum. The General Accounting Office and the HHS Office of the Inspector General have noted the paucity of known data related to such approaches. Seclusion and restraint use varies dramatically with a range of facility and staff knowledge on prevention and alternatives. A number of organizations, including APA, have developed guidelines on these practices. Training, technical assistance, and leadership are priority needs in this area. In response, the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA) has called for the reduction and ultimate elimination of such practices in behavioral health. This session will provide an overview of SAMHSA's National Action Plan to realize this vision including findings from multi-site grant programs that have implemented and evaluated effective approaches to prevent, reduce, and eliminate seclusion and restraint. Updates on staff training tools, federal regulations, and model policies will be provided. The professional and personal

impact of the use of seclusion and restraint will also be addressed.

## TARGET AUDIENCE(S):

Psychiatrists who provide services in a variety of clinical settings as well as program administrators, and researchers.

## REFERENCES:

1. Journal of Psycho-Social Nursing; 2004; 42:(9). Special Issue on Alternatives to Seclusion and Restraint.
2. Moving from Coercion to Collaboration in Mental Health Services; U.S. Dept of Health & Human Services/SAMHSA, 2004.

**Workshop 10** **Thursday, October 6**
**8:00 a.m.-9:30 a.m.**

## ADDRESSING THE BEHAVIORAL HEALTH NEEDS OF THE MEDICALLY UNDERSERVED: INTEGRATING MENTAL HEALTH SERVICES INTO THE PRIMARY CARE SETTING

Rodrigo A. Muñoz, M.D., *Past President, American Psychiatric Association, and Consultant, APA/IPS Scientific Program Committee, 3130 5th Avenue, San Diego, CA 92103-5839*; Nora Cole, M.F.T.; Paul Hubley, M.D.; Claudio O. Cabrejos, M.D.

## EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, participants will demonstrate a sound understanding of the behavioral health needs of the medically underserved, and identify successful strategies for integrating mental health services within a primary care setting.

## SUMMARY:

The recent Presidential Commission on Mental Health underscored what has been known for years—behavioral health services in this country are fragmented; too many have unmet needs; and barriers impede care for those with mental illness. Twenty-eight percent of Americans have a diagnosable mental health and/or addictive disorder, yet less than one-third of them ever seek treatment.

Nonetheless, millions of primary care patients experience symptoms related to behavioral health disorders; 70% of primary care visits have a psychosocial basis; and the majority of Americans receive treatment for behavioral health conditions from a primary care physician. We also know that the medically under-served are at higher risk for poor health status and have more unmet mental health needs than the population at large.

Clearly, behavioral health is an essential component of primary care service delivery. This workshop will focus on one community health center's approach to integrating mental health services into the primary care setting. A multidisciplinary team from Family Health Centers of San Diego will share its experiences with routine depression screening, intensive primary care provider health education, case management, monitoring of patient's self-management goals, individual psychotherapy, medication management, group support, and computerized self-monitoring of mood, medication adherence, sleep, and behavior patterns.

## REFERENCES:

1. Simon G: Psychiatric disorder and functional somatic symptoms as predictors of health care use. Psychiatric Medicine 1992; 10:49–60.
2. Quirk MP, et al: A look to the past; directions for the future. Psychiatric Quarterly 2000; 71 (1):79–95.

**Workshop 11** **Thursday, October 6**
**8:00 a.m.-9:30 a.m.**

## COLLABORATIVE PARTNERSHIPS: COMMUNITY PSYCHIATRY AND COMMUNITIES OF FAITH

*2004-2006 APA/Bristol-Myers Squibb Fellows*

Lorrie K. Garces, M.D., *Psychiatry Resident, University of Florida College of Medicine, 2004-2006 APA/Bristol-Myers Squibb Fellow and Liaison, IPS Scientific Program Committee, PO Box 100256, Gainesville, FL 32610*; C. Britt Peterson, M.D., M.P.H., *Psychiatry Resident, University of New Mexico School of Medicine, and 2004-2006 APA/Bristol-Myers Squibb Fellow, 2805 Carolina Street North East, Albuquerque, NM 87110*

## EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should (1) appreciate the historical relationship between faith-based organizations and public psychiatry, (2) understand the methods and outcomes for systems of care where faith-based organizations and mental health programs intersect, (3) recognize the benefits and difficulties present in the organization and funding of existing partnerships.

## SUMMARY:

Persons with mental illness have historically had many obstacles accessing community resources and overcoming societal stigma along the road to recovery. Faith-based organizations have traditionally filled a myriad of vital roles in the community including access to social services, housing, counseling, and recovery-oriented services. The shared commitments between community psychiatry and communities of faith offer potential avenues in serving the needs of those afflicted by mental

illness. There is a large amount of literature discussing how an individual's spirituality influences their personal experiences with mental health care. However, significantly less has been oriented toward how clirical psychiatric systems intersect with faith-based systems and the type of outcomes that result from these partnerships. This workshop will examine some of the existing programs that have linked these two domains and consider the treatment and education models they utilize. This workshop will address the potential positive public health impacts of these systems on decreased stigmatization, increased access, and improved quality of services. Additionally, it will discuss possible obstacles to partnerships, including issues surrounding government funding of these projects.

## TARGET AUDIENCE(S):

Mental health professionals.

## REFERENCES:

1. Sharing a Legacy of Caring: Partnerships between Health Care and Faith-Based Organizations. Washington D.C., National Center for Cultural Competence, 2002.
2. Walters J, Neugeboren B: Collaboration between mental health organizations and religious institutions. Psychiatric Rehabilitation Journal 1995; 19(2):51–7.

**Workshop 12** **Thursday, October 6**
**10:00 a.m.-11:30 a.m.**

## AMERICAN PSYCHIATRIC ASSOCIATION'S PRACTICE GUIDELINE ON PSYCHIATRIC EVALUATION OF ADULTS: REVISION 2006

*APA Steering Committee on Practice Guidelines*

John S. McIntyre, M.D., *Vice President for Behavioral Health; Chair, Department of Psychiatry and Behavioral Health, Unity Health System; and Past President, American Psychiatric Association, 81 Lake Avenue, Third Floor, Rochester, NY 14608*; Michael J. Vergare, M.D., *Professor and Chair, Department of Psychiatry and Human Behavior, Jefferson Medical School, and Professor and Chair, Department of Psychiatry, Albert Einstein Medical Center, 8860 Germantown Avenue, Philadelphia, PA 19118*; Francis G. Lu, M.D.

## EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to understand objectives and development process of the APA practice guidelines project; and know how to use the practice guideline on psychiatric evaluation of adults to help determine how to perform evaluations and what domains to address.

## SUMMARY:

Since 1991, APA has published 14 practice guidelines using an evidence-based process that results in recommendations that are both scientifically sound and clinically useful to practicing psychiatrists. Practice Guideline for the Psychiatric Evaluation of Adults was first published in 1995. A complete revision of the guideline was begun in 2004 and is expected to be published in 2006. Workshop panelists will discuss the development process for APA practice guidelines and the specific recommendations of this guideline, highlighting areas where practice has most evolved since 1995 and where changes are expected in the 2006 edition, including sociocultural issues, patient confidentiality and HIPAA, team evaluations, neuroimaging, and use of structured instruments. Attendees are invited to comment on the recommendations, implications for the field, and dissemination and evaluation strategies.

## TARGET AUDIENCE(S):

Psychiatrists who perform psychiatric evaluations, especially residents in training.

## REFERENCES:

1. American Psychiatric Association. Practice guideline for the psychiatric evaluation of adults. Am J Psychiatry Nov (Suppl); 1995.

**Workshop 13** **Thursday, October 6**
**10:00 a.m.-11:30 a.m.**

## FROM DOUBLE BLIND TO DOUBLE BLIND: INCREASING MINORITIES IN RESEARCH

Annelle B. Primm, M.D., M.P.H., *Director, Division of Minority and National Affairs, American Psychiatric Association, 1000 Wilson Boulevard, Suite 1825, Arlington, VA 22209*; Basil D. Halliday, M.S.C.; Christopher Edwards, Ph.D.

## EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to identify barriers to minority participation in psychiatric research, understand the impact of the lack of minority participation in psychiatric research on mental health disparities, and implement strategies to maximize minority enrollment and retention in psychiatric research.

## SUMMARY:

The psychiatric literature contains mounting evidence that there are racial and ethnic disparities in mental health and mental health care. Furthermore, there is evidence in the ethnopsychopharmacology literature that

genetic polymorphisms underlie differences in pharmacokinetics and pharmacodynamics among these populations. These differences have important implications for choice of psychopharmacologic agents as well as dosing and monitoring strategies.

Conducting clinical research is essential to further understand the ways in which minority populations respond to the full range of psychiatric treatment modalities and experience differential outcomes. However, minority participation in clinical trials has been low due to a number of reasons, including scientific convenience and expediency, lack of opportunity for minorities to participate, limited knowledge of the research process, and a legacy of distrust.

The direct benefit of increased minority participation in the clinical trials process is that adequate representation of these groups in the sample size is not only prudent, but is a win-win-win opportunity for the pharmaceutical industry, patients, and medicine, in general. As such, a concerted and focused effort must be made by psychiatric researchers to go beyond conventional and (already proven) ineffective methods to be more inclusive of racial and ethnic minorities in all phases of the clinical research.

## TARGET AUDIENCE(S):

Clinicians, trainees, researchers, educators, and policymakers.

## REFERENCES:

1. Noah BA: The participation of underrepresented minorities in clinical research. American Journal of Law and Medicine 2003; 29:221–245.
2. Cargill V: Increasing diversity in clinical trial populations. The American Journal of MultiCultural Medicine 1 (1):27–30.

**Workshop 14** **Thursday, October 6**
**10:00 a.m.-11:30 a.m.**

# HERBS, NEEDLES, AND GARDENS: COMPLEMENTARY AND ALTERNATIVE TREATMENT APPROACHES IN PSYCHIATRY

*2004–2006 APA/Bristol-Myers Squibb Fellows*

Farah Munir, D.O., *Psychiatry Resident, Cleveland Clinic Foundation, and 2004-2006 APA/Bristol-Meyers Squibb Fellow, 1133 West 9th Street, #702, Cleveland, OH 44113*; Sarah P. Barrios, M.D.; Matthew O. Hurford, M.D.; Diane E. McLean, M.D., Ph.D.

## EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to demonstrate knowledge of a sampling of complementary and alternative treatment practices that are increasingly being chosen by mental health consumers.

## SUMMARY:

Almost one-third of consumers in the U.S. are using alternative and complementary therapies for medical conditions. Despite a small, yet growing body of evidence on such treatment approaches, mental health providers are often overwhelmed by the task of attempting to merge alternative therapies with traditional psychiatric practice. A widening gulf between the perspectives of clients and providers is the unfortunate result, causing confusion among consumers and posing a potential threat to the therapeutic alliance. This workshop aims to draw practitioners of "traditional" psychiatric medicine closer to the diverse therapeutic perspectives that are shared by the providers and consumers of alternative treatment practices. The workshop will begin with a review of the literature on the use of homeopathic and nutritional alternatives to traditional psychopharmacologic treatments. Individual, non-pharmacologic treatments, including a variety of cross-cultural practices such as the traditions of acupuncture and mindfulness meditation, will be reviewed. To look at alternative approaches from a group perspective, successful community-based initiatives, such as horticulture therapy and urban renewal partnerships, will be introduced. Finally, these diverse approaches will be tied together to provide a sociocultural framework derived from explanatory models of mental illness and well-being through which to view client perceptions of complementary medicine. The overall aim of the workshop is to link historical perspective with clinical practice to enable mental health practioners to better understand and meet the diverse needs and expectations of mental health consumers.

## TARGET AUDIENCE(S):

Psychiatrists, psychologists, social workers and students.

## REFERENCES:

1. Eisenberg DM, Kessler RC, Foster C, Norlock FE, Calkins DR, Delbanco TL: Unconventional medicine in the United States: prevalence, costs and patterns of use. New England Journal of Medicine 1993; 328:246–252.
2. Complementary and alternative medicine and mental health care: shared challenges. Complementary Health Practice Review 2003; 8(3):193–7.

**Workshop 15** **Thursday, October 6**
**3:30 p.m.-5:00 p.m.**

## HOW TO SELL JAIL DIVERSION: REAL COSTS AND REAL BENEFITS

*APA Corresponding Committee on Jails and Prisons*

Henry C. Weinstein, M.D., *Clinical Professor of Psychiatry, New York University School of Medicine, 1111 Park Avenue, New York, NY 10128*; Henry J. Steadman, Ph.D.; Mark R. Munetz, M.D.

### EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to (1) identify the fiscal implications of treating people with mental illness in the justice system and understand the relevance of these issues to communities developing jail diversion programs; and (2) know what resources exist to effectively approach elected officials about redirecting resources from the criminal justice system to community-based mental health services.

### SUMMARY:

Programs to divert people with mental illness from jail into community-based services have dramatically increased in recent years. The TAPA Center for Jail Diversion lists over 300 jail diversion programs currently operating in the U.S. These programs are developed in part in response to the recognition that resources are more appropriately spent on community-based mental health services for people with mental illness than on incarceration. This theme has been a focus of recent activities of the APA's Criminal Justice Mental Health Initiative and the APA Corresponding Committee on Jails and Prisons. In this interactive workshop, Henry J. Steadman, Ph.D., will provide an overview of the available empirical data on fiscal impact of people with mental illness in the justice system. Henry C. Weinstein, M.D., will describe the contents of a resource kit compiled by APA to provide APA district branches and state associations with information that can be used to approach elected officials about redirecting resources from the criminal justice system to community-based mental health services. Mark Munetz, M.D., will conclude with thoughts on how these fiscal issues are relevant to communities developing jail diversion programs and what additional information and resources would be helpful in advocacy efforts.

### TARGET AUDIENCE(S):

1. Attendees interested in data on cost savings and cost shifting between mental health and criminal justice; 2. Attendees involved in education and advocacy with elected officials.

### REFERENCES:

1. Cowell AJ, Broner N, Dupont R: The cost-effectiveness of criminal justice diversion programs for people with serious mental illness co-occurring with substance abuse. Journal of Contemporary Criminal Justice 2004; 20(3):292–315.
2. Clark RE, Ricketts SK, McHugo GJ: Legal system involvement and costs for persons in treatment for severe mental illness and substance use disorders. Psychiatric Services 1999; 50(5):641–647.

**Workshop 16** **Thursday, October 6**
**3:30 p.m.-5:00 p.m.**

## ADDRESSING DISPARITIES IN HEALTH CARE: TEACHING AND LEARNING

Carolyn B. Robinowitz, M.D., *Secretary-Treasurer, APA Board of Trustees, and Clinical Professor, Department of Psychiatry, George Washington University School of Medicine, 5225 Connecticut Avenue, N.W., #514, Washington, DC 20015*; Annelle B. Primm, M.D., M.P.H., *Director, Division of Minority and National Affairs, American Psychiatric Association, 1000 Wilson Boulevard, Suite 1825, Arlington, VA 22209*; Rodrigo A. Muñoz, M.D.

### EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, participants will become familiar with disparities in health care, with particular emphasis on disparities in psychiatric care, and will become aware of learning tools to prevent and minimize such disparities.

### SUMMARY:

Recent studies have shown that despite the steady improvements in the overall health of the United States, racial and ethnic minorities experience a lower quality of health services and are less likely to receive routine medical procedures and have higher rates of morbidity and mortality than non-minorities. Disparities in health care exist even when controlling for gender, condition, age, and socio-economic status.

