
# 1997 Syllabus and Proceedings Summary

49th Institute on Psychiatric Services
October 24-28, 1997 ★ Washington, DC

American Psychiatric Association

# CERTIFICATE OF ATTENDANCE

*This certificate provides verification of your completion of educational activities at the 1997 Institute on Psychiatric Services.*

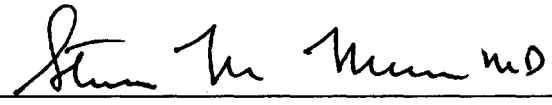
*This is to certify that*

_____

*Attended the 1997 Institute on Psychiatric Services of the American Psychiatric Association*
*October 24-28, 1997*
*Washington, DC*

*and participated in _____ hours of CME offerings that have met the criteria for ACCME Category 1 CME credit.*

*Herbert S. Sacks, M.D.*
*APA President*



*Steven M. Mirin, M.D.*
*Medical Director*

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

*The APA designates this educational activity for up to 42 hours in Category 1 credit towards the AMA Physician's Recognition Award and for the CME requirement of the APA. Each physician should claim only those hours of credit that he/she actually spent in the educational activity.*

# DAILY LOG FOR ATTENDANCE AT CME FUNCTIONS AT THE 1997 INSTITUTE ON PSYCHIATRIC SERVICES, OCTOBER 24-28, 1997, WASHINGTON, DC

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

| DAY | TITLE OF SESSION | NUMBER OF HOURS/ CME CATEGORY |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | TOTAL | |

# HOW TO OBTAIN CME CREDIT FOR THE 1997 INSTITUTE

The American Psychiatric Association is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to sponsor continuing medical education (CME) for physicians. The APA certifies that the continuing medical education activities designated as Category 1 for the 1997 Institute sessions meet the criteria for Category 1 of the Physician's Recognition Award of the American Medical Association and for the CME requirements of the APA.

The scientific sessions of the official Institute program, with some exceptions, meet the criteria for Category 1 CME credit, these sessions include: CME Courses; Full-Day Sessions; Industry-Supported Symposia; Innovative Programs; Lectures; Symposia; and Workshops. Other Sessions are designated for Category 2 CME credit. These sessions include: Clinical Consultations; Debates; Discussion Groups; Forums; Multimedia Sessions; and Posters.

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

* * * * * * * * *

## CME REQUIREMENTS FOR APA MEMBERS

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

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

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

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

## HOW TO FULFILL THE CME REQUIREMENTS OF APA

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

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

*(Continued)*

# HOW TO FULFILL THE CME REQUIREMENTS OF APA (Cont'd)

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

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

You may also *report your CME activities directly to the APA*, using the official APA report form. This form may be obtained from the APA Office of Education, 1400 K Street, NW, Washington, DC 20005 or call (202) 682-6111 or filed electronically via the APA Home Page.

# APA REPORT FORM

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

**CATEGORY 1:**

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

**CATEGORY 2:**

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

# EXEMPTIONS

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

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

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

NATIONAL ASSOCIATION OF SOCIAL WORKERS - METRO WASHINGTON CHAPTER

CONTINUING EDUCATION CREDIT FORM
APA Institute on Psychiatric Services
October 24-28, 1997
Washington, DC

In order to receive continuing education credits for this conference, you must complete, sign, and submit this form to the NASW office by November 29, 1997. A certificate will be mailed to you at the address listed on this form within 60 days of receipt of all requests. There is a $5.00 processing fee for the certificate.

Name _____ Daytime Phone # _____

Address _____ Social Security # _____

_____ DC License # _____
*(if applicable)*

## *RECORD OF SESSIONS ATTENDED*

| *DAY* | *TITLE OF SESSION* | *NUMBER OF HOURS* |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

*(continued)*

| *DAY* | *TITLE OF SESSION* | *NUMBER OF HOURS* |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

*TOTAL HOURS:* _____

Up to 42 hours of continuing education credit can be earned at this conference.

_____ _____

*Participant's Signature* *Date*

**Return completed form, by November 29, 1997, with check made payable to NASW-Metro:**

Continuing Education Coordinator
NASW-Metro Washington Chapter
2025 Eye Street, N.W., #106
Washington, DC 20006

# CONTINUING MEDICAL EDUCATION

# SYLLABUS

# AND

# PROCEEDINGS SUMMARY

# FOR

## THE FORTY-NINTH

# INSTITUTE ON PSYCHIATRIC SERVICES

## October 24-28, 1997

## Washington, DC

The American Psychiatric Association
Institute on Psychiatric Services
1400 K Street, N.W.
Washington, DC 20005
(202) 682-6396

# AMERICAN PSYCHIATRIC ASSOCIATION

## 1997 SCIENTIFIC PROGRAM COMMITTEE

Carol A. Bernstein, M.D.
*Chairperson, Scientific Program Committee,*
Director of Residency Training and
Associate Professor of Clinical Psychiatry
Department of Psychiatry
New York University Medical Center
New York, NY

Tana A. Grady, M.D.
*Vice-Chairperson, Scientific Program Committee*
Director of Residency Training,
Assistant Professor of Psychiatry
Department of Psychiatry, and
Associate Dean of Medical Education
Duke University Medical Center
Durham, NC

Troy L. Thompson II, M.D.
The Daniel Lieberman Professor
Department of Psychiatry and Human Behavior
Jefferson Medical College
Philadelphia, PA

Michelle Riba, M.D.
Associate Chair for Education and Academic Affairs
Department of Psychiatry
University of Michigan Medical Center
Ann Arbor, MI

Harvey Bluestone, M.D.
Department of Psychiatry
Bronx-Lebanon Hospital
Bronx, NY

## CONSULTANTS

Ian E. Alger, M.D.
*Multimedia*
Department of Psychiatry
New York Hospital-Cornell Medical College
Bronx, NY

Stephen M. Goldfinger, M.D.
Vice-Chairman
Department of Psychiatry
State University of New York,
Downstate Medical Center
Brooklyn, NY

Laurie M. Flynn, M.A.
Executive Director
National Alliance for the Mentally Ill
Arlington, VA

Brian Crowley, M.D.
*Local Arrangements*
Past President, Washington Psychiatric Society
Washington, DC

## LIAISONS

John J. Spollen III, M.D.
*1996-1998 APA/Mead Johnson Fellow*
Charleston, SC

John A. Talbott, M.D.
*Psychiatric Services*
Professor and Chairman, Department of Psychiatry
University of Maryland School of Medicine
Institute of Psychiatry and Behavioral Sciences
Baltimore, MD

## 1997-1998 APA BOARD OF TRUSTEES AND STAFF

### 1997-1998 APA OFFICERS
Herbert S. Sacks, M.D., *President*
Rodrigo A. Muñoz, M.D., *President-Elect*
Allan Tasman, M.D., *Vice-President*
Daniel B. Borenstein, M.D., *Vice-President*
Paul S. Appelbaum, M.D., *Secretary*
Fred Gottlieb, M.D., *Treasurer*

### TRUSTEES
Harold I. Eist, M.D.
Mary Jane England, M.D.
Jerry M. Wiener, M.D.
Kathleen M. Mogul, M.D.
Carol A. Bernstein, M.D.
Michelle Riba, M.D.
Herbert S. Peyser, M.D.
Edward C. Leonard, Jr., M.D.
Charles L. Bowden, M.D.
Richard A. Shadoan, M.D.
Norman A. Clemens, M.D.
Marcia Kraft Goin, M.D., Ph.D.
Diana L. Dell, M.D.
Alisa B. Busch, M.D.
Jeremy Lazarus, M.D. *(Speaker)*
Donna M. Norris, M.D. *(Speaker-Elect)*

### APA STAFF
Steven M. Mirin, M.D., *Medical Director*

### OFFICE TO COORDINATE ANNUAL MEETINGS
Cathy L. Nash, *Director*, (202) 682-6237
Jill L. Gruber, *Coordinator, Institute on Psychiatric Services*, (202) 682-6314
Gwynne S. Jackson, *Administrator, Industry-Supported Symposia*
(202) 682-6172
Vernetta V. Copeland, *CME Course Coordinator*, (202) 682-6836
Enid D. Morales, *Administrative Assistant*, (202) 682-6396

### MEETINGS AND EXHIBITS MANAGEMENT
Ken Robinson, *Director*,
(202) 682-6100
Kevin J. Klipsch, *Exhibits Manager*,
(202) 682-6196
Sara Daviage, *Senior Meetings Coordinator*,
(202) 682-6078

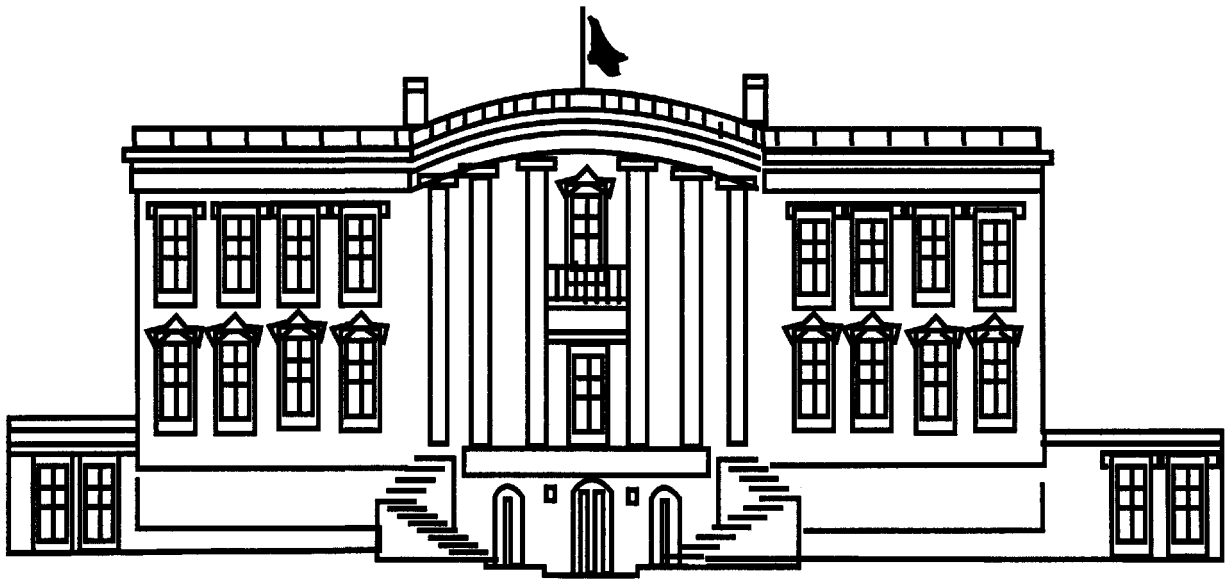
### OFFICE OF EDUCATION
Rosalind Keitt, M.A., *Acting Director*,
(202) 682-6130
Kathleen Debenham, M.A., *Administrator, Continuing Education & Evaluation*,
(202) 682-6111

### DIVISION OF PUBLIC AFFAIRS
John Blamphin, *Director*, (202) 682-6138
Lynn Schultz-Writsel, *Deputy Director, Operations*, (202) 682-6220
Diane Pennessi, *Manager, Internal Affairs*,
(202) 682-6141
Melissa Katz, *Media Coordinator*,
(202) 682-6142

### ADVERTISING SALES
Ray Purkis, *Director*, (908) 964-3100

# TABLE OF CONTENTS





*This page intentionally left blank*

**Course 1** **Friday, October 24**
**8:00 a.m.-12 noon**

## MEDICAL TREATMENT OF THE REPEATEDLY VIOLENT

Michael M. Welner, M.D., *Department of Psychiatry, New York University, 58 E. 79th Street, Floor 4R, New York, NY 10021-0221*

### EDUCATIONAL OBJECTIVES:

At the conclusion of this course, the participant should be able to: 1) understand the neurophysiologic subclassification and pharmacologic management of recidivistically violent patients; 2) identify the myths and facts about hormonal and surgical interventions; and 3) systematically choose treatment using a decision tree.

### SUMMARY:

Violence is a common symptom of many individuals who present for psychiatric care. Violence as an occasional and rarely exhibited behavior, sometimes in the context of self-defense, is not the domain of the biological psychiatrist. When repeatedly violent individuals continue to disrupt society and inflict permanent damage on others, however, psychiatry is often seen as having failed. It will explore the neuropsychiatric understanding that enables us to subclassify recidivistic violence as a series of syndromes. A battery of questions will be presented for the evaluation of such behavior. Pharmacological and other treatment options for the repeatedly violent patient will be reviewed. Serotonergic medications, sympathetic antagonists, anticonvulsants, mood stabilizers, antipsychotics, and sedative hypnotics have increasingly well-defined treatment niches. The myths and facts about hormonal and surgical interventions will also be examined.

Participants will then consult on fictitious cases referred for treatment of recidivistic violence to practice treatment selection. Finally, a decision tree will be presented to assist in a systematic choice of treatment. Participants will acquire the fundamental and advanced understanding needed to provide care for the repeatedly violent.

### TARGET AUDIENCE(s):

Psychiatrists and neuropsychologists charged with the responsibility of treating the repeatedly violent patient.

### REFERENCES:

1. Tancredi L, Volkow N: Neutral subtrates of violent behavior: implications for law and public policy. *International Journal of Law and Psychiatry* 11: pp 13-49, 1988.
2. Raine A: *The Psychopathology of Crime*. San Diego: Academic Psychiatric Press, pp 1993.

**Course 2** **Friday, October 24**
**8:00 a.m.-12 noon**

## PROGRAM DEVELOPMENT FOR DUAL DIAGNOSIS: MENTAL ILLNESS, DRUG ADDICTION AND ALCOHOLISM

Kathleen Sciacca, M.A., *Executive Director, Sciacca Comprehensive Service Development for Mental Illness, Drug Addiction & Alcoholism, 299 Riverside Drive, 3E, New York, NY 10025*

### EDUCATIONAL OBJECTIVES:

At the conclusion of this course, the participant should be able to: 1) understand systemic issues and contrasting models in mental health and substance abuse that impede services; 2) differentiate various profiles of clients who have dual/multiple disorders; 3) provide education for clients, staff and families, including etiology/physiology; 4) utilize a treatment approach from "denial" to "recovery" including engagement and readiness measures; 5) implement program materials: screening, assessment, outcome and data; 6) recognize pertinent areas of staff development, training and supervision; and 7) conceptualize a component of services within an existing or new program.

### SUMMARY:

Course content will include: a) criteria for differentiating various profiles of persons with dual/multiple disorders and severe mental illness and their treatment needs; b) systemic issues, such as evolution of contrasting methods and philosophies for mental illness, drug addiction and alcoholism; c) parallels between each disorder, treatment and recovery; d) interaction effects of dual/multiple disorders and physiology; e) a detailed outline of a "non-confrontational" treatment model and engagement at various motivation and readiness levels, intervention strategies from "denial" to "recovery", and structure and content of education group treatment and process; f) dynamic treatment considerations and indications for program development protocol/ materials (screening, engagement, readiness scales, assessment, client progress, data collection, and outcome forms for use in mental health and substance abuse settings); and g) community-wide program development, networking and use of new and traditional models of ancillary programs.

### TARGET AUDIENCE(s):

Administrators, program managers, clinicians and direct care providers from mental health and substance abuse fields.

### REFERENCES:

1. Sciacca K, and Thompson CM: Program development and integrated treatment across systems for dual

diagnosis: mental illness, drug addiction and alcoholism, MIDAA. *The Journal of Administration,* vol. 23, no. 3, Summer 1966.
2. Sciacca K and Hatfield AB: The family and the dually diagnosed patient. *Double Jeopardy,* (eds) Lehman AF, and Dixon LB, Harwood Academic Publishers, 1995, Chapt 12, pp 193-209, 1995.

**Course 3** **Friday, October 24**
**9:00 a.m.-4:00 p.m.**

## ASSESSMENT AND TREATMENT OF PATIENTS WITH MENTAL RETARDATION

Ruth M. Ryan, M.D., *Department of Public Psychiatry, University of Colorado, 4200 E. 9th Avenue, C-249-27, Denver, CO 80262*

### EDUCATIONAL OBJECTIVES:

At the conclusion of this course, the participant should be able to: 1) accurately and comprehensively diagnose persons with developmental disabilities; and 2) devise successful treatment plans with the individual and team that include behavioral, pharmacological and nonpharmacological techniques.

### SUMMARY:

Persons with developmental disabilities (e.g., mental retardation, autism) present a complex, fascinating and potentially rewarding challenge to psychiatrists and mental health professionals. The faculty will illustrate methods of accurate psychiatric diagnosis, comprehensive medical and behavioral assessment, and present updated information on pharmacologic and nonpharmacologic modalities of treatment. A multidimensional, team-oriented, habilitative approach will be emphasized.

The information presented will be relevant to any setting. Videotaped case examples and a review of the literature will also be included. Participant examples, questions and discussion will be strongly encouraged. Format will include lectures, videotaped case examples and group discussion.

### REFERENCES:

1. Aman MG: Drugs and learning in mentally retarded persons. In *Advances in Human Psychopharmacology,* JAI Press (delete Breuning studies; have been retracted), 1984.
2. Carter G, et al: Mortality in the mentally handicapped: a 50 year survey at the Stoke Park group of hospitals (1930-1980). *The Journal of Mental Def Research,* 27, 143-156, 1983.

**Course 4** **Friday, October 24**
**1:00 p.m.-5:00 p.m.**

## LIVING WITH ALZHEIMER'S DISEASE

Paul A. Kettl, M.D., *Associate Professor, Department of Psychiatry, Pennsylvania State University College of Medicine, P.O. Box 850, Hershey, PA 17033-0850*

### EDUCATIONAL OBJECTIVES:

At the conclusion of this course, the participant should be able to more effectively diagnose Alzheimer's Disease, understand the medication treatments for the disorder, and care for family members of the affected individual.

### SUMMARY:

This course will examine the clinical steps for caring for individuals with Alzheimer's Disease. To begin, the disease process and pathology will be reviewed along with diagnostic tools in making the assessment of Alzheimer's Disease. Then, medication treatment for the disorder will be reviewed including the use of cholinesterase inhibitors, estrogen and anti-inflammatory agents.

The second half of the course will focus on the interpersonal care of Alzheimer's Disease with particular emphasis on care for the family, nursing home care, as well as tips on how to care for yourself through this difficult process.

### TARGET AUDIENCE(s):

Physicians, social workers or nurses involved in the clinical care of those suffering from Alzheimer's Disease.

### REFERENCES:

1. American Association for Geriatric Psychiatry Board of Directors, American Geriatrics Society Clinical Practice Committee: Psychotherapeutic medications in the nursing home. *J Am Geriatr Soc,* 40:946, 1992.
2. Coyne AC, Reichman WE, Berbig LJ: The relationship between dementia and elder abuse. *Am J Psychiatry,* 150:643, 1993.

**Course 5** **Friday, October 24**
**1:00 p.m.-5:00 p.m.**

## HOW TO MEASURE OUTCOMES WITHOUT BREAKING THE BANK

Gabriel Kaplan, M.D., *Chairman, Department of Psychiatry, Franciscan Health, 991 Chimney Ridge Drive, Springfield, NJ 07081-3701*; James R. Westphal, M.D., *Deputy Chairman, Department of Psychiatry, Louisiana State University Medical Center, 1606 Regatta Drive, Shreveport, LA 71119*

## EDUCATIONAL OBJECTIVES:

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

## SUMMARY:

Clinicians are increasingly asked to demonstrate effectiveness of treatment in both the public and private sectors. Measuring outcomes not only serves the purpose of demonstrating value to managed care and public agencies, but also allows clinicians to improve quality of care. Outcomes systems costing thousands of dollars are now available. However, these are financially prohibitive for most clinicians. Faculty will discuss valid tools found in the public domain or available at a reasonable price that can be combined to create an outcomes system.

The presentation is divided into four sections. The first, Basic Concepts, will outline quality improvement notions such as cycle of quality, efficacy, effectiveness, dimensions, motivation, methodology, and outcome theory. The Adult Outcome Tools section will review scales used to measure health/ function status (HSQ-12, GAS), symptoms (SCL-90, BPRS, Beck), and satisfaction (CSQ). Section three, Child Outcome Tools, will describe scales utilized with youngsters to determine general functioning (CBCL) and specific symptomatology (Conners, CDI). The purpose of the final section, Practicum, is to provide the audience an opportunity to apply principles learned during this course, such as cost and clinical appropriateness of scales, by selecting an outcomes system for various practice settings.

## TARGET AUDIENCE(s):

Mental health professionals wishing to learn about cost-effective outcomes tools. No prior knowledge of this topic is required.

## REFERENCES:

1. Hunkeler EM, Westphal JR, and Williams M: Computer assisted patient evaluation systems: advice from the trenches. *Behav Health Tomorrow,* 5:3;73-75, 1996.
2. Hunkeler EM, Westphal JR, and Williams M: Developing a system for automated monitoring of psychiatric outpatients: a first step to improve quality. *HMO Pract,* 9:4;162-167, 1995.

**Course 6** **Saturday, October 25 8:00 a.m.-12 noon**

# COGNITIVE THERAPY FOR SEVERE MENTAL DISORDERS

Jesse H. Wright, M.D., *Professor of Psychiatry, University of Louisville, and Medical Director, Norton Psychiatric Clinic, P.O. Box 35070, Louisville, KY 40232-5070*; G. Randolph Schrodt, Jr., M.D.

## EDUCATIONAL OBJECTIVES:

At the conclusion of this course, the participant should be able to: 1) utilize cognitive therapy interventions for inpatients; 2) apply cognitive therapy techniques to symptoms of psychosis and bipolar disorder; 3) identify treatment adherence problems using the cognitive therapy approach; and 4) maximize relapse prevention in patients with recurrent symptoms.

## SUMMARY:

In recent years, cognitive therapy methods have been developed to meet the special needs of patients with chronic or severe psychiatric symptomatology. This course presents the newer cognitive therapy applications for the treatment of inpatients, individuals with bipolar disorder, and those experiencing psychotic symptoms. Cognitive- behavioral conceptualizations and specific treatment procedures are described for these patient groups. Several modifications of standard cognitive therapy techniques are suggested for the treatment of severe or persistent mental disorders.

Participants in this course will learn how to adapt cognitive therapy for patients with problems such as psychomotor retardation, paranoia, hypomania, treatment resistance, and nonadherence to pharmacotherapy recommendations. Cognitive therapy procedures are illustrated through case discussions, role plays, demonstrations, and videotaped examples. Worksheets that can facilitate the application of cognitive therapy techniques will be provided. Participants will also have the opportunity to discuss applications of cognitive therapy for their own patients. Format will include lectures, videotapes, demonstrations and discussion.

## REFERENCES:

1. Basco MR, Rush AJ: *Cognitive Behavioral Treatment of Manic Depressive Disorder.* New York City: Guilford Press, (1996).
2. Bowers WA: Cognitive therapy with inpatients. In Freeman A, Simon MK, Arkowitz H, Beutler L, (eds) *Handbook of Cognitive Therapy.* New York City: Plenum Press, 1989.

**Course 7** **Saturday, October 25 8:00 a.m.-12 noon**

# INTERPRETATION, EMPATHY OR AUTHENTICITY?

Martha C. Stark, M.D., *Teaching Analyst, Boston Psychoanalytic Institute, and Supervising Analyst, Massachusetts Institute for Psychoanalysis, 3 Ripley Street, Newton Centre, MA 02159-2209*

## EDUCATIONAL OBJECTIVES:

At the conclusion of this course, the participant should be able to: 1) understand the relationship between empathy and authenticity; 2) examine the therapist's "use of self" to inform both understanding and intervention; and 3) recognize the role of enactment in the relational matrix.

## SUMMARY:

This course will focus on how clinicians position themselves from moment to moment in relation to the patient and how that position informs both what they come to know about the patient and what they then say or do. The intent of this course is not to offer a prescription for what clinicians should do, but provide a description of what they can do at any given point in time. How participants choose to intervene will be based, in part, on how they conceive of the therapeutic action, whether it involves enhancement of the patient's knowledge, validation of the patient's experience, and/or participation in relationship with the patient. In addition, the therapist's focus is alternatively the patient's internal dynamics, the patient's affective experience, and the patient's relational dynamics.

The most therapeutically-effective stance is one in which participants can achieve an optimal balance between: 1) positioning themselves outside the therapeutic field (to formulate interpretations); 2) decentering from their own experience (to respond empathically to the patient); and 3) remaining very much centered within their own experience (to "use the self" to engage interactively with the patient). The emphasis throughout this course will be on the translation of theory into practice. Format will include lectures, case presentations and discussion. Course Level: Participants should have experience in psychodynamic psychotherapy.

## REFERENCES:

1. Bacal HA: British object-relations theorists and self psychology: some critical reflections. *Int J Psycho-Anal,* 68:81-98, 1987.
2. Baker R: The patient's discovery of the psychoanalyst as a new object. *Int J Psycho-Anal,* 74:1223-1233, 1993.

**Course 8** **Saturday, October 25**
**8:00 a.m.-12 noon**

## PSYCHIATRY AND PRIMARY CARE: SHARING CARE

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

## EDUCATIONAL OBJECTIVES:

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

## SUMMARY:

The increasingly prominent role of the primary care physician delivering mental health care can be enhanced if supportive, collaborative partnerships can be established with psychiatrists and mental health services.

This course, which presents a number of strategies for collaborative or shared mental health care between family physicians and psychiatrists, will help psychiatrists and other mental health professionals develop the skills necessary to work effectively with primary care providers. The prevalence, presentation, and management of mental health problems in primary care and problems in the relationship between psychiatry and primary care will be reviewed. Principles outlined to guide shared mental health care and three different sets of implementation strategies will be presented. These aim to: a) improve communication; b) strengthen liaison linkages; and c) bring mental health services into primary care. Examples of each will be provided.

The implications of shared mental health care for residency training, for research, for academic departments of psychiatry, and for serving isolated or underserved populations will be discussed. Finally, the course will offer practical guidelines on how to work productively with primary care physicians, how to establish collaborative relationships, and ways in which models of shared care can be adapted to different communities.

## TARGET AUDIENCE(s):

Any mental health provider, especially psychiatrists.

## REFERENCES:

1. Barrett JE, Barrett JA, Oxman TE, Gerber PD: The prevalence of psychiatric disorders in a primary care practice. *Arch Gen Psychiatry,* 45:1100-1106, 1988.
2. Bridges K, Goldberg D: Somatic presentation of DSM-111 psychiatric disorders in primary care. *J Psychosomatic Research,* 29, 563-569, 1985.

**Course 9** **Saturday, October 25**
**1:00 p.m.-5:00 p.m.**

## EFFECTIVE STEPFAMILY THERAPY

John S. Visher, M.D., *Lecturer, Psychiatry Emeritus, Stanford University School of Medicine, and Co-Founder, Stepfamily Association of America, 599 Sky Highway Road, Lafayette, CA 94549-5225*; Emily B.

Visher, Ph.D., *Adjunct Faculty, John F. Kennedy University, and Co-Founder, Stepfamily Association of America, 599 Sky Highway Road, Lafayette, CA 94549*

## EDUCATIONAL OBJECTIVES:

At the conclusion of this course, the participants should be able to enhance their skills in working with stepfamilies or with individuals in stepfamilies by increasing their knowledge of: 1) the differences in working with stepfamilies or individuals in stepfamilies as contrasted to those in nuclear families; 2) stepfamily characteristics and integration; 3) dynamics that interfere with stepfamily integration; 4) specific therapeutic strategies that have been effective in working with stepfamilies or with individuals in stepfamilies; and 5) therapeutic pitfalls when working with stepfamily members.

## SUMMARY:

Remarriage families are becoming the most common type of family in the United States, and there are growing numbers of remarriage families throughout the world. Many stepfamily members seek therapeutic assistance particularly during the early months after the remarriage. These stepfamilies and the adults and children in them are at risk for various manifestations of stress, anxiety, depression, and symptoms of tension. The redivorce rate in the United States is just about the same as it is for first-marriage families, 50% of whom end their marriages within the first five years. New research shows that effective stepfamily therapy requires that therapists be knowledgeable about structural and dynamic differences between remarried and other types of families and about interventions that are especially helpful for individuals in this type of family.

This course will discuss important differences between working with stepfamily and nuclear family members. It will focus on stepfamily dynamics and therapeutic strategies that have been effective. Topics examined include: discipline issues; dealing with former spouses; forming good stepfamily relationships; and understanding complicating individual dynamics including whom to see, and the relationship between past family experiences and present difficulties. Format will include lectures, case vignettes, small-group workshops, and discussion.

## REFERENCES:

1. Ahrons CR: The Good Divorce: *Keeping Your Family Together When Your Marriage Comes Apart.* New York, Harper Collins Publisher, 1994.
2. Burt M: *Stepfamilies Stepping Ahead: An Eight Step Program for Successful Stepfamily Living.* Lincoln, NE: Stepfamily Association of America, 1989.

**Course 10** **Saturday, October 25**
**1:00 p.m.-5:00 p.m.**

# COMPUTERS IN PSYCHIATRY: A HANDS-ON EXPERIENCE

Tal Burt, M.D., *Chief Resident, Department of Psychiatry, New York University Medical Center, 120 East 37th Street, Apt. 3F, New York, NY 10016-3024;* Waguih W. Ishak, M.D., Russell F. Lim, M.D., Cletus S. Carvalho, M.D.

## EDUCATIONAL OBJECTIVES:

At the conclusion of this course, the participant should be able to utilize computers to: 1) enter and retrieve patient data, and generate treatment plans and outcome measures; 2) access reference resources; 3) research patient data; and 4) communicate with other professionals. In addition, the participants will become acquainted with the spectrum of available hardware and software necessary to operate computers.

## SUMMARY:

The course is designed to meet the needs of professionals who work in private, group or hospital-based environments. Participants need to have basic knowledge of operating computers (IBM or Macintosh), including use of mouse and keyboard. In recent years there has been a significant increase in information load and demands for standardization of treatment. Computers are powerful in storing large amounts of data and performing standardized operations quickly and reliably.

Participants will be introduced to a number of software applications for patient records among which is software developed by the faculty. They will enter patient data, retrieve it, and customize the software to their needs. Participants will also learn how to access the information they need from office or home and how to use queries for research purposes. Computerized online technology has made the excitement of annual meetings possible on an almost daily basis. Participants will acquaint themselves with Email, news groups, BBS, and access them online. They will also learn how to create their own homepage. Format will include lecture, computer screen projection, and hands-on practice of the principles learned. Software will be distributed and there will be approximately one computer terminal per two participants. Bringing personal laptops is encouraged since it will maximize hands-on time.

## REFERENCES:

1. Modai I, Rabinowitz J: Why and how to establish a computerized system for psychiatric case records. *Hosp Community Psychiatry,* 44:1091-5, 1993.
2. Lim R: The Internet: applications for mental health clinicians in clinical settings, training and research. *Psychiatric Services,* 47:597-599, 1996.

**Course 11** **Sunday, October 26**
**8:00 a.m.-12 noon**

## HOW TO DIAGNOSE AND TREAT ADHD IN CHILDREN AND ADULTS

Sanjay Jasuja, M.D., *Medical Director, California Institute of Behavioral Sciences, 701 Welch Road, Suite 203, Palo Alto, CA 94304*

### EDUCATIONAL OBJECTIVES:

At the conclusion of this course, the participant should be able to: 1) diagnose and treat ADD in children and adults; and 2) elaborate on common and unique pharmacological options for treating ADHD/ ADD in childhood through adulthood.

### SUMMARY:

The Attention-Deficit / Hyperactivity Disorder (ADHD) is a complex condition that has been treated in children for more than 30 years. Contrary to the past belief that children outgrow ADHD/ADD when they enter adolescence, current research shows that only one-third of these cases may outgrow it, the rest will have the condition during adolescence and adulthood. Questions about whether ADD is being over-diagnosed or under-diagnosed have been raised. Diagnosis and treatment of this disorder are rather complex.

Comprehensive treatment approaches, including single and combined psychopharmacology, cognitive-behavioral approaches, etc., will be discussed. Various kinds of psychopharmacological agents that are helpful will be discussed, including the subtle differences in side effects. ADD is characterized by difficulties in sustaining attention, easy distractibility, forgetfulness, fidgetiness, history of hyperactivity or hypoactivity during childhood, high impulsivity, impatience, and high emotional reactivity. It is not uncommon for ADD patients to have secondary feelings of anxiety and depression.