This disparity is magnified in the recognition and treatment of mental disorders. Biases and stereotypic beliefs have resulted in limited care for persons with mental disorders, with financial barriers as well as stigmatizing disincentives to access. Reasons for these disparities are complex and poorly understood. Socioeconomic inequality, individual behavioral risk factors, limited access, and cultural factors play a role. All involved agree there is need for greater education of physicians as well as policy makers to minimize and prevent such disparities. The American Medical Association and the National Medical Association have formed a consor-

tium, of which the APA is a member, to eliminate disparities. The presenters, and leaders in the consortium, will present three educational programs that have been successful in addressing disparities and which are useful for groups and organizations as well as individual practitioners. This will be an experiential and interactive session. Attendees will participate actively in the educational programs presented.

## TARGET AUDIENCE(S):

This presentation is aimed at clinicians (including residents) and educators.

## REFERENCES:

1. Smedly BD, Stith AY, Nelson AR (Eds.); Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care. Washington, DC: Institute of Medicine; 2002.
2. Department of Health and Human Services. Mental Health: Culture, Race, and Ethnicity. A Supplement to Mental Health: A Report of the Surgeon General. Washington, DC: U.S. Public Health Service; 2000.
3. AMA Council on Scientific Affairs, Racial and Ethnic Disparities in Health Care, Chicago, IL December, 2002.

**Workshop 17** **Thursday, October 6**
**3:30 p.m.-5:00 p.m.**

# INTERNATIONAL PERSPECTIVES ON EVIDENCE-BASED PRACTICE

Kenneth S. Thompson, M.D., *Director, Institute for Public Health and Psychiatry, Western Psychiatric Institute and Clinic; Associate Professor of Psychiatry and Public Health, University of Pittsburgh Medical Center, and Former APA/Bristol-Myers Squibb Fellow, 3811 O'Hara Street, Pittsburgh, PA 15213*; Alan Rosen, M.D.; Christina van der Feltz, M.D., Ph.D.; C.J. Witte, M.D.; Neal H. Adams, M.D., M.P.H.

## EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, participants will be able to compare and contrast the approach to evidence-based medicine in Europe, Australia, and the U.S.

## SUMMARY:

An evidence-based approach to the practice of medicine, with its focus on assessing the quality of evidence supporting clinical practices, is becoming a key element in the transformation of psychiatry in the United States and around the world. In this workshop, psychiatrists from Europe and Australia will discuss the evolution of the evidence-based approach in their respective regions of the world. The use of clinical guidelines and their development will be considered. Differences in the interpretation and use of evidence in the design and implementation of clinical services will be highlighted.

## TARGET AUDIENCE(S):

Clinical administrators and practicing clinicians.

## REFERENCES:

1. Sackett DI, Rosenberg WM, Gray JA, Haynes RB, Richardson WS: Evidence based medicine: what it is and what it isn't. BMJ 1996; 212(7023):71–2.
2. Torrey WC, Drake RE, Dixon L, Burns BJ, Flynn L, et al: Implementing evidence-based practices for persons with severe mental illnesses. Psychiatr Serv 2001; 52:45–50.

**Workshop 18** **Friday, October 7**
**8:00 a.m.-9:30 a.m.**

# CONCEPTUALIZING PSYCHOLOGICAL AND SOCIAL MEANING OF UNPROTECTED SEXUAL BEHAVIOR IN THE ERA OF HIV

Marshall Forstein, M.D., *Director of Psychiatric Residency Training, Department of Psychiatry, Cambridge Hospital, Harvard School of Medicine, 1493 Cambridge Street, Cambridge, MA 02139*

## EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to (1) recognize the psychological complexity of unprotected sexual behavior in people at risk for HIV infection; (2) understand psychotherapeutic models for approaching patients participating in unprotected sexual behavior; (3) recognize countertransference issues that frequently arise in the therapeutic relationship with people at risk for HIV infection.

## SUMMARY:

In spite of extensive public health education about risk behaviors for HIV, and significant knowledge in the public about the routes of transmission, new infections continue, indicating that knowledge does not correlate or seem to impact behavior change. Many models of behavior change have been proposed to explain why people in spite of knowledge do not act to protect themselves and others.

The workshop leader, who has worked with hundreds of people with HIV infection, will summarize a variety of social and psychological models that may help to explain the inconsistency between knowledge and behavior, addressing issues such as the impact of stigma, social isolation, problems with self-esteem and self-efficacy, psychiatric disorders, and substance use. Concepts

such as ''barebacking,'' duty to warn, and partner notification will be discussed.

The workshop will be an opportunity to talk frankly about the psychotherapeutic strategies that might be useful in addressing risk behavior. Participants will be encouraged to share countertransferential feelings that inevitably arise in working with people who find it difficult to change their behavior.

This workshop is intended for people who are working with people infected or at risk for HIV infection.

## REFERENCES:

1. Dodds JP, Mercey DE, Parry JV, Johnson AM: Increasing risk behaviour and high levels of undiagnosed HIV infection in a community sample of homosexual men. Sex Transm Infect 2004; 80(3):236–40.
2. Salazar LF, DiClemente RJ, Wingood GM, Crosby RA, Harrington K, Davies S, Hook EW 3rd, Oh MK: Self-concept and adolescents' refusal of unprotected sex: a test of mediating mechanisms among African American girls. Prev Sci 2004; 5(3):137–49.

**Workshop 19** **Friday, October 7**
**8:00 a.m.-9:30 a.m.**

# DEVELOPING INNOVATIVE NEW PROGRAMS IN COMMUNITY MENTAL HEALTH SETTINGS

*2004–2006 APA/Bristol-Myers Squibb Fellows*

Mark E. Hubner, M.D., *Psychiatry Resident, Wright State University School of Medicine, and 2004–2006 APA/Bristol Myers Squibb Fellow, 75 Hawthorne Glen Trail, Beavercreek, OH 45440*; Naveen C. Thomas, M.D., M.P.H.; Annette M. Matthews, M.D.; Judy A. Greene, M.D.; Anita S. Everett, M.D.

## EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should have an idea of some common obstacles found in developing innovative programs for the community mental health setting and resources available to help overcome these obstacles.

## SUMMARY:

Historically community mental health has been active in developing new ways to meet the needs of underserved populations. Following a brief introduction to the literature on developing new community mental health programs, this presentation describes three innovative programs from various parts of the country. One program addresses the unmet needs of Latinos in North Carolina, the second program describes efforts to prevent morbidity from methamphetamines in Oregon, and the last program found a way to couple services for the mentally retarded and developmentally delayed with mental health services in Ohio. Each profile details the recognized unmet need and how each community worked in creative ways to meet that need. The presentation concludes by summarizing common lessons learned from these three examples and expands them into a working outline of how a community might approach new program development.

## TARGET AUDIENCE(S):

Psychiatrists, psychologists, social workers, other mental health professionals involved in or interested in starting new community mental health programs.

## REFERENCES:

1. Corrigan PW, McCracken SG: An interactive approach to training teams and developing programs. New Directions for Mental Health Services 1998; (79):3–12.
2. 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.

**Workshop 20** **Friday, October 7**
**8:00 a.m.-9:30 a.m.**

# OVERCOMING THE OBSTACLES OF IMPLEMENTING EVIDENCE-BASED PRACTICES: THE CALMAP EXPERIENCE

*American Association of Community Psychiatrists*

Neal H. Adams, M.D., M.P.H., *Director of Special Projects, California State Department of Mental Health, 4129 Cherryvale Avenue, Soquel, CA 95073*; Karen Kalk, M.H.A.; Gina Cordato

## EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to (1) develop a project structure for the implementation of EBPs; (2) facilitate the development of a multi-stakeholder organizational structure to effect the relevant change; (3) understand the tasks involved in creating a high-level project plan; and (4) facilitate development of an appropriately detailed implementation plan.