Comorbidity with bipolar illness and anxiety disorders will be elaborated. Complicated clinical cases will also be discussed, along with pharmacological algorithms. The good news is that ADD responds very well to treatment.

### TARGET AUDIENCE(s):

General psychiatrists, child and adolescent psychiatrists, behavioral pediatricians, psychologists, social workers, and other health professionals. No advanced preparation or training is required.

### REFERENCES:

1. Zametkin AJ, Nordahl TE, Gross M, King AC, Semple WE, Rumsey J, Hamburger SD, and Cohen RM: Cerebral glucose metabolism in adults with hyperactivity of childhood onset. *The New England Journal of Medicine,* vol. 323, pp 1361-1366, November 15, 1990.
2. Matochik JA, Nordahl TE, Gross M, Semple WE, King AC, Cohen RM, and Zametkin AJ: Effects of acute stimulant medication on cerebral metabolism in adults with hyperactivity. *Neuropsychopharmacology,* vol. 8, no. 4, pp 377-386, 1993.

**Course 12** **Sunday, October 26**
**9:00 a.m.-4:00 p.m.**

## ETHICAL ISSUES IN PSYCHIATRIC PRACTICE

Jeremy A. Lazarus, M.D., *Speaker of the APA Assembly, and Associate Professor, Department of Psychiatry, University of Colorado, 8095 East Prentice Avenue, Englewood, CO 80111-2705*; Donna E. Frick, M.D., Maria T. Lymberis, M.D., Kathleen M. Mogul, M.D., Arthur Zitrin, M.D.

### EDUCATIONAL OBJECTIVES:

At the conclusion of this course, the participant should be able to: 1) identify ethical dilemmas in psychiatry that impact on the daily practice of psychiatry; and 2) understand how to apply ethical guidelines, practical approaches and solutions to these dilemmas.

### SUMMARY:

The faculty will present an overview of psychiatric ethics and methods of ethical problem solving. Specific discussions will focus on ethical problems involving: 1) informed consent; 2) forced treatment; 3) confidentiality; 4) legal/ethical questions; 5) sexual misconduct; 6) boundary violations; 7) relationships with other mental health professionals; 8) financial issues; 9) managed mental health; and 10) conflicts of interest. Questions about specific cases will be presented to demonstrate methods of ethical problem solving when there are conflicting ethical values to be weighed. Pertinent applications, opinions and positions of APA and its Ethics Committee will be explored. Participants will have adequate time to present their questions and cases in these or other areas of psychiatric ethics for discussion with the faculty.

### REFERENCES:

1. American Psychiatric Association: *Ethical concerns about sexual involvement between psychiatrists and patients.* (Videotape and discussion guide.) Washington, D.C., Author, 1986.
2. American Psychiatric Association: *The principles of medical ethics with annotations especially applicable to psychiatry.* Washington, D.C., Author, 1989.

**Course 13** **Sunday, October 26**
**9:00 a.m.-4:00 p.m.**

## RISK MANAGEMENT IN MANAGED BEHAVIORAL HEALTH CARE DELIVERY

Andrew B. Molchon, M.D., *President, Cognitive Therapy Institute of Greater Washington, 5113 Leesburg Pike, Suite 106, Falls Church, VA 22041-3204*; Susan King, J.D., *Professional Risk Management Services, 1000 Wilson Boulevard, Suite 2500, Arlington, VA 22209*; Douglas G. Jacobs, M.D., Frederick M. Jacobsen, M.D., Steven S. Sharfstein, M.D., Claudia Schlosberg, J.D.

### EDUCATIONAL OBJECTIVES:

At the conclusion of this course, the participant should be better able to understand the profound changes that managed care has wrought in behavioral health care and be able to devise strategies to cope with these changes while minimizing legal risks associated with managed care.

### SUMMARY:

The explosive growth of managed care has resulted in increased medical and legal risk for behavioral health professionals. Clinical, administrative and contractual issues will be covered, including potential pitfalls in contracting with managed care organizations (including hold-harmless, indemnification, and "gag clauses"), effects of managed care on the therapist/patient relationship, risks of abandonment and premature termination of treatment, potential risk factors inherent in "split therapy" (medication management and therapy done by different providers), risks of treating large numbers of patients who are seen infrequently for medication management only, and special issues relating to patient confidentiality in a managed care environment.

The practitioner will learn basic differences in philosophy between traditional mental health practice and practice in a managed care environment and how these differences can affect clinical decision making in managed care. Issues relating to managed behavioral health care in the public sector will be discussed. Finally, the practitioner will learn strategies to minimize legal risks in practicing in managed care, and at the same time maintain quality and ethical standards.

### TARGET AUDIENCE(s):

All mental health professionals. While the emphasis will be on group and individual private practice, this course will also be applicable to public and institutional settings as well.

### REFERENCES:

1. Austad CS: Can psychotherapy be conducted effectively in managed care settings? In Lazarus A: *Controversies in Managed Care.* Washington, D.C., American Psychiatric Press, 1996.
2. Gutheil TG: Suicide and suit: liability after self destruction. In Jacobs DG (ed), *Suicide and Clinical Practice.* Washington, D.C., American Psychiatric Press, 1992.

**Course 14** **Monday, October 27**
**8:00 a.m.-12 noon**

## MEDICATION BACKUP: A PRACTICAL GUIDE

Richard Balon, M.D., *Department of Psychiatry and Behavioral Sciences, University Psychiatric Center, Wayne State University, 2751 E. Jefferson Street, Suite 200, Detroit, MI 48207*; Thomas Carli, M.D., Kenneth R. Silk, M.D., JoAnn MacBeth, J.D., Jeremy A. Lazarus, M.D., Kevin B. Kerber, M.D.

### EDUCATIONAL OBJECTIVES:

At the conclusion of this course, the participant should be able to: 1) identify problems and goals of medication backup as a treatment modality; 2) identify risks and benefits of providing medication backup to patients; 3) recognize the legal, ethical and managed care issues regarding this practice pattern; and 4) articulate guidelines for optimal communication patterns with the nonphysician therapist.

### SUMMARY:

Medication backup is the practice of a psychiatrist prescribing psychotropic medication to patients who are in therapy with nonphysician providers. Medication backup is a growing psychiatric practice pattern driven in part by the cost-containment pressures of managed care companies, as well as increased numbers of nonphysician mental health service providers.

This course will offer practical guidelines on medication backup for psychiatrists. Both positive and negative aspects of medication backup will be discussed. Furthermore, the psychodynamic issues that emerge when providing medication backup will be presented. Problem areas, such as legal and ethical issues and working with personality disordered patients, will be highlighted. The dilemmas of providing medication backup in managed care systems will be reviewed. Finally, the faculty will offer a panel discussion using clinical case examples to emphasize key concepts. Format will include lectures, slides, questions-and-answer sessions, and a panel discussion.

### REFERENCES:

1. Braunwald E (ed), Isselbacher K, et al: *Principles of Internal Medicine.* McGraw Hill, New York City, 1987.

2. Karasu T: Psychotherapy and pharmacotherapy: toward an integrative model. *Am J Psych,* 139:9, 1982.

**Course 15** **Monday, October 27**
**8:00 a.m.-12 noon**

## INTEGRATED MODELS FOR THE TREATMENT OF DUAL DIAGNOSIS

Kenneth Minkoff, M.D., *Medical Director, Choate Health Systems, 23 Warren Avenue, Woburn, MA 01801-4979*

### EDUCATIONAL OBJECTIVES:

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

### SUMMARY:

This course will provide a brief overview of the problem of dual diagnosis, with emphasis on substance abuse and dependence among the seriously mentally ill. Barriers to the development of integrated treatment will be described, followed by a presentation of an integrated disease and recovery model for both disorders that addresses those barriers. This model is then used to organize a structured approach to assessment, diagnosis and treatment. In this model, clinical interventions for this population can be individualized based on phases of recovery, diagnosis, and level of acuity, severity, disability, and motivation for treatment for each disease. This analysis is used to describe the components of a comprehensive dual-diagnosis system of care. Individual strategies of psychotherapeutic intervention, as well as integrated program models, are described for each phase of recovery. Attention will be paid to the issue of psychopharmacologic management strategies for psychiatrically symptomatic patients abusing substances. Participants will be encouraged to bring .clinical and programmatic case problems for discussion to illustrate the application of those principles. This is a repeat of a course given last year. Format will include lecture, slides and group discussion.

### REFERENCES:

1. Center for Substance Abuse Treatment (CSAT): *Assessment & Treatment of Patients with Coexisting Mental Illness & Alcohol & Other Drug Abuse.* T.I.P. Series #9, DHHS Publication No. (SMA), 94-2078 (Dept of Health & Human Services) 1994.
2. Deegan PE: Recovery: the lived experience of rehabilitation. *Psych Rehab J.,* 11(4): 11-19, 1988.

**Course 16** **Monday, October 27**
**9:00 a.m.-4:00 p.m.**

## BUSINESS METHODS APPLIED TO STRATEGIC PLANNING

Erica Weinstein, M.D., *Medical Director, Marlboro Psychiatric Hospital, 546 County Road, #520, Marlboro, NJ 07746-1069*; Janne L. Nemyo, M.A., *Director of Speech Pathology, Marlboro Psychiatric Hospital, 546 County Road, #520, Marlboro, NJ 07746*; Gregory P. Roberts, M.S.W., John C. Whitenack, B.A.

### EDUCATIONAL OBJECTIVES:

At the conclusion of this course, the participant should be able to: 1) understand the use of systems analysis in strategic planning; 2) become familiar with techniques of alternate dispute resolution; 3) understand the uses of forecasting and planning methods; and 4) become familiar with methods used in cost analysis.

### SUMMARY:

This course presents four practical business techniques and their application to medical management, with special reference to strategic planning. Qualitative techniques include systems analysis and conflict resolution. Quantitative techniques include time series forecasting and project planning. Each section includes a description of the method, general application and case examples.

### TARGET AUDIENCE(s):

Managers and others interested in organizational performance and planning. Experience is not essential.

### REFERENCES:

1. Lapin LL: *Quantitative Methods for Business Decisions.* The Dryden Press, Harcourt Brace College Publishers, Sixth Edition, 1994. (Chapter 19: Project planning with PERT, pp 722-761 and Chapter 5: Forecasting, pp 139-188.)
2. Frost PJ, Mitchell VE, and Nord WR: *Managerial Reality - Balancing Techniques, Practice, and Values.* Harper Collins, 1990. (Chapter 9: Ethical managers make their own rules, pp 315-321.)

**Course 17** **Monday, October 27**
**1:00 p.m.-5:00 p.m.**

## NEW MODELS IN SERVICE DELIVERY: NEUROPSYCHIATRY

Stephen I. Kramer, M.D., *Director, Psychiatry Resident Education, Bowman Gray School of Medicine, Medical Center Boulevard, Winston-Salem, NC 27157*; Peter B. Rosenquist, M.D., *Medical Director, Wake Forest Behavioral Health Services, Bowman Gray School of Medicine, Medical Center Boulevard, Winston Salem, NC 27157-0001*; Doreen L. Hughes, M.D.

### EDUCATIONAL OBJECTIVES:

At the conclusion of this course, the participant should be able to: 1) identify areas of demand, marketability and potential collaborators for a subspecialty psychiatric service; 2) apply principles of cost-effectiveness analysis to formulate an economic argument for the need of his/her subspecialty service; and 3) develop an action plan that meets the needs of the market and furthers organizational and individual goals.

### SUMMARY:

This course is designed for individuals who currently offer or wish to market a psychiatric subspecialty service. A subspecialty orientation offers the clinician a greater sense of mastery, the freedom to offer state-of-the-art treatment, and the chance to establish meaningful outlets for research and teaching. As managed care plans come under regulatory pressure to monitor the quality as well as the cost of psychiatric services, a new opportunity exists to demonstrate the value of subspecialty services. Using examples from a successful neuropsychiatry program, the faculty in this course will guide participants through the process of creating a marketable subspecialty niche.

During the course, participants will be engaged in the process of formulating their own specific plan of action. Essential elements of any psychiatric subspecialty services plan include cogent economic arguments to justify the service need, obtaining necessary credentials and continuing education, and identifying potential costumers and collaborators. Course participants will learn how to create practical solutions to deal with their individual and institutional priorities for clinical services delivery, education and research. Format will include lecture presentations and discussion segments.

### REFERENCES:

1. Benson DF: Neuropsychiatry and behavioral neurology: past, present, and future. *J Neuropsychiatry Clin Neurosci,* 8:351-357, 1996.
2. Eisenberg JM: A guide to the economic analysis of clinical practices. *JAMA, 262:2879-86, 1989.*

**Course 18** **Monday, October 27**
**1:00 p.m.-5:00 p.m.**

## SECLUSION AND RESTRAINT

Helen G. Muhlbauer, M.D., *Director, Comprehensive Psychiatric Emergency Program, Bronx-Lebanon Hospital Center, 1276 Fulton Avenue, Bronx, NY 10456*; William A. Fisher, M.D., Michael L. Perlin, J.D., Magda F. Embden, M.A.

### EDUCATIONAL OBJECTIVES:

At the conclusion of this course, the participant should be able to: 1) understand the clinical issues around seclusion/restraint; 2) have a state-of-the-art knowledge of research on the subject; 3) apply new JCAHO standards for seclusion/ restraint meaningfully; 4) understand legal standards; and 5) apply techniques for reduction and control of acute violence.

### SUMMARY:

This course will give a thorough grounding in clinical, practical, legal and regulatory issues involved in seclusion and restraint procedures. The course will emphasize the 1997 Joint Commission on Accreditation of Healthcare Organization's standards for these procedures and allow participants to translate these into meaningful care plans. Clinical studies on seclusion and restraint will be reviewed. Issues of countertransference will be examined. Interpretation of regulations and standards, with illustrations of preventive and alternative interventions to decrease the use of restrictive measures will be clarified. Legal issues will be examined on the federal and state levels. Regulation of seclusion and restraint in different states will be compared.

A certified Crisis Prevention Institute instructor will teach hands-on techniques to defuse violence. This course will help the participant to deal with difficult clinical and managerial situations, reduce physical risk to clinician and patient, and allow for meaningful risk management of one of the most hazardous activities in your institution.

### TARGET AUDIENCE(s):

Clinicians, supervisors, and counsel working or managing inpatient/emergency settings.

### REFERENCES:

1. Adelman SA: Pills as transitional objects: a dynamic understanding of the use of medication in psychotherapy. *Psychiatry,* 48: 246-253, 1985.
2. Appelbaum PS: General guidelines for psychiatrists who prescribe medications for patients treated by nonmedical psychotherapists. *Hosp Comm Psychiatry,* 42:281-282, 1991.

**Course 19** **Monday, October 27**
**1:00 p.m.-5:00 p.m.**

## REDUCING PRESCRIPTION MEDICATION LIABILITY

Michael R. Arambula, M.D., *General and Forensic Psychiatry, Private Practice, 14800 US 281 North, #110, Registry, San Antonio, TX 78232*

### EDUCATIONAL OBJECTIVES:

At the conclusion of this course, the participant should be able to: 1) recognize potential malpractice risks associated with psychopharmacologic medications; and 2) identify how to reduce malpractice risk with risk management.

### SUMMARY:

This course, which will be divided into four parts, is designed for the general psychiatrist who prescribes psychoactive medication and is concerned about associated malpractice liability. Part I will provide a working knowledge of medical malpractice law, particularly as it applies to the psychopharmacological treatment of patients. This framework will aid in understanding Part II, which will examine representative malpractice cases and results from a nationwide PIAA study of prescription medication malpractice claims by indemnity, drug class, error type, and injury. Issues in malpractice liability associated with neuroleptics, narcotics, analgesics, and benzodiazepines will be emphasized.

The first two parts will provide a foundation for the remainder of the course. Part III will focus on risk management via record keeping and telephone calls. Part IV will examine risk-prevention measures and patient education, informed consent, and drug selection to reduce the risk of medication malpractice liability. This course will provide the necessary tools for evaluating potential areas of liability when treating patients with psychotropic medications. More importantly, it will help participants minimize the malpractice risks associated with prescribing. Course Level: Participants should be familiar with psychopharmacologic agents and their side effects. Format will include lectures, slides and question-and-answer sessions.

### REFERENCES:

1. Farrell MJ: Medication malpractice: claims, culprits and defenses. *American Journal of Trial Advocacy,* vol. 16:65, pp 65-107, 1992.
2. DuPont RL and DuPont CM: The treatment of anxiety: realistic expectations and risk by controlled substances. *The Journal of Law, Medicine & Ethics,* vol. 22:3, pp 206-214, 1994.

**Course 20** **Tuesday, October 28**
**8:00 a.m.-12 noon**

## COGNITIVE THERAPY: THE BASICS

Dean Schuyler, M.D., *Private Practice, 6280 Montrose Road, Rockville, MD 20852-4119*

### EDUCATIONAL OBJECTIVES:

At the conclusion of this course, the participant should be able to: 1) understand the language of the cognitive model; 2) apply the cognitive model to an individual patient or to a group of disorders; 3) utilize interventive techniques based upon the model; and 4) build upon this foundation with further reading, advanced course work, and supervision to gain the requisite skills to do cognitive therapy.

### SUMMARY:

This course will present the cognitive conceptual model for understanding psychopathology, including basic principles, the concept of the automatic thought, cognitive errors and cognitive schemas. By utilizing clinical examples, role playing and the participants" experiences, a facility will be developed for identifying and working with automatic thoughts. A broad range of treatment techniques derived from the model will be described. The use of visual confrontation and of structured materials will be highlighted. This is a repeat of a course given last year. Format will include lecture, clinical examples and workshops.

### REFERENCES:

1. Schuyler D: Cognitive model of depression: an alternative system. *Clinical Advances in the Treatment of Depression,* vol.1, no. 4, 1987.
2. Schuyler D: Cognitive therapy addresses the needs of the depressed. *Clinical Advances in the Treatment of Depression,* vol. 1, no. 6, 1987.

**Course 21** **Tuesday, October 28**
**8:00 a.m.-12 noon**

## PROMOTING STAFF DEVELOPMENT AND AVOIDING BURNOUT

Douglas H. Hughes, M.D., *Harvard Medical School, Boston Veterans Affairs Medical Center, 150 South Huntington Avenue, #116A, Boston, MA 02130*; Domenic A. Ciraulo, M.D., Carol C. Nadelson, M.D., Paul Summergrad, M.D.

### EDUCATIONAL OBJECTIVES:

At the conclusion of this course, the participant should be able to: 1) identify signs of professional burnout in their faculties; 2) have an appreciation of possible

ameliorating measures; and 3) identify means to promote the academic and nonacademic careers of their staff.

## SUMMARY:

This course will focus on various means to promote staff development and discuss situations and stressors that can adversely affect staff performance. Dr. Hughes will review the literature and practical guidelines to help managers identify and address staff burnout. Interventions that enhance workgroup autonomy and provide opportunities for professionals to use their skill while developing their competence may help reduce burnout. Dr. Ciraulo will discuss how substance abuse may contribute or possibly be a symptom of emotional burnout in staff. Traditionally this has been a highly sensitive area to even discuss, much less confront in the workplace environment. Some subtle signs of substance abuse and measures to address them gently, but effectively will be reviewed. Dr. Nadelson will explain how societal expectations may contribute to burnout for women professionally. Successfully managing the roles of spouse, parent and caregiver to elderly parents differentially effects women in contemporary society. The professional woman faces unique challenges in her professional development while attempting to manage personal commitments. Dr. Summergrad will discuss how in order for psychiatry to remain a fertile environment to train residents and other professionals, managers need to model and teach ways to be academically productive in spite of significant clinical demands. Format will include lectures with slide presentations, discussion and question-and-answer session.

## REFERENCES:

1. Leibenluft E, Summergrad P, Tasman A: The academic dilemma of the inpatient unit director. *Am J Psychiatry,* 146:73-76, 1989.
2. Hughes D: Suicide and violence assessment in psychiatry. *Gen Hosp Psychiatry,* 18:416-421, 1996.

**Debate 1** **Friday, October 24**
**8:00 a.m.-9:30 a.m.**

## PHYSICIAN-ASSISTED SUICIDE: SHOULD IT BE LEGAL?

Alan A. Stone, M.D., *Department of Psychiatry, Harvard University, Cambridge, MA 02138-2996*; Lawrence Hartmann, M.D., Arthur T. Meyerson, M.D.

### EDUCATIONAL OBJECTIVES:

This debate will try to clarify, from the point of view of psychiatry, some values and conflicts in the current fluid national and international debate on physician-assisted suicide (PAS). The affirmative debater will argue that PAS, with careful guidelines, should be legal.

### NEGATIVE SUMMARY:

Physicians should use their knowledge and skills to help their patients. That usually means curing or alleviating illness or pain and promoting health, and it usually but not always means helping to prolong the patient's life.

We will discuss some arguments that have been raised for and against PAS. Good values clash with other good values in this area. We will touch on the widespread wish for one simple, clear rule or guideline, and the inadequacy of all the major candidates for a single clear rule; the question of "who owns your life?"; the relevance of suffering, dignity, the patient's wishes, and control (all of which may be harmed by banning PAS); the "slippery slope" metaphor ("all assistance in dying leads to more and more abusive killing") vs. the hazy-swamp metaphor; pain relief and palliative and hospice care (to be considered and encouraged, but not always available, adequate, or desired); depression (is it per se depression for a patient with e.g., terminal cancer to want to die with some comfort sooner rather than later?). How can we cautiously develop and try out careful ethical guidelines? If all PAS is illegal in all relatively advanced societies, that will tend to discourage attempts to think through, discuss, and try out careful guidelines for something that is fairly rare, but is (now and historically, nationally and internationally) present in the practice of many good physicians and the wishes of many good people.

### AFFIRMATIVE SUMMARY:

The debate on physician-assisted suicide tends to focus on the patient's needs for relief from pain and suffering and when so framed, the majority of physicians and lay persons believe that it should be the patient's right, at least under limited circumstances. This simple fact is often presented, in the context of a democratic society, as a reason for its legalization. However, even if one accepts the premise of that argument, two essential questions remain: should the practice of relief of suffering require our society to legalize the practice of terminating the life of a suffering person when that requires an affirmative act on the part of some person, and should that person be a physician? The position that the act should be legalized if performed by someone can be argued but not convincingly, and the counter arguments are at least as compelling. The argument against physicians being the agents or even the angels of death is compelling when the art and science of medicine, and particularly psychiatry, are taken into account.

### REFERENCES:

1. Dworkin R, et al: Assisted suicide: the philosophers' brief, *N.Y. Review of Books,* XLIV#5:3/27/97, pp. 41–47.
2. Baron C, et al: A model state act to authorize and regulate physician assisted suicide, *Harvard Journal on Legislation, V. 33, winter, 1996.*

**Debate 2** **Tuesday, October 28**
**8:00 a.m.-9:30 a.m.**

## CAN ETHICAL PSYCHIATRISTS WORK UNDER MANAGED CARE?

Harvey Bluestone, M.D., *Professor of Psychiatry, Albert Einstein College of Medicine, 1285 Fulton Avenue, Bronx, NY 10456-3401*; Robert Michels, M.D., Harold I. Eist, M.D.

### EDUCATIONAL OBJECTIVE:

At the conclusion of this debate, participants should be able to understand the basic ethical issues involved in psychiatric practice in the setting of managed care.

### AFFIRMATIVE SUMMARY:

The practice of psychiatry, like that of the rest of medicine, involves serving patients, their families, and their communities. One way in which the community influences medical practice is through the construction of political, social, and economic systems for the delivery of health care. We are currently undergoing a revolution in the dominant structure of health care delivery in the United States. The emerging system, labeled "managed care," emphasizes some ethical dilemmas while minimizing others. None of the problems it presents are new or unique, and psychiatrists have long grappled with them in other settings while serving their patients. It is essential that psychiatrists continue to do so, so that they may continue to fulfill their most fundamental ethical injunction, providing the best possible care and treatment for their patients.

### NEGATIVE SUMMARY:

"Managed care" is primarily concerned about prices to corporations for health care. To control prices to

corporations, "managed care" has actually increased the overall costs of health care by dumping into the public sector, by failing to provide optimal care, by making access more difficult, by limiting treatment options, by limiting formularies, by intruding destructively into the doctor-patient relationship, by disregarding confidentiality, and by "cream skimming," cherry picking," and kicking people out of hospitals "quicker and sicker." As Amsel states, ". . . we have gone from a health care system with some abuse and fraud to a fraud and abuse system with some health care."

It is unethical to participate in fraudulent systems of care, it is unethical to participate in systems that gag physicians, thereby preventing informed consent. It is unethical to participate in systems that so threaten a physician's economic security that the physician's primary duty to patients is jeopardized or compromised. It is unethical to participate in systems that require doctors to lie. It is unethical to participate in systems that put the wealth of corporations before the health of employees. It is unethical to participate in systems that discriminate against the seriously and persistently mentally ill, children, minorities, and the elderly. It is unethical to participate in systems that increase morbidity and suffering.

## REFERENCES:

1. Michels R: Improving outpatient psychiatric care (Editorial). *New England Journal of Medicine* 336(8):578–79, 1997.
2. Amsel L: Corporate healthcare *Tikkun* V. 12, May/June 1997.
3. Peeno L: Former managed care doc confesses medical misdeeds before congress *Louisville Medicine,* June 1997.

## Discussion Group 1

**WITHDRAWN**

## Discussion Group 2 — Saturday, October 25 8:00 a.m.-9:30 a.m.

### THE PSYCHIATRY OF POLITICS

Paul A. Kettl, M.D., *Associate Professor, Department of Psychiatry, Pennsylvania State University College of Medicine, P.O. Box 850, Hershey, PA 17033-0850*

### SUMMARY:

Will Rogers said, "In a democracy, any individual can run for Congress . . . and that's the chance you take." In 1996, Paul Kettl, M.D., ran for Congress, won the Democratic nomination for his district in the Harrisburg, Pennsylvania, area, and then lost in the general election to an eight-term incumbent.

In this discussion group, Dr. Kettl will discuss "The psychiatry of politics," i.e., how political questions are framed to maximize attention and support from the general public. In addition, special political issues of importance to psychiatrists, including parity for mental health insurance, physician-assisted suicide, the stigma against psychiatry, and managed care issues will be discussed.

Participants will be encouraged to present problems they have experienced in accessing political figures and political institutions for discussion. Finally, we will psychiatrically analyze the "spin" of current problems in politics.

The target audience for this discussion group includes all meeting participants.

### REFERENCES:

1. Kettl PA: That's politics. *JAMA* 267:798, 1992.
2. Kettl PA: The politics of suicide. Abstract. *Syllabus and Proceedings Summary* 149th Annual Meeting of the American Psychiatric Association, American Psychiatric Press, Inc., Washington, D.C., 1996.

## Discussion Group 3 — Saturday, October 25 8:00 a.m.-9:30 a.m.

### THE FRAGMENTATION OF MEDICINE: A PERSPECTIVE

Priyamvada Narayanan, M.D., *Medical Student, Department of Psychiatry, McGill University, 160 East 48th Street, Apt.14-H, New York, NY 10017-1225*

### SUMMARY:

In medical school, anatomy, physiology, and associated sciences force the student into thinking of the parts and not the whole. By the time clinical contact is made with the whole person, the student is already programmed to dissect and analyze the parts via isolation of the bits from the whole. The premise of our education and training in medicine has become, to a large extent, the application of biological science to human problems. We are trained to look narrowly at the science of the disease and in doing so compromise on learning the art of helping people heal.

Psychiatry, of all the medical specialties, directly deals with the balance between the art and science of medicine. This topic should be of interest to psychiatrists, especially students and educators. This fragmentation process, with its emphasis on science and objectivity, will be discussed to suggest reasons for it, to describe its impact on the medical profession with special emphasis on psychiatry, and, finally, to suggest ways of addressing the problem.

Interaction will be fostered by requesting comments on all aspects of the discussion as well as encouraging participants to contribute relevant personal experiences.

### TARGET AUDIENCE:

Medical students, residents, and educators.

### REFERENCES:

1. Barker PJ: *Ethical Issues in Mental Health*, Chapters 1 & 4 Chapman and Hall, London, 1991.
2. Gordon LE: *Mental Health of Medical Students: The Culture of Objectivity in Medicine*, p2–10 Pharos, Spring, 1996.

## Discussion Group 4 — Saturday, October 25 10:00 a.m.-11:30 a.m.

### YOU'VE COME A LONG WAY BABY: PROFESSIONAL WOMEN IN 1997

Carolyn B. Robinowitz, M.D., *Associate Dean for Students, and Professor of Psychiatry, Georgetown University School of Medicine, 3900 Reservoir Road, N.W., Suite 1E113, Washington, DC 20007*

### SUMMARY:

Over the past two decades, women have increasingly entered professional training; women now represent almost 50% of psychiatric residents. Historically, women chose psychiatry in amounts disproportionate to their numbers. Psychiatry was seen by students and faculty alike as welcoming to women, responsive to family issues, flexible in work opportunities and scheduling, and promoting fairness across gender lines.

As the numbers of women in medicine increased, the proportion of women entering psychiatry has decreased, possibly reflecting some lessened interest in psychiatry as well as increased opportunities elsewhere. Women now choose specialties previously felt to be off limits or less welcoming.

Women psychiatrists' careers and practice tend to be similar to those of women everywhere in terms of earnings, advancement, and job satisfaction. Women's experiences differ from those of their male colleagues; women report more covert and institutionalized sexism, harassment, and discrimination (missed opportunities), as well as absence of mentoring.

Men and women have different styles of leadership. Women tend to motivate by information and power sharing, enhancing others' self-worth, job satisfaction, and success; men rely on organizational structure, and rewards and punishment. Professional women have special issues. Women often have a need to be liked, to be nice, to be peacemakers, and problem-solvers. Women frequently experience discomfort in self-promotion, and tend to be generative rather than self-protective. Both men and women are uncomfortable when women are competitive and assertive.

Many rationales have been suggested for the inequities: biologically based cognitive differences, motherhood, normative alternatives, lack of role models and mentors, low intellectual self-confidence, chilly climate, and socialization.

This session will highlight issues, consider resource development, as well as define strategies for successful coping. Concrete planning for the future will be included.

## TARGET AUDIENCE:

Women students and practicing professionals; men in leadership.

## REFERENCES:

1. De Titta M, Robinowitz CB, More WW: The future of psychiatry: psychiatrists of the future *Am J Psychiatry* 148: 853–858, 1991.
2. Baker LC: Differences in earnings between male and female physicians, *NEJM* vol 334, April 11, 1996.

**Discussion Group 5** **Saturday, October 25**
**10:00 a.m.-11:30 a.m.**

## WHAT MAKES PSYCHOTHERAPY MOST EFFECTIVE?

Abdul Basit, Ph.D., *Assistant Professor, Department of Psychiatry, University of Chicago Psychiatric Rehabilitation Center, 7230 Arbor Drive, Tinley Park, IL 60477*; Jim Mathisen, *Doctoral Student in Clinical Psychotherapy, Adler School of Psychology, Chicago, IL*; Don Pinkston, *Graduate, Jane Addams School of Social Work, Chicago, IL*

## SUMMARY:

A massive amount of research work has been carried out to determine the relative effectiveness of the various therapeutic techniques. Until recently, however, almost no attention has been devoted to the characteristics of therapists that are crucial in evaluating the outcome. There is now a growing body of evidence that attitudinal and experiential elements of therapists are, in fact, most significant. Unfortunately, the emphasis has been more on learning techniques than on helping therapists to develop qualities that are necessary to become effective. Any change in behavior or any attempt to help people change cannot be successfully accomplished unless the client has an *anchor point.* And in any type of therapy, the therapist is the anchor point. Regardless of the therapeutic objective and technical procedures, the therapist is indeed a potent therapeutic agent. The discussion will point out that the role of the therapist is one of the crucial factors in the successful outcome of therapy. We will delineate why anchor point is considered absolutely necessary in the East. The characteristics and attributes that are essential for an effective therapist will be explored and examples will be given to illustrate the point. A comparison of Western and Eastern approaches will be made and similarities and differences will be discussed to determine whether we need to reexamine current method and approach.