## SUMMARY:

The effective implementation of mental health evidence-based practices (EBPs) presents numerous challenges to behavioral health providers. This often includes the need for organizational re-engineering a shift in attitudes as well as skills training. CalMAP, the California adaptation of TMAP, uses an implementation model and approach that effectively overcomes many obstacles

associated with implementing EBPs. CalMAP offers a systematic means to increase the actual use of medication EBPs, to improve and standardize documentation and outcome measures to increase care coordination, and to shift the clinician-client relationship away from ''compliance'' toward ''alliance.''

The CalMAP implementation model includes project management, learning collaboratives, development teams, change management, and provider training. CalMAP has used these methods to successfully achieve individual change in attitudes and behaviors, facilitate creation of strategies for local adaptation, and develop the provider and staff skills needed to successfully apply the EBP. Workshop presenters will discuss the use of project management and operational modeling, strategies to achieve fidelity, and steps to develop a peer facilitated educational program. Tactics addressed will include client and family stakeholder involvement, balancing local innovation with broad standardization, and the organizational structure to sustain implementation in resource competitive/constrained environments.

## TARGET AUDIENCE(S):

Directors, medical directors, and managers of mental health provider organizations.

## REFERENCES:

1. Drake RE, Goldman HH, Leff S, et al: Implementing evidence-based practices in routine mental health service settings. Psychiatric Services 2001; 52:179–182.
2. Newstead Jim: A perspective on change, in the toolbook CalMAP Change Management Workshop. Alliance Healthcare Associates 2004.

**Workshop 21** **Friday, October 7**
**1:30 p.m.-3:00 p.m.**

# THE DO'S AND DON'TS OF COLLABORATING WITH THE PHARMACEUTICAL INDUSTRY

Carolyn B. Robinowitz, M.D., *Secretary-Treasurer, APA Board of Trustees, and Clinical Professor, Department of Psychiatry, George Washington University School of Medicine, 5225 Connecticut Avenue, N.W., #514, Washington, DC 20015*; Donald M. Hilty, M.D., *Associate Professor, Department of Psychiatry, University of California at Davis, 2230 Stockton Boulevard, Sacramento, CA 95817*; Michael D. Jibson, M.D., Ph.D.

## EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, participants will become aware of the positive and negative aspects of work with the pharmaceutical industry, and develop a series of guidelines to assist them in this work.

## SUMMARY:

Departments of psychiatry, psychiatric organizations, residents, students, and practicing psychiatrists are all affected by their interaction with the pharmaceutical industry. Clinical services, research, and education all depend in no small part on grants and gifts from Pharma. Several studies have documented the impact of pharmaceutical marketing on physician practice an impact that most physicians deny. Many ethicists voice concerns about relationships with industry, noting the high cost of marketing, which raises the price of drugs, making them less accessible for patients; the potential for skewing data or omitting studies with negative outcomes; the potential for masking marketing as education; as well as the impact on the physician patient relationship. At the same time, funding (often unrestricted) by industry has been vital for many departments of psychiatry; psychiatric organizations; and research, educational, and clinical endeavors.

This workshop will address the positive and negative aspects of working with industry, describing the impact of marketing on physician behavior, and developing a series of ''do's and don'ts'' for work with pharmaceutical companies and their representatives to ensure appropriate ethical and clinical behaviors, to strengthen education and research, and to promote a ''win-win'' collaboration. Following brief presentations, there will be opportunity for active audience participation and discussion.

## TARGET AUDIENCE(S):

This session is aimed particularly at residents, but is appropriate for all clinicians and educators.

## REFERENCES:

1. Sigworth et al: Pharmaceutical branding of resident physicians. JAMA 2001; 286:1024–1025. Influence of Funding Source on Outcome, Validity, and Reliability of Pharmaceutical Research. Council on Scientific Affairs, American Medical Association, 2004.
2. Dana J, Loewenstein G: A social science perspective on gifts to physicians from industry. JAMA 2003; 290:252–255.

**Workshop 22** **Friday, October 7**
**1:30 p.m.-3:00 p.m.**

# INTERNATIONAL PERSPECTIVES ON THE RECOVERY COMMUNITY AND PSYCHIATRY

Kenneth S. Thompson, M.D., *Director, Institute for Public Health and Psychiatry, Western Psychiatric Institute and Clinic; Associate Professor of Psychiatry and Public Health, University of Pittsburgh Medical Center, and*

*Former APA/Bristol-Myers Squibb Fellow, 3811 O'Hara Street, Pittsburgh, PA 15213*; Alan Rosen, M.D.; C.J. Witte, M.D.; David L. Cutler, M.D.

## EDUCATIONAL OBJECTIVES:

At the end of this workshop, participants will appreciate the different trajectories of the recovery movement and its links with community psychiatry in the U.S., Europe, and Australia.

## SUMMARY:

The emergence of the concept of recovery in the United States has turned some elements of psychiatric practice on their head. In particular, it challenges any suggestion of paternalism and shifts notions of hierarchy in the provision of care. While psychiatrists have long sought to engage patients in their care, the recovery approach reverses the field and has consumers seeking to direct psychiatrists in the care they wish to receive. This dynamic is playing out around the globe with variations dependent on culture, history, and culture. In this workshop, participants from Europe, Australia, and the U.S. will discuss the ways recovery is informing public policy in their respective countries and its impact on psychiatric practice and the role of psychiatrists.

## TARGET AUDIENCE(S):

Administrators and practicing clinicians.

## REFERENCES:

1. Anthony WA: Recovery from mental illness: the guiding vision of the mental health service system in the 1990s. Psychosocial Rehabilitation Journal 1993; 16(4):11–23.
2. Jacobson N, Greenley D: What is recovery? a conceptual model and explication. Psychiatric Services 2001; 52(4):482–485.

**Workshop 23** **Friday, October 7**
**3:30 p.m.-5:00 p.m.**

# GRADUATION FROM ASSERTIVE COMMUNITY TREATMENT TO LESS INTENSIVE SERVICES

*American Association of Community Psychiatrists*

Ana L. Hackman, M.D., *Assistant Professor, Department of Psychiatry, University of Maryland Medical School, 630 West Fayette Street, Baltimore, MD 21201*; Curtis N. Adams, Jr., M.D., *Assistant Professor, Department of Psychiatry, University of Maryland Medical School, 630 West Fayette Street, Baltimore, MD 21201*; Keith R. Stowell, M.D.

## EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, participants will recognize opportunities to facilitate reintegration of patients from ACT into traditional community mental health care programs.

## SUMMARY:

Assertive Community Treatment (ACT) provides the most intensive outpatient services available in the community and is indicated for some patients with severe mental illness (SMI). The original model does not include discharging patients to less intensive services. However, reimbursement issues and other practical considerations may make such transitions necessary and some patients may do well in less intensive treatment.

This workshop describes our experience at the University of Maryland's ACT team in transitioning 67 patients to less intensive community mental health center (CMHC) services within our own system. These patients had met treatment goals and were no longer requiring intensive services. A retrospective chart review was completed for individuals transitioned between 10/95 and 2/03. At the end of the review period, 48 individuals (72%) continued to do well with less intensive services. Nineteen (28%) had returned to ACT services or were lost to follow up. Factors that may facilitate successful transition include continuity of provider.

The panel will consider the literature, describe chart review results, discuss the team's approach to transitioning patients, and share patients' reported experiences with ACT treatment and transition to CMHC. Then with the audience we will consider the ACT model and explore clinical issues around transition, particularly as it relates to patient experiences of recovery.

## TARGET AUDIENCE(S):

Psychiatrists, social workers, nurses, consumers, family members interested in provision of services to people with SMI.

## REFERENCES:

1. Mueser KT, Bond G, Drake R, Resnick SG: Models of community care for severe mental illness: a review of research on case management. Schizophrenia Bulletin 1998; 24:35–74.
2. Salyers MP, Masterson TW, Fehete DM, Picone JJ, Bond GR: Transferring clients from intensive case management. American Journal of Orthopsychiatry 1998; 68:233–245.

**Workshop 24** **Friday, October 7**
**3:30 p.m.-5:00 p.m.**

## DISPARITIES IN LEADERSHIP AND COMPETENCIES: INTERNATIONAL MEDICAL GRADUATES AND MINORITY PSYCHIATRISTS

Rodrigo A. Muñoz, M.D., *Past President, American Psychiatric Association, and Consultant, APA/IPS Scientific Program Committee, 3130 5th Avenue, San Diego, CA 92103-5839*; Annelle B. Primm, M.D., M.P.H., *Director, Division of Minority and National Affairs, American Psychiatric Association, 1000 Wilson Boulevard, Suite 1825, Arlington, VA 22209*; David L. Cutler, M.D.; Sanjay Dube, M.D.; Jeremy A. Lazarus, M.D.

### EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, participants should be able to identify problems in the professional path of IMGs and other minority psychiatrists, evaluate the strategies needed to help them, and help them implement necessary changes in education and career planning.

### SUMMARY:

IMGs and other minority psychiatrists are underrepresented among psychiatrists in positions of leadership, board certified psychiatrists, and psychiatrists at the highest positions in academia. This workshop evaluates the opportunities, obstacles, and initiatives that may determine whether every APA member may advance toward the same success achieved by other psychiatrists.

### REFERENCES:

1. McMahon GT: Becoming a physician: coming to America—international medical graduates in the United States. N Engl J Med 2004; 350:2435–2437, Jun 10, 2004. Perspective.
2. Iglehart JK: The quandary over graduates of foreign medical schools in the United States. N Engl J Med 1996; 334:1879–1884, Jun 20, 1996. Health Policy Reports.

**Workshop 25** **Friday, October 7**
**3:30 p.m.-5:00 p.m.**

## PREVENTING SUICIDE IN CORRECTIONAL FACILITIES

*APA Caucus of Correctional Psychiatrists*

Henry C. Weinstein, M.D., *Clinical Professor of Psychiatry, New York University School of Medicine, 1111 Park Avenue, New York, NY 10128*; Kathryn A. Burns, M.D., M.P.H.; Annette L. Hanson, M.D.; Cassandra F. Newkirk, M.D.; Kenneth G. Gilbert, M.D.

### EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to describe in depth the components necessary to develop an adequate correctional suicide prevention program.

### SUMMARY:

It has long been recognized that the risk of suicide is substantially higher among incarcerated jail and prison inmates than that of the general non-incarcerated population. For this reason, jails and prisons must have suicide prevention programs for identifying and responding to suicidal inmates. This interactive workshop will critically review and explore in depth the components deemed necessary for an adequate correctional suicide prevention program: staff training, screening, monitoring, crisis care and follow-up, housing, communication and coordination with security staff, sentinel event review, and critical incident debriefing. Presenters will also review critical litigation/legal decisions in this area; discuss relevant professional and accrediting body standards; and information about model programs. Participants will actively review sample policies and procedures to identify policy strengths and/or deficiencies. While the role of the psychiatrist in correctional suicide prevention programs will be highlighted, this workshop is targeted toward all mental health professionals working in jails and/or prisons, full or part-time who either provide care directly to inmates or have an administrative role in the provision of care to inmates.

### TARGET AUDIENCE(S):

Psychiatrists, psychologists, social workers, nurses, psychiatric aides, administrators, security administration.

### REFERENCES:

1. American Psychiatric Association: Psychiatric Services in Jails and Prisons, Second Edition, Washington DC, American Psychiatric Press, 2000.
2. Hayes LM: Prison Suicide, An Overview and Guide to Prevention, Washington, DC, National Institute of Correction, 1995.

**Workshop 26** **Saturday, October 8**
**8:00 a.m.-9:30 a.m.**

## PERSON-CENTERED TREATMENT PLANNING: A TOOL FOR SYSTEM TRANSFORMATION AND RECOVERY

*American Association of Community Psychiatrists*

Neal H. Adams, M.D., M.P.H., *Director of Special Projects, California State Department of Mental Health,*

*4129 Cherryvale Avenue, Soquel, CA 95073*; Diane Greider, M.S.; Edward Diksa, Ph.D., Sc.D.

## EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to identify the key elements and process for creating a person-centered, recovery-oriented individual service plan, describe how current practice differs from a person-centered approach, propose strategies for effecting systems change using the individual planning process, and better understand consumer and family concerns/perspectives in person-centered planning.

## SUMMARY:

This workshop is designed to help administrative and clinical leaders in mental health and substance abuse delivery systems transform their organizations in order to provide a truly effective, outcome-driven, and recovery-oriented approach. The need for systems/practice change and new strategies has been made abundantly clear in the President's Mental Health Commission and IOM Quality Chasm reports. Experience has demonstrated that changes in attitude and practice regarding individualized service plans can provide an unparalleled opportunity to make recovery a reality for both clients and providers—and at the same time satisfy critical requirements for the documentation of medical necessity that supports payment for services, state regulations, etc., as well as quality care. This presentation will address the administrative, clinical, and consumer-related issues that need to be considered in effecting practice change—moving current practice to a consumer and family driven approach requires both an understanding of the process as well as a plan for training and implementation. This workshop will provide administrators/managers and providers with practical information about the principles of person-centered planning in comparison to current practice, along with solutions for changing a system's performance. These are essential strategies for service organizations to use in assuring recovery-oriented person-centered services and outcomes.

## TARGET AUDIENCE(S):

Psychiatrists and other mental health practitioners, medical directors, administrators, payers.

## REFERENCES:

1. Adams N, Greider D: Treatment Planning for Person-centered care. Elsevier, 2004.
2. White W, et al: in Recovery in Mental Illness, Ralph R, Corrigon P (editors). American Psychological Assoc Press 2004.

**Workshop 27** **Saturday, October 8**
**8:00 a.m.-9:30 a.m.**

# CHALLENGES IN TREATMENT OF PATIENTS OF SOUTH ASIAN ORIGIN ACROSS THE LIFESPAN

*Indo-American Psychiatric Association*

Asha S. Mishra, M.D., *Professor of Psychiatry, Virginia Commonwealth University Medical College, 6801 Lucy Corr Boulevard, Chesterfield, VA 23832*; Nalini V. Juthani, M.D., *Training Director, Department of Psychiatry, Bronx Lebanon Health Center, Albert Einstein College of Medicine, 17 Pheasant Run, Scarsdale, NY 10583*; Vedavyasa B. Biliyar, M.D.; Rudra Prakash, M.D.

## EDUCATIONAL OBJECTIVES:

At the conclusion of the session, the participant should understand the unique challenges in treatment of patients of South-Asian origins across the lifespan and recognize culturally acceptable interventions and effective strategies.

## SUMMARY:

South Asians are a growing minority (2 million, 2000 U.S. census) that encompasses people who are immigrants, naturalized citizens, born in the U.S., or descendents of South Asians. The myth of the model minority secondary to their higher levels of education and/or per capita income stereotypes this group, while individuals quietly suffer from mental illnesses, limited resources, and poor access to care. This workshop will highlight culturally based life span, gender issues that challenge the evaluation and management of South Asians. The burden of depression, psychosis, suicide, substance abuse, gambling, domestic violence, marital and intergenerational conflict, and isolation in men, women, elderly, and adolescents will be discussed by the presenters. Cultural identity, degree of acculturation, burden of immigration, intercultural conflicts, isolation in the elderly, lack of support from the extended family, etc., will serve as the cultural umbrella under which the clinical conditions and their manifestations will be examined.

Interactive participation from the audience will enhance the understanding and management of these clinical conditions. Culturally acceptable interventions will be discussed.

## TARGET AUDIENCE(S):

Mental professionals who serve South Asian patients.