## TARGET AUDIENCE:

Mental health professionals doing psychotherapy.

## REFERENCES:

1. Barlow DH: Health care policy, psychotherapy research, and the future of psychotherapy. *American Psychologist* 51:10–1050–1058, 1996.
2. Brazier D: *ZEN Therapy - Transcending the Sorrows of the Human Mind.* New York, John Wiley & Sons, Inc., 1996.

**Discussion Group 6** **Saturday, October 25**
**1:30 p.m.-3:00 p.m.**

## WILL FUTURE PSYCHIATRISTS BE PSYCHOTHERAPISTS? PROS AND CONS

Troy L. Thompson II, M.D., Member, APA Institute Scientific Program Committee, and *The Daniel Lieberman Professor, Department of Psychiatry and Human Behavior, Jefferson Medical College and Hospital, 1025 Walnut Street, Room 320, Philadelphia, PA 19107-5005*

**SUMMARY:**

Managed care appears to be pushing many psychiatrists in the direction of not providing psychotherapy but of becoming physicians who primarily manage psychotropic medications and provide psychiatric consultation when requested by nonphysician mental health professionals and other physicians. These roles and functions for psychiatrists are important; however, whether future psychiatrists should learn psychotherapy as a core residency requirement and what role being a psychotherapist should or will play in their future practice is an area of disagreement. When examining younger colleagues recently, many senior psychiatrists find them significantly lacking in core psychotherapy knowledge and skills (e.g., being able to describe basic psychological conflicts and defenses and present a psychodynamics formulation). The questions below and other issues relating to the pros and cons of psychiatrists learning to be competent psychotherapists and doing so as part of their future professional role will be discussed. Do psychiatrists not need to learn psychotherapy because other mental health professionals may do psychotherapy as well at less expense? Are basic psychotherapy knowledge and skills essential to conduct screening psychiatric evaluations, including assessing suitability for various psychotherapies? Should psychiatrists be educationally equipped to combine medication and psychotherapy for some patients, and can such care be more clinically and cost effective? If so, for what types of patients is that likely to be the case? Is it important for psychiatrists to know basic psychotherapy to serve as leaders of mental health care teams? Do psychiatrists need to be able to provide basic psychotherapy supervision to nonphysician members of mental health teams to have credibility as appropriately leading such teams and to assure biologic and psychosocial interventions are being optimally integrated?

**REFERENCES:**

1. Thompson TL II: Psychiatry: the primary care mental health profession. *Psychosomatics* 26:441–447, 1985.
2. Thompson TL II, Folks DG, Silverman JJ: Challenges and opportunities for consultation-liaison psychiatry in the managed care environment. *Psychosomatics* 38:70–75, 1997.

**Discussion Group 7** **Saturday, October 25**
**3:30 p.m.-5:00 p.m.**

## CONSUMER EXPERIENCE OF STIGMA

*National Alliance for the Mentally Ill*

Otto Wahl, Ph.D., *Professor of Psychology, George Mason University, 4400 University Drive, Fairfax, VA 22030*; Maggie Scheie-Lurie, *Consumer Outreach Coordinator, National Alliance for the Mentally Ill, Membership Department, 200 North Glebe Road, Arlington, VA 22203*

**SUMMARY:**

In the first nationwide study of the experiences of stigma of mental health consumers, 1,301 individuals from 49 states responded to a survey asking about specific stigma and discrimination experiences in their lives. Results confirm the widespread experience of stigma and discrimination that accompanies mental illnesses. The vast majority of participating individuals, for example, reported that they avoided telling others about their mental illnesses and worried that others would view them unfavorably if their status as a mental health consumer was revealed. Stigma experiences such as overhearing offensive comments about mental illnesses, seeing hurtful depictions of mental illness in the mass media, and being treated as less competent by others were common. In addition, about a third of respondents indicated that they had been turned down for health insurance because of their mental illness and denied treatment because of lack of adequate insurance. These and other results will be discussed, along with implications and additional components of the research.

**REFERENCES:**

1. Fink PJ, et al: Consequences of stigma for persons with MI: evidence from social sciences, in: Fink PJ, Tasman A: *Stigma and Mental Illness* Washington, D.C., APA Press, Inc. 1992.
2. Wahl Otto: *Media Madness: Public Images of Mental Illness*, Rutgers University Press, 1995.

**Discussion Group 8** **Sunday, October 26**
**8:00 a.m.-9:30 a.m.**

## GREAT IDEA! HOW TO PATENT IT?

Laurence Manber, Ph.D., J.D., *Patent Attorney with Steinberg, Raskin and Davidson, Suite Penthouse K, 3530 Henry Hudson Parkway, Bronx, NY 10463*

**SUMMARY:**

Clinicians are often in the best position to recognize the need for improvements in the tools they use every day. You often come up with good ideas for computer software, medical devices, books, or clinical programming. How can you find out if your idea is really novel? How can you protect your idea while you test and explore it? This forum will provide you with basic information on intellectual property and the medical procedure patent controversy. You will have the opportunity to present your ideas and discuss how they might best be protected.

## TARGET AUDIENCE:

Clinicians, administrators.

## REFERENCES:

1. Pressman D: *Patent It Yourself*, 5th ed. Berkeley, Nolo Press, 1996.
2. Fishmans: *The Copyright Handbook*, 3rd ed. Berkeley, Nolo Press, 1996.

**Discussion Group 9** **Sunday, October 26**
**8:00 a.m.-9:30 a.m.**

## PRIVATIZING ACUTE FORENSIC INPATIENT EVALUATIONS

Ted Lawlor, M.D., *Medical Director, Department of Mental Health, Western Massachusetts Area, One Prince Street, Northampton, MA 01061*; Barbara Granata, Ed.D., *Director of Clinical and Forensic Services, Department of Mental Health, Western Massachusetts Area, One Prince Street, Northampton, MA 01061*

## SUMMARY:

The functions of assessing people for competency to stand trial and criminal responsibility have historically been carried out in state institutions—mental health hospitals and/or department of corrections facilities. In some instances these evaluations can occur in noninstitutional community settings, but this option has limited applicability and utility. In April 1992, all acute civil patients and some acute forensic patients in western Massachusetts began being admitted to a private psychiatric facility, and in November 1993, a private general hospital unit was added.

Public opinion and departmental resource allocation have limited this initiative to approximately 50% of all acute forensic evaluations; the remainder have been evaluated in more traditional settings. Overall, almost all the people considered mentally ill have been served in the private facilities, except those whose charges include murder and rape.

The components of this program will be presented, along with outcome data and comparisons with more traditional forensic services. This enterprise reveals that many forensically involved, mentally ill people can be successfully evaluated and managed in private units, resulting in excellent care close to home, mainstreaming, and destigmatization.

General topics of interest for discussion include privatization, local care, violence in the forensic population, and stigma.

## TARGET AUDIENCE:

Mental health professionals, family members, consumers.

## REFERENCES:

1. Grisso T, et al: A national survey of hospital and community-based approaches to pretrial mental health evaluations. *IPS* 47:642–644, 1996.
2. Hoge MA, et al: Defining managed care in public sector psychiatry. *H&CP* 45:1085–1089, 1994.

**Discussion Group 10** **Sunday, October 26**
**10:00 a.m.-11:30 a.m.**

## PSYCHOPHARMACOLOGY AND THE NONPHYSICIAN CLINICIAN

Karen K. Milner, M.D., *Clinical Instructor, Department of Psychopharmacology, University of Michigan Medical Center, Riverview Building, Ann Arbor, MI 48109*

## SUMMARY:

With the ascendancy of the community mental health centers in the 1970's and the burgeoning growth of HMO's in the last decade, nonphysician clinicians are increasingly being asked to assume a larger role in the day-to-day management of medication for their clients. For example, in assertive community treatment teams, nonphysician clinicians deliver medication to clients and report back to the team psychiatrist about response, side effects, and compliance. This necessitates an intimate familiarity with psychotropic medication by the nonphysician clinician. The development of new classes of medication, the use of familiar agents for new indications, and the lengthening list of drug interactions, make it a challenging task for all clinicians to maintain the necessary knowledge base in this treatment arena. It is critically important that psychiatrists educate nonphysician clinicians as to the use of medication. The purpose of this discussion group is to provide a forum for clinicians to explore ways in which this information can be shared and to look at factors that facilitate or inhibit the process.

## REFERENCES:

1. Nonphysician psychotherapist-physician pharmacotherapist: a new model for concurrent treatment, *Psychiatric Clinics of North America*, 13:307–322, 1990.
2. Allen Frances, M.D., The Split Treatment Model: Interactions Between Psychotherapy and Pharmacotherapy, pp. 431–465. *The Psychotherapist's Guide to Psychopharmacology, Second Edition.* Gitlin MJ (ed.), American Psychiatric Press, Inc., Washington, D.C., 1996.

**Discussion Group 11** **Sunday, October 26 1:30 p.m.-3:00 p.m.**

## LIVING WITH HIV/AIDS WHILE IN PSYCHOTHERAPY

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

### SUMMARY:

Expanded medical research and interventions are moving HIV/AIDS toward becoming a chronic illness. These changes have implications for the psychotherapists who provide care for people affected by HIV/AIDS.

This facilitated discussion group will explore the psychotherapeutic relationship between a clinician and a person living with HIV/AIDS. The discussion should be enhanced by the moderator's own clinical research in which interviews were conducted with 36 clinical social workers and 20 persons living with HIV/AIDS in Boston, New York, Atlanta, San Francisco, and Chicago. The 20 persons living with HIV/AIDS were each paired with the same clinical social workers they were with in psychotherapy and who were also research respondents.

The complexity and depth of the therapeutic process will be discussed by the participants from these perspectives: 1) the psychological factors involved in the progression of the HIV virus, including the impact of the protease inhibitors, which influence the treatment relationship; and 2) aspects of the transference and countertransference dynamics, which shape the content of the psychotherapeutic relationship. The discussion group will conclude by considering some of the social and psychological implications of the strengths and vulnerabilities of this mutually shared psychotherapeutic process.

### TARGET AUDIENCE:

Psychotherapists, including clinical social workers, psychiatrists and psychologists, who are currently working with people living with HIV/AIDS, or who are interested in this work.

### REFERENCES:

1. Martin M, Henry-Feeney J: Clinical services to persons with AIDS: the parallel nature of the client and worker process. *Clinical Social Work Journal* 17(4):337–349, 1989.
2. Schaffer B: The critical and difficult role of the psychotherapist in the treatment of the HIV-positive patient. *Journal of the American Academy of Psychoanalysis* 22(3):505–518, 1994.

**Discussion Group 12** **Sunday, October 26 3:30 p.m.-5:00 p.m.**

## ACADEMIC PSYCHIATRY: BETWEEN MIND, BRAIN AND MANAGED CARE

Roger E. Meyer, M.D., *Senior Scholar in Residence, Association of Academic Health Centers, and Clinical Professor of Psychiatry, Georgetown University, 2900 Glover Drive, N.W., Washington, DC 20016*

### SUMMARY:

Academic psychiatry departments are facing extraordinary pressures in the context of their service programs, their educational programs, and the growing breadth of their teaching and research responsibilities across multiple fields of knowledge. These pressures range from neurobiology and genetics on the one hand, to the biopsychosocial issues in clinical practice on the other hand. The discussion leader was funded by the MacArthur Foundation to study the ways in which academic psychiatry departments across the country have reconfigured their services and educational programs for the 21st century. Data from 48 departments of psychiatry, plus an additional 25 faculty practice plans, provide data from 73 academic health centers. Financial data were provided by 33 departments of psychiatry. These data form the basis for a wide ranging discussion on the different strategies that are being followed in academic health centers to deal with the new health care environment—and how these institutional initiatives are impacting on psychiatry departments. What are the options for academic psychiatry in these times? The discussion should be lively. The data, which have been collected and analyzed, should help to focus the discussion. The discussion leader has been principal investigator on the MacArthur Foundation grant. He was chair of psychiatry for 16 years at UConn, and served from 1993 to 1995 as VP for health affairs at George Washington University.

### TARGET AUDIENCE:

Psychiatry faculty and trainees and clinicians concerned about the future of the field.

### REFERENCES:

1. Meyer RE, Stotsky S: Managed care & the role & training of psychiatrists. *Health Affairs* Vol. 14 No. 3 pp. 65–77, 1995.
2. Blumenthal D, Meyer GS: Academic health centers in a changing environment. *Health Affairs* 15:2 pp 200–215, 1996.

**Discussion Group 13** **Sunday, October 26**
**3:30 p.m.-5:00 p.m.**

## ETHICAL DILEMMAS IN THE ERA OF MANAGED CARE

Vivian B. Pender, M.D., *Clinical Assistant Professor, Department of Psychiatry, Cornell University Medical College, 247 West 87th Street, Apt. 7-F, New York, NY 10024*

### SUMMARY:

The explosion of managed care into the marketplace has exponentially forced psychiatric professionals to make increasingly complex ethical choices. Increased public awareness, high technology, and better access to medical services have made decisions that were confined to the privacy of the professional's conscience now shared by patients, insurance agents, and government officials. As the body of knowledge in the field of psychiatry expands, a psychiatric professional can only be expert in a specific disease or treatment. In addition, being an expert in psychiatric ethics does not make one an expert in moral ethical matters. Health care professionals are faced daily with difficult ethical dilemmas nevertheless. The relationship with the patient, for example, whether previously guided by covenant, code, or contract, is now dictated predominantly by payment and rationing of resources. Managed care excludes reimbursement and, therefore, treatment for personality disorders and substance abuse. What becomes of treatments for these problems? Informed managed care consent and legislative advocacy are other issues in which the psychiatric professional may become involved. Is this ethical? Finally, how does the professional protect confidentiality, the cornerstone of psychiatric treatment? Participants in this discussion group will be encouraged to bring clinical examples from their work to foster awareness of the ethical issues in their professional decisions and discuss new approaches to these dilemmas.

### TARGET AUDIENCE:

All health care professionals, patient advocates, and family members.

### REFERENCES:

1. Veatch RM: *Medical Ethics.* Boston, Jones and Bartlett, 1996.
2. Reinhardt UE, et al: Health tracking: from the field. *Health Affairs* 15(4):81–114, 1996.

**Discussion Group 14** **Monday, October 27**
**8:00 a.m.-9:30 a.m.**

## RACISM: MENTAL OR SOCIAL PROBLEM?

Khushro B. Unwalla, M.D., *Department of Psychiatry, Loma Linda University, 7411 Windrose Drive, Highland, CA 92346*; David E. Schultz, M.D., *Associate Residency Director, Department of Psychiatry, Loma Linda University, 25763 Van Leuven Street, Apt. 75, Loma Linda, CA 92354*

### SUMMARY:

The moderators will discuss racism and the recent explosion in the incidence of hate-related crimes. We will speculate on the factors in society that may have encouraged the rise of attitudes that foster this kind of violence and prejudice. The latest information about personality characteristics that are related to or predict interracial violence will be presented.

Are the perpetrators of such crimes responsible for their acts, or are they victims of poverty, lack of opportunity, and poor education? Should racism and hate crimes be classed as a mental disorder, as some have recently argued, or should they be considered a social problem? Will calling racism a mental illness absolve people of personal responsibility? How can psychiatrists help promote cultural understanding and harmony in the community in which they work? We will pose these questions and ask participants to discuss these issues in an open forum.

### TARGET AUDIENCE:

Psychiatrists, psychiatric residents, psychologists, social workers.

### REFERENCES:

1. Carter JH: Racism and mental health professionals, *Psychiatric News* Oct. 4, 1996.
2. Muntaner C, Javier NF: The Bell Curve—on race, social class, and epidemiology research, *American J of Epidemiology* 144(6):531–6 Sept. 15, 1996.

**Discussion Group 15** **Monday, October 27**
**8:00 a.m.-9:30 a.m.**

## EVALUATING THE ABILITY TO CONSENT

Robert R. Conley, M.D., *Assistant Professor, Department of Psychiatry, University of Maryland, P.O. Box 21247, Baltimore, MD 21228*; Raymond Love, Pharm.D., *Associate Professor, Department of Pharmacy, University of Maryland, 100 Penn Street, Baltimore, MD 21201*

### SUMMARY:

The necessity of frequently obtaining informed consent in psychiatric settings has been accepted and mandated. The process for obtaining this consent is often not clear, particularly when dealing with populations whose cognition or judgment is potentially impaired. We developed the Evaluation to Sign Consent (ESC)

instrument to assess capacity to consent. The ESC is a quick, easily administered method for assessing mental capacity to give informed consent. It is an operational evaluation of a subject's ability to answer relevant questions regarding a specific study or treatment. The formal consent process requires disclosure of the risks, benefits, alternatives, and nature of a procedure or study in detail. The ESC distills these categories of information down to the specifics likely to be of most concern to the subject. Thus, the ESC covers the risks, the nature of a subject's participation, methods for addressing distress, and how to withdraw consent. This discussion group will cover the methods of obtaining consent in public hospital settings. Participants will learn how to do this evaluation and will discuss its relative merits. It will be of interest to all those who have to carry out informed consent procedures.

## TARGET AUDIENCE:

Clinicians and administrators who must develop informed consent procedures.

## REFERENCES:

1. Appelbaum PS, Roth LH: Clinical issues in the assessment of competency. *Am J Psychiatry* 138(11):1462–1467, 1981.
2. Delano SJ, Zucker JL: Protecting mental health research subjects without prohibiting process. *Hospital & Community Psychiatry* 45(6):601–603, 1994.

**Discussion Group 16** **Monday, October 27**
**1:30 p.m.-3:00 p.m.**

## SHAPING A SYSTEM OF PSYCHIATRIC CARE FOR THE HOMELESS: A NEW YORK MODEL

Katherine Falk, M.D., *President and Founder, Project for Psychiatric Outreach to the Homeless, Inc., 141 East 88th Street, New York, NY 10128-2248*; Gail Albert, Ph.D., *Executive Director, The Project for Psychiatric Outreach to the Homeless, Inc., 120 Riverside Drive, New York, NY 10024*

## SUMMARY:

Untreated mental illness is common in the homeless population and is a major public health problem. It is now recognized that traditional hospital-based care is inadequate to treat this group and that successful treatment must be community-based while retaining essential linkages to hospitals. The system of care must also include outreach and nontraditional engagement of homeless clients. The Project for Psychiatric Outreach to the Homeless, Inc. (PPOH) describes the unique approach it has developed in New York City over the last ten years for discussants interested in replication in other cities.

PPOH uses resources already present, working through existing community-based social service agencies, hospital residency training programs, and volunteer psychiatrists to create a city-wide network of community-centered psychiatric treatment for the homeless in New York, which is solidly linked with inpatient hospital units. In 1996, over 1,000 mentally ill homeless people were treated. Outcome measures are provided, including changes in service needs, and placement and continuation in housing.

## TARGET AUDIENCE:

Residency training directors and clinicians working with the homeless mentally ill.

## REFERENCES:

1. Katz SE (ed): *Intensive Treatment of the Homeless Mentally Ill.* Washington, DC: American Psychiatric Press, 1993.
2. Bachrach LL: On exporting and importing model programs. *Hospital and Community Psychiatry,* 39(12):1257–8, 1988.

**Discussion Group 17** **Monday, October 27**
**1:30 p.m.-3:00 p.m.**

## MANAGED CARE AND COMMUNITY PSYCHIATRY

Harold I. Eist, M.D., *Medical Director, Montgomery Child and Family Health Services, Department of Psychiatry, Howard University, and Past President, American Psychiatric Association 5705 Rossmore Drive, Bethesda, MD 20814-2227*

## SUMMARY:

"Managed care," as we know, is designed to reduce corporate spending on health care. To argue that care has always been "managed" is to miss the point. "Managed care" focuses on *price* not *care* nor *cost*, and the spin off costs of "managed care" in dumping into the public sector, the excess costs of caretaking for people kicked out of the hospital quicker and sicker, its attack on basic medical and community care values, which puts patient welfare before corporate profits have been enormous. This session will focus not only on the depredations of "managed care" that have led to an ever-decreasing percentage of the health care dollar going to treatment of the mentally ill, but will focus on approaches to reversing this trend.

## REFERENCE:

1. Eist HI: *Transnational Corporations, Politics and the Crisis in Psychiatry*, Distinguished Guest Lecture,

The Royal College of Psychiatry, Bournemouth, England July 2, 1997.

**Discussion Group 18** **Monday, October 27**
**3:30 p.m.-5:00 p.m.**

## A PSYCHIATRIST'S PREGNANCY: TRANSFERENCE ISSUES

Brenda J. Roman, M.D., *Assistant Professor of Psychiatry, Wright State University School of Medicine, P.O. Box 927, Dayton, OH 45401*; Ann K. Morrison, M.D., *Associate Director, and Assistant Professor, Community Psychiatry, Wright State University School of Medicine, P.O. Box 927, Dayton, OH 45401*

### SUMMARY:

Years ago, analysts had little understanding of the impact that pregnancy of an analyst can have on patients. Since the 1970's, however, the psychoanalytical literature has indeed revealed the tremendous impact that a therapist's pregnancy can have on patients. Still little exists in the literature describing the impact that a mental health professional's pregnancy can have on those with severe and persistent mental illnesses. Intense transference issues exist in this population as these women struggle with multiple issues of loss of motherhood. Choice, chance, and custody loss all contribute to these losses; yet these issues are often ignored. This workshop will examine the transference reactions, as experienced by two psychiatrists in the CMHC population during their pregnancies. Countertransference is equally common and intense in the community treatment setting as staff struggle to best meet the needs of women with serious mental illness and their children. Countertransference issues will be identified and explored in the workshop. Participants will be invited to share their own experiences with the pregnancies of staff and patients in their clinical sites.

### REFERENCES:

1. Pielack LK: Transference, countertransference, and the mental health counselor's pregnancy. *Journal of Mental Health Counseling*. 11:155–176, 1989.
2. Bridges NA, Smith JM: The pregnant therapist and the seriously disturbed patient: managing long-term psychotherapeutic treatment. *Psychiatry* 51:104–109, 1988.

**Discussion Group 19** **Tuesday, October 28**
**8:00 a.m.-9:30 a.m.**

## WORKING WITH CLOZAPINE PARTIAL RESPONDERS

Richard H. McCarthy, M.D., *Assistant Professor, Department of Psychiatry, New York Hospital-Cornell Medical Center, 21 Bloomingdale Road, White Plains, NY 10605-1504*; Bradford B. Perry, M.D., *Assistant Professor, Department of Psychiatry, New York Hospital-Cornell Medical Center, 21 Bloomingdale Road, White Plains, NY 10605*

### SUMMARY:

Clozapine is arguably the most important single advancement in the treatment of seriously ill schizophrenic patients since chlorpromazine. Unfortunately, many patients do not fully respond to clozapine. We support the use of clozapine in responders and its withdrawal in nonresponders; however, it is our experience that such distinctions are far more difficult than the research literature would indicate. Indeed, it is typical for most, if not all, patients to accrue some benefit from clozapine.

Discontinuation of clozapine in these partially responding patients is far more difficult. To date, most discussions on this topic have focussed on a prior differentiation of responders from nonresponders, the appropriate interval for clozapine treatment to proceed, and the implicit, if not explicit, rationing of clozapine, based on cost-benefit considerations. There has been little discussion of the differential assessment and management of clozapine partial responders.

Issues relevant to clozapine partial response include use of clozapine as a monotherapy and avoidance of polypharmacy, the appearance of intervening pathology such as OCD symptoms, observational biases due to persistent adverse effects, and the importance of availability of psychosocial interventions on response.

We invite clinicians with experience with clozapine patients to attend this session and to actively discuss these issues.

### REFERENCES:

1. Peacock L, Gerlach J: Clozapine treatment in Denmark: concomitant psychotropic medication and hematologic monitoring in a system with liberal usage practices. *Journal of Clinical Psychiatry* 55:2 44–49, 1994.
2. Risperidone augmentation of clozapine. *Pharmacopsychiatry*: 28:61–63. 1995.

**Discussion Group 20** **Tuesday, October 28**
**10:00 a.m.-11:30 a.m.**

## MEASURING OUTCOMES: MANAGED CARE AND CLINICAL PRACTICE IN GENERAL

Harold Alan Pincus, M.D., *Deputy Medical Director, and Director, Office of Research, American Psychiatric Association, 1400 K Street, N.W., Washington, DC 20005*

## SUMMARY:

Research on the impact of managed care on access, quality, outcomes, and costs of mental health and substance abuse services has been limited due to the lack of generalizability of studies, the "black box" focus of much of the research, the dynamic changes in mental health and substance abuse managed care, and the proprietary nature of the health care industry. Participants will discuss frameworks for understanding the organizational, financial, and procedural features of health plans and the effect of these features on the characteristics and flow of patients through health plans, and the selection and utilization of treatments. The diverse research priorities of key stakeholders—public and private purchasers, managed care organizations, providers, patients, and their families—will be discussed along with a broader societal agenda for delineating the outcomes of health care plans. Critical research and methodologic issues in studying the effects of managed care will be outlined, including issues related to identifying and selecting appropriate outcome measures and developing appropriate methods for risk adjustment to adequately control for patient selection bias. In addition, participants will discuss the application of systematic assessment tools in routine practice and the APA's new project in development—the *Handbook of Psychiatric Measures and Outcomes.*

## REFERENCES:

1. Pincus HA, Zarin DA, West JC: Peering into the "black box": measuring outcomes of managed care. *Arch Gen Psychiatry* 53:870–877, 1996.
2. Wells KB, Astrachan BM, Tischler GL, Unutzer J: Issues and approaches in evaluating managed mental health care. *The Millbank Quarterly* 73:57–75, 1995.

**Full-Day Session 1** **Friday, October 24**
**8:30 a.m.-5:00 p.m.**

## GENDER ISSUES AND MENTAL ILLNESS

*American Academy of Clinical Psychiatrists*

Richard Balon, M.D., *Department of Psychiatry and Behavioral Sciences, University Psychiatric Center, Wayne State University, 2751 E. Jefferson Street, Suite 200, Detroit, MI 48207*; Valerie F. Holmes, M.D., *President, American Academy of Clinical Psychiatrists, and Department of Psychiatry, Duke University Medical Center*, Kathleen Merikangas, Ph.D., Kimberly A. Yonkers, M.D., Lee S. Cohen, M.D., Timothy D. Brewerton, M.D., Richard S. Schottenfeld, M.D., Charles L. Rich, M.D., Piérre Tran, M.D., Donald W. Goodwin, M.D., Godehard Oepen, M.D., Ph.D., Michael E. Thase, M.D., Robert H. Howland, M.D., Dale A. D'Mello, M.D., Barbara M. Rohland, M.D.

### EDUCATIONAL OBJECTIVES:

Meeting participants will learn about gender differences in mental illness to include information about epidemiology, women and psychopharmacological treatment, pregnancy and mental illness, consultation-liaison psychiatry with a focus on breast cancer, psychiatric aspects of obesity and binge eating, substance abuse, and suicide.

### SUMMARY:

Participants will share findings regarding an array of subjects presented by AACP members. They will learn about the use of multiple antimanic drugs in bipolar disorder, schizophrenic disorders, and comorbid medical illness; Medicaid managed mental health in Iowa; breast feeding and alcoholism; olanzapine vs. risperidone; placebo aspects in psychopharmacology; and sertraline maintenance therapy in chronic depression.

### REFERENCES:

1. Guy-Grand B, Appelbaum M, Crepaldi G, et al: International trial of long-term dexfenfluramine in obesity. *Lancet* 1989; 2:1142–1144.
2. Stunkard AJ, Berkowitz R, Tanrikut C, et al: d-Fenfluramine treatment of binge eating disorder. *Am J Psychiatry* 1996; 153:1455–1459.
3. Brewerton TD: Toward a unified theory of serotonin dysregulation in eating and related disorders. *Psychoneuroendocrinology* 1995; 20:561–590.
4. Ferguson DM, Feighner JP: Fluoxetine-induced weight loss in overweight non-depressed humans. *Intl J Obesity* 1987; 11 (Suppl 3):163–170.

**Full-Day Session 2** **Friday, October 24**
**8:30 a.m.-5:00 p.m.**

## THE AIDS EPIDEMIC AMONG PEOPLE WITH MENTAL ILLNESS

*Joint Session with the APA AIDS Education Project and Columbia University HIV Mental Health Training Project*

Francine Cournos, M.D., *Professor of Clinical Psychiatry, Columbia University, 722 West 168th Street, Unit 112, New York, NY 10032*; Marshall Forstein, M.D., *Medical Director, HIV Services/Mental Health and Addiction Services, Department of Psychiatry, Cambridge Hospital, 1493 Cambridge Street, Cambridge, MA 02139*; J. Stephen McDaniel, M.D., Francisco Fernandez, M.D., Eric G. Bing, M.D., Barbara J. Silver, Ph.D., Paul Tricarico, R.N., Ellen Stover, Ph.D., James Satriano, Ph.D., Lisa Goodman, Ph.D., Ewald Horwath, M.D., Meg Kaplan, Ph.D., Richard Herman, Marlene J. Dunsmore, M.S.W, L.C.S.W., Brian J. Ladds, M.D., Karen McKinnon, M.A.

### EDUCATIONAL OBJECTIVES:

This program will provide comprehensive information and skills about the critical HIV-related issues facing people with mental illness; participants will gain knowledge of the epidemiology of HIV infection, recognize patients' risk behaviors and intervene appropriately, and diagnose and treat HIV-related complications within the context of continuing mental health care.

### SUMMARY:

HIV infection is prevalent among people with severe mental illness. Rates in published studies of psychiatric samples are 4% to 23%. This program will review all facets of the problem and ways to stem the epidemic and treat those affected by it.

A morning plenary session will include an overview of the AIDS epidemic in this population, presentation of federal research, service, and policy initiatives, case-based discussion of the legal and ethical issues facing providers, and research-based findings concerning the link between psychiatric symptoms and risk, the relationship of sexual abuse and trauma to HIV risk behaviors, injection drug use, prevention models, neuropsychiatric aspects of HIV infection, and access to health care.

The afternoon will consist of workshops that will provide participants with state-of-the-art, hands-on skills in specific areas, including pre- and post-test counseling, risk/transmission reduction, interventions for homeless and forensic populations, antiretroviral-psychotropic drug interactions, and providing integrated health and mental health care.

Presenters will be nationally recognized experts in HIV/AIDS and mental illness who will share their expe-

riences and the most up-to-date information and materials available including books, pamphlets in English and Spanish, training manuals, male and female condoms, and videos.

## TARGET AUDIENCE:

All mental health care providers, students, consumers, and their family members.

## REFERENCES:

1. Cournos F, Empfield M, Horwath E, et al: HIV seroprevalence among patients admitted to two psychiatric hospitals. *American Journal of Psychiatry* 148:1225–1230, 1991.
2. Susser E, Valencia E, Conover S: Prevalence of HIV infection among psychiatric patients in a New York City men's shelter. *American Journal of Public Health* 83:568–570, 1993.
3. Kalichman SC, Sikkema KJ, Kelly JA, et al: Use of a brief behavioral skills intervention to prevent HIV infection among chronic mentally ill adults. *Psychiatric Services* 46:275–280, 1995.
4. McKinnon K, Cournos F, Sugden R, et al: The relative contributions of psychiatric symptoms and AIDS knowledge to HIV risk behaviors among people with severe mental illness. *Journal of Clinical Psychiatry* 41:506–513, 1996.

**Full-Day Session 3** **Saturday, October 25**
**8:30 a.m.-5:00 p.m.**

# PLANNING AND DELIVERY OF MENTAL HEALTH CARE TO THE COMMUNITY AGED

Mark R. Nathanson, M.D., *Associate Professor of Psychiatry, Geropsychiatry Fellowship, Columbia University for Geriatric and Gerontology Rehabilitation, 100 Haven Avenue, Tower 1, 29F, New York, NY 10032*; Susan Fox, M.S.W., *Associate Executive Director, Shorefront Mental Health Center, 3712 Coney Island Avenue, Brooklyn, NY 11283*; Carl I. Cohen, M.D., Susan Rice, M.S.W., John Toner, Ph.D., Harry Schwartz, Ph.D., Lauren S. Bernard, M.S.W.

## EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation the participant will recoginize: 1) the shifting population demographic trends as we enter the next century where the fastest growing segment of the population will be the over 80 group; 2) innovative service models must be implemented to bring mental health services in proximity to increasingly frail seniors who at best have been reluctant to access traditional mental health services; 3) that the aging population is at high-risk for dementing illnesses, depressive disorders, delirium, alcoholism, and anxiety disorders which, if detected early, can be treated effectively with medication and/or psychotherapy, 4) that minority and special high-risk groups such as immigrant are posing particular dilemmas to the mental health worker and attention must be targeted to their particular needs; 5) that under new welfare reform the mental health community is likely to experience a flood of mental distress as numbers of people experience financial and social disequilibrium; 6) that geriatric mental health must include a team approach of multidisciplinary professions particularly in nursing, social work, psychology, and psychiatry and networking of services will be important to maximize efficiency; 7) that fund raising and administrative skills are essential to negotiating the community and political forces in conflict with goals of maintaining seniors in their communities; 8) that models such as supportive service and the Naturally Occurring Retirement Community legislation in New York State have led to effective and efficient service delivery to frail elderly in need; and 9) that the psychiatrist has an important role in assessment, consultation, supervision, education, and treatment planning for complex patients with manifold medical and psychiatric disorders.

## SUMMARY:

This full-day presentation incorporates experts in geriatric mental health from direct service providers to community organizers. Thus, the scope of the discussion will range from the microscopic management of geriatric psychopathology, included a discussion on planning community services for specific target populations, i.e., the immigrant Russians in Brooklyn, and conclude with an overview of networking strategies and political agendas for fostering interest in the financial viability of community services.

Dr. Nathanson will coordinate a lively presentation and discussion of these areas. He will give an overview of the day's material and review the model program for frail seniors in Coney Island. Dr. Schwartz will review strategies for networking services and obtaining political support. Dr. Cohen will cover special needs of community mental health for the minority African-American population. Ms. Rice will discuss her experiences as a home visiting social worker in the New York City area. Dr. Toner will review strategies to develop educational models to train professionals in geropsychiatry. Ms. Fox will discuss her expertise in the Russian immigrant and the particular mental health issues that arise in this group.

## TARGET AUDIENCES:

Mental health providers interested in aging.

## REFERENCES:

1. Cantor MH, and Gurland B: Growing Older in New York City in the 90's. NY Center for Policy On Aging of the New York Community Trust, 1993.

2. Glasscote R, Gudeman JE, and Miles CE: Creative Mental Health Services for the Elderly. Washington: American Psychiatric Association, 1977.
3. Hunt M, and Ross L: Naturally Occurring Retirement Communities: a multi-attribute examination of desirability factors, *The Gerontologist*, 1990; 30, 5, 667–674.
4. Marans RW, Feldt AG, Pastalan LS, et al: Retirement communities: present and future. In: *Housing for a Maturing Population*, Washington, DC: The Urban Institute, 1983.

**Full-Day Session 4** **Sunday, October 26**
**8:30 a.m.-5:00 p.m.**

## CREATING THE ROLE OF THE URBAN PUBLIC SECTOR PSYCHIATRIST

Jules M. Ranz, M.D., *Director, Public Psychiatry Fellowship, New York State Psychiatric Institute, 722 W. 168th Street, New York, NY 10032*; Ruth Graver, M.D., Joseph S. Weiner, M.D., Ph.D., Anthony T. Ng, M.D., Michael F. Grunebaum, M.D., James P. Wolberg, M.D., Mary E. Barber, M.D., Susan M. Deakins, M.D., Sara L. Kellermann, M.D., Ralph Aquila, M.D., Paula G. Panzer, M.D., Tracy Roth, M.D., Hunter L. McQuistion, M.D., Julia Eilenberg, M.D., Laura Dalheim, M.D., Pamela A. Weinberg, M.D.

### EDUCATIONAL OBJECTIVES:

At the conclusion of this full-day program, participants will understand the importance of developing a strategy for creating their own roles as psychiatrists in the public sector. They will learn how the Public Psychiatry Fellowship teaches this strategy, will see how its alumni translate this approach into their work in public-sector agencies, and will have the opportunity to receive consultation in creating strategies for their roles at their own public-sector agencies.

### SUMMARY:

Following the fellowship's popular seminar at the 1996 Institute on Psychiatric Services on the role of the psychiatrist as medical director, the Public Psychiatry Fellowship of Columbia University has organized a full-day program on strategies for creating the role of the psychiatrist in public-sector agencies. We will first review the results of our surveys demonstrating how Public Psychiatry Fellowship alumni create active roles for themselves in the public sector, and then describe how the fellowship provides specific training for the strategies involved in creating these roles. We will then present four workshops on various strategies fellowship alumni have followed to create their own roles as psychiatrists in public-sector agencies. The day will end with an opportunity for participants to receive consultations from fellowship faculty and alumni on creating the role of the psychiatrist in public-sector agencies.

### TARGET AUDIENCE:

Psychiatrists working in the public sector.

### REFERENCES:

1. AACP Guidelines for Psychiatric Leadership in Organized Delivery Systems for Treatment of Psychiatric and Substance Disorders, *Community Psychiatrist* 9:6–7, 1995
2. Clark GH, Vaccaro JV: Burnout among CMHC psychiatrists and the struggle to survive. *Hospital and Community Psychiatry* 38:843–47, 1987
3. Diamond RJ, Goldfinger SM, Pollack DA, Silver M: The role of psychiatrists in community mental health centers: a survey of job descriptions *Community Mental Health Journal* 31:571–77, 1995
4. Diamond RJ, Stein LI, Susser E: Essential and nonessential roles for psychiatrists in community mental health centers. *Hospital and Community Psychiatry* 42:187–89, 1991
5. Nadler, Tushman, Hatvany (editors): *Managing Organizations*, Little Brown, 1982
6. Pollack DA, Cutler DL: Psychiatry in community mental health centers: everyone can win. *Community Mental Health Journal* 28:259–267, 1992
7. Posavac EJ, Carey RG: *Program Evaluation Methods and Case Studies;* Prentice Hall, New Jersey, 1989
8. Ranz JM, Rosenheck S, Deakins S: Columbia University's Fellowship in Public Psychiatry *Psychiatric Services* 47:512–516, 1996

**Full-Day Session 5** **Monday, October 27**
**8:30 a.m.-5:00 p.m.**

## TRAUMA AND HEALING: INTERGENERATIONAL TRANSMISSION

Roberta J. Apfel, M.D., M.P.H., *Associate Clinical Professor of Psychiatry, Harvard Medical School, The Cambridge Hospital, 170 Chestnut Street, Newton, MA 02165-2711*; Bennett Simon, M.D., *Clinical Professor of Psychiatry, Harvard Medical School, 170 Chestnut Street, Newton, MA 02165-2711;* Maurice Apprey, Ph.D., Carl C. Bell, M.D., Julie C. Goschalk, L.I.C.S.W., Charles W. Huffine, Jr., M.D., John P. Woodall, M.D.

### EDUCATIONAL OBJECTIVES:

The participant should be able to understand the modes of intergenerational transmission of violence and hatred within groups and families, as well as learn about interventions that reduce the risk of such transmission.

## SUMMARY:

"Identification with the aggressor" has been a catchphrase in explaining how children of violent parents themselves may become violent parents. We are now refining our understanding of how the effects of trauma, violence, and hatred in one generation are transmitted to succeeding generations. Studies of group phenomena—ethnic, national, racial, religious—and intrafamilial phenomena suggest modes of transmission and interception of trauma. Presenters will discuss studies of different groups that will contribute to better understanding of these phenomena: descendents of Holocaust survivors and of Nazi perpetrators, including dialogue between these two groups; the African-American experience and the long-term effects of slavery; interethnic historic problems in the former Yugoslavia; the transgenerational nature of Cypriot Greek-Turkish conflicts. There will also be material on the dilemma of how and why some abused children grow up to be abusing parents, but how most such children do not. The effects of parental psychosis on young children and practical means of intervention with these individuals will be discussed. The panel will attempt to integrate the knowledge and experience obtained to date in these diverse areas of investigation and intervention and suggest future directions for this work.

## TARGET AUDIENCE:

Mental health professionals working in situations of violence involving and affecting children and youth.

## REFERENCES:

1. Apfel RJ, Simon B: *Minefields in their Hearts: The Mental Health of Children in War and Communal Violence*, New Haven, Yale Univ. Press, 1996.
2. Apprey M: Broken Lines, Public Memory, Absent Memory: Jewish and African Americans Coming to Terms with Racism. *Mind & Human Interaction*, Vol. 7, #3 1996.
3. Baron D: *Fear and Hope: Three Generations of the Holocaust.* Cambridge. MA. Harvard Univ. Press, 1995.
4. Fonagy P, et al: Measuring the ghost in the nursery: *Journal American Psychoanalytic Association* 41:957–990, 1993.

**Industry-Supported Symposium 1** — **Friday, October 24 6:30 a.m.-8:00 a.m.**

## PATIENT AND PHYSICIAN: CRITICAL CONNECTIONS IN THE TREATMENT OF SCHIZOPHRENIA

*Supported by Zeneca Pharmaceuticals*

Harold I. Eist, M.D., *Medical Director, Montgomery Child and Family Health Services, and Department of Psychiatry, Howard University, 5705 Rossmore Drive, Bethesda, MD 20814-2227*

### EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, participants should be able to recognize the benefits and uses of a new audio-visual program designed to help patients and their families understand a diagnosis and the subsequent treatment of schizophrenia.

### SUMMARY:

Despite the advent of new, atypical antipsychotic agents appropriate to the treatment of schizophrenia, for many patients and their families, a diagnosis of schizophrenia continues to be seen as more of a "death sentence" than would a diagnosis of cancer or heart disease. A new patient-education videotape developed by the American Psychiatric Association through support from Zeneca Pharmaceuticals has been designed for the physician to use directly with these patients and their families. The program seeks to dispel both the stigma and myths surrounding schizophrenia and to present hope to the newly diagnosed patient and his or her family. The "premiere" of this new tool for the physician and community health care provider will illustrate methods for use and emphasize—through dramatic comparisons of surveyed attitudes—the myths, stereotypes, and misconceptions that are still carried today by patients, families, friends, and health care providers about schizophrenia and those who experience the illness.

### REFERENCES:

1. *Practice Guideline for the Treatment of Patients with Schizophrenia,* American Psychiatric Press, 1997.
2. *The New Pharmacotherapy of Schizophrenia,* American Psychiatric Press, 1996.

**Industry-Supported Symposium 2** — **Friday, October 24 12 noon-1:30 p.m.**

## TREATMENT OF BIPOLAR DISORDER THROUGHOUT THE LIFE CYCLE

*Supported by Abbott Laboratories*

Alan F. Schatzberg, M.D., Kenneth T. Norris, Jr. *Professor & Chairman, Department. of Psychiatry & Behavioral Sciences, Stanford University School of Medicine, Department of Psychiatry Stanford Medical College, TD114, Stanford, CA 94305-5490*

### EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, participants should be able to diagnose bipolar disorder in all age groups and select optimal treatments.

### SUMMARY:

The past few years have witnessed a proliferation of information regarding bipolar disorder. This symposium consists of three talks, each of which will highlight new findings in the area. Dr. Stanley Kutcher will present on the diagnosis and treatment of bipolar disorder in adolescence, emphasizing effects on cognition and school performance, and differential response of the disorder to specific pharmacotherapy. Dr. Paul Keck will discuss the presentation and treatment of mania in the elderly. Last, Susan McElroy will present data on maintenance studies in bipolar disorder. Implications for clinical management will be emphasized.

### No. 2A
### BIPOLAR DISORDER IN ADOLESCENTS

Stanley P. Kutcher, M.D., *Professor and Chief, Department of Psychiatry, Dalhousie University, 5909 Jubilee Road, Halifax, NS, Canada, B3H 2E2*

### SUMMARY:

Bipolar disorder is a severe and chronic psychiatric disorder that often appears during adolescence. This presentation will review the following recent information about adolescent-onset bipolar disorder and will include published and unpublished material as well as data from ongoing research into this condition: clinical presentation, course and outcome, treatment and acute mania, treatment of depression in bipolar disorder, and long-term treatment of bipolar disorder.

At the completion of the presentation the participant should be updated on progress in understanding adolescent bipolar disorder and have an appreciation of the most appropriate treatments for various phases of this illness in teenagers.

### No. 2B
### BIPOLAR DISORDER IN THE ELDERLY: RECENT ADVANCES

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

Susan L. McElroy, M.D.; John W. Kasckow, M.D., Ph.D.

## SUMMARY:

Studies of clinical populations suggest that mania is a common cause of psychiatric hospitalization in the elderly. The syndrome of geriatric mania is also highly heterogenous. Until recently, little was known about the clinical presentation and course of bipolar disorder in the elderly and its association with comorbid psychiatric and medical illness. Data from the University of Cincinnati Mania Project regarding the phenomenology, comorbidity, treatment response, and one-year outcome of elderly patients (>65 years old) with bipolar disorder will be presented. In addition, data from other recent treatment studies will be reviewed and their clinical implications discussed.

## No. 2C
## PROPHYLACTIC TREATMENT OF BIPOLAR DISORDER

Susan L. McElroy, M.D., *Biological Psychiatric Program, University of Connecticut College of Medicine, 231 Bethesda Avenue, ML 559, Cincinnati, OH 45267-0559*

## SUMMARY:

The objective of this presentation is to provide an update on studies examining the prophylactic treatment of bipolar disorder. First, older controlled studies of lithium and carbamazepine in the prophylactic treatment of patients with bipolar disorder will be reviewed. Then, several recent studies comparing valproate with lithium in the prophylactic treatment of both adults and adolescents with bipolar disorder will be presented and compared with the older studies. It will be suggested that available studies indicate that valporate is as effective as lithium in the prevention of manic and possibly depressive episodes. Preliminary experience with other psychotropic agents in the prophylactic treatment of bipolar disorder, especially new antiepileptic drugs and atypical antipsychotics, will also be discussed.

## REFERENCES:

1. Bowden CL: Treatment of Bipolar Disorder. In: Schatzberg AF, Nemeroff CB: *Textbook of Psychopharmacology.* Washington, American Psychiatric Press, pp. 603–614, 1995.
2. Papatheodorou G, Kutcher S: Treatment of Bipolar Disorder in Adolescents. In: Shulman K, Tohen M, Kutcher S (eds.): *Mood Disorders Across the Life Span* Wiley, New York, pp. 159–186, 1996.
3. Dunn KL, Rabins PV: Mania in old age. In: Shulman KI, et al, (eds.): *Mood Disorders Across the Life Span.* New York, NY: John Wiley & Sons, 1996.
4. McElroy SL, Weller E: Psychopharmacologic treatment of bipolar disorder across the life span. In: Dickstein LJ, Riba MB, Oldham JM (eds.): *American Psychiatric Press Review of Psychiatry,* Vol 16. Washington, DC: American Psychiatric Press, pp. IV-31–IV-85.

**Industry-Supported Symposium 3** — **Friday, October 24 7:30 p.m.-10:30 p.m.**

## ANXIETY DISORDERS: IDENTIFYING THE CRITICAL CHALLENGES

*Supported by Pfizer U.S. Pharmaceuticals*

Jonathan R.T. Davidson, M.D., *Professor of Psychiatry, Duke University Medical Center, 637 Totten Place, Chapel Hill, NC 27514-6718*

## EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, participants should be able to enhance their recognition and treatment of anxiety by understanding the growing role of self-help interface between anxiety and substance abuse barriers to treatment in women, importance of primary care, and treatment resistance.

## SUMMARY:

Accurate recognition and effective treatment of the anxiety disorders (ADs) are within reach for all. Unfortunately, this has not yet happened because of failure to seek help, physician failure to recognize the disorder, complicating factors in the clinical picture, barriers to care, and failure of response to normal treatments. This symposium will highlight the above issues, with each presenter offering information that will enable the professional to enhance his or her effectiveness in managing AD. Ms. Ross will describe the important role of self-help, support groups, and advocacy organizations, describing how health professionals can work productively with this sector. She will present results from a survey of anxiety disorder support groups. Dr. Brady will review the relationship between AD and substance abuse, including issues of recognition, classification, and treatment techniques. Dr. Grady will discuss barriers to treatment for anxiety disorders in women, including issues related to the luteal phase and other factors that limit achieving optimal response to treatment.

More AD is treated in primary care settings than in mental health settings. Dr. Kathol will review AD in primary care, patterns of presentation, management challenges, and ways in which psychiatry and primary care can work together productively. Dr. Roy-Byrne will re-

view treatment-refractory anxiety, its definition, its magnitude, and successful treatment strategies.

## No. 3A
## ANXIETY AND SUBSTANCE USE DISORDERS

Kathleen T. Brady, M.D., *Associate Professor, Department of Psychiatry, Medical University of South Carolina, 171 Ashley Avenue, Charleston, SC 29425-0742*

### SUMMARY:

Anxiety disorders and substance use disorders commonly co-occur, but the nature of the relationship is often poorly understood. The use of some substances (cocaine, marijuana) can cause symptoms of anxiety, while withdrawal from other substances (alcohol, sedative hypnotics, opiates) is also marked by symptoms of anxiety. It is also likely that individuals with anxiety disorders self-medicate symptoms of anxiety with substances of abuse, which can further complicate the diagnostic picture and make differential diagnosis more difficult. In this talk, the prevalence of comorbid anxiety disorders and substance use disorders will be discussed. Prevalence of comorbidity from epidemiologic samples and treatment-seeking samples will be compared. Considerations in differential diagnosis, such as order of onset of disorders as well as the minimum necessary period of abstinence for diagnostic clarity, will be discussed. A number of studies exploring both psychotherapeutic and pharmacotherapeutic treatment options in individuals with a variety of anxiety disorders and substance use disorders will be discussed. Specifically, data will be presented from a pharmacologic treatment study of panic disorders in alcoholics, psychotherapeutic treatment of social phobia in alcoholics, and pharmacotherapeutic approaches to the treatment of post-traumatic stress disorder in individuals with substance use disorders.

## No. 3B
## TREATMENT-REFRACTORY PANIC, GAD AND SOCIAL PHOBIA

Peter P. Roy-Byrne, M.D., *Department of Psychiatry, University of Washington, Harborview Medical Center, 325 9th Avenue, Box 359911, Seattle, WA 98104*

### SUMMARY:

Because of the available range of effective treatments for anxiety, most anxiety-related morbidity and cost is associated with treatment refractories due to poor patient adherence, clinician error, or frank resistance to treatment. Common clinician errors include inadequate patient education and preparation, misidentification of comorbid psychiatric and medical conditions, incorrect medication dose or duration, or failure to use concomitant cognitive or other psychotherapy. Refractory panic, GAD, and social phobia are often associated with comorbid depression, phobia, substance abuse, personality disorder, and specific medical illness (COPD, sleep apnea, epilepsy, Parkinson's or thyroid disease), and components that remain treatment nonresponsive (anticipatory anxiety, phobia, hypochondriasis, specific panic symptoms, or cognitive vs. somatic anxiety), can guide selection of augmenting pharmacotherapy or specific psychotherapy and may also identify paradoxical anxiogenic effects of usually effective medications. Use of novel medications may also prove beneficial, although careful, systematic trials combining more traditional agents and therapies are usually more productive.

## No. 3C
## PHARMACOLOGIC TREATMENT OF ANXIETY DISORDERS IN WOMEN

Tana A. Grady, M.D., *Director of Residency Training, Department of Psychiatry, Duke University Medical Center, Box 3837, Durham, NC 27710*

### SUMMARY:

Most anxiety disorders are at least twice as common in women as in men. This gender difference is important for understanding the etiology of anxiety disorders. Additionally, it is important to recognize the potential role of exogenous hormones, menstrual cycle hormonal changes, and pregnancy on both the etiology and pharmacologic treatment of anxiety disorders in women.

Pharmacologic management of anxiety disorders with antidepressants, benzodiazepines, and mood stabilizers will be reviewed, with an emphasis on gender differences in efficacy and side-effect profile. There will be specific attention to the potential pharmacodynamic and pharmacokinetic differences across the menstrual cycle and with the use of exogenous hormones, particularly oral contraceptive agents. Finally, there will be a review of the use of pharmacologic agents for treatment of anxiety disorders during pregnancy, with emphasis on the risk-to-benefit ratio.

## No. 3D
## ANTIDEPRESSANTS IN PTSD: WHICH DRUG? WHICH PATIENT? WHICH TRAUMA?

Jonathan R.T. Davidson, M.D., *Professor of Psychiatry, Duke University Medical Center, 637 Totten Place, Chapel Hill, NC 27514-6718*

## SUMMARY:

A growing literature now exists on the use of medications in post-traumatic stress disorder (PTSD). Early studies focused on combat veterans who showed positive responses to tricyclic and irreversible MAOI antidepressants. Subsequent studies of SSRI therapy have failed to demonstrate evidence of efficacy in this population, but there is mixed evidence for the benefit of brofaromine in such subjects.

Recent trials of SSRIs in civilians with PTSD show good effect; the majority of subjects in these studies were women.

Some symptoms appear to be more drug responsive than others and findings depend on the drug and trauma population under study. Antidepressants can also have a positive effect on symptoms other than the core PTSD features, as will be described.

This presentation will review the major findings to date regarding antidepressants in PTSD and will report on the possible importance of trauma type and gender on drug response.

## No. 3E
## FACING THE CHALLENGE: SELF-HELP AND ADVOCACY

Jerilyn Ross, M.A., L.I.C.S.W., *Ross Center for Anxiety and Related Disorders, 4445 42nd Street, NW, Suite 311, Washington, DC 20016*

## SUMMARY:

In spite of the fact that anxiety disorders are the most prevalent mental health problem in the United States, affecting more than 26 million Americans and costing in excess of $46 billion a year, anxiety disorders continue to be minimalized, trivialized, misdiagnosed, and mistreated. Although in recent years tremendous strides have been made in understanding the causes and nature of anxiety disorders and in developing new treatments, huge gaps still exist in knowledge, dissemination of information, and access to care.

The Anxiety Disorders Association of America (ADAA) responds to an average of 60,000 information requests a year from the public. Many who write and call ADAA describe the devastating impact their disease has had on their life and the difficulty of being taken seriously and/or finding effective treatment. Since 1980, through its network of self-help groups, a dedicated board of directors and scientific advisory board, several thousand consumer and professional members, and high visibility with the national media, ADAA has been advocating for more research, destigmatization, and better access to care.

This presentation will focus on how consumers, clinicians, and researchers are working together to bring forth the message that anxiety disorders are REAL, SERIOUS, and TREATABLE and to improve the quality of life of those suffering from these disorders.

## No. 3F
## ANXIETY IN THE PRIMARY CARE SETTING

Roger G. Kathol, M.D., *Professor of Psychiatry and Internal Medicine, University of Iowa, 200 Hawkins Drive, Iowa City, IA 52242*

## SUMMARY:

Anxiety is seen in many patients with medical illness. It can occur as a primary anxiety disorder, in association with another psychiatric illness, be caused by medications, or be related to organic disorder. If anxiety is primary, then the behavioral/ emotional syndrome can be treated the same way that anxiety without a medical illness is treated. If anxiety is related to another psychiatric illness, then primary treatment depends on the coexisting psychiatric illness. If anxiety is caused by a medication or substances that the patient is taking, like cold preparations or excessive caffeine, discontinuation of the offending agent is advised. If anxiety is related to medical illness, it could be due to the stress or change necessitated by the illness, or a direct result of the physiologic changes from the illness itself. In the first instance, support and/or short-term psychotherapy can be helpful. In the latter, treatment of the medical condition should alleviate symptoms without the need for anxiety-specific intervention. When anxiety persists in patients with chronic medical illness, even when thought to be related to the stress of the illness, then anxiety-specific therapy, such as medication and/or psychotherapy, should be considered. In the primary care setting, differentiating among various causes of anxiety can be difficult. It requires attention to medical and psychiatric components of the patient's history and a physical assessment. Sometimes laboratory testing is indicated. Once the etiology is narrowed down, the clinician can be more comfortable that the specific approach to the patient is likely to lead to improvement. Treatment will alleviate symptoms and decrease functional impairment.

## REFERENCES:

1. Kushner MG, Sher KT, Bietner BD: The relationship between alcohol problems and anxiety disorders. *Am J Psychiatry* 1990; 147:685–695.
2. Yonkers KA, Ellison JM: Anxiety Disorders in Women and Their Pharmacological Treatment In: *Psychopharmacology and Women: Sex, Gender and Hormones*—Jensvold MF, Halbreich U, Hamilton JA (eds). Washington, DC: American Psychiatric Press, Inc., 1996; pp. 261–285.

3. Roy-Byrne PP, Wingerson D, Cowley D, Dager S: Psychopharmacologic treatment of panic GAL and social phobia. *Psychiatric Clinics of North America* 1993; 16:719–736.
4. Stoudermire A: Epidemiology and psychopharmacology of anxiety in medical patients. *J Clin Psychiatry* 1996; Vol 7(Supp 7); 64–72.

**Industry-Supported Symposium 4** **Saturday, October 25 6:30 a.m.-8:00 a.m.**

## COMORBIDITY FACTORS AND THE TREATMENT OF DEPRESSION

*Supported by Pfizer U.S. Pharmaceuticals*

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

### EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, participants should be able to enhance their recognition and treatment of depression by understanding the influence of comorbidity factors such as alcohol dependence, anxiety disorders, and chronicity. Participants will also enhance their knowledge of how these factors influence patient outcomes and cost of treatment for depression.

### SUMMARY:

Effective management of depression is often complicated by comorbidity factors. This symposium will investigate the impact of these factors on treatment and health outcomes of depression, with each author offering insight that will enable clinicians to enhance their ability to manage this disorder.

Dr. Mason will describe the management of depression secondary to alcohol dependence, focusing on issues of pharmacologic treatment and the risk for relapse. Dr. Hirschfeld will review the recognition and management of anxiety associated with depression. Dr. Schatzberg will focus on the management of both chronic and recurrent depressions, emphasizing long-term pharmacologic management.

## No. 4A
## MANAGEMENT OF DEPRESSION SECONDARY TO ALCOHOLISM

Barbara J. Mason, Ph.D., *Associate Professor and Director, Division of Substance Abuse, University of Miami School of Medicine, 1400 NW 10th Avenue, Suite 314, Miami, FL 33136*

### SUMMARY:

Depression has many important health consequences including poor medical care outcomes, longer general hospital stays, and increased risk of suicide in alcoholics. Early diagnosis and effective treatment of depression in alcoholics may thereby result in more cost-effective use of health care dollars. Controversy exists over when and how to treat alcohol-dependent patients with antidepressant medication. A six-month double-blind, placebo-controlled trial of desipramine was conducted in 71 patients with primary alcohol dependence stratified on the presence or absence of major depression. Depression was measured with a Hamilton rating score (HAM-D). Drinking was assessed using a timeline interview, with breath alcohol concentration and collateral verification. Treatment with a clinically determined dose of desipramine was initiated after a median of eight days of abstinence. Among depressed patients, HAM-D scores decreased, number of abstinent days were greater, and patients rated a higher degree of satisfaction with desipramine than placebo. Nondepressed groups did not differ on drinking outcome. In conclusion, major depression secondary to alcohol dependence that is diagnosed after at least one week of abstinence can remain stable in some placebo-treated alcoholics and can respond to antidepressant medication. Treating depression secondary to alcoholism may reduce risk for drinking relapse in some patients. Use of desipramine to reduce relapse in nondepressed alcoholics is not supported.

## No. 4B
## RECOGNITION AND MANAGEMENT OF ANXIETY

Robert M.A. Hirschfeld, M.D., *Chairman, Department of Psychiatry and Behavioral Science, University of Texas Medical Branch, 1200 Graves Building, Galveston, TX 77550-2774*

### SUMMARY:

The majority of patients with major depression and dysthymia will often suffer from a comorbid anxiety disorder that may include panic disorder, obsessive-compulsive disorder, social phobia, generalized anxiety disorder, and post-traumatic stress disorder. Patients with major depression and dysthymia may also suffer from subsyndromal anxiety symptomatology. The presence of anxiety symptoms or syndromes can have a substantial effect on the patient's clinical presentation and prognosis. The presence of comorbid anxiety and depression substantially influences treatment selection and clinical management. For example, patients with current or recent panic disorder are at substantially higher risk for suicide in the near term. A rationale for the selection of treatment modalities will be presented, focusing on

pharmacologic agents that have a broad spectrum of efficacy, including both depression and anxiety disorders, and that have a benign side-effect profile.

## No. 4C
## MANAGEMENT OF CHRONIC AND RECURRENT DEPRESSION

Alan F. Schatzberg, M.D., Kenneth T. Norris, Jr. *Professor & Chairman, Department of Psychiatry & Behavioral Sciences, Stanford University School of Medicine, Department of Psychiatry, Stanford Medical College, TD114, Stanford, CA 94305-5490*

### SUMMARY:

Data will be presented from an ongoing multicenter study of 635 patients who met criteria for chronic major depression for the past two years or major depression for six months superimposed on dysthymia for the previous two years. Previous treatment history indicates patients had rarely received somatic therapy or received inadequate trials of medication. Patients in this study were treated with either sertraline or imipramine for 12 weeks under double-blind, random-assignment conditions. Responders were continued for 16 weeks and then enrolled in a maintenance protocol for 76 weeks. Nonresponders during the acute 12-week study were crossed over to the other drug and, if they responded, were entered into continuation therapy. Data will be presented on the acute and continuation phases of the study. Both treatments were effective during acute and continuation phases. The "burn-out" rate during continuation did not differ between the two drugs. Some patients gained further antidepressant effect during continuation. Implications of these data will be discussed.

In recent years, several studies have revealed that imipramine, fluoxetine, sertraline, or imipramine are effective in preventing recurrence over one to five years. These studies will be reviewed and the issues of dose and side effects during maintenance will be discussed.

### REFERENCES:

1. Leibowitz MR, Hollander E, Schneier F: Anxiety and depression: discrete diagnostic entities? *J Clin Psychopharmacol* 1990; 10(3):61S–66S.
2. Mason BJ, Kocsis JH, Ritvo EC, Cutler RB: A double-blind, placebo-controlled trial of desipramine in primary alcohol dependence stratified on the presence or absence of major depression. *Journal of the American Medical Association* 1996; 275:10:761–767.
3. Frank E, Kupfer DJ, Perel DM, et al: Three-year outcome for maintenance treatment in recurrent depression. *Arch Gen Psychiatry* 1990; 47:1093–1099.

**Industry-Supported Symposium 5** **Saturday, October 25 12 noon-1:30 p.m.**

## WHEN DEPRESSION IS ONLY ONE OF THE PROBLEMS

*Supported by Wyeth-Ayerst Laboratories*

Philip T. Ninan, M.D., *Associate Professor, Department of Psychiatry, Emory University, 1701 Uppergate Drive, Room 126, Atlanta, GA 30322*

### EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, participants should be able to discuss the management of depression with comorbid anxiety and general medical conditions.

### SUMMARY:

The syndrome of major depression is characterized by the core emotion of sadness. Similarly, the syndromes considered anxiety disorders have worry as their core component. However, anxiety in its various manifestations is seen in the majority of patients with major depression. Comorbidity of subsyndromal and syndromal anxiety disorders and major depression occur frequently both at the time of evaluation and historically. In addition, the presence of an anxiety disorder increases the risk for the development of major depression in the future. Thus, the categorical distinction between major depression and the anxiety disorders is often confounded in clinical practice. Concurrent subsyndromal anxiety and depressive symptoms have been termed mixed anxiety-depressive disorder. Comorbidity of anxiety and depressive syndromes can be a sign of greater severity. Various biochemical, behavioral, and other theoretical explanations have been proposed for comorbid anxiety and depression.

The treatment of comorbid anxiety and depression is a challenge to clinicians. Likewise, the management of comorbid physical disorders in depressed patients is not easy. The clinician always has to be vigilant in choosing antidepressant medications that do not result in drug-drug interactions. This can be particularly problematic in the elderly, who tend to be on multiple medications. Additionally, a determination needs to be made as to whether any of the medications medically ill patients are taking are themselves the cause of the depression, or if depression is a component of the disorder. The pharmacological management of patients with depression-associated anxiety and with depression concomitant to physical illness will be discussed.