## REFERENCES:

1. Doorway Thoughts, Cross-Cultural Health Care for Older Adults, Chap 6, p 68–80.

2. Working with East Indian American Families, in Working with Asian-Americans, edited by Lee E.

**Workshop 28** **Saturday, October 8**
**8:00 a.m.-9:30 a.m.**

## REAL WORLD APPLICATIONS OF EVIDENCE-BASED PROGRAMS FOR PERSONS IN THE JUSTICE SYSTEM

*Substance Abuse and Mental Health Services Administration*

Henry J. Steadman, Ph.D., *President, Policy Research Associates, Inc., 345 Delaware Avenue, Delmar, NY 12054*; Fred C. Osher, M.D.; Andrea White, M.S.W.; Roger Fallot, Ph.D.

### EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to identify the importance of access to evidence-based and promising practices in community-based programs for people with co-occurring disorders in contact with the justice system and identify the implications for research, policy, and practice in the treatment of people with co-occurring disorders involved with the criminal justice system as related to evidence-based and promising practices.

### SUMMARY:

The purpose of this interactive workshop is to advance the understanding of the state of the field for evidence-based and promising practices as related to persons with co-occurring mental and substance use disorders in contact with the criminal justice system. The National GAINS Center for Evidence-Based Programs in the Criminal Justice System coordinated four expert panel meetings in 2005 on issues related to housing, trauma, supported employment, and ACT (Assertive Community Treatment). Each expert panel meeting began with an integrated research summary followed by interactive discussion facilitated by Henry J. Steadman, Ph.D. Results of these meetings were published in a series of issue briefs outlining the discussion and outcomes of the expert panel meetings on how evidence-based practices relate to the criminal justice system. In this workshop, Henry J. Steadman, Ph.D., will provide an overview of the expert panel meetings and facilitate an interactive discussion with Fred Osher, M.D., Roger Fallot, Ph.D., and Andrea White, MSSW to describe the process and outcomes of the ACT, trauma, and housing meetings. Henry J. Steadman will conclude with thoughts on future directions for research, policy, and practice to provide effective services for people with co-occurring disorders in contact with the justice system.

### TARGET AUDIENCE(S):

1. Attendees interested in the implementation of evidence-based and promising practices for persons with co-occurring disorders in contact with the criminal justice system; 2. Attendees involved in program development, management, and research for people with mental and substance use disorders.

### REFERENCES:

1. Lamberti JS, Weisman R, Faden DI: Forensic Assertive Community Treatment: preventing incarceration of adults with severe mental illness. Psychiatric Services 2004; 55:1285–1293.
2. Torrey WC, Drake RE, Dixon L, Burns BJ, Flyma L, Rush AJ, Clark RE, Klatzker D: Implementing evidence-based practices for persons with severe mental illnesses. Psychiatric Services 2001; 52:45–50.

**Workshop 29** **Saturday, October 8**
**10:00 a.m.-11:30 a.m.**

## ADVANCES IN GAY AND LESBIAN MARRIAGES: PSYCHIATRIC AND PERSONAL PERSPECTIVES

*Association of Gay and Lesbian Psychiatrists*

Gene A. Nakajima, M.D., *Director, Center for Special Problems, City and County of San Francisco Department of Public Health, Community Behavioral Health Services, and Former APA/Bristol-Myers Squibb Fellow, 1700 Jackson Street, San Francisco, CA 94109*; Ellen Haller, M.D., *Adjunct Professor, University of California at San Francisco, 401 Parnassus Ave, San Francisco, CA 94122-2720*; Marshall Forstein, M.D.; Mary E. Read, M.D.

### EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, participants will: (1) have explored the legal, social, and psychological issues involved in the evolution of same sex marriage; (2) understand the impact of the same-sex marriage debate on the social and internal experience of lesbian, gay, bisexual, and transexual people and their supporters.

### SUMMARY:

Married (or nearly married) gay and lesbian psychiatrists will discuss the psychodynamic and social meaning of resistance to same-sex marriage (SSM), and the importance of acceptance of same-sex relationships to mental health. Mary Read, M.D., will describe her decision to drive up to San Francisco from Los Angeles in February 2004 to be married in San Francisco's City Hall. She will describe the reaction from her family and friends. Ellen Haller, M.D., had an appointment to be

married; however, just four days before her wedding in SF, the California Supreme Court ruled that SF had to immediately cease and desist the granting of SSM licenses, thus canceling the appointment. She will describe the difficulty explaining these legalities to her seven-year-old son. Gene Nakajima, M.D., was married in Vancouver several months before marriages were allowed in the U.S., and he will discuss the emotional journey traveling to another country for marriage. Marshall Forstein, M.D., will explore the history of obtaining the legal right for same-sex marriage in Massachusetts and some of the emotional experiences that he and his family and other same-sex couples with children report. This workshop is for general psychiatrists who will be encouraged to describe their own and their patient's reactions and experiences to SSM.

## TARGET AUDIENCE(S):

Mental health professionals who see gay and lesbian patients.

## REFERENCES:

1. Cabaj RP: History of gay acceptance and relationships, in On the Road to Same-Sex Marriage: A Supportive Guide to Psychological, Political, and Legal Issues, Edited by Cabaj RP, Purcell DP. San Francisco, Josey Bass, 1998.
2. Townsand M: Mental health issues and same-sex marriage, in On the Road to Same-Sex Marriage: A Supportive Guide to Psychological, Political, and Legal Issues. Edited by Cabaj RP, Purcell DP. San Francisco, Josey Bass, 1998.

**Workshop 30** **Saturday, October 8**
**10:00 a.m.-11:30 a.m.**

# SOCIO-CULTURAL ISSUES IN MEDICAL DECISIONAL CAPACITY ASSESSMENTS

Ramaswamy Viswanathan, M.D., D.Sc., *Director, Consultation Psychiatry, State University of New York, Downstate Medical Center, 450 Clarkson Avenue #127, Brooklyn, NY 11203-2098*; Stephen M. Goldfinger, M.D.; Ramotse Saunders, M.D.; Vasudha Ahuja, M.D.; Amjad Hindi, M.D.

## EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to appreciate the impact of socio-economic and cultural factors in decisional capacity assessments in complex medical situations, and learn how an approach with socio-cultural sensitivity will help the patients and optimize the doctor-patient relationship.

## SUMMARY:

Even though some may view psychiatrists' assessment of patients' decisional capacity in medical settings solely in terms of legal principles and psychopathology, in this workshop we will show how incorporating socio-economic and cultural sensitivity will enhance the clinician's work, and the outcome for our patients. Many patients who refuse life-saving or other important procedures are found to have intact decisional capacity. Yet many of these patients change their mind after a psychiatric consultation. One has to appreciate the influence of a number of socio-cultural variables in this setting, some pertaining to the patients, and some pertaining to the physicians and the health care system. Sometimes treatment refusal may be nothing more than a manifestation of cultural divide, and a doctor's closing this gap by understanding and empathy may help the patient overcome unwarranted anxiety at the root of his/her refusal. Our panelists will discuss some case examples where consideration of cultural and socio-economic factors led to a better doctor-patient relationship and a better outcome for the patient, discuss how they overcame some cultural barriers, their own and those of their patients, and explore with the audience how to incorporate socio-cultural sensitivity in approaching consent to and compliance with medical treatment.

## TARGET AUDIENCE(S):

Physicians and trainees, other health care professionals.

## REFERENCES:

1. Boran M, Viswanathan R: Separating subculture from psychopathology. Psychiatric Services 2000; 51:678.
2. Ganzini L, Volicer L, Nelson W, Derse A: Pitfalls in assessment of decision-making capacity. Psychosomatics 2003; 44:237–243.

**Workshop 31** **Saturday, October 8**
**10:00 a.m.-11:30 a.m.**

# A RESIDENT'S GUIDE TO TREATING TRAUMA PATIENTS

*APA Committee of Residents and Fellows*

Lea E. DeFrancisci, M.D., *Psychiatry Resident, Saint Vincents Hospital, 144 West 12th Street, Room 175, New York, NY 10011*; Amir Garakani, M.D.; Murray B. Stein, M.D.

## EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the resident should be able to better treat patients who have been traumatized. Furthermore, the resident will be able to

identify the personal effects of caring for trauma victims and learn to mitigate these effects.

## SUMMARY:

After September 11, many psychiatric residents in New York hospitals had to deal with an influx of victims and families who were traumatized by the events. Psychiatric residents at all New York hospitals were the first responders to this incident, either seeing the patients in our ER or later in our offices. This workshop seeks to educate residents on how to help patients in crisis, and to minimize the acute consequences of trauma as well as PTSD once it has developed. Residents will be presented with anonymous case studies to discuss in an interactive manner. Furthermore, there will be resident education on new research, which shows how clinicians who work with many symptomatic patients may become traumatized themselves and how to mitigate this risk.

## TARGET AUDIENCE(S):

Psychiatric residents.

## REFERENCES:

1. Fullerton CS, Ursano RJ, Wang L: Acute stress disorder, post-traumatic stress disorder, and depression in disaster workers. AJP 2004; 161:1370–76.
2. American Psychiatric Association: Practice Guidelines for the Treatment of Patients with Acute Stress Disorder and Posttraumatic Stress Disorder. American Journal of Psychiatry 2004; supp vol 161:11.

**Workshop 32** **Saturday, October 8**
**10:00 a.m.-11:30 a.m.**

# SUBSTANCE ABUSE IN THE PRISON SETTING

Leo L. Gallofin, M.D., *Department of Psychiatry, Cedars Sinai Medical Center, 8730 Alden Drive, Room W101, Los Angeles, CA 90048*; Jeffrey N. Wilkins, M.D., *Director of Addiction Medicine, Department of Psychiatry, Cedars Sinai Medical Center, 8730 Alden Drive, Room E130, Los Angeles, CA 90048*; Thomas J. Rosko, M.D.; Janet A. Martin, M.D.; Katherine G. Ruiz-Mellott, M.D.

## EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize how prison inmates are able to acquire substances of abuse and identify preventative measures to curtail this emergent issue.

## SUMMARY:

More than 2 million individuals, or 0.7% of the U.S. population, are incarcerated in county, state, and federal prisons. Within this population, approximately 10% to 15% of these individuals suffer from mental illnesses, and an estimated 3% to 11% of this mentally ill prison population has comorbid substance abuse issues. Despite their imprisonment, inmates are still able to acquire and use substances of abuse, or use legitimate pharmaceuticals in abusive ways. The latter is especially troublesome, as is it involves a physician prescribing and dispensing medications to the individual. This workshop will educate participants in the means by which prisoners can obtain both legal and illegal substances of abuse. It will also highlight the health-related risks of drug abuse in correctional facilities, particularly intravenous and blood-borne diseases. Finally, we will offer recommendations to help stem the epidemic of substance abuse in prison settings, including the identification of secondary gain issues for particular medications and better secondary/tertiary programs for rehabilitation and relapse prevention.

## REFERENCES:

1. Conklin TJ: Self-reported health and prior health behaviors of newly admitted correctional inmates. American Journal of Public Health 2000; 1939–1941.
2. Karch SB, Stephens BG: Drug abusers who die during arrest or in custody [issue of the day]. Journal of the Royal Society of Medicine 1999; 110–113.

**Workshop 33** **Saturday, October 8**
**10:00 a.m.-11:30 a.m.**

# THE ROLE OF PSYCHIATRISTS IN MOVING TO SELF-DIRECTED CARE

*Substance Abuse and Mental Health Services Administration and the American Association of Community Psychiatrists*

Carole Schauer, M.S.N., *Consumer Affairs Specialist, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services, 1 Choke Cherry Road, Rockville, MD 20857*; J. Rock Johnson, J.D.; Nancy Fudge

## EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to the articulate the principles, values, models, and benefits of self-directed care used in service provision for people with disabilities including those with mental illnesses, and identify approaches they can use to promote self-directed care with clinicians and patients through policy and program development and education.

## SUMMARY:

Self-directed care provides a new model for mental health care that promotes self-determination and per-

sonal responsibility. Used for more than a decade in other disability fields, persons with disabilities received support services for community living at a cost no greater than that of agency-based models of care and with generally higher levels of satisfaction. Funds, often through a variety of means, are transferred to informed persons with disabilities, who become the payor, determine how and by whom their needs are met, and monitor the quality of services they receive. This interactive workshop will describe the self-directed care model and its principles, values, and benefits. Operational elements of person-centered planning, individual budgeting, financial management, expanded provider network, and coaching will be highlighted. A participant will describe her experience in such a program. Interactive discussion will focus on identifying the roles of the psychiatrist in promoting adoption of this approach through policy and program development and consumer and provider education. Self-directed care has the potential to assist persons with mental illnesses achieve recovery, because, in part, it empowers these individuals and makes the service delivery system more consumer oriented, as called for in the report from the President's New Freedom Commission on Mental Health.

## TARGET AUDIENCE(S):

Clinicians program/service directors, state mental health officials, consumers and families.

## REFERENCES:

1. Phillips B, Mahoney K, Simon-Rusinowitz L, Schore J, et al: Lessons from the Implementation of Cash and Counseling in Arkansas, Florida, and New Jersey, 2003.
2. Cook JA, Terrell S, Jonikas JA: Promoting Self-Determination for Individuals With Psychiatric Disabilities Through Self-Directed Services: A Look at Federal, State and Public Systems as Sources of Cash-Outs and Other Fiscal Expansion Opportunities, 2004.

**Workshop 34** **Sunday, October 9**
**8:00 a.m.-9:30 a.m.**

# TELEPSYCHIATRY: A RESOURCE FOR CULTURALLY COMPETENT RURAL PSYCHIATRIC CARE

Russell F. Lim, M.D., *Assistant Clinical Professor, Behavioral Health Clinic, Department of Psychiatry and Behavioral Sciences, University of California School of Medicine at Davis; and Medical Director, Northgate Point, Regional Support Team, 2230 Stockton Boulevard, Sacramento, CA 95817*; Donald M. Hilty, M.D.; Satyanarayana Chandragiri, M.D.

## EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant will be able to (1) describe how the Surgeon General's Supplement to the Report on Mental Health, the Institute of Medicine's Unequal Treatment, and the New Freedom Commission's Report on Mental Health all state that ethnic minorities receive less care, and lower quality mental health care than the Caucasian majority, and (2) describe how telemedicine can provide culturally competent care to rural areas.

## SUMMARY:

In 2001, the Surgeon General of the United States released a supplement to the report on mental health entitled ''Culture, Race, and Ethnicity,'' which stated that ''culture counts'' in the diagnosis and treatment of the four major ethnic groups, that ethnic minorities bear a higher burden from unmet mental health needs than the general population, and that access to mental health services to ethnic minorities should be increased by providing cultural and linguistically appropriate services. Given the recent report from the Institute of Medicine, entitled ''Unequal Treatment,'' as well as the New Freedom Commission report, it is clear that many ethnic minorities are not able to access mental health care, and those that have access have received sub-standard care. This workshop will present summaries from the above reports and will present two examples of agencies that are providing services to ethnic minority patients in rural communities and their contrasting approaches, one example from Oregon, and one example from California, which will present data from a clinician survey of their awareness of patients' need for culturally competent psychiatric care.

## TARGET AUDIENCE(S):

The intended audience is consumers, community psychiatrists, and administrators.

## REFERENCES:

1. Cerda GM, Hilty DM, Hales RE, Nesbitt TS: Use of telemedicine with ethnic groups. Psychiatr Serv 1999; 50(10):1364.
2. Cox J: Rural general practice: a personal view of current key issues. Health Bull (Edinb) 1997; 55(5):309–15.