## No. 5A
## MANAGING DEPRESSION WITH ASSOCIATED ANXIETY

Philip T. Ninan, M.D., *Associate Professor, Department of Psychiatry, Emory University, 1701 Uppergate Drive, Room 126, Atlanta, GA 30322*

## SUMMARY:

The treatment of comorbid anxiety and depression is a particular challenge to clinicians. Various pharmacological and psychotherapeutic treatments are available. The pharmacological management of patients with comorbid symptoms vs. syndromes will be discussed. Clinical medicine attempts to treat syndromes rather than independently treat individual symptoms. The pros and cons of symptomatic versus syndromal management will be discussed in relationship to anxiolytics and sedative/hypnotics.

## No. 5B
## OPTIMIZING TREATMENT FOR DEPRESSION IN THE FACE OF COMORBID MEDICAL CONDITIONS

John M. Zajecka, M.D., *Clinical Director, Department of Psychiatry, Rush Presbyterian/St. Luke's Hospital, 1725 West Harrison Steet, Suite 955, Chicago, IL 60612*

## SUMMARY:

Epidemiological and clinically based studies show high comorbidity rates between depression and other psychiatric disorders. Early recognition and intervention for both depression and these other disorders can maximize acute and long-term outcomes and reduce the morbidity and mortality of these common comorbid disorders. There is increasing availability of effective treatment options for managing patients with such comorbid disorders, including monotherapies and augmentation strategies.

Updating and organizing this influx of knowledge may lessen the apparent complexity of choosing effective treatment(s) for the variety of clinical presentations depression may take with these other comorbid psychiatric conditions. A systematic approach, which can be tailored to the individual patient, will be presented for the management of depression associated with panic attacks, post-traumatic stress disorder, social phobia, obsessive-compulsive disorder, eating disorders, substance abuse, and bipolar depression.

## REFERENCES:

1. Eyeshefsky L: Drug interactions of antidepressants. *Psychiatric Annals* 1996; 26:342–350.
2. Nemeroff MD: Depression with comorbid anxiety. *Primary Psychiatry* 1997; 4:53–67.
3. Zajecka JM, Ross JS: Management of comorbid anxiety and depression. *J Clin Psychiatry* 1995; 56 (suppl 2), 10–13.

**Industry-Supported Symposium 6** **Saturday, October 25 12 noon-1:30 p.m.**

## PRACTICAL MANAGEMENT OF DEMENTIA

*Joint Session with the Geriatric Psychiatry Alliance*

Gary W. Small, M.D., *Professor of Psychiatry, University of California at Los Angeles and Director, Aging Center, 760 Westwood Plaza, Los Angeles, CA 90024-8300; Lon S. Schneider, M.D.*

## EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, participants should be able to assess patients with dementia, deal with common management issues, and show knowledge of pharmacologic and psychosocial treatments.

## SUMMARY:

This symposium will review recent national consensus recommendations for the treatment of dementia, with a focus on management issues for the practicing psychiatrist. The presenters will be participating in the 1997 Consensus Development Conference for the Treatment of Alzheimer's Disease and Related Dementias, cosponsored by the Geriatric Psychiatry Alliance, the Alzheimer's Association, and the American Geriatrics Society. After the chair's introduction, there will be four 25-minute presentations, followed by a 20-minute formal discussion and audience participation. Dr. Gary Small (co-chair of the Consensus Panel) will review diagnostic and assessment issues, including epidemiology, phenomenology, office evaluation, and laboratory assessment. Dr. George Grossberg will cover common management issues such as driving, conservatorship, reimbursement, and when to hospitalize. Dr. Lon Schneider will focus on pharmacologic interventions, including cognitive enhancers and drugs for behavioral management. Dr. Linda Teri will cover a range of psychosocial issues involving patient and caregiver interventions, community support, and living options. Dr. Peter Rabins (co-chair of the Consensus Panel) will provide an overview to stimulate audience participation.

## No. 6A
## DIAGNOSIS AND ASSESSMENT OF DEMENTIA

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

**SUMMARY:**

This presentation will review diagnostic and assessment issues regarding dementia, including epidemiology, phenomenology, office evaluation, and laboratory assessment. The dementia syndrome is characterized by impaired cognition (including memory loss) that interferes with daily functioning. It afflicts 5% of people over age 65 and nearly 50% of people over age 85. Alzheimer's disease (AD), a gradually progressive disorder, accounts for an estimated 60% of dementia cases, but many other conditions require consideration, including stroke disease, drug effects, and depression. Risk factors for AD include age, prior head trauma, and the apolipoprotein E-4 (APOE-4) allele. Adequate assessment involves a careful medical and physical history (involving reliable collateral sources) and examination; screening laboratory tests may uncover secondary medical conditions that can impair cognition. Such behavioral complications as psychosis, agitation, and depression are common. Standardized rating scales (e.g., Mini-Mental State Examination, Hamilton Depression Rating Scale) are useful for initial office screening. Symptom checklists can efficiently identify a variety of complaints during initial evaluation and follow-up. A detailed neuropsychological assessment will be more effective in identifying and quantifying specific deficits and providing a baseline for follow-up comparisons. Structural imaging studies (e.g., CT, MRI) will identify strokes or space-occupying lesions; functional studies (e.g., PET, SPECT) may confirm clinical impressions. Presence of APOE-4 increases the likelihood of a diagnosis of AD in an already demented patient. Such genetic testing is not recommended for asymptomatic persons.

## No. 6B
## LEGAL AND MANAGEMENT ISSUES IN DEMENTIA

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

**SUMMARY:**

Psychiatrists play a major role in the diagnostic evaluation of competency in older adults. A familiarity with causes of progressive impairment as well as reversible syndromes is important. Knowledge of various forms of surrogate management including guardianship, is vital, especially with each state having its own statutes. This paper will detail the psychiatrist's role in the competency evaluation process and discuss surrogate management options.

Psychiatrists play a key role in the diagnostic evaluation of dementia, in the treatment of the psychiatric symptoms of dementia as they evolve, and in working with families and other health care providers. At times, psychiatric hospitalization may be required, whether in cases of failure of outpatient management or when the patient poses a danger to self or to others. This paper will detail common scenarios that may necessitate psychiatric hospitalization of demented patients, such as depression, aggressivity, or psychosis, and will then review outcomes.

## No. 6C
## PHARMACOLOGIC INTERVENTIONS

Lon S. Schneider, M.D., *Associate Professor of Psychiatry, University of Southern California, 2011 Zonal Avenue, HMR-101, Los Angeles, CA 90033-1071*

**SUMMARY:**

This presentation will focus on pharmacologic interventions, including cognitive enhancers and drugs for behavioral management. By the end of 1997, there will be a variety of efficacious medications to treat Alzheimer's disease. During the past year, two new cholinesterase inhibitors were approved for the treatment of cognitive symptoms; there is evidence that antioxidants such as vitamin E or selegiline may modify the course of the illness; and several newer atypical neuroleptics are available for treating behavioral symptoms. Aspects of choosing a cholinesterase inhibitor and the type of responses to be expected will be discussed as will the medication treatment of behavioral symptoms. New approaches to optimizing clinical management of Alzheimer's disease will also be discussed.

## No. 6D
## PSYCHOSOCIAL TREATMENT IN ADULT DEMENTIA: CONSENSUS CONFERENCE RESULTS

Linda Teri, Ph.D., *Professor of Psychiatry, University of Washington, 1959 NE Pacific Street, MS 356560, Seattle, WA 98195*

**SUMMARY:**

This presentation will provide an overview of nonpharmacologic treatment approaches for optimal management of patients with dementia. Clinical knowledge and empirical studies will be presented along with recommendations from the January 1997 Consensus Development Conference for the Treatment of Alzheimer's Disease and Related Dementias, cosponsored by the Geriatric Psychiatry Alliance, the Alzheimer's Association, and the American Geriatrics Society. The importance of providing nonpharmacological treatment to patients

and their caregivers either instead of or as an adjunct to pharmacotherapy will be discussed. A variety of treatment modalities (e.g., behavior therapy, psychoeducational formats, environmental modifications, caregiver support, and training programs) will be surveyed, and the relevant literature presented. The importance of physician and nonphysician members of the caregiving team will be discussed, as will ways in which to become informed about living options and community resources.

## REFERENCES:


1. Department of Health and Human Services. Agency for Healthcare Policy and Research Clinical Guidelines Number 19: *Recognition and Initial Assessment of Alzheimer's Disease and Related Dementias.* Washington, DC Government Printing Office 1996 (AHCPR publication no: 97–0702).
2. American Association for Geriatric Psychiatry, American Geriatrics Society, and Alzheimer's Association *1997 Consensus Development Conference: Alzheimer's Disease and Related Dementias.* Small G, Rabins P, Barry P, Dekosky S, (eds.) January 1997.
3. Department of Health and Human Services. Agency for Healthcare Policy and Research Clinical Guidelines Number 19: *Recognition and Initial Assessment of Alzheimer's Disease and Related Dementias.* Washington, DC' Government Printing Office 1996 (AHCPR publication no:97–0702).
4. Grossberg GT, Zimny G: Medical-Legal Issues. In *Comprehensive Review of Geriatric Psychiatry.* Sadavoy, J. et al, (eds.), American Psychiatric Press, Inc., Washington, D.C., pp. 1037–1050, 1996.
5. Lake JT, Grossberg GT: Management of psychosis, agitation, and other behavioral problems in Alzheimer's disease. *Psychiatric Annals,* 1996; 26:1–6.
6. Schneider LS, Tariot PN: Treatment of dementia. In: *Clinical Geriatric Psychopharmacology: Third Edition.* Edited by C Salzman. Williams & Wilkins, Baltimore, Maryland (in press).
7. Tariot PN, Schneider LS: Non-neuroleptic treatment of complications of dementia: applying clinical research to practice. In: *Geriatric Psychopharmacology.* Edited by JC Nelson. Marcel Dekker, Inc., New York, (in press).
8. Teri, Rabins, Whitehouse, et al: Management of behavioral disturbance in AD; current knowledge and future directions. *ADAD: An International Journal.* 1992; 6:77–88.
9. Teri: Nonpharmacological approaches to management of patient behavior. In: Gutman (ed.) *Shelter and Care of Persons with Dementia.* Vancouver, BC., 1992.
10. Teri, Logsdon, Wagner, Uomoto: The caregiver role in behavioral treatment of depression in dementia patients. In: Light, Lebowitz & Neiderehe. *Stress Effects on Family Caregivers of AD Patients.* NY: Springer Press, 1994.


**Industry-Supported Symposium 7** **Saturday, October 25 7:00 p.m.-10:00 p.m.**

# INDICATIONS AND REAL WORLD APPLICATIONS OF ATYPICAL ANTIPSYCHOTICS

*Supported by Zeneca Pharmaceuticals*

Jeffrey A. Lieberman, M.D., *Professor of Psychiatry and Pharmacology, Department of Psychiatry, University of North Carolina, 101 Manning Drive, CB #7160, Chapel Hill, NC 27599*

## EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, participants should be able to review the indications for and applications of atypical antipsychotics in the treatment of community-based patients

## SUMMARY:

Atypical antipsychotics have brought about significant improvements in the treatment of patients with acute exacerbations of schizophrenia, largely because of their more favorable safety and acceptability profiles. Encouraged by the recent advances in schizophrenia care these new agents have afforded, investigators are studying the efficacy of atypical antipsychotics in a number of related disorders. The symposium "Indications and Real World Applications of Atypical Antipsychotics" will focus on this emerging body of knowledge. Treatment paradigms for patients with first-episode and nonrefractory schizophrenia will begin the review, followed by a discussion of the use of antipsychotics for the control of aggressive behavior and the violent patient. Child- and adolescent-onset psychoses have been difficult to treat because of adverse effects from existing treatments. The reduced risk of tardive dyskinesia and greater tolerability associated with the atypicals suggest that they may be good candidates for treatments of these troubling disorders. Patients who experience psychotic features in conjunction with mania or depression have been particularly resistant to mood stabilizers alone. Early studies suggest that the atypical antipsychotics are useful adjunctive medications for this patient population. Elderly patients are particularly sensitive to the adverse effects of traditional antipsychotics. Early indications suggest the atypicals are better tolerated and show positive effects on reducing psychosis and agitation among elderly patients with dementias. These studies will be reviewed. By reducing the burden of extrapyramidal side effects, it is hoped that so too will the risk of tardive dyskinesia be lessened. The final speaker will review the current data

on tardive dyskinesia and discuss treatment plans for those unfortunate enough to develop it.

## No. 7A
## TREATMENT OF FIRST-EPISODE AND NON-REFRACTORY SCHIZOPHRENIA

Jeffrey A. Lieberman, M.D., *Professor of Psychiatry and Pharmacology, Department of Psychiatry, University of North Carolina, 101 Manning Drive, CB #7160, Chapel Hill, NC 27599*

### SUMMARY:

Treatment responses for patients experiencing a first episode of schizophrenia and those with nonrefractory schizophrenia are different from the responses seen in patients who have experienced multiple episodes. A greater number of the first-episode/nonrefractory patients recover, respond to a lower dose of medication, have fewer residual symptoms, and have an increased sensitivity to side effects. Studies have shown that early intervention during the initial episode of illness can improve long-term outcome. An important question is whether atypical antipsychotic drugs can provide any greater efficacy in the treatment of patients in this stage of their illness. This presentation will describe data from studies on the treatment outcomes of first-episode patients receiving conventional and atypical antipsychotic medications. The differential effects on side effects, psychopathology, and long-term outcome will be presented and discussed.

## No. 7B
## MANAGEMENT OF AGGRESSIVE PATIENTS AND VIOLENT BEHAVIOR

Jan Volavka, M.D., Ph.D., *Professor of Psychiatry, Nathan S. Kline Institute, 140 Old Orangeburg Road, Orangeburg, NY 10962*

### SUMMARY:

One of the principal reasons for admission to a psychiatric hospital is violent behavior. Most of the initial violence subsides soon after the admission; however, a small percentage of patients continue to show violent or aggressive behavior. These patients do not respond to conventional antipsychotic drugs despite receiving high doses. Uncontrolled studies with several of the atypical antipsychotics have shown positive results with this population above and beyond the general antipsychotic drug effects. This presentation will explore the antiaggressive efficacy of a number of the atypical antipsychotic medications. Case reports of successful reductions in aggression with adjunctive use of mood stabilizers, selective serotonin reuptake inhibitors, benzodiazepines, and beta-adrenergic blockers will also be presented.

## No. 7C
## USE OF ANTIPSYCHOTICS IN CHILD- AND ADOLESCENT-ONSET PSYCHOSIS

Linmarie Sikich, M.D., *Assistant Professor of Psychiatry, University of North Carolina at Chapel Hill, CB 7160, 101 Manning Drive, Chapel Hill, NC 27514*

### SUMMARY:

Psychotic disorders in children and adolescents are a significant public health concern and consume a disproportionate amount of mental health care resources. Psychotic symptoms in the pediatric population occur within several neuropsychiatric disorders and are much more prevalent than generally thought. One in 200 adolescents requires treatment for psychotic symptoms. Outcome studies in schizophrenia and major affective disorders indicate that prognosis is worse in early-onset cases. Effective treatment without undo risks is essential for improving outcome and reducing costs to society. Ideal treatment would reduce both positive and negative symptoms, enhance the child's ability to learn, and improve adaptive functioning while incurring minimal side effects. Atypical antipsychotics hold promise for doing this.

We will discuss available information regarding the efficacy and side effects of haloperidol and the atypical antipsychotics, clozapine, risperidone, and olanzapine in children and adolescents. Their use will be discussed in developmental disabilities as well as in schizophreniform and affective illnesses. It is essential to define the advantages and disadvantages of treatment with classical and specific atypical antipsychotics in particular populations so that the most appropriate agent can be prescribed.

## No. 7D
## MANAGING PATIENTS WITH RECURRENT AND REFRACTORY MOOD DISORDERS WITH ANTIPSYCHOTICS

Joseph R. Calabrese, M.D., *Director, Mood Disorders Program, Case Western Reserve University, 11400 Euclid Avenue, Suite 200, Cleveland, OH 44106-3986*

### SUMMARY:

Clinical experience accumulated over the last two decades indicate that 20%–50% of patients with bipolar disorder fail to respond to lithium. Recent data suggest that severity of mania, and psychotic symptoms in partic-

ular, predicts poor response to lithium, carbamazepine, and valproate. These treatment-refractory bipolar and schizoaffective patients are given maintenance neuroleptic treatment in order to control symptoms, and are thus at risk for tardive dyskinesia. Therefore, a large number of refractory manic patients with persistent psychotic and mood disorder symptoms need more effective therapies. To explore the efficacy of clozapine in the acute management of hospitalized mania, an open-label, prospective, clozapine monotherapy study was carried out. After a seven-day washout, 25 acutely manic patients with either bipolar disorder or schizoaffective disorder-bipolar subtype who were lithium-, anticonvulsant-, and neuroleptic-resistant and/or intolerant were treated with clozapine monotherapy and evaluated over 13 weeks. Marked improvement in both mood and psychotic symptoms was noted in 64% of patients. The response of the bipolar patients was superior to that of the schizoaffective patients. Rapid cyclers did as well as non-rapid cyclers. These results suggest clozapine and the atypical antipsychotics may be effective therapy for treatment-resistant bipolar and schizoaffective mania.

## No. 7E
## COGNITIVE AND BEHAVIORAL EFFECTS OF TYPICAL ANTIPSYCHOTICS IN THE ELDERLY: NEW TREATMENT ALTERNATIVES

John W. Newcomer, M.D., *Assistant Professor of Psychiatry and Psychology, Washington University School of Medicine, 4940 Children's Place/Box 8134, St. Louis, MO 63110-1002*

### SUMMARY:

An important predictor of functional outcome in patients with schizophrenia is the degree of cognitive impairment they experience in areas like memory and attention. Similarly, elderly patients with a variety of dementing processes can experience functional outcomes that depend on the severity of their cognitive deficits. In schizophrenia, impairments in declarative memory (the capacity to learn and recall facts and events) can be quantitatively large in comparison to impairments in other cognitive functions. Despite recent advances in treatments for dementia, there are currently no specific biological treatments for memory and learning impairments for patients with schizophrenia. While antipsychotic medications remain the primary means of affecting outcome of psychotic symptoms, many of these agents, particularly the older ones, produce only modest cognitive benefits and in some cases important adverse cognitive effects. For example, some antipsychotics adversely affect learning and memory performance. This presentation will review the underlying biological effects of individual medications with a special emphasis on the cognitive effects of the new atypical antipsychotics. Future treatments for cognitive impairments will emerge from current neurobiological studies of cognitive function. We have already learned a great deal about a number of pharmacological factors that can impact performance.

## No. 7F
## AVOIDING TARDIVE DYSKINESIA, TREATING IT WHEN IT OCCURS

Rajiv Tandon, M.D., *Associate Professor of Psychiatry, University of Michigan Medical Center, 1500 East Medical Center Drive, Room 8806, Ann Arbor, MI 48109-0116*

### SUMMARY:

While conventional antipsychotic medications are effective in reducing the psychopathology of various psychotic disorders, their use is associated with a whole range of adverse effects that hinder patient acceptance of and compliance with treatment. Extrapyramidal side effects (EPS) and the risk of tardive dyskinesia (TD) are two important adverse effects associated with conventional antipsychotic treatment. A variety of patient characteristics such as age and gender, nature and duration of antipsychotic treatment, and other factors modify the risk of TD. Atypical antipsychotics are significantly better than conventional antipsychotics with regard to these side effects. By definition, all atypical antipsychotics are associated with a lower risk of EPS than conventional antipsychotics; there are individual differences between different atypical antipsychotics with regard to this EPS advantage. This EPS advantage of the atypical agents translates into several secondary benefits, including the possibility of a lower risk of TD. With respect to TD, basic pharmacological studies, including animal models, suggest that atypical antipsychotics will cause less TD than will conventional neuroleptics. In fact, data suggest that atypical medications may have a possible ameliorative effect on TD movements. Prospective studies indicate that the risk of TD is less for the atypical antipsychotics than for conventional agents. While this lower/negligible TD risk is clearly established for clozapine, emerging data with other atypical agents suggest this to be the case with them as well. It is hypothesized that less EPS seen in early treatment with the atypical agents is prognostic of less TD. If these studies are accurate, then the atypical antipsychotic agents are likely to become the antipsychotic drugs of choice for various psychiatric disorders with psychotic features.

### REFERENCES:

1. Lieberman JA: Treatment effects on the course of schizophrenia: potential benefits of atypical antipsy-

chotics in first-episode patients. In: Brunello N, Racagni G, Langer S, Mendlewicz J, (eds.). *Critical Issues in the Treatment of Schizophrenia.* Basel: Karger. 1995;10:106–114.
2. Spencer EK, Campbell M: Children with schizophrenia: diagnosis, phenomenology and pharmacotherapy. *Schizophr Bull* 1994; 20:713–725.
3. Frazier JA, Giedd JN, Kayse D, et al: Childhood-onset schizophrenia: brain MRI rescan after 2 years of clozapine maintenance treatment. *Am J Psychiatry* 1996; 153:564–566.
4. Lykes WC, Cueva JE: Risperidone in children with schizophrenia. *J Am Acad Chir Adol Psychiatry* 1996; 35:405–406.
5. Calabrese JR, Kimmel SE, Woyshville MJ, et al: Clozapine in treatment refractory mania. *Am J Psychiatry* 1996; 153:759–764.
6. Davis KL, Berger PA, Holister LE: Tardive dyskinesia and depressive illness *Psychopharmacol Commun* 2:125–130, 1976.
7. Newcomer JW: Schizophrenia and delusional disorders. In: Guze SB, (ed.). *Washington University Adult Psychiatry.* St. Louis: Mosby Year-Book. 13:211–240, 1997.
8. Kane JM, Casey DE, Daniel DG, Newcomer JW: Antipsychotic agents: minimizing side effects to maximize compliance. *J Clin Psychiatry* October 1996.
9. Jipson MD, Tandon R: A summary of new research findings on the new antipsychotic drugs. *Essential Psychopharmacol* 1996; 1:27–37.
10. Kane JM, Woerner M, Borenstein M, et al: Integrating incidence and prevalence of tardive dyskinesia. *Psychopharmacol Bull* 1986; 22:254–258.
11. Morgenstern H, Glazer WM: Identifying risk for tardive dyskinesia among long-term outpatients maintained with neuroleptic medications: results of Yale Tardive Dyskinesia Study. *Arch Gen Psychiatry* 1993; 50:723–733.

**Industry-Supported Symposium 8** — **Sunday, October 26 6:30 a.m.-8:00 a.m.**

## CONQUERING PSYCHOSIS: FROM MOLECULES TO MANAGED CARE

*Supported by Eli Lilly and Company*

Stephen M. Stahl, M.D., Ph.D., *Director of Clinical Neuroscience, and Adjunct Professor, Department of Psychiatry, University of California at San Diego, 8899 University Center Lane, Suite 130, San Diego, CA 92122-1009*

### EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, participants should be able to correlate clinical observations with basic psychopharmacological data pertaining to the "atypical" antipsychotic medications and to consider available outcome data that will help clinicians and care systems determine the value of the new antipsychotic agents in the face of limited resources.

### SUMMARY:

The introduction of a new generation of antipsychotic agents is rapidly altering clinical practice. In this symposium, information from multiple perspectives will inform clinicians about the safety, efficacy, and effectiveness of these compounds. Olanzapine, one of the newest agents, will be compared with typical and other atypical medications available to practitioners. Dr. Stephen Stahl will describe the properties of olanzapine and other novel agents. He will explain how they act on brain mechanisms underlying schizophrenia.

Dr. Glazer will present the latest information pertaining to the acute clinical profile of the new generation of antipsychotic drugs. This presentation will survey what we know about relapse patterns, tardive dyskinesia risk, quality of life, and pharmacoeconomics. A study comparing risperidone to olanzapine will be included. A brief discussion of principles for organizing services that maximize effectiveness of this new generation of antipsychotic agents will also be presented.

## No. 8A
## HOW A CLASSICAL NEUROLEPTIC WORKS

Stephen M. Stahl, M.D., Ph.D., *Director of Clinical Neuroscience, and Adjunct Professor, Department of Psychiatry, University of California at San Diego, 8899 University Center Lane, Suite 130, San Diego, CA 92122-1009*

### SUMMARY:

The chlorpromazine revolution defined the *typical* molecule for treatment of psychosis. Newer typical antipsychotics evolved as a series of prominent dopamine-2 (D2) antagonists. The clozapine revolution defined the *atypical* molecule, since it marked the first improvement in efficacy over typical antipsychotics. Newer atypical antipsychotics are evolving in a rapid cascade and from two theoretical perspectives: First, serotonin-2 (5HT2) antagonist properties are a key dimension, together with D2 antagonist properties, of the new atypical antipsychotics. Thus, SDA (*serotonin-2 dopamine-2 antagonism*) is one theme for the new agents, which sort themselves across a spectrum of relative 5HT2 versus D2 antagonism. Which balance of SDA will be optimal remains undetermined, but already it seems clear that significant 5HT2 antagonism enhances the tolerability of D2 antagonism. Secondly, the atypical molecules em-

ulate the other complex pharmacology of the clozapine molecule. This includes alpha 1 antagonist properties, but also, anticholinergic, antihistaminergic, D1, D4, 5HT3, 5HT6, and perhaps even other aspects of the atypical clozapine molecule. A specific portfolio of these properties, in the ideal proportions, is hypothesized to underlie the enhanced efficacy of clozapine. The new atypical molecules all differ in their composition of these properties, and it is possible that one or more of the new compounds might define the efficacy of clozapine without the side effects.

## No. 8B
## HOW ATYPICAL ANTIPSYCHOTICS WORK DIFFERENTLY FROM CLASSICALS

William M. Glazer, M.D., *Associate Clinical Professor, Department of Psychiatry, Harvard Medical School, 100 Beach Plum Lane, Menemsha, MA 02552*

### SUMMARY:

This presentation will incorporate clinical observations to complement Dr. Stahl's presentation on the molecular basis for the new generation of antipsychotic medications. These medications cost money in systems of care that are strapped by limited budgets. A critical issue is the *value* of these new agents. This presentation will apply the pharmacologic principles delineated by Dr. Stahl to clinical practice. Focus will be placed on acute and maintenance efficacy and safety issues related to the new generation of antipsychotics (clozapine, risperidone, olanzapine). The presentation will survey what we know about relapse patterns, TD risk, quality of life, and cost of atypicals compared with typicals. In addition, a study comparing risperidone with olanzapine will be presented. Since it is clear that chronic psychotic conditions are not treated adequately by medication alone, the presenter will briefly delineate principles for organizing services that maximize the effectiveness of the new generation of antipsychotic agents.

### REFERENCES:

1. Stahl SM: *Essential Psychopharmacology.* Cambridge University Press, New York, 1996.
2. Glazer W: What are "best practices?" understanding the concept. *Hospital & Community Psychiatry.* 1994; (11):1067–1068.
3. Sederer LI, Dickey B: *Outcomes Assessment in Clinical Practice.* Baltimore: Williams & Wilkins, 1995.

**Industry-Supported Symposium 9** — **Sunday, October 26 12 noon-1:30 p.m.**

## MODEL BUILDING FOR BEST MULTIDISCIPLINARY PRACTICE

*Supported by Eli Lilly and Company*

William M. Glazer, M.D., *Associate Clinical Professor, Department of Psychiatry, Harvard Medical School, 100 Beach Plum Lane, Menemsha, MA 02552*

### EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, participants should be able to identify multidisciplinary issues related to consultation, collaboration, and supervision; to discuss the role that psychopharmacology plays in the disease state management of psychotic disorders; and to discuss the theoretical underpinnings of disease state management of psychotic disorders.

### SUMMARY:

The outlook for persons suffering from chronic psychotic conditions has never been better. New advances in pharmacotherapy have enabled individuals to achieve levels of functioning previously thought unattainable. To assure successful outcomes, multidisciplinary treatment modalities, which provide the support and training needed for long-term community reintegration, must be able to incorporate these improvements into their routine approach to the patient. Professionals in all disciplines need education in the disease state management approach to treatment, a cost-effective way of achieving long-term stabilization within the community setting.

Emphasizing the role of the physician/nurse team, William Glazer, M.D., and Kimberly Littrell, APRN, CS, CGP, will present a series of themes designed to help clinicians understand and implement models for "Best Multidisciplinary Practice." Strategies to be included in this model building would emphasize clinical pharmacology as the cornerstone upon which biopsychosocial theories can be successfully applied for the production of optimal, long-term outcomes. The model building would discuss the four main tenets for successful multidisciplinary treatment of psychotic disorders. Those four tenets are: establishing the framework for reintegration, creation of a multidisciplinary team, the multidisciplinary treatment plan, and assessment of outcomes and quality improvement of services. Dr. Glazer will emphasize system level themes, while Ms. Littrell will focus primarily on patient-level considerations.

Audience interaction will be encouraged at various times throughout this 90-minute program. Time will be devoted to problem solving on issues regarding disease-state management in a managed care setting. Possible discussion topics include troublesome issues regarding selecting and monitoring patients receiving atypical anti-

psychotic agents, balancing large case loads, coordinating care through various agencies, finding new support resources, and implementing innovative patient management strategies to improve outcomes.

## No. 9A
## MULTIDISCIPLINARY TEAMWORK IN MOTION

William M. Glazer, M.D., *Associate Clinical Professor, Department of Psychiatry, Harvard Medical School, 100 Beach Plum Lane, Menemsha, MA 02552*

### SUMMARY:

In multidisciplinary settings, working relationships are often impaired by a lack of understanding about roles and responsibilities of the various stakeholders. To assure effective multidisciplinary working relationships, the presenter will teach participants to identify and define consultative, collaborative, and supervisory relationships, and to recognize how these different associations impact the coordination of care of persons suffering from severe and persistent psychotic conditions. Next Dr. Glazer will discuss how a disease-state management model of treatment provides a viable alternative to expensive hospitalization costs by reducing relapse and promoting higher levels of functioning.

One of the greatest sources of tension in multidisciplinary settings is scarcity of resources. Dr. Glazer will discuss various "rationing" issues that impact optimal care of individuals with psychotic disorders. Formulary management themes will be addressed here. All members of the multidisciplinary team need to understand the crucial role that psychopharmacology plays and, more specifically, the role that the new "atypical" antipsychotic agents play in the management of psychotic disorders. Participants will be able to identify discipline-specific advantages to using new, atypical antipsychotics in treating psychosis.

## No. 9B
## MODEL BUILDING FOR BEST MULTIDISCIPLINARY PRACTICE: PATIENT CONSIDERATIONS

Kimberly Littrell, A.P.R.N., C.S., C.G.P., *Promedica Research Center, 3758 Lavista Road, Suite 100, Tucker, GA 30084*

### SUMMARY:

There is reason for considerable optimism in the current treatment of patients with schizophrenia. Recent pharmacological advances have led to improved functioning, thereby facilitating patients, perhaps for the first time, to be "available" for nonpharmacologic interventions. However, in order to implement these strategies effectively, clinicians must first embrace the concept of *disease state management* and understand its relationship to the care of individual patients. Often mistaken for a traditional "case management" model of care, disease state management reflects a comprehensive biopsychosocial orientation in the treatment of psychosis. It is important to remember that true disease state management requires multiple services and diverse treatment approaches from a variety of professionals working in concert with the needs of the patient. Clinicians begin the management process with a formal assessment of current functionality, potential abilities and capabilities, and available resources for achieving desired outcomes.

Nonpharmacologic disease management strategies will be discussed, with particular emphasis on such interventions as symptom management, relapse prevention, group psychotherapy, social skills training, vocational rehabilitation, and family psychoeducation. Participants will also learn clinically relevant measurements to monitor and record outcomes of treatment (PANSS, Drug Attitude Inventory, Social Adjustment Scale, Independent Living Skills Survey, and Psychiatric Distress Scale). A conceptual model for the treatment and reintegration of adults with schizophrenia will be presented that emphasizes an individualized approach. This outpatient prototype utilizes a multidisciplinary team and combines pharmacotherapy and nonpharmacologic reintegration strategies with a focus in five areas: 1) medical, 2) educational, 3) residential, 4) vocational, and 5) social.

Videotape of patients receiving atypical antipsychotic medication will be used to assist participants in identifying needs of the recovering patient.