**Workshop 35** **Sunday, October 9**
**8:00 a.m.-9:30 a.m.**

# PSYCHIATRY AND THE GLOBAL WAR ON TERRORISM: A DUAL LOYALTY CONFLICT

Julianne Flynn, M.D., *Associate Residency Training Director, Department of Psychiatry, Wilford Hall Medical*

*Center, 2200 Bergquist Drive, Suite 1, Lackland AFB, TX 78236*; Jeffrey F. Johns, M.D., *Psychiatry Resident, Wilford Hall Medical Center, 2200 Bergquist Drive, Suite 1, Lackland AFB, TX 78236*; David J. Walick, M.D.

## EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to (1) demonstrate knowledge of the role of psychiatry in the global war on terrorism, (2) demonstrate knowledge of medical and psychiatric ethical codes relevant to detainees, and (3) discuss the ethical dilemmas military psychiatrists face in this war.

## SUMMARY:

Recent events in the global war on terrorism in Iraq and Guantanamo Bay have brought attention to the dual loyalty military physicians face when caring for enemy detainees. Psychiatric training gives certain physicians specific skills that might be useful to military commanders in interrogating detainees. This dual loyalty conflict creates several unique ethical challenges for uniformed psychiatrists. How we observe our professional ethics, both medical and military, will determine how we are viewed by our civilian counterparts, by our patients, and by society at large. We will start with a summary of recent events involving psychiatry and this war. We will follow that with a brief review of medical and psychiatric ethical codes relevant to the care of detainees. We will then proceed with a discussion of the inherent dual loyalty conflict of military psychiatrists and propose two possible approaches to this conflict. The presenters will engage in a panel discussion followed by a question and answer period with the goal of furthering consensus of the role of military psychiatrists in this war. We hope to use this workshop as an opportunity to actively seek input from all participants, civilian and military, who are concerned about this subject.

## TARGET AUDIENCE(S):

Concerned psychiatrists, military psychiatrists.

## REFERENCES:

1. Howe EG: Dilemmas in military medical ethics since 9/11. Kennedy Inst Ethics J 2003; 13:2.
2. Singh JA: American physicians and the dual loyalty obligations in the ''war on terror.'' BMC Medical Ethics 2003; 4:4.

**Workshop 36** **Sunday, October 9**
**8:00 a.m.-9:30 a.m.**

# ESTABLISHING PROTOCOLS IN RELATION TO POTENTIAL SIDE EFFECTS AND THEIR IMPACT ON RECOVERY

Charles W. Collins, M.D., *Associate Dean and Medical Director, Department of Psychiatry, University of Cincinnati, 375 Compton Road, Cincinnati, OH 45215-4145*; Jacqueline Collins, M.D.; Diana McIntosh, Ph.D.

## EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to recognize collaboration between physicians and advanced practice nurses with prescriptive authority and discuss the establishment of protocols in community mental health agencies that monitor and address potential side effects of antipsychotic medications that affect recovery.

## SUMMARY:

The presenters of this workshop will discuss a model used in a community mental health agency, Central Clinic in Cincinnati, Ohio, to establish protocols in relation to potential medication side effects and their effect on a client's recovery. The presenters will briefly describe a division within Central Clinic, Mental Health Access Point (MHAP), and the elements of the collaborative relationship between the psychiatrist and advanced practice psychiatric nurses within MHAP. Next, the presenters will cite practice evidence, research, and standards related to potential side effects of antipsychotic medications. The presenters will then elicit audience participation to discuss the establishment of protocols in community mental health agencies that monitor and address potential side effects of antipsychotic medications that effect recovery. The successes and challenges of implementing the protocols will be discussed. Case vignettes will illustrate the use of such protocols and the impact of the recovery on the client. Lastly, the audience will be invited to discuss the strengths and limitations of models used around the country.

The target audience is psychiatric administrators, psychiatrists, advanced practice psychiatric nurses with prescriptive authority and other clinicians who work in public settings.

## TARGET AUDIENCE(S):

Administrators, psychiatrists, nurses, clinicians in community mental health.

## REFERENCES:

1. Hales A: Perspectives on prescribing-pioneers' narratives and advice. Perspectives in Psychiatric Care 2002; 38:79–88.
2. Clinical Guidelines on the Identification, Evaluation, and Treatment of Overweight and Obesity in Adults: The Evidence Report. NIH Publication 98-4083 Bethesda, MD National Institutes of Health, 1998.

**Workshop 37** **Sunday, October 9**
**10:00 a.m.-11:30 a.m.**

## PERSONAL PERSPECTIVES OF PSYCHIATRISTS WORKING IN RECOVERY

Mark Ragins, M.D., *Medical Director, Village Integrated Services, 456 Elm Avenue, Long Beach, CA 90802-2426*; Amy S. Hoffman, M.D.; Joel S. Feiner, M.D.; Anita S. Everett, M.D.; Suzanne E. Vogel-Scibilia, M.D.

### EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to have an understanding of the personal experiences of psychiatrists working in recovery settings to facilitate improved psychiatrist participation in recovery settings.

### SUMMARY:

As our system moves toward a recovery model, psychiatrists may be expected to be an obstacle. Contrary to this expectation, a number of psychiatrists are already actively working in and promoting recovery. This workshop brings together a group of these psychiatrists from a variety of backgrounds and settings to discuss our personal experiences and transformations as well as our impact on the programs and systems we work in. Our focus will be on the personal and practice changes (e.g. roles, boundaries, risk taking, working alongside consumer staff, self-disclosure, authority, control, and responsibility) rather than on system or funding issues. Our goal is to learn from each other's stories, as well as the audience's stories, and to help newcomers to recovery visualize the possibilities ahead of them.

### TARGET AUDIENCE(S):

Psychiatrists working in recovery or moving towards it, and program managers of recovery oriented programs.

### REFERENCES:

1. Ragins M: Building a Road to Recovery. Mental Health Association of LA 2002.
2. Noordsy DL, et al: Recovery oriented psychopharmacology: redefining the goals of antipsychotic treatment. J Clin Psych 2000; 61: suppl 3 22–29.

**Workshop 38** **Sunday, October 9**
**10:00 a.m.-11:30 a.m.**

## CULTURAL FACTORS AROUND ENGAGEMENT WITH ACT PATIENTS

Theodora G. Balis, M.D., *Assistant Professor, Department of Psychiatry, University of Maryland Medical School, 630 West Fayette Street, Baltimore, MD 21210*; Ann L. Hackman, M.D.; Curtis N. Adams, Jr., M.D.

### EDUCATIONAL OBJECTIVES:

At the conclusion of the workshop, the participant should be able to recognize the challenges that are faced in the engagement phase of treatment with culturally diverse patients with serious mental illness and learn ways to improve their ability to work with a diverse patient population.

### SUMMARY:

Cultural factors contribute to the health disparities in the U.S. including access to treatment, utilization of services, and health outcomes. A recent report by the Institute of Medicine describing racial gaps in the delivery of health care suggests that components of the physician-patient relationship might be contributing factors despite even the best of intents. Physician-patient relationship factors, such as interpersonal communication, trust, and mutual understanding of cultural differences in health needs and expectations might, in fact, be affected by the race and ethnicity of both patients and providers. More work is needed to examine how the therapeutic alliance may affect treatment and recovery in SMI patients specifically.

This workshop will describe our experiences with how racial, religious, and cultural differences in many of our patients in an urban ACT clinic affect engagement and the therapeutic alliance. Our patient population is diverse, including over 70% African American, several from various religious groups, and immigrants. The staff is also culturally diverse including African Americans immigrants from Nigeria, Ireland, and India.

This workshop will review the literature on the topic of engagement with SMI patients from different cultural groups and discuss our experience in working with them in an ACT team.

### TARGET AUDIENCE(S):

Psychiatrists, psychiatry residents, and mental health professionals working in community settings.

### REFERENCES:

1. Johnson R, Saha S, et al: Racial and ethnic differences in patient perceptions of bias and cultural competence in health care. Journal of General Internal Medicine 2004; 19 (2) 101–110.
2. Boehnlein J: Psychiatry and Religion, The Convergence of Mind and Spirit. American Psychiatric Press, 2000.

# SYLLABUS INDEX