### REFERENCES:

1. Glazer W: What are "best practices?" understanding the concept. *Hospital & Community Psychiatry.* 1994; (11):1067–1068.
2. Sederer LI, Dickey B: *Outcomes Assessment in Clinical Practice.* Baltimore: Williams & Wilkins, 1995.
3. Guidelines for psychiatrists in consultative, supervisory, or collaborative relationships with nonmedical therapists. *Am J Psychiatry* 1980; 137:11, 1489–1491.
4. Johnson CG, Littrell KH, Magill AM: Starting patients on clozapine in a partial hospitalization program. *Hospital and Community Psychiatry. 45*(3):264–268, 1994.
5. Littrell KH: Maximizing schizophrenia treatment outcomes: a model for reintegration. *Psychiatric Rehabilitation Journal. 19*(1):75–77, 1995.
6. Littrell KH, Littrell SH: Therapeutic efficacy of olanzapine, *Journal of the American Psychiatric Nurses Association, 3*(1): S8–S14, 1997.

**Industry-Supported Symposium 10** **Sunday, October 26 7:00 p.m.-10:00 p.m.**

## MANAGING ANXIETY DISORDERS: PHARMACOLOGIC ADVANCES

*Supported by Eli Lilly and Company*

Krishna DasGupta, M.D., *Citadel Psychiatric Clinic, 2001 Reed Road, Fort Wayne, IN 46815*

### EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, participants should be able to effectively treat panic disorder, obsessive-compulsive disorder, and social phobia with newer pharmacologic agents. In addition, participants should be able to recognize and manage side effects of newer antidepressant agents.

### SUMMARY:

During the past five years, the pharmacologic management of anxiety disorders has progressed considerably. The advent of the selective serotonin reuptake inhibitors (SSRIs) and other newer antidepressants has significantly expanded effective pharmacotherapeutic options for these highly prevalent and potentially disabling disorders. In fact, SSRIs are now considered first-line pharmacologic agents for the treatment of panic disorder, obsessive-compulsive disorder, and social phobia. Not only do they provide a valuable addition for management of acute episodes, but because of their favorable side-effect profile, the SSRIs offer significant advantages for long-term treatment of these chronic and recurrent illnesses.

This symposium will provide a review of recent data regarding pharmacotherapeutic management of panic disorder, obsessive-compulsive disorder, and social phobia, with emphasis on the role of SSRIs and other newer antidepressants. Strategies for management of resistant cases will be discussed. Because effective use of newer agents requires a thorough knowledge of adverse effects, strategies for minimizing and managing side effects will be reviewed.

## No. 10A
## SOCIAL PHOBIA: CURRENT TREATMENT STRATEGIES

James W. Jefferson, M.D., *Dean Foundation for Health, Research and Education, 2711 Allen Boulevard, Middleton, WI 53562*

### SUMMARY:

Social phobia is a prevalent, yet underrecognized and undertreated condition. The National Comorbidity Survey found a 12-month prevalence of 7.9% and a lifetime prevalence of 13.3% for this condition. Historically, alcohol has played a central role as a social lubricant and as self-medication for social phobia. More recently, other pharmacotherapies have been subjected to scientific scrutiny and have emerged as effective and safe treatments. Most, but not all, studies of beta blockers have found them to be useful for performance anxiety, but less so for generalized social phobia. Clonazepam has been beneficial as a short-term (double-blind study) and long-term (open study) treatment, but whether these results can be generalized to benzodiazepines as a class is unclear. While monoamine oxidase inhibitors are effective drugs for social anxiety, their difficulty of use (phenelzine, tranylcypromine) or unavailability (brofaromine, moclobemide) have made them less preferred. Benzodiazepines, particularly clonazepam, outshined placebo as effective treatments. The SSRIs, however, are emerging as treatments of choice for generalized social phobia based on results of both open and double-blind studies. Cognitive behavior therapy is a well-established intervention both alone and together with medication. More often than not, at least one other psychiatric disorder coexists with social phobia. Given the high prevalence of comorbid conditions, treatment combinations are often the preferred routes to success.

## No. 10B
## ADVANCES IN THE PHARMACOTHERAPY OF PANIC DISORDER

Peter P. Roy-Byrne, M.D., *Department of Psychiatry, University of Washington, Harborview Medical Center, 325 9th Avenue, Box 359911, Seattle, WA 98104*

### SUMMARY:

The mainstays of pharmacologic treatment of panic disorder have been, in order of historic and chronologic development, tricyclic antidepressants and MAO inhibitors in the 1960's and 1970's, high-potency benzodiazepines in the 1980's and, more recently, in the 1990's, selective serotonin reuptake inhibitors (SSRIs). Controlled studies now support the previously reported anecdotal efficacy of SSRIs, while anecdotal reports now suggest efficacy for both venlafaxine and nefazodone. Despite widespread public and clinician education, barely 50% of the most symptomatic patients received optimal pharmacotherapy in a recent study. Newer antidepressants have increased patient adherence due to their greater tolerability, and meta analytic reviews suggest they may provide greater efficacy than older agents due to a broader spectrum of action. One study of longer-term treatment with paroxetine suggests greater sustained tolerability defined by less severe side effects than in the acute phase and reduced patient dropout compared with earlier tricyclic studies. Whether SSRIs

will improve the long-term course of panic disorder, which has been characterized by clear residual symptomatology despite noticeable improvement, remains to be seen. The comparable, and in some studies, greater efficacy of cognitive-behavioral treatment (CBT) compared with tricyclics and benzodiazepines must now be reevaluated using these new and more powerful and tolerable agents. Consistent with this caveat, a recent study with fluvoxamine did suggest greater medication efficacy compared with CBT.

## No. 10C
## OCD: UPDATE ON PHARMACOLOGICAL MANAGEMENT

Teresa A. Pigott, M.D., *Department of Psychiatry, Georgetown University, 3750 Reservoir Road, NW, Washington, DC 20007*

### SUMMARY:

Epidemiological surveys indicate that the anxiety disorder, obsessive-compulsive disorder (OCD), is the fourth most common psychiatric illness in the U.S. Characterized by a chronic, but fluctuating course, OCD is frequently complicated by comorbid conditions such as mood and/or additional anxiety disorders. Separate multicenter, placebo-controlled trials of the serotonin reuptake inhibitors (SRIs) clomipramine, paroxetine, fluoxetine, sertraline, and fluvoxamine have established their efficacy in the treatment of OCD. Direct comparisons of SRIs suggest similar efficacy, but reduced tolerability, for clomipramine in comparison with fluoxetine, fluvoxamine, sertraline, and paroxetine in patients with OCD. Unfortunately, most patients achieve only partial symptom reduction (mean improvement, 25% to 40% from baseline) despite adequate SRI trials. Results from controlled trials of adjuvant lithium, buspirone, or thyroid hormone added to ongoing SRI therapy in OCD have been disappointing. However, a controlled study suggests that OCD patients with comorbid tic disorder preferentially respond to neuroleptic augmentation. These and associated studies will be presented in this symposium, as well as an overview of strategies for OCD patients who fail to respond to conventional pharmacotherapeutic interventions.

## No. 10D
## ADVERSE EFFECTS OF NEWER ANTIDEPRESSANTS

Krishna DasGupta, M.D., *Citadel Psychiatric Clinic, 2001 Reed Road, Fort Wayne, IN 46815*

### SUMMARY:

During the last decade, antidepressant options have greatly expanded. Seven new antidepressants (i.e., bupropion, fluoxetine, nefazodone, mirtazapine, paroxetine, sertraline, and venlafaxine) with milder side effects and lower therapeutic indices than MAOIs and TCAs have become available. Several newer antidepressants, particularly the SSRIs, have shown great promise in the treatment of anxiety disorders.

Side-effect profiles differ not only across classes of antidepressants, but within the same class. Gastrointestinal upset and sexual dysfunction caused by several new antidepressants may result from serotonergic mechanisms. Many newer agents cause sedation and/or activation as well as cognitive impairment. Because many women of childbearing age suffer from anxiety disorders, clinicians must be aware of new data regarding the use of antidepressants during pregnancy and lactation. Fortunately, strategies that minimize most adverse effects are available. Awareness of such strategies enables clinicians to optimize compliance.

In summary, side effects of newer antidepressants are generally mild and can be effectively minimized with appropriate management. Individuals suffering from anxiety disorders may be more likely to seek and accept treatment now that these effective and well-tolerated medications are available.

### REFERENCES:

1. Jefferson JW: Social phobia: a pharmacologic treatment overview. *J Clin Psychiatry* 1995; 56(suppl 5):18–24.
2. Roy-Byrne PP, Cowley DS: Treatment of panic disorder. In Dunner DL (ed.), *Current Psychiatric Therapy II.* WB Saunders, in press.
3. Pigott T: OCD: Where the serotonin-selectivity story begins. *J Clin Psychiatry* 1996; 57:11–20.
4. McElroy SL, Keck PE, Friedman LM: Practical management of antidepressant side effects: an update. *Practical Clinical Strategies in Treating Depression in a Managed Care Environment,* Hales RE, Yudofsky SC (eds). APA, Washington DC, 1996.
5. McElroy SL, Keck PE, Friedman LM: Practical management of antidepressant side effects: an update. *Practical Clinical Strategies in Treating Depression in a Managed Care Environment,* Hales RE, Yudofsky SC (eds.) APA, Washington DC, 1996

**Industry-Supported Symposium 11** **Monday, October 27 6:30 a.m.-8:00 a.m.**

## MANAGEMENT OF SEXUAL DYSFUNCTION IN DEPRESSION

*Supported by Glaxo Wellcome Inc.*

Troy L. Thompson II, M.D., *Scientific Program Committee, The Daniel Lieberman Professor, Department of*

*Psychiatry and Human Behavior, Jefferson Medical College and Hospital, 1025 Walnut Street, Room 320, Philadelphia, PA 19107-5005*

## EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, participants should be able to distinguish between sexual dysfunction due to organic causes, psychotropic medications, and psychogenic causes, to describe the role of antidepressants and other psychotropic medications in sexual dysfunction; to identify alternative medications and approaches.

## SUMMARY:

Building upon Master's and Johnson's pioneering efforts that documented the human sexual response cycle and Kaplan's classification and explanation of sexual dysfunctions, the clinician can now effectively diagnose and treat a wide variety of sexual dysfunctions. This symposium will review the human sexual response cycle, a tripartite psychophysiological phenomenon that is mediated by the nervous, vascular, and endocrine systems. Accurate classification of sexual disorders demands a careful history and appropriate physical and laboratory investigations. A systematic approach to such information gathering will be presented to allow DSM-IV classification. Review of common medical diseases and treatments, both surgical and pharmacologic, that cause sexual dysfunction demonstrate the need to partition organic from psychogenic causes. Rational treatment planning can then occur utilizing both psychotherapeutic and somatic interventions. Dysfunctions due to psychotropic agents will be discussed and approaches to ameliorate such problems presented. Injection therapy, mechanical treatments, and surgical interventions to restore functioning will also be reviewed to update the clinician on the full range of treatment options for sexual dysfunctions.

## No. 11A
## THE SEXUAL SIDE EFFECTS OF COMMONLY-PRESCRIBED DRUGS: MEDICAL CONSIDERATIONS

Theresa L. Crenshaw, M.D., *Director, Crenshaw Clinic, and Co-Director, Human Sexuality, Department of Reproductive Medicine, University of California Medical School*

## SUMMARY:

A variety of medical and surgical disorders compromise sexual functioning. The clinician must understand the psychological consequences of an illness as well as the specific nuances of the diseases that limit full sexual activity. Many treatments, both pharmacologic and surgical, also limit sexual functioning. This presentation will provide a clinical template to incorporate the general psychological effects of illness, the sexual pathophysiology of common diseases, and the interpersonal dimensions that lead to sexual dysfunction in the medically ill.

## No. 11B
## MANAGEMENT OF ANTIDEPRESSANT-INDUCED SEXUAL DYSFUNCTION

Troy L. Thompson II, M.D., *Scientific Program Committee, The Daniel Lieberman Professor, Department of Psychiatry and Human Behavior, Jefferson Medical College and HospitaL, 1025 Walnut Street, Room 320, Philadelphia, PA 19107-5005*

## SUMMARY:

Sexual dysfunction is a common complaint that is seen in primary care and psychiatry practice as a result of the increasing administration of antidepressant medication, especially the SSRIs. Newly published data and clinical observation suggest that there is a relatively high incidence of sexual dysfunction associated with the use of these agents, which may prevent optimal utilization of these agents by patients in need of antidepressant therapy. This presentation will present the latest information on the incidence and type of sexual dysfunctions commonly associated with the SSRI antidepressants and will describe effective alternative and adjunctive treatments that are useful in treating the sexual dysfunction associated with their use. The presentation will explore the role of drug holiday, evaluate switching to other compounds, and will discuss the use of other classes of psychotropic drugs.

## REFERENCES:

1. Wise TN: Sexual dysfunction in the medically ill. *Psychosomatics* 1983; 24:787–801.
2. Renshaw DC: Sexuality and depression, *Journal of Psychiatric Treatment and Evaluation* 1983; 5:451–455.
3. Thompson WL, Thompson TL, II: Improving sexual function in patients with chronic respiratory disease. *J Clin Practice Sexuality* 1986; 2:8–22.

**Industry-Supported Symposium 12** — **Monday, October 27, 12 noon-1:30 p.m.**

## PSYCHIATRIC PATIENTS, SMOKING AND SMOKING CESSATION

*Supported by Glaxo Wellcome Inc.*

Alexander H. Glassman, M.D., *Department of Psychiatry, Columbia University, 722 West 168th Street, New York, NY 10032-2603*; John R. Hughes, M.D.

## EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, participants should be able to understand the linkage between smoking and psychiatric illness and how to treat patients who smoke.

## SUMMARY:

This symposium will deal with the special relationship between psychiatric illness and cigarette smoking. Patients with either schizophrenia or major depression are much more likely to be cigarette smokers and much less likely to be interested in or able to succeed in smoking cessation. This symposium will look at the potential reasons for this relationship. We will examine the action of nicotine on the reward system and address the issue of whether activating this system might be therapeutic in either depression or schizophrenia. In addition, we will examine the effects of nicotine on cognitive and sensory processing systems and explore whether the heavy use of nicotine in this illness is a form of self medication.

Beyond the reasons for increased use is the question of cessation failure. What should the clinician do? The efficacy of usual nicotine replacement treatments will be reviewed. They will be compared with the newer non-nicotine and antidepressant drug and combination treatments. In addition to the problem of poor cessation rates among psychiatric patients is the question of the risk of withdrawing nicotine from psychiatric patients. Do psychiatric symptoms worsen, and if they do, is that exacerbation short or long term?

## No. 12A
## WHY DO PSYCHIATRIC PATIENTS SMOKE SO MUCH?

Alexander H. Glassman, M.D., *Department of Psychiatry, Columbia University, 722 West 168th Street, New York, NY 10032-2603*; Lirio Covey, Ph.D.

## SUMMARY:

Smoking had long been thought of as a nervous habit and therefore obviously more common among psychiatric patients. In 1988, we first reported that the mere history of major depression in individuals not presently depressed predicted higher rates of smoking and lower rates of cessation. This has now been replicated several times. There is now evidence that this association is based on common genes. In addition, it is now clear that withdrawal symptoms are worse in smokers with a lifetime history of depression and that those individuals, if they are able to stop, are at increased risk of developing new episodes of major depression.

In addition to the association between smoking and depression, there is a link between smoking and schizophrenia. Here, not only is the frequency of smoking higher, but the ingestion of nicotine is significantly elevated. The reason for this frequent and heavy use has only recently begun to be explored.

During the last decade there has been an explosion of information about reward centers and their relationship to drug abuse, including nicotine. This relationship can be seen as a potential reason, although not the exclusive reason, for the heavy use of nicotine in both depression and schizophrenia.

## No. 12B
## TREATING NICOTINE DEPENDENCE IN MENTAL HEALTH SETTINGS

John R. Hughes, M.D., *Professor of Psychiatry, University of Vermont, 38 Fletcher Place, Burlington, VT 05401-1419*

## SUMMARY:

Because many psychiatric patients die from smoking-related disorders, those who smoke and who are not in crisis should be given brief advice to motivate them to consider smoking cessation. The advice should focus on patients' personal motivators for and barriers to cessation. Repeated advice to quit and offers to help over time do increase quit rates. Those patients interested in quitting should be recommended to use the nicotine patch and/or nicotine gum plus attendance at group behavioral therapy. Patients should be seen at 2, 7, 14, and 28 days post-cessation to prevent withdrawal-induced psychiatric syptomatology and to monitor for cessation-induced changes in medication levels. Bupropion should be considered for those who prefer a non-nicotine therapy, have a history of depression upon cessation, or fail nicotine replacement. Other treatments for those who fail gum or patch include clonidine, nicotine nasal spray, and nicotine inhaler. Because psychiatric patients are so vulnerable to nicotine dependence, psychiatrists should participate in advocacy work to decrease smoking.

## REFERENCES:

1. Glassman AH: Cigarette smoking: implications for psychiatric illness. *Am J Psychiatry* April 1993; 150:4, 546–553.
2. Covey LS, Glassman AH, Stetner: Major depression following smoking cessation. *Am J Psychiatry.* 1997; 154:263–265.
3. Freedman R, et al: Nicotine receptors and the pathophysiology of schizophrenia. In: *Advances in Pharmacological Sciences: Effects of Nicotine on Biological Systems II.* Birkhauser Verlag Basel, 307–312, 1995.

4. Hughes JR, et al: APA Practice Guidelines for the Treatment of Nicotine Dependence. *Am J Psychiatry.* 1996; 153:S1–S31.

**Industry-Supported Symposium 13** **Monday, October 27 5:30 p.m.-8:30 p.m.**

## MAINTAINING THE CONTINUUM OF CARE: FROM PSYCHIATRIC EMERGENCIES TO COMMUNITY REINTEGRATION

*Joint Session with the American Association for Emergency Psychiatry*
*Supported by Janssen Pharmaceutica and Research Foundation*

Michael H. Allen, M.D., *Director, Psychiatry Emergency Services, Bellevue Hospital Center, 462 First Avenue, GS11, New York, NY 10016*

### EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, participants should be able to diagnose and treat an agitated patient in the psychiatric emergency service; to select the proper medication to maintain compliance and ease transitioning; to understand how managed care affects behavioral health care; to realize the importance of community reintegration.

### SUMMARY:

The complexity of the health care environment is increasing dramatically. The number of new treatments and the number of new settings are both growing rapidly. This symposium will provide an overview of new antipsychotic medications and examine their applications in the emerging mental health system. Patient care will be considered from initial crisis management through stabilization and definitive treatment to community reintegration. The influence of different methods of cost containment will be presented as they apply to decisions about treatment setting and medication selection. Broader measures of outcome will be suggested, reflecting the current understanding of the protean manifestations of schizophrenia and the high cost of relapse and disability. The effects of cognition, insight, motivation, and compliance will also be reviewed.

## No. 13A
## INITIAL SELECTION OF ANTIPSYCHOTIC MEDICATIONS IN AGITATED PATIENTS

Roderick Shaner, M.D., *Medical Director, Los Angeles County Department of Mental Health, 1937 Hospital Place, Los Angeles, CA 90033-1071*

### SUMMARY:

Antipsychotic medications have long played a major role in initial treatment of agitated behavior. Early use of low-potency phenothiazines such as chlorpromazine was complicated by unwanted sedation, hypotension, and anticholinergic effects. Guidelines for "rapid neuroleptization" using sequential doses of high-potency antipsychotic medications such as haloperidol and fluphenazine were developed during the 1970's and 1980's. Rapid neuroleptization was complicated by a significant incidence of acute extrapyramidal side effects and by the danger of malignant neuroleptic syndrome. Efforts to decrease dosage-related untoward effects of rapid tranquilization and to improve patient comfort made concurrent use of benzodiazepines and high-potency antipsychotic medications commonplace in the 1980's and 1990's. Several new factors now influence the use of antipsychotics for initial control of agitation. First, there has been increasing interest in definitive, diagnosis-specific treatment in emergency settings that may avoid some inpatient treatment. Second, increased sensitivity to the rights of involuntary admissions has led to greater emphasis on minimizing uncomfortable dosages of antipsychotic medications and greater reliance on benzodiazepines and mood stabilizers. Third, the introduction of novel antipsychotic agents (risperidone, olanzapine) has led their initial selection.

## No. 13B
## DRUG SELECTION, COMPLIANCE AND TRANSITIONING IN PSYCHIATRIC EMERGENCY SERVICE UNITS

Michael H. Allen, M.D., *Director, Psychiatry Emergency Services, Bellevue Hospital Center, 462 First Avenue, GS11, New York, NY 10016*

### SUMMARY:

As part of efforts to manage the seriously mentally ill in community settings, the focus of crisis services is shifting from triage to treatment. Since medication noncompliance is a major cause of relapse and emergency presentation, it is increasingly important to identify poor compliance and address it at each step in the process of care. This presentation will review the literature on diagnosis in emergency settings, compliance with patient referrals from emergency services, and compliance with medications in the community. Risk factors for poor compliance are discussed, including those that pertain to the patient, the illness, the physician, the treatment setting, and the medications. Methods of detecting noncompliance are described, and suggestions for improving compliance are presented. The pharmacology of the newer antipsychotic drugs is discussed in this context.

## No. 13C
## COMMUNITY REINTEGRATION AND PSYCHOSOCIAL TRAINING

Nina R. Schooler, Ph.D., *Director, Psychosis Research Program, and Professor of Psychiatry, University of Pittsburgh, 3811 O'Hara Street, Pittsburgh, PA 15213*

### SUMMARY:

If a psychiatric emergency room (PES) experience is followed by a hospitalization, the patient's life may be badly disrupted as a function of the psychotic experience and the interruption in activities of daily life. Therefore, the period of transition from the hospital back to the community is an important one. This period—sometimes called the stabilization period—falls between acute treatment and longer-term maintenance treatment. There has been only limited study of the factors that predict successful restabilization in the community and even less work in developing psychosocial programs that foster a successful transition.

This presentation will first review data regarding predictors of successful community stabilization. It will also describe two methods that may help patients to negotiate the transition. The first is a community reaentry program based on brief, focused, skills training for patients, and the second a psychoeducational workshop program for family members.

## No. 13D
## HOW MANAGED CARE AFFECTS BEHAVIORAL HEALTH CARE

James M. Schuster, M.D., M.B.A., *Director, Emergency Psychiatric Service, Department of Psychiatry, Allegheny General Hospital, 320 East North Avenue, Pittsburgh, PA 15212-4772*

### SUMMARY:

Prompt initiation of care and access to a broad spectrum of care are widely recognized as essential for quality behavioral health services. Managed care has had both positive effects in providers' efforts to achieve these goals, such as encouraging prompt provision of care, and negative impacts, such as benefit limitations. This presentation will outline the impact of managed care upon the development and delivery of clinical services. It will review how managed care affects the initiation of services in urgent and emergent situations, ongoing treatment plans, and the care of chronically ill patients. Managed care has affected a variety of treatment modalities for patients with both commercial and public payers, and the mix of treatments available for patients in managed care systems will be outlined. The presentation will conclude with a review of how at least some managed care systems are moving from sometimes adversarial reviews of care to focusing on quality and outcomes in partnership with providers.

### REFERENCES:

1. Allen MH: (Collaborating Author) *Handbook of Emergency Psychiatric Med.* Kaplan HI, Sadock BJ (eds). New York; Williams & Wilkins, 1993.
2. Keith SJ, Schooler NR: Psychosocial and pharmacotherapeutic strategies for long-term treatment of schizophrenia, in Costa Silva JA, Nadelson CC (eds). *International Review of Psychiatry, Vol. #1.* APPI, Washington, DC.
3. Schooler NR, et al: Transition from acute to maintenance treatment: prediction of stabilization. *Int Clin Psych.* 11(Suppl 2); 85–92, 1996.
4. Smith TE, et al: Training hospitalized patients with schizophrenia in community reintegration skills. *Psych Serv* 47:1099–1103, 1996.

**Industry-Supported Symposium 14** **Tuesday, October 28 6:30 a.m.-8:00 a.m.**

## RAISING TREATMENT EXPECTATIONS IN SCHIZOPHRENIA

*Supported by Novartis Pharmaceuticals Corporation*

David Pickar, M.D., *Chief, Experimental Therapeutic Branch, National Institute of Mental Health, Building 10, Room 4N-212, 10 Center Drive, Bethesda, MD 20813*

### EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, participants should be able to convey a need to reevaluate the definition of an "adequate response" in schizophrenia pharmacotherapy and to elucidate means by which clozapine use may be optimized in order to maximize treatment efficacy.

### SUMMARY:

Neuroleptics have been the standard treatment for schizophrenia for at least half a century. Prior to the recognition of negative symptoms as a pathophysiological feature of some forms of schizophrenia, the ability of neuroleptics to alleviate hallucinations and delusions (ie, positive symptoms) was considered therapeutically adequate, despite the common adverse effect of EPS and the high risk of tardive dyskinesia (TD). Hence, patients demonstrating diminished psychosis after taking neuroleptics were classified as treatment responders. The definition of an "adequate response" should be modified in light of the development of a newer generation of antipsychotics led by clozapine. Alleviation of positive and negative symptoms of schizophrenia can now

be achieved with much less risk of EPS and TD, both adverse effects that significantly affect patient compliance. Treatment expectations should be raised. A large population of patients on antipsychotic medications are, in fact, partial responders. Clozapine has been shown to be efficacious in patients with suboptimal responses to neuroleptics and other antipsychotics, alleviating characteristic symptoms, improving cognitive function, reducing hospitalization, suicide and violence. The benefits of clozapine far outweigh its risks. Optimizing pharmacotherapy should be stressed in the treatment of schizophrenia.

## No. 14A
## SCHIZOPHRENIA TREATMENT: WHAT IS AN ADEQUATE RESPONSE?

David Pickar, M.D., *Chief, Experimental Therapeutic Branch, National Institute of Mental Health, Building 10, Room 4N-212, 10 Center Drive, Bethesda, MD 20813*

### SUMMARY:

The alleviation of the positive symptoms of schizophrenia remains to be a central criterion in evaluating treatment efficacy. For some, this constitutes an adequate response. However, the largest population of patients on antipsychotic medications are, in fact, partial responders, with some form of residual symptomatology. More accurate guidelines in distinguishing a responder from a partial responder is crucial, especially since the newer generation of antipsychotics exhibit the ability to improve functional and behavioral aspects of psychosis, above and beyond mere alleviation of positive symptoms.

Likewise, the difference between a partial responder and a treatment-resistant patient should be more clearly defined. Because inadequate treatment may lead to irreversible neuronal damage, an earlier diagnosis of treatment-resistance with subsequent clozapine therapy can potentially result in a greater level of recovery. Ultimately, higher expectations should be made of therapeutic outcomes—ie, improvement of the positive/negative symptoms, behavioral excesses, and functional deficits of schizophrenia.

## No. 14B
## OPTIMIZING CLOZAPINE TREATMENT

Carol J. VanderZwaag, M.D., *Associate Medical Director, Rehabilitation Unit, John Umstead Hospital, 1003 12th Street, Butner NC 27509-1626*

### SUMMARY:

Clozapine is the gold standard in treatment-resistant schizophrenia. However, despite its efficacy in this population of patients, there are those who remain partial responders. Both inherent individual differences in brain structure and/or chemistry and a failure to optimize clozapine treatment may contribute to a partial response. Data suggest that serum clozapine may be valuable in evaluating a partial response to treatment. Monitoring of serum clozapine levels may enhance outcomes by limiting adverse effects and maximizing the benefits of clozapine therapy.

### REFERENCES:

1. Brenner HD, et al. (1990) Schizophr Bull:6:551–561.
2. Clozapine Study Group; *Br J Psychiatry* 163:150–154, 1993.
3. Fleischhacker WW, Hummer M; *Drugs* 53:915–929, 1997.
4. Meltzer and Okayli; *Am J Psychiatry* 152:183–190, 1995.

## INNOVATIVE PROGRAMS: SESSION 1

**Innovative Program 1** **Friday, October 24**
**10:00 a.m.-10:30 a.m.**

### WORKING WITH STREET YOUTH IN TORONTO

John H. Langley, M.D., *Department of Psychiatry, University of Toronto, 229 Grenview Boulevard South, Etobicoke, ON, Canada M8Y 3V1*

### EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to develop a mental health consultation service to a homeless youth shelter, and to recognize some of the more common psychiatric problems and treatment issues in this population.

### SUMMARY:

There has been much discussion in Ontario about providing mental health services to underserved populations, but usually areas outside the metropolitan core are mentioned. However, the homeless in the inner city are truly underserved. Psychiatric care is almost nonexistent.

One group of the homeless is transitional-age youth. They range from age 16 to about 22 to 24 years old. This group traditionally is hard to serve as individuals do not fit into child or adult programs. Downtown Toronto attracts these youth who often come from dysfunctional or abusive homes. Some become involved in prostitution or criminal activities and others abuse street drugs. This is a fascinating group with whom to work as some are struggling with normal adolescent developmental issues in an abnormal setting while others may be showing the first signs of a major mental illness. Many of these youth end up living on the streets and using youth hostels.

Work with homeless populations in the downtown core of the city of Toronto was undertaken as part of "career track" residency training in the department of psychiatry at the University of Toronto. A mental health consultation service to Covenant House, a youth hostel in downtown Toronto, was developed. Covenant House is Toronto's largest youth shelter with 75 beds. It also provides comprehensive outreach support and health care. The medical clinic is staffed by three nurses and a part-time family doctor. Previous to the program's implementation, there was one psychiatrist who visited for a few hours about once per month.

The presentation begins with a short slide tour of Covenant House and the vicinity. Experiences at Covenant House as the service was developed are discussed. Representative cases are presented, material from a group for female sexual abuse survivors is reported, and a description of how the service has grown from a client-centered model to consultee-based and program-based activities is included. Finally, plans for the future in working with homeless youth are outlined.

### TARGET AUDIENCE:

Community/adolescent psychiatrists.

### REFERENCES:

1. Caplan G, Caplan RB: *Mental Health Consultation and Collaboration.* San Francisco, Ca, Josse-Bass, Inc., 1993.
2. Reilly JJ, et al: Psychiatric disorders in and service use by young homeless people. *Medical Journal of Australia* 161(7):429–32, Oct. 3, 1994.
3. Hazzard A, et al: Group therapy with sexually abused adolescent girls. *American Journal of Psychotherapy* Vol. XL, No. 2, April 1986.

**Innovative Program 2** **Friday, October 24**
**10:30 a.m.-11:00 a.m.**

### PROGRAMS FOR DUALLY DIAGNOSED MENTALLY ILL AND MENTALLY RETARDED YOUTH

Stephen M. Soltys, M.D., *Director of the South Carolina Department of Mental Health, P.O. Box 485, Columbia, SC 29202*; Elizabeth Strope, Ph.D., *Clinical Assistant Professor, Department of Psychiatry, University of Missouri at Columbia, 3 Hospital Drive, Columbia, MO 65201*

### EDUCATIONAL OBJECTIVES:

At the conclusion of this innovative program, the participant should be able to utilize the information presented to develop treatment programs for youth who are both mentally retarded and mentally ill and successfully resolve organizational system problems that hinder the development of such programs.

### SUMMARY:

Separate state divisions or departments usually provide mental health services to the mentally ill and the mentally retarded/developmentally disabled. Clients who are dually diagnosed often have a mix of needs, which are not adequately provided by either system. Specialized services often are not available.

The Missouri Department of Mental Health has made developing dual diagnosis programming a priority since fall of 1995. This effort first required tearing down the administrative walls, which the Divisions of Comprehensive Psychiatric Services and Mental Retardation/ Developmental Disabilities had built between each other. Groups of staff from both divisions who were in

favor of this process were then brought together to assess what services this population needed and developed program proposals that blended staff and funding from both divisions. The result was the formulation of a number of children and youth initiatives, which filled a serious gap in our service delivery system.

The format will be a short (15-minute) overview of the Missouri experience, followed by questions or participant discussion of their own experiences with practical administrative and clinical issues, which arise in the development of dual diagnosis programs, moderated by two individuals who helped begin the Missouri effort.

## REFERENCES:

1. Dosen A: Diagnosis and treatment of psychiatric and behavioral disorders in mentally retarded individuals: the state of the art. *Journal of Intellectual Disability Research*, 37:1–6, 1993.
2. Lovell RW, Reiss AL: Dual diagnosis: psychiatric disorders in developmental disabilities. *Pediatric Clinics of North America*, 40:579–591, 1993.

**Innovative Program 3** **Friday, October 24**
**11:00 a.m.-11:30 a.m.**

## AN UNORTHODOX APPROACH TO ADD

William S. Horowitz, M.D., *Attending Psychiatrist, Village Counseling, 73-302 Highway 111, Palm Desert, CA 92260*

## EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to recognize, diagnose, and treat common varieties of attention deficit disorder in the child, adolescent, and adult populations without the use of Ritalin or amphetamines, utilizing only tricyclic antidepressants in doses intermediate between pediatric and antidepressant levels.

## SUMMARY:

The purpose of this presentation is to offer the clinical experience of treating over 800 cases of childhood and adult attention deficit disorder safely and highly effectively with tricyclic antidepressants, avoiding altogether the use of methylphenidate, pemoline, and amphetamines with their attendant problems. The target populations in which this disorder is much more prevalent than generally recognized are: youngsters with learning and behavior disorders, adults misdiagnosed as "seriously mentally ill" (often manic depression), adults with substance-abuse histories and/or antisocial behavior, and high-functioning (often professional) adults with only circumscribed symptoms. The incidence approaches 25% to 50% in some populations (e.g., probationers from domestic violence), representing significant economic benefit for the agency involved in successfully treating them, as well as quality of life for the patients.

Typical and pathognomonic signs and symptoms, which suggest the diagnosis, are presented (*read, speed,* and *feet*), as well as detailed dosing schedules of psychopharmacologic agents used. In addition, the existence of significant resistance to therapy on the part of the patients, clinical staffs, and social agencies is discussed.

## TARGET AUDIENCE:

This clinical presentation could be of interest to *all* psychiatrists, including those treating adult law offenders and substance abusers, and psychiatrists and allied professionals who suspect that they, themselves, may have this disorder.

## REFERENCES:

1. Johnson A, Giuffre RM, O'Malley K: ECG changes in pediatric patients on tricyclic antidepressants, desipramine and imipramine. *Can J Psychiatry* Mar;41(2):102–6, 1996.
2. Sarne Y, Mandel J, Goncalves MH, et al: Imipramine binding to blood platelets and aggressive behavior in offenders, schizophrenics, and normal volunteers. *Neuropsychobiology* 31(3):120–4, 1995.

# INNOVATIVE PROGRAMS: SESSION 2

**Innovative Program 4** **Friday, October 24**
**1:30 p.m.-2:00 p.m.**

## ACADEMIA AND THE COMMUNITY: ENDURING MISSIONS, EVOLVING STRATEGIES

Thomas L. Horn, M.D., *Chief of Clinical Services, Department of Psychiatry, Western Psychiatric Institute and Clinic, 3811 O'Hara Street, Pittsburgh, PA 15213-2593*

## EDUCATIONAL OBJECTIVES:

At the conclusion of this innovative program, the participant should be able to 1) understand a model of partnership between academic centers and community facilities and providers, 2) understand some of the issues involved in care network formation, and 3) understand the interplay of institutional missions in developing partnerships.

## SUMMARY:

This innovative program will provide for discussion of the ways in which one academic center, the University

of Pittsburgh, is attempting to work with community-based providers in our geographic region to build a care network and ultimately an integrated delivery system. This effort presents unusual opportunities for academic-community partnering and mutual teaching and learning, while creating a more effective health care delivery system. The perspectives represented are: roles and opportunities for physicians, adult services, child and adolescent services, the community mental health provider's view, and the community drug and alcohol provider's view. The audience will be asked to participate in a discussion of the ways in which academic-community partnering in such network development may and may not advance the missions of the respective organizations, as well as the potential impact on the health status of the community.

## TARGET AUDIENCE:

Behavioral health care providers, all disciplines; administrators of community mental health and academic programs; residents and other trainees.

## REFERENCES:

1. Foreman S: Social responsibility and the academic medical center: building community-based systems for the nation's health. *Academic Medicine* 69(2):97–102, Feb 1994.
2. Redington TJ, Lippincott J, Linday D, Wones R: How an academic health center and a community health center found common ground. *Academic Medicine* 70(1):21–6, Jan 1995.

**Innovative Program 5** **Friday, October 24**
**2:00 p.m.-2:30 p.m.**

## THE VIEW FROM THE COMMUNITY: NEEDS AND OPPORTUNITIES

Roy Lahet, M.Div., *Executive Director, Northern Southwest Community Mental Health and Mental Retardation Drug and Alcohol Services, 100 River Avenue, Pittsburgh, PA 15212*; Timothy J. Merlin, M.A., *Executive Director, Comprehensive Substance Abuse Services, 203 South Maple Avenue, Greensburg, PA 15601*

## EDUCATIONAL OBJECTIVES:

At the conclusion of the presentation, participants will understand the important issues, barriers, and opportunities in developing several models of collaborative service development by community-based providers and an academic center in Western Pennsylvania; and understand the specific steps taken to overcome barriers, develop partnerships, and open new services.

## SUMMARY:

Two community-based mental health, drug, and alcohol centers discuss their work with an academic center in developing needed services. One provider is part of the Pittsburgh Mercy Health System. The other is a free-standing drug and alcohol program. Community needs for services are discussed that could be met only through creative partnerships. History and current concerns had to be resolved in order to build new collaborative responses to community needs. The results of these partnerships are presented through description and discussion of the models, mechanisms to eliminate barriers to cooperation, and sharing of resources. Specific new services and models may form the basis for a multicounty care network.

## REFERENCES:

1. Buchanan DR: Building academic-community linkages for health promotion: a case study in Massachusetts. *American Journal of Health Promotion.* 10(4):262–269, 1996.
2. Hargrove DS: The role of community mental health centers in public-academic linkages. In P.Wohl, H.F. Myers, J.E.Callan (Eds.), *Serving the Seriously Mentally Ill: Public-Academic Linkages in Services, Research and Training.* Washington, DC. American Psychological Association. 1993, pp. 95–97.

**Innovative Program 6** **Friday, October 24**
**2:30 p.m.-3:00 p.m.**

## THE VIEW FROM ACADEMIA: GOALS AND BARRIERS

David F. Raney, M.D., *Clinical Director, Child and Adolescent Psychiatry, Western Psychiatric Institute and Clinic, 3811 O'Hara Street, Pittsburgh, PA 15213-2593;* Anthony M. Trachta, M.S.W., *Director, Managed Care for Psychiatric Services, and Associate Clinical Administrator, Western Psychiatric Institute and Clinic, 3811 O'Hara Street, Pittsburgh, PA 15213*

## EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to identify traditional barriers to positive collaboration; identify market forces which may present the opportunity to overcome traditional barriers; and describe an effective strategy for defining win/win partnerships.

## SUMMARY:

Academic health centers and community providers generally have had highly variable histories of collaboration, with some successes and some failures. The academic center may be perceived by community providers

as elitist, focused overwhelmingly and inappropriately on research, and noncollaborative. Community providers may be perceived by the academic center as not valuing the "higher calling" of training and research and as being non collaborative. Town-gown issues appear almost ubiquitous.

The sweeping changes in the economical landscape of health care may provide a unique opportunity to work through historical barriers to create a more integrated and high-quality partnership between community providers and academic medical centers. Ultimately, the integrated systems developed may provide better care, better training opportunities, and better research opportunities. Achieving a new integrated system requires an agreement on mutual goals and a process for resolving conflict over time. This presentation reviews factors that have led to a largely positive win/win collaboration between the Western Psychiatric Institute and Clinic of the University of Pittsburgh Medical Center and the Northern Southwest Community Mental Health Center.

## REFERENCES:

1. Page L: Trailblazing: shaking the ivory tower. *American Medical News* August 8, 1994, pages 6–8.
2. *Preview of the Future for Major Academic Health Centers*: The Advisory Board Company, Washington, D.C. 1994.

# INNOVATIVE PROGRAMS: SESSION 3

**Innovative Program 7** **Friday, October 24**
**3:30 p.m.-4:00 p.m.**

## INCORPORATING A BUSINESS MANAGER INTO TRAINING

Ann K. Morrison, M.D., *Associate Director, and Assistant Professor, Community Psychiatry, Wright State University School of Medicine, P.O. Box 927, Dayton, OH 45401*; Brenda J. Roman, M.D., *Assistant Professor of Psychiatry, Wright State University School of Medicine, P.O. Box 927, Dayton, OH 45401*

## EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, participants should be able to recognize the importance of integrating business issues into residency training, learn one model for introducing residents to this area, and describe the educational benefit of this program.

## SUMMARY:

Residents entering practice need both solid clinical and basic managerial skills. Training often isolates residents from the "tainted" business world, giving the message that the business of medicine is "dirty work" best left to others. Residents often have little didactic or clinical exposure to the business of medicine; therefore, they have few skills to navigate in the complex business world when presented with problems. They also do not have the knowledge base to evaluate or solve the dilemmas faced in the combined business and medicine worlds. To address this void we have mainstreamed the department business manager into our training program across many topics and years. The business manager directs and participates in didactics on billing procedures; financial issues in medicine, ethics, and finances; managed care organizations; and public mental health systems. In many of these didactics he co-teaches with physicians, especially in "role-play" exercises. Additionally, the business director acts as a supervisor for the chief resident on administrative and financial issues in medicine.

At the conclusion of this presentation, participants will learn about one department's experience with integrating the business manager into training and the positive effect this has had on residents concerning attitudes about financial issues in medicine.

## REFERENCES:

1. Kollisch DO, Lingley RW: Teaching medical students about money management in primary care practice. *Academy of Medicine* 70:436, 1995.
2. Cawley PJ: Learning the business of medicine. *JAMA*, Vol. 265, No. 1, page 114, January 1991.

**Innovative Program 8** **Friday, October 24**
**4:00 p.m.-4:30 p.m.**

## THE MENTAL HEALTH EXECUTIVE LEADERSHIP PROGRAM

Daniel R. Wilson, M.D., *Medical Director, Pauline Warfield-Lewis Center, and Associate Professor of Psychiatry, University of Cincinnati, 1101 Summit Road, Cincinnati, OH 45237*; Robert J. Ronis, M.D., *Director, Residency Training, and Director, Public Psychiatry, Department of Psychiatry, University Hospitals of Cleveland, 11100 Euclid Avenue, Cleveland, OH 44106*; Lon C. Herman, Barbara Bolek, Terrence A. Smith, A. Leslie Abel

## EDUCATIONAL OBJECTIVES:

At the conclusion of this innovative program, participants should be able to recognize the relevance of focused managerial and traditional business education for leaders in public mental health service delivery systems.

## SUMMARY:

Under the auspices of a training grant from the Ohio Department of Mental Health, the Department of Psychiatry and the Health Care Executive Education Program of the Weatherhead School of Management at Case Western Reserve University created a "Mental Health Executive Leadership Program." A pilot group of six, selected from more than 50 applicants participated in 1995–96, attending six day-long sessions with the executive education program and a business planning seminar incorporating major elements of the curriculum, including strategic planning, finance, marketing, and other aspects of the traditional business plan. Plans were presented to state and regional planning authorities in a final day-long session. In 1996–97, 12 participants are enrolled and will be mentored by the original six "fellows" as well as the faculty. An overview of the curriculum and programmatic enhancements as well as examples of the planning projects will be presented.


## TARGET AUDIENCE:

Public mental health administrators, clinicians, educators.

## REFERENCES:


1. Talbott JA, Hales RE, Keill SL (eds): *Textbook of Administrative Psychiatry.* Washington DC, American Psychiatric Press, 1992.
2. Keill S: *Administrative Issues in Public Mental Health.* San Francisco, Jossey-Bass, Spring 1991.


**Innovative Program 9** **Friday, October 24**
**4:30 p.m.-5:00 p.m.**

## FIVE FINANCIAL SURVIVAL STRATEGIES FOR CONSULTATION SERVICES


Joseph L. Antonowicz, M.D., *Director, Consultation-Liaison Services, Leheigh Valley Hospital, 1243 S. Cedar Crest Boulevard, Allentown, PA 18103*


## EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to list financial areas of importance for consultation-liaison services and describe associated strategies to enhance financial viability within each area.


## SUMMARY:

Justifying one's existence can be fun as well as profitable. As economic pressures squeeze consultation-liaison services, paying attention to business is essential in achieving a self-sufficient service, or at least proving that it is not a hideous drag on the rest of the institution. This hospital-based group has defined five basic strategies that involve changing attitudes as well as behaviors. First, timely and accurate billing is not unseemly, unacademic, or hopeless. Second, a broad base of consultation sites compensates for decreasing traditional inpatient opportunities. Skilled nursing facilities, rehabilitation hospitals, and county area agencies on aging often desire psychiatric consultation and will contract for liaison activities. Hospital outpatient settings such as cancer centers, radiation oncology departments, and women's health centers can be fine sources of consultations. Third, "payer mix" is not an obscene phrase because expanding into reimbursable services balances existing nonreimbursable ones. Friendly communication with administrators who negotiate insurance contracts leads to the inclusion of psychiatric consultation payment. Fourth, it is beneficial to document and promote that consultation improves income to the hospital (e.g. enhanced DRG payment for comorbid organic mental disorders and delirium) or decreases some expensive aspect of medical treatment (e.g. ventilator days for trauma patients). Fifth, diplomatic "neutrality" in any turbulent and contentious medical staff atmosphere avoids the stoppage of consultation requests in apparent retaliation to hospital administrators. Behaving like "regular physicians" includes such niceties as weekend attending rounds and holiday gift baskets if other physician groups do so.


## TARGET AUDIENCE:

Members of hospital-based consultation liaison services.

## REFERENCES:


1. Goldberg RJ, Stoudemire A: The future of consultation-liaison psychiatry and medical-psychiatric units in the era of managed care. *General Hospital Psychiatry* 17(4):268–77, 1995.
2. Hall RC, Frankel BL: The value of consultation-liaison interventions to the general hospital. *Psychiatric Services* 47(4):418–20, 1996.


# INNOVATIVE PROGRAMS: SESSION 4

**Innovative Program 10** **Saturday, October 25**
**8:00 a.m.-8:30 a.m.**

## URGENT CARE: A NEW MODEL OF EVALUATION AND REFERRAL


Nancy Piluso, R.N.C., *Program Director, Urgent Care, and Department of Psychiatry, University of Maryland, 645 West Redwood Street, Baltimore, MD 21201*; Fred C. Osher, M.D., David R. McDuff, M.D.

## EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the audience will understand the rationale for and the clinical and administrative changes required in altering an emergency psychiatric service from a consultant model to a fully staffed urgent care model.

## SUMMARY:

Psychiatric emergency services at the University of Maryland Medical Center were traditionally provided by a solo psychiatric resident (with limited attending backup during business hours) around the clock until October 1995. As demand for these services increased, the volume of psychiatric patients in the emergency department (ED) increased dramatically (FY 91, number of visits = 1,384; FY 95, number of visits = 2,499). To meet these needs, our department developed an Urgent Care Program, consisting of easy-access walk-in services 90 hours/week. Expanded services include addiction treatment, brief case management, and a single point of entry into all hospital- and community-based programs in the area. In our first month of operation (October 1995), we evaluated 55 patients in the Urgent Care Program and provided 134 psychiatric consultations and 184 drug/alcohol consultations in the emergency department. By our 12th month (September 1996), we saw 321 patients in urgent care, 207 psychiatric consultations in the ED, and 121 drug/alcohol consultations in the ED. We will discuss the origin and development of our program over the first two years of its operation, with special emphasis on the creation of seamless transitions from the single point of entry to other levels of care.

## REFERENCES:

1. Ellison JM, Wharff EA: More than a gateway: the role of the emergency psychiatry service in the community health network. *H&CP* 36(2):180–185, 1985.
2. Wellin E, Slesinger DP, Hollister CD: Psychiatric emergency services: evolution, adaptation and proliferation. *Soc Sci Med* 24(6):475–482, 1987.

**Innovative Program 11 Saturday, October 25 8:30 a.m.-9:00 a.m.**

## SYSTEM CHANGES IN EMERGENCY PSYCHIATRY: THE WASHINGTON, DC, EXPERIENCE

Robert W. Keisling, M.D., *Medical Director, Emergency Psychiatric Response Unit, Government of the District of Columbia, 1881 Newton Street, N.W., Washington, DC 20010-1016*; Lien A. Hung, M.D., *Medical Officer, Emergency Psychiatric Response Division, Government of the District of Columbia, and former APA/Mead Johnson Fellow*, 2001 Barrowfield Road, Fort Washington, MD 20744

## EDUCATIONAL OBJECTIVES:

At the conclusion of this innovative program the participant should be able to understand the system changes that need to be made to enhance emergency services.

## SUMMARY:

In 1987 emergency psychiatry services were reorganized in the District of Columbia. Emphasis was placed on increased outreach and mobile crisis services. During the past 10 years there has been a 40% decrease in emergency room visits and hospitalizations. This session will focus on the system changes necessary to enhance emergency services, including the staff resistance and bureaucratic obstacles that had to be overcome. Linkages with community programs will be discussed, and examples of successful as well as unsuccessful efforts will be given. The adaptability of these initiatives to managed care programs will be explored.

## REFERENCES:

1. Elliott R: Mental health reform in Georgia, 1992–1996. *Psychiatric Services*: Vol. 47: 1205–1215, 1996.
2. Breslow RE, Klinger BI, Erickson BJ: Characteristics of managed care patients in a psychiatric emergency service. *Psychiatric Services*: Vol. 47: 1259–1261, 1990.

**Innovative Program 12 Saturday, October 25 9:00 a.m.-9:30 a.m.**

## THE DRUG ASSIST PHARMACY SERVICES PROGRAM

Sally E. Brown, D.P.H., *Administrator, Department of Radiology, University of Connecticut Health Center, 263 Farmington Avenue, Farmington, CT 06030-2905*; Monty Schwartz, M.B.A., *Pharmacist, 24 Fort Pleasant Avenue, Springfield, MA 01108*

## EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to: recognize chronically mentally ill clients appropriate for enrollment in the DAPS Program; discuss how a client is enrolled and monitored in the DAPS Program; understand the importance of medication compliance in the chronically mentally ill population; demonstrate how the DAPS Program increases medication compliance; and discuss the importance of the DAPS Program from the provider, client, and reimbursement perspective.

## SUMMARY:

The Drug Assist Pharmacy Services Program (DAPS) is an innovative program that serves as an alternate model for drug delivery to the chronically mentally ill. The DAPS Program provides drugs on a weekly basis to the home or residence of its clients in a unique drug dispensing unit, which is customized to meet the specific needs of the individual client. In addition, the program provides an educational/counseling component to facility staff and individual clients about the effects and side effects of their medications.

Drug therapy is the cornerstone of treatment for the chronically mentally ill with the costs of noncompliance with medication being very high. The single most important determinant of medication compliance is the treatment regimen itself. The DAPS Program provides a consistent means of medication delivery in a format that simplifies the treatment regimen.

A research study examined the question of whether the DAPS Program leads to increased compliance with medication as measured by a count of the drug dispensed and the drug returned for each client. The study also examined the impact of compliance on DAPS clients measuring the number of psychiatric hospitals and the length of stay and comparing them with a control population.

Results found a high level of compliance (89.9%) with medication in the DAPS clients and a statistically significant increase in the number of hospitalizations among clients with poor compliance scores, which strongly supports the effectiveness of the program.


## TARGET AUDIENCE:

Caregivers involved with patient's medication.

## REFERENCES:


1. Blackwell B: The drug defaulter. *Clinical Pharmacology and Therapeutics* 13 (6) 841–848, 1972.
2. Fitzgerald JD: The influence of the medication on compliance with therapeutic regimens, In: Sackett DL, Haynes B: *Compliance with Therapeutic Regimens*. Baltimore: The Johns Hopkins Univ Press, 1976.


# INNOVATIVE PROGRAMS: SESSION 5

**Innovative Program 13 Saturday, October 25 10:00 a.m.-10:30 a.m.**

## MOBILE COMMUNITY SUPPORT IN THE SOUTH BRONX


Andrew A. Trauben, M.D., *Psychiatrist, Community Mental Health Services, Visiting Nurse Service, 450 East 149th Street, Bronx, NY 10455*; Katherine Levine, C.S.W., *Program Coordinator, Community Mental Health Services, Visiting Nurse Service, 450 East 149th Street, Bronx, NY 10455*; David C. Lindy, M.D., Neil Pessin, Ph.D.


## EDUCATIONAL OBJECTIVES:

At the conclusion of this innovative program, the participant should be able to 1) identify the core components of a family-driven psychiatric outreach service for children and adolescents at risk of psychiatric hospitalization, and 2) describe three tools that aide in the development of a collaborative relationship with the families of seriously emotionally disturbed children while maintaining an appropriate focus on maintaining patient safety.


## SUMMARY:

Since 1986, the Visiting Nurse Service of New York (VNS) has had extensive experience providing a range of outreach services to over 5,000 patients a year. Currently, VNS operates a federally funded Mobile Community Support Team (MCST) serving serious emotionally disturbed children. This team serves the Mott Haven section of the South Bronx, one of the poorest community districts in the country. The MCST seeks to create a continuum of mental health care that is family friendly and collaborative. This session will describe the MCST's first year of operation, as well as specific psychoeducational and cognitive behavioral tools found critical to the task of insuring safety within a family collaborative model. Audience participation will be used in demonstrating these tools. Case vignettes will also be used to demonstrate these tools and the work of the team. Finally, the audience will be encouraged to discuss the case vignettes, the tools, and to share related experiences from their own treatment settings and systems of care.


## TARGET AUDIENCE:

Mental health professionals interested in seriously emotionally disturbed children and families.

## REFERENCES:


1. Diamond R, Factor R.: Treatment resistant patients or a treatment resistant system? *Hospital and Community Psychiatry* 45 (3): 197, March 1994.
2. England M, Cole R: Building systems of care for youth with serious mental illness. *Hospital and Community Psychiatry* 43 (6) 630, June 1992.

**Innovative Program 14 Saturday, October 25 10:30 a.m.-11:00 a.m.**

## THE USE OF MOBILE CRISIS PHOTOGRAPHS WITH EMERGENCY ROOM STAFF

Madeleine M. O'Brien, M.D., *Department of Psychiatry, Community Mental Health Services, Visiting Nurse Service, 251 Benedict Avenue, Tarrytown, NY 10591-4301*; David C. Lindy, M.D., *Chief Psychiatrist, Community Mental Health Services, Visiting Nurse Service, 1250 Broadway, 3rd Floor, New York, NY 10001*; Neil Pessin, Ph.D., Leila B. Laitman, M.D.

### EDUCATIONAL OBJECTIVES:

At the conclusion of this innovative program, the participant should be able to 1) understand sources of communication breakdowns between mobile crisis and emergency room staffs, and 2) recognize the utility of multimedia aids in clinical presentations in appropriate settings.

### SUMMARY:

Anyone who has worked in psychiatric outreach has had the experience of finding hospital-based colleagues who, however competent and well intentioned, have difficulty understanding the significance of certain data gathered in the field. The patient's behavior in his/her own home, the condition of the home, and information obtained "on the scene" from family or neighbors can all provide key data regarding the need for hospitalization. However, overwhelmed ER staff may still feel admission is not indicated on the basis of their evaluation in the hospital. While these cases are relatively infrequent, they are disturbing when they do occur because then a very sick patient does not receive badly needed care.

The Visiting Nurse Service of New York's Community Mental Health Services (VNS) operates a free-standing mobile crisis service in New York City. Our service is administratively distinct from the many local emergency rooms seeing our patients who require hospitalization. It is therefore particularly important for us to communicate effectively if we are to best serve our patients.

We will present experience from a pilot program utilizing photographs taken of patients' homes during the mobile crisis visit to provide additional data for ER staff. We will present clinical vignettes and show some representative photographs. We will also present data from interviews with ER staff regarding their reactions to the photographs and their impact on the decision to hospitalize. Participants will also be encouraged to share their reactions, as well as to discuss issues of informed consent, confidentiality, and possible patient exploitation.

### TARGET AUDIENCE:

Mobile crisis workers, psychiatric emergency room staff.

### REFERENCES:

1. Cohen NL, *Psychiatry Takes to the Streets: Outreach and Crisis Intervention for the Mentally Ill.* New York: The Guilford Press, 1990.
2. Lindy DC, Laitman L, Pessin N, Schwartz L: An attempt to evaluate efficacy in a mobile crisis service in New York City. *Emergency Psychiatry,* Vol. 2 (1); 1996.

**Innovative Program 15 Saturday, October 25 11:00 a.m.-11:30 a.m.**

## GERIATRIC MENTAL HEALTH HOME CARE SERVICES IN A NATURALLY OCCURRING RETIREMENT COMMUNITY

Leila B. Laitman, M.D., *Psychiatrist, Community Mental Health Services, Visiting Nurse Service, 41-61 Kissena Boulevard, Flushing, NY 11355*; Linda Sacco, C.S.W., *Program Coordinator, Community Mental Health Services, Visiting Nurse Service, 1601 Bronxdale Avenue, Bronx, NY 10462*; David C. Lindy, M.D., Neil Pessin, Ph.D.

### EDUCATIONAL OBJECTIVES:

At the conclusion of this innovative program, the participant should be able to 1) recognize the psychiatric service needs of the geriatric population in the community, and 2) recognize organizational issues of collaboration between community, home-based, and facility-based services.

### SUMMARY:

The nationwide incidence of mental illness and/or dementia in older adults has been estimated to be from 18% to 28%, much of which goes unrecognized and untreated. New systems of care for the geriatric mentally ill are necessary to address a growing public health problem as Americans age.

The Naturally Occurring Retirement Community (NORC) is a concept describing a neighborhood with a large population of long-time residents who have now become elderly. The community attempts to develop appropriate systems to respond to the needs of this naturally occurring population with a system of comprehensive, yet local care.

Co-op City is a planned low/moderate income community built in the 1960's and contained within a two-mile radius in the Bronx. It is also home to over 7,500 elders, many of whom are frail and lack social supports. This session will focus on the efforts of the Co-op City

NORC to develop a mental health program through a collaboration of providers, including the Visiting Nurse Service of New York, which has extensive experience in providing mental health outreach services to geriatric patients. We will discuss clinical, administrative, and political issues involved in developing this service. We also hope to share our experiences with colleagues working with the geriatric mentally ill since we believe that the Institute will increasingly need to be a forum for discussing these important issues.

### TARGET AUDIENCE:

Mental health professionals interested in the geriatric mentally ill.

### REFERENCES:

1. Breakey W: *Integrated Mental Health Services Modern Community Psychiatry.* New York: Oxford University Press, 1996.
2. Citywide Geriatric Committee. *The Continuum of Care: Meeting the Mental Health Needs of Older Adults.* Hunter College School of Social Work, 1995.

## INNOVATIVE PROGRAMS: SESSION 6

### Innovative Program 16 Saturday, October 25 1:30 p.m.-2:00 p.m.

### THE "PAL" PROGRAM: BUILDING COMMUNITY PARTNERSHIPS

Kathleen A. Clegg, M.D., *Director, Public Academic Liaison Program, Department of Psychiatry, University Hospitals of Cleveland, 11100 Euclid Avenue, HP-2206, Cleveland, OH 44106*

### EDUCATIONAL OBJECTIVES:

At the conclusion of this program, participants will be able to recognize the value of a community-university collaboration in the training of psychiatrists and the provision of quality psychiatric care to consumers.

### SUMMARY:

Now in its seventh year, Cleveland's PAL program represents a true collaboration between university and local community. Funded by the Cuyahoga County Community Mental Health Board, PAL provides dedicated faculty and advanced psychiatry residents for clinical and educational services to board agencies. PAL graduates and affiliated faculty now account for more than half the psychiatric providers and most of the medical leadership of the agencies, and PAL provides more than 10,000 clinical service hours and 500 educational hours each year, and has resulted in several other state-university and local-university collaborations. The history of this collaboration, curricular features, and supervisory relationships will be discussed, as well as future plans in the context of Ohio's developing managed public behavioral health systems.

### TARGET AUDIENCE:

Residents and faculty interested in community psychiatry education.

### REFERENCES:

1. Santos AB, Ballenger JC, Bevilagua JL, et al: A community-based public academic liaison program. *American Journal of Psychiatry* 151:1181–1188, 1994.
2. Ronis RJ: Public Academic Liaison (PAL): community service and education through creative collaboration. *Innovations and Research* 1:3, 1992.

### Innovative Program 17 Saturday, October 25 2:00 p.m.-2:30 p.m.

### RESIDENCY EXPERIENCE IN AN ADULT MOBILE CRISIS TEAM

Cynthia S. Vrabel, M.D., *Senior Instructor, Department of Psychiatry, University Hospitals of Cleveland, 11100 Euclid Avenue, HP-2210, Cleveland, OH 44106*

### EDUCATIONAL OBJECTIVES:

At the end of this program, participants will be able to describe the scope of services provided by the "Adult Mobile Crisis Team," and recognize the value of the educational experience provided by the "Adult Mobile Crisis Team" for psychiatry residents.

### SUMMARY:

This program will showcase a unique program in psychiatric residency training in community mental health currently in place at Case Western Reserve University. Residents function as members of the Adult Mobile Crisis Team, which provides crisis intervention to a wide range of clients in Cuyahoga County, Ohio. The Mobile Crisis Team has been functioning as the first point of contact for clients entering the public psychiatry system since July 1996. Psychiatric residents gain experience in multiple facets of crisis intervention—accompanying team members on outreach calls, providing telephone consultation to the Mobile Crisis Team (primarily social workers and nurses), doing emergency psychiatric evaluations, and participating in crisis intervention treatment planning. The population served by the Mobile Crisis Team ranges from clients in crisis who have no prior history of psychiatric intervention to chronically ill psychiatric patients experiencing an exacerbation of their illness. The Mobile Crisis Team has afforded psy-

chiatric residents the opportunity to learn much needed skills for the practice of psychiatry in the present day—including diverting clients from utilizing the emergency room in crisis as well as cutting down on utilization of state hospital bed days—through accessibility, use of alternatives to hospitalization, and close, coordinated community follow up.

### TARGET AUDIENCE:

Faculty and residents involved in psychiatric residency training in community mental health.

### REFERENCES:

1. Zealberg JJ, Santos AB, Fisher KK: Benefits of mobile crisis programs. *Hospital and Community Psychiatry* 44:16–17, 1993.
2. Zealberg JJ, et al: A mobile crisis program: collaboration between emergency psychiatric services and police. *Hospital and Community Psychiatry* 43:612–615, 1992.

## Innovative Program 18 Saturday, October 25 2:30 p.m.-3:00 p.m.

## THE "ALL-OHIO" INSTITUTE ON COMMUNITY PSYCHIATRY

Robert J. Ronis, M.D., *Director, Residency Training, and Director, Public Psychiatry, Department of Psychiatry, University Hospitals of Cleveland, 11100 Euclid Avenue, Cleveland, OH 44106*

### EDUCATIONAL OBJECTIVES:

At the end of this presentation, participants should be able to recognize the value of organizing and implementing a participatory multidisciplinary regional or state educational meeting.

### SUMMARY:

In 1995 as a "payback" for their receiving a supporting grant from the Office of Systems and Training Development of the Ohio Department of Mental Health, the public psychiatry program at Case Western Reserve University created a statewide celebration of community psychiatry entitled "The All-Ohio Institute on Community Psychiatry." Modeled after the APA's annual Psychiatric Services meeting, this participatory program included national and regional speakers, workshops, showcase presentations, and a poster session on the theme "The Future of Public Psychiatry," and drew more than 250 participants in the first year. Following its success the program organized a second institute, entitled "Culture, Capitation and Creativity: Managing with Managed Care," for which registration had to be closed at 450 participants due to space considerations. A "third annual" institute is planned for fall 1997, and plans for a fourth event in 1998 are underway. The unanticipated outcome of this program has been its success as a politically neutral mobilizing force for disparate community-based programs in Ohio, whose enthusiasm for sharing and mutual learning apparently lacked an appropriate forum. The discussion will focus on the "How To . . . " aspects and the potential benefits (and risks!) of planning such an event.

### TARGET AUDIENCE:

Residents and faculty interested in community psychiatry education.

### REFERENCES:

1. Santos AB, Ballenger JC, Bevilagua JL, et al: A community-based public academic liaison program. *American Journal of Psychiatry* 151:1181–1188, 1994.
2. Ronis RJ: Public Academic Liaison (PAL): community service and education through creative collaboration. *Innovations and Research* 1:3, 1992.

## INNOVATIVE PROGRAMS: SESSION 7

## Innovative Program 19 Sunday, October 26 10:00 a.m.-10:30 a.m.

## A LESBIGAY PROGRAM FOR THE CHRONICALLY MENTALLY ILL

Ronald E. Hellman, M.D., *Director, Lesbigay Program, South Beach Psychiatric Center, 25 Flatbush Avenue, Brooklyn, NY 11217*

### EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to recognize the common concerns of lesbian women and gay men with chronic mental illness, to understand why their needs have not been met in the mainstream psychiatric setting, and to describe an affirmative model of treatment within the mainstream setting for this subpopulation that addresses and rectifies these concerns.

### SUMMARY:

Gays and lesbians constitute a proportionate minority of individuals with chronic mental illness. In long-term psychiatric programs they are largely an ignored or invisible subgroup. This presentation will describe a community mental health center program for lesbian women and gay men with chronic mental illness that began in January 1996. The program addresses essential but neglected issues in the psychosocial rehabilitation of sexual minority individuals who require long-term psy-

chiatric treatment. Those who work with the chronically mentally ill are encouraged to attend and discuss their experience with this varied clientele and their thoughts on the development of programs to meet their needs.

## TARGET AUDIENCE:

Those who work with the chronically mentally ill.

## REFERENCES:

1. Hellman R: Issues in the treatment of lesbian women and gay men with chronic mental illness. *Psychiatric Services* 47:1093–1098, 1996.
2. Ball S: A group model for gay and lesbian clients with chronic mental illness. *Social Work* 39:109–115, 1994.

**Innovative Program 20 Sunday, October 26 10:30 a.m.-11:00 a.m.**

## ALTERNATIVE SENTENCEE: INMATE, PATIENT OR BOTH?

Marilyn Seide, Ph.D., *Manager, Adult Services, Department of Mental Health, Riverside County, P.O. Box 7549, Riverside, CA 922513*

## EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participants should be able to identify who might benefit from an alternative sentencing program and how best to develop and implement such a program. Participants should further be able to recognize potential barriers and pitfalls to establishing such a program and strategies for potential pitfalls avoiding them.

## SUMMARY:

It is generally accepted today, indeed almost at the level of cliche, that our jails have become the largest repository for the mentally ill in the country. In fact, the Los Angeles County jail is often referred to as our largest mental hospital. With the downsizing of state hospitals and the increasing difficulty of obtaining inpatient care for many psychiatrically impaired individuals in this managed care era, jail placement for disturbed/disturbing arrestees is probably all too often the disposition of choice, at least initially.

The acknowledgment by county corrections officials, ultimately responsible for the oversight of mentally ill inmates, that placing these prisoners in the overcrowded, underbudgeted prison setting was perhaps not appropriate, given their behavior, and further that these difficult detainees were making their mission of care and containment more difficult to carry out, was the first step in the process of persuading the many different agencies involved that an alternate approach was desirable. This approach would acknowledge the event that led to incarceration, but nevertheless would focus on appropriate treatment as the key to changing behavior.

This presentation will focus on the background, preparation, implementation, and preliminary results of an innovative approach addressing the needs of mentally ill offenders in a conservative California county's main jail. At the conclusion of this presentation, the participant should be able to identify who might benefit from an alternative sentencing program and how best to develop and implement such a program

## TARGET AUDIENCE:

Staff involved with mental health and corrections.

## REFERENCES:

1. Torrey EF, Stieber J, Ezekiel J, et al: *Criminalizing the Seriously Mentally Ill.* Arlington, Va. National Alliance for the Mentally III, 1992.
2. Steadman HJ, Morris SM, Dennis DL: The diversion of mentally ill persons from jails to community-based services: a profile of programs. *American Journal of Public Health*, Vol. 85, No. 12, December 1995.

**Innovative Program 21 Sunday, October 26 11:00 a.m.-11:30 a.m.**

## THE NATURALLY OCCURRING RETIREMENT COMMUNITY: A MODEL PROGRAM OF MENTAL SERVICE DELIVERY TO THE COMMUNITY ELDERLY

Mark R. Nathanson, M.D., *Associate Professor of Psychiatry, Geropsychiatry Fellowship, Columbia University for Geriatric and Gerontology Rehabilitation, 100 Haven Avenue, Tower 1, 29F, New York, NY 10032*

## EDUCATIONAL OBJECTIVES:

At the conclusion of the presentation, the participant should understand the concepts of Aging In Place and Naturally Occurring Retirement Communities in light of our aging population choosing to remain in familiar communities.

## SUMMARY:

This program will focus on the elderly who have retired, but are still living in the community. Topics presented will include the demographic shifts predicted in the next century accompanied by a striking rise in the older, frail dependent segment of the population; the prevalence and spectrum of mental disorders of the aged particularly depressive disorders, dementia, anxiety disorders, delusional disorders, alcoholism, and delirium; the need for planning and implementing community based services emphasizing early case identification and

prevention, differential diagnosis and treatment, and the value of individual and group psychotherapy in the aged in conjunction with medication as indicated; supportive service models which have proven effective in the United States; the importance of community support and educational initiatives, collaborative networking of services and supervision of mental health professionals in a highly stressful arena; community based mental health care will be delivered by a team including clinical nurse specialists, social workers, psychologists and psychiatrists; and the important role of the psychiatrist in differential diagnosis of complex cases, treatment planning, consultation with and supervision of professional staff.

## REFERENCES:

1. Hunt ME, Jeldt AG, Marans RW, et al: Retirement communities: an American original. *Journal of Housing for the Elderly* 1 (no. 314): 7–17, 1983.
2. La Greca AJ, Streib GF, Folts WE: Retirement communities and their life stages. *Journal of Gerontology* 40 (No. 2):211–218, 1985.

# INNOVATIVE PROGRAMS: SESSION 8

**Innovative Program 22** **Sunday, October 26**
**1:30 p.m.-2:00 p.m.**

## HOSPITAL DOWNSIZING: PLANNING WITH UNCERTAINTY

Gregory P. Roberts, M.S.W., *Chief Executive Officer, Marlboro Psychiatric Hospital, 546 County Road, #520, Marlboro, NJ 07746*; Janne L. Nemyo, M.A., John C. Whitenack, B.A.

## EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to recognize some of the general, as well as some specific, managerial issues in hospital downsizing; and understand a method of dealing with uncertainty in strategic planning.

## SUMMARY:

This presentation describes the strategic planning process used to downsize an 800-bed public psychiatric hospital, with a view toward eventual closure.

Managerial issues that will be discussed include:

1) The analysis of competing priorities; and

2) The role of "minor" events causing major consequences.

Uncertainty plays a major role in logistical and financial planning. The development of a task force geared toward short-range planning and flexible implementation strategies will be described.

## REFERENCES:

1. Castellani PJ: Closing institutions in New York State: implementation and management lessons. *Journal of Policy Analysis and Management* 11 pp593–611, 1992.
2. Frost PJ, Mitchell, VE, Nord WR: *Managerial Reality—Balancing Techniques, Practice, and Values.* Harper Collins Chapter 9.: Ethical Situations at Work. pp309–315, 1990.

**Innovative Program 23** **Sunday, October 26**
**2:00 p.m.-2:30 p.m.**

## DOWNSIZING: REVISING THE MISSION OF A CRISIS UNIT

Erica Weinstein, M.D., *Medical Director, Marlboro Psychiatric Hospital, 546 County Road, #520, Marlboro, NJ 07746-1069*; Janne L. Nemyo, M.A., *Director of Speech Pathology, Marlboro Psychiatric Hospital, 546 County Road, #520, Marlboro, NJ 07746*; Gregory P. Roberts, M.S.W., Elizabeth McCloughlin, R.N.

## EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should become familiar with a practical model and specific techniques for strategic planning in constraining circumstances and uncertain conditions.

## SUMMARY:

This presentation will analyze the managerial process used to revise the mission of a psychiatric hospital's crisis unit during a period of downsizing.

The case example addresses issues of:

1) Retraining staff using limited resources;
2) Adhering to labor management agreements;
3) Patient placement and logistics;
4) Minimization of clinical risk; and
5) Staff morale.

The presentation then describes the process by which patients needing crisis management were eventually absorbed into the general patient population.

## REFERENCES:

1. Castellani PJ: Closing institutions in New York State: implementation and management lessons. *Journal of Policy Analysis and Management* 11 pp593–611, 1992.
2. Frost PJ, Mitchell, VE, Nord WR: *Managerial Reality—Balancing Techniques, Practice, and Values.* Harper Collins Chapter 9.: Ethical Situations at Work. pp 309–315, 1990.

**Innovative Program 24** **Sunday, October 26**
**2:30 p.m.-3:00 p.m.**

## TREATMENT MOTIVATORS FOR PEOPLE WITH SCHIZOPHRENIA AND OTHER PSYCHOTIC ILLNESSES

Thomas H. Picard, M.D., *Program Director, Hope Unit, The Menninger Clinic, P.O. Box 829, Topeka, KS 66601-0829*; Evelyn P. Unkefer, M.S.W., *Team Leader, Community Residence Program, Partial Hospital Service, The Menninger Clinic, Box 829, Topeka, KS 66601*; Jason Sellers, B.S.

### EDUCATIONAL OBJECTIVES:

At the conclusion of this program, the participant should be able to 1) understand recovery rehabilitation principles and direct skills videotaped training, 2) recognize activities that enhance active use of self as motivators for rediscovering meaningfulness, and 3) demonstrate knowledge of recovery-focused individualized goal setting.

### SUMMARY:

Managed care demands protracted biologically focused treatment for persons with lifelong serious mental illness. Individual needs of these consumers are often overlooked in the fast-paced process. The neurobiological illnesses plus medications, which do help with stabilization, often cause negative experiences and behaviors in consumers, including devastation of one's complete sense of self, oversleeping, overeating, apathy, and desperate lack of motivation. Psychiatric treatment must encompass the recovery rehabilitation philosophy of individualized treatment and provide practical motivators for this population. This session will introduce innovative motivators, which instill hope, rebuild the sense of self, and enhance functioning for this seriously mentally ill population. These motivators include: individualized recovery goals, psychoeducational activities emphasizing the devastating impact of the neurobiological illness, the impact of substance abuse, direct skills videotaped communication training, medication management, and family education. These approaches enhance self-efficacy by dealing directly with stigma in society's oppression of people with serious mental illness. These methods enhance coping by introducing meaningfulness in goal setting and the active initiative use of self. Consumers also receive concrete videotaped feedback, which expands their communication skills, increasing their self-confidence.

### REFERENCES:

1. Spaniol, Leroy & Koehler, Martin (ed): *The Experience of Recovery, The Center for Psychiatric Rehab.* Sargent College Boston University, 1994.
2. Publications Committee of IAPSRS (ed): *An Introduction to Psychiatric Rehabilitation* IAPSRS Publication, 1994.

## INNOVATIVE PROGRAMS: SESSION 9

**Innovative Program 25** **Sunday, October 26**
**3:30 p.m.-4:00 p.m.**

## HOUSING THE HOMELESS MENTALLY ILL IN NEW YORK CITY

Charles M. Barber, M.A., *Director, Garden House, 500 West 167th Street, New York, NY 10032*; Scott R. Masters, M.D., *Consulting Psychiatrist, Garden House, 588 Broadway Street, #405, New York, NY 10012*; Sabra Goldman, M.A., Daniel Johannson, M.Div., Bari Liebman, M.A., Cherie Makay, M.A.

### EDUCATIONAL OBJECTIVES:

At the conclusion of this program, participants will learn creative strategies to work with former homeless adults with mental illness, and more effective ways of working with them over the long term.

### SUMMARY:

This presentation will explore the experiences of one New York City agency, ARMI Inc., in providing housing and case management services to formerly homeless adults with mental illness. ARMI serves 100 adults in scattered-site apartments and two residences with differing levels of supervision and structure. Over time, agency administrators and clinicians have learned what works and what doesn't in engaging and treating this challenging population. Specific issues covered will be: (1) Our strongly clinical orientation: residents are required to be in treatment; case managers are closely supervised by consulting psychiatrists. (2) The necessity of providing individualized service plans and flexible services within the clinical framework. (3) Community relations: how we have established ourselves in neighborhoods that have opposed us. (4) Our discovery that those with personality disorders do better in the apartments, while those with schizophrenia do better in the residences. (5) Outcomes: 75% of clients have remained in treatment; hospitalization rates have decreased by 80%.

### TARGET AUDIENCE:

Community psychiatrists and administrators.

### REFERENCES:

1. Anthony WA, Blanch A: Research on community support services: what have we learned? *Psychosocial Rehabilitation Journal*, 12:55–8, 1989.

2. Carling PJ: Housing and supports for persons with mental illness: emerging approaches to research and practice. *Hospital and Community Psychiatry* 44:439–449, 1993.

**Innovative Program 26** **Sunday, October 26**
**3:30 p.m.-4:00 p.m.**

## STOP OUT-OF-HOME PLACEMENT: REVERSE THE TREND

Robert M. Simon, M.A., *Program Director and Owner, Family TEAMWORK, Inc., 10855 Lee Highway, Suite 220, Fairfax, VA 22030*; Joseph J. Palombi, M.D., *Neuropsychiatric Services of Greater Washington, 6404 Seven Corners Place, Falls Church, VA 22030*

### EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to understand the essential strategies necessary for maintaining a youth who is diagnosed as experiencing schizophrenia, school phobia, and depression, in the youth's own house rather than place the same youth in a hospital or residential treatment facility.

### SUMMARY:

Family TEAMWORK, Inc., provides an array of services to achieve the service outcomes desired by families and referring agencies. Toward providing the highest quality of services, Family TEAMWORK is licensed by the Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services.

Family TEAMWORK services are tailored to the individual needs of families and family members. Within 24 hours of referral, Family TEAMWORK staff meet with the family; thereafter, both assigned and back-up staff are available to the family on a 24-hour-a-day basis. Family crises or emergencies are dealt with by staff as they occur. Further, as each family situation warrants, Family TEAMWORK staff forge partnerships with both formal and informal resources in the community to bring the family additional stabilizing supports.

Family TEAMWORK now offers three broad categories of service: 1) counseling, 2) mentoring, and 3) transportation only. Plans are underway to add homemaking as another category of service. Counseling and mentoring services are typically provided in the family's home, at a frequency of eight or more hours a week for an average of 12 weeks.

### REFERENCES:

1. Berg I: *Family Based Services: A Solution Focused Approach*, Milwaukee: Brief Family Therapy Center, 1992.
2. McGowan B: *Reaching High Risk Families* New York. Aldine deGruyter, 1990.

**Innovative Program 27** **Sunday, October 26**
**3:30 p.m.-4:00 p.m.**

## OUTPATIENT COMMITMENT: TWO YEARS IN NEW YORK CITY

Howard Telson, M.D., *Assistant Clinical Professor of Psychiatry, New York University School of Medicine, 215 E. 24th Street, #321, New York, NY 10010-3804*; Jennifer Leeds, C.S.W., M.P.H., *Supervisor, Department of Social Work, Bellevue Hospital, 462 First Avenue, New York, NY 10016*

### EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation the participant should be able to 1) understand the clinical and legal theories underlying outpatient commitment, 2) understand Bellevue Hospital Center's implementation of a three-year outpatient commitment pilot program, and 3) understand the data of the first two years of Bellevue's pilot program.

### SUMMARY:

Over the past 40 years the treatment of seriously and persistently mentally ill individuals has shifted from hospitals to the community due to a variety of changes in mental health practice, law, and policy. One consequence of this has been the so-called "revolving door" syndrome, whereby some psychiatric patients become noncompliant with treatment and require repeated acute hospitalizations in order to regain stability. Outpatient commitment is a controversial intervention that has been developed to compel patients to accept treatment and thereby maintain community tenure.

In 1994 New York State passed legislation calling for a three-year pilot program to provide "involuntary outpatient treatment of mentally ill persons." The law also mandated an independent study to evaluate the program's success in preventing relapse and also participant satisfaction.

This paper will describe Bellevue Hospital Center's implementation of the pilot program since July 1995. It will review the first two years of clinical data and provide preliminary conclusions regarding outcome from the perspectives of clinicians, patients, family members, and government officials.

### REFERENCES:

1. Munetz MR, Grande T, Kleist J, Peterson GA: The effectiveness of outpatient civil commitment. *Psychiatric Services* 47:1251–3, 1996.
2. Torrey EF, Kaplan RJ: A national survey of the use of outpatient commitment. *Psychiatric Services* 46:778–784, 1995.

## INNOVATIVE PROGRAMS: SESSION 10

**Innovative Program 28** **Monday, October 27**
**8:00 a.m.-8:30 a.m.**

### THE VULNERABLE ADULT IN THE COMMUNITY: LESSONS FROM A CAPITATED MENTAL HEALTH PROGRAM

Gerard Gallucci, M.D., M.H.S., *Assistant Professor and Director, Creative Alternatives, Department of Psychiatry, Johns Hopkins Bayview Medical Center, 4940 Eastern Avenue, B-3-South, Baltimore, MD 21224-4304*; Wayne Swartz, L.C.S.W., *Administrator, Community Psychiatry Program, Johns Hopkins Bayview Medical Center, 4940 Eastern Avenue, Baltimore, MD 21224*; Varsha M. Vaidya-Kunnirickal, M.D., Wendy Shepard, M.S.N., Sheila Stewart, R.N., M.S.

### EDUCATIONAL OBJECTIVES:

At the conclusion of this program the participant should be able to identify some of the ethical and clinical issues involved with caring for the vulnerable adult patient with psychiatric illness in the community.

### SUMMARY:

Creative Alternatives is part of a five-year demonstration project that provides mental health and case management services to severe and persistently ill patients in the Baltimore vicinity. The project is a component of the Community Psychiatry Program of the Johns Hopkins Bayview Medical Center. Capitated funding has encouraged flexibility and innovation. A number of challenges have emerged that relate to the ethical issues of providing care for vulnerable adult patients in the community. These include issues related to client choice, housing, general medical care, and family participation.

The multidisciplinary staff will provide clinical venue to highlight some of the challenges faced by this innovative program.

### REFERENCES:

1. Harris M, Bergman H: Capitation financing for the chronically mentally ill: a case management approach. *Hospital & Community Psychiatry* 39:68–72, 1988.
2. Marshall P: The mental health HMO: capitation funding for the chronic mentally ill. Why an HMO? *Community Mental Health Journal* 28:111–120, 1992.

**Innovative Program 29** **Monday, October 27**
**8:30 a.m.-9:00 a.m.**

### MEDICAID MANAGED CARE AND ACADEMIC PSYCHIATRY

Kenneth S. Thompson, M.D., *Director, Institute for Public Health and Psychiatry, Western Psychiatric Institute and Clinic, and Former APA/Mead Johnson Fellow, 3811 O'Hara Street, Pittsburgh, PA 15213*; Diane P. Holder, M.S.W., *Vice President for Psychiatric Services, UPMC, and Assistant Professor of Psychiatry, Western Psychiatric Institute and Clinic, 3811 O'Hara Street, Pittsburgh, PA 15213*; Anthony M. Trachta, M.S.W.

### EDUCATIONAL OBJECTIVES:

At the conclusion of this program, the participant should be able to recognize the issues facing academic departments of psychiatry with the advent of managed care Medicaid and identify possible responses.

### SUMMARY:

Academic medical centers across the country are attempting to adjust to the new world of managed care. For those centers that have historically provided significant levels of publically funded care, the shift of Medicaid funding into managed care capitation has brought many challenges. This session will explore the experiences and actions of Western Psychiatric Institute and Clinic (WPIC) as it prepares for the advent of Medicaid managed care. The "added value" of being an academic medical center in the public sector will be emphasized by focusing on the capacity of academic providers to develop and promulgate "best practices" and innovations, to provide training and education, and to work in partnership with community providers, families, and consumers. Strategic decisions regarding the structure of WPIC's response, such as its decision to become an insurer and not just a provider, to remain not for profit, and to participate in public/private partnerships, will be discussed in light of the strengths WPIC brings to the service system.

### REFERENCES:

1. Meyer RE, Sotsky S: Managed care and the role and training of psychiatrists. *Health Affairs* 14:3, 1995.
2. Severino SK, Chung H: Health care reform: implications for academic psychiatric institutions. *Journal of MH Admin* 22(1):77–84, 1995.

**Innovative Program 30** **Monday, October 27**
**9:00 a.m.-9:30 a.m.**

### PARTNERING WITH HIGH-COST CLIENTS IN A MANAGED CARE SETTING

Robert T. Quinlivan, L.C.S.W., *Director, Managed Care, Telecare Corporation, 3211 Jefferson Street, San*

*Diego, CA 92110*; David P. McWhirter, M.D., *Supervising Psychiatrist, Telecare Corporation, 3211 Jefferson Street, San Diego, CA 92110*

## EDUCATIONAL OBJECTIVES:

At the conclusion of this program, the participant should be able to accurately identify high-cost users, understand the most common precipitants of inpatient admissions, and learn how to design and implement innovative program approaches for this group.

## SUMMARY:

This program will focus on an organizational approach to identifying and partnering with a group of high-cost clients in a managed care environment. In February 1996, the Telecare Corporation was awarded a contract by San Diego County Mental Health Services to reduce the cost of care for a group of the 100 highest cost users of inpatient services in 1995. The contract required a reduction of costs by 40%. To date, the program has reduced cost by nearly 70%.

Summary data will be shared with program participants on over 3,500 emergency inpatient admissions. The careful analysis of these data, which revealed the most common precipitants of admission, produced a program designed to reduce hospital use and increase community interventions.

Dr. David McWhiter, supervising psychiatrist, will thoroughly discuss the role of the psychiatrist in a community-based, comprehensive care program. He will highlight the unique program philosophy of partnership, rather than management of this group of individuals. The concept of partnership has resulted in a program with demonstrated cost savings, superior clinical outcomes, and numerous individual success stories.

The presentation will be interactive, with an emphasis on a discussion challenging the notion of managing vs. partnering with clients. Specific examples of the positive results of partnering, as well as negative results of traditional management approaches, will also be given. This program was initially described in the *Psychiatric Services* Best Practices Column in August 1996.

## TARGET AUDIENCE:

Psychiatrists, mental health administrators, managed care executives.

## REFERENCES:

1. Quinlivan R, McWhirter DP: Designing a comprehensive care program for high-cost clients in a managed care environment. *Psychiatric Services* 47:816–815, 1996.
2. Quinlivan R, Hough R, Crowell A, et al: Service utilizations and cost of care for severely mentally ill clients in an intensive case management program. *Psychiatric Services* 46:365–371, 1995.

# INNOVATIVE PROGRAMS: SESSION 11

**Innovative Program 31** **Monday, October 27**
**10:00 a.m.-10:30 a.m.**

## PSYCHIATRY AND PRIMARY CARE: WORKING TOGETHER

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

## EDUCATIONAL OBJECTIVES:

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

## SUMMARY:

Although psychiatry is now placing greater emphasis on collaboration with primary care practitioners, relatively few mental health programs have succeeded in developing strong collaborative partnerships with referring family physicians. This session explores ways in which psychiatrists and other mental health workers can work more closely with primary care physicians. It covers five areas: 1) problems that currently exist in the relationship between psychiatry and primary care, 2) what family physicians are looking for from psychiatric services, 3) principles that should underlie shared (collaborative) mental health care, 4) strategies that can bring about shared mental health care, and 5) ways to implement these ideas in any community. The session will be interactive. Discussions of each of these five areas will begin with an introductory overview, after which innovative program participants will be invited to contribute their own experiences.

## TARGET AUDIENCE:

Any mental health care provider, especially psychiatrists.

## REFERENCES:

1. Royal College of Psychiatrists and Royal College of General Practitioners: *Shared Care of Patients with Mental Health Problems*. London, 1993.
2. Strathdee G, Fisher N, McDonald E: Establishing psychiatric attachments to general practice: a six stage plan. *Psychiatric Bull* 16:284–286, 1992.

**Innovative Program 32** **Monday, October 27**
**10:30 a.m.-11:00 a.m.**

## MEDICAL CRISIS COUNSELING CENTER

Mark J. Ehrenreich, M.D., *Director of Consultation-Liaison Psychiatry, Department of Psychiatry, University of Maryland, 645 West Redwood Street, Baltimore, MD 21201-1542*; Victoria E. Wilson, M.S.W., *Clinical Coordinator, Department of Psychiatry, University of Maryland, 645 West Redwood Street, Baltimore, MD 21201*

### EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to: 1) recognize the need for targeted brief psychotherapeutic intervention for people living with life-changing illnesses or injury, 2) identify the eight central emotional issues faced by those living with life-changing illnesses and injury, and 3) identify the necessary steps in developing and implementing a new psychiatric service within the department of psychiatry in a major teaching hospital.

### SUMMARY:

The University of Maryland Division of Consultation/ Liaison Psychiatry recently established a Medical Crisis Counseling Center (MCCC). The goal of this center is to serve the needs of patients and families affected by medical illness and injury. The MCC Center was developed, in part, because the fast pace of today's hospital environment has made it more difficult to adequately meet the psychosocial needs of the medically ill. The cornerstone of the services provided by the center is medical crisis counseling, a short-term therapy developed by Irene Pollin, M.S.W., which focuses on the medical illness and the patient and/or family member's adjustment to it. Typical issues dealt with in therapy include fears of loss of control, stigma, dependency, abandonment, changes in self-image, anger, isolation, and death. Additional services provided include stress reduction techniques; medication management for anxiety, depression, and sleep disorders; counseling prior to hospitalization; and grief counseling. The center is staffed by a part-time social work coordinator and a medical director. It also serves as a training site for advanced trainees. To date, hospital social workers and the consultation/liaison psychiatry service have been the primary sources of referrals.

### TARGET AUDIENCE:

Mental health professionals associated with general medical systems.

### REFERENCES:

1. Pollin I, Kanaan SB: *Medical Counseling Short-Term Illness.* New York, NY, W.W. Norton and Company, Inc., 1995.
2. Pollin I, Golant SK: *Taking Charge: Overcoming the Challenges of Long-Term Illness.* New York, Random House, Inc., 1994.

**Innovative Program 33** **Monday, October 27**
**11:00 a.m.-11:30 a.m.**

## MODEL CLINIC FOR WOMEN'S MID-LIFE HEALTH CARE

Michelle R. Simon, M.D., *Instructor of Psychiatric Medicine, University of Virginia, 2955 Ivy Road, Suite 210 Northridge, Charlottesville, VA 22903*; Anita L.H. Clayton, M.D., *Associate Professor of Psychiatry, University of Virginia, Drawer C, BRH UVA HSC, Charlottesville, VA 22901*; Joanne Pinkerton, M.D.

### EDUCATIONAL OBJECTIVES:

At the conclusion of this program, the participant should be able to: 1) state the rationale for a multidisciplinary approach to health care for women in mid-life, 2) identify the relationship of endocrine, somatic, and psychic symptoms to the pre-, peri-, and post-menopausal period, and 3) make use of the described structure for early intervention in reproductive-related mood disorders.

### SUMMARY:

The Women's Midlife Health Center at the University of Virginia is a multidisciplinary group including gynecologists, endocrinologists, cardiologists, psychiatrists, pain management specialists, nutritionists, nurse educators, radiologists, and breast specialists. The center is dedicated to the holistic care of women in midlife, defined as the years following the active reproductive years. Many women choose their OB/GYN as their primary care physician and rely heavily on these doctors for coordination of their care.

As psychiatrists, we are involved with the women's center doing new patient evaluations referred from any of the other members of the team. These new patients are seen at the women's center to facilitate rapid feedback to the referring physician, and to help promote a better understanding of the psychiatrist's role. Fifty of the 59 women referred in the first year completed patient satisfaction surveys with 90% mostly to very satisfied with services received. Part of this close connection with the physicians provides for early intervention of patients with psychological symptoms, and many women are seen prior to changes or cessation in their menses.

There is a paucity of clinical information known about the psychiatric aspects of menopause and this clinical setting lends itself to a number of different research venues.

## TARGET AUDIENCE:

Psychiatrists who specialize in the treatment of depression and anxiety.

## REFERENCES:

1. Larsen DL, Attlassen CC, Hargreaves WA, Nguyen TD: Assessment of client/patient satisfaction: development of a general scale. *Evaluation and Program Planning*, 2, 197–207, 1979.
2. Pearlstein TB: Hormones and depression: what are the facts about premenstrual syndrome, menopause, and hormone replacement therapy? *American Journal of Obstetrics & Gynecology,* 173(2): 646–53, 1995.

# INNOVATIVE PROGRAMS: SESSION 12

**Innovative Program 34** **Monday, October 27**
**3:30 p.m.-4:00 p.m.**

## HOUSING, HEALING: INTEGRATING CARE OF THE HOMELESS

Erik J. Garcia, M.D., *Assistant Professor of Medicine, University of Massachusetts Medical Center, 55 Lake Avenue North, Worcester, MA 01655*

## EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should understand the multiple service needs of the homeless population.

## SUMMARY:

Worcester, Massachusetts, is the home of U Mass Medical Center and numerous human service agencies, the largest of which is Community Healthlink (CHL), a private, nonprofit, comprehensive mental health, substance abuse, and health care center. Within CHL is a multidisciplinary health care for the homeless project (Homeless Outreach & Advocacy Project/HOAP). HOAP began in 1985 with federal grant money from the McKinny Act and has grown from additional grant monies over the years.

Many health care for the homeless projects were created in the 1980's, but very few were started *within and as part of* a community mental health center. Medical, mental health, housing, and economic needs are simultaneously addressed under one umbrella agency (CHL) that is affiliated with U Mass Medical Center. Additionally, several specialized services have been developed through collaborative efforts with shelters and other nonprofits. The project consists of a multidisciplinary team of case managers, nurses, mental health social workers, internists, and psychiatrists. This group meets weekly as a team and goes into the community as a team engaging, treating, and ultimately housing homeless individuals. The project operates on the principle that all needs must eventually be addressed before successful stable housing can be achieved. Through case examples, the objective of this presentation is to show how HOAP works.

## REFERENCES:

1. Falk K, Albert G: *Treating Mentally Ill Homeless Persons: A Handbook for Psychiatrists.* New York, New York: The Project Outreach to the Homeless, Inc.
2. Herman DB, Struening EL, Barrow SM: Self-assessed need for mental health services among homeless adults. *Hospital and Community Psychiatry.* 44(12): 1181–1183, 1993.

**Innovative Program 35** **Monday, October 27**
**4:00 p.m.-4:30 p.m.**

## OASIS HOUSE: A HAVEN FOR HOMELESS MENTALLY ILL ADULTS

Eileen C. Reilly, M.D., *Department of Psychiatry, University of Massachusetts Medical Center, 72 Jaques Avenue, Worcester, MA 01610*

## EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to understand some of the obstacles in the delivery of care to the homeless, and homeless mentally ill, and how these obstacles can creatively be overcome.

## SUMMARY:

Oasis House is a temporary residential program for homeless, mentally ill persons, located in Worcester, Massachusetts. Many clients come directly from the city's shelters and have severe, untreated psychiatric disorders. Once clients are living at the house, efforts are made to engage them in psychiatric and medical treatment. Members of the Homeless Outreach and Advocacy Project, including psychiatrists, nurses, and case managers go to the home to outreach and provide care. Emphasis is on a consistent attempt to build alliances and establish trust. The majority of clients eventually accept medical and psychiatric care, and move from Oasis House to stable, permanent housing.

## REFERENCES:

1. Dixon L, Friedman N, Lehman A: Compliance of homeless mentally ill persons with assertive community treatment. *Hospital and Community Psychiatry* 44(6);581–583, 1993.
2. Talbott JA, Lamb HR: Summary and recommendations. In: Lamb HR (ed.): *The Homeless Mentally Ill.* Washington, D.C.: American Psychiatric Assoc., pp. 1–10, 1984.


**Innovative Program 36** **Monday, October 27**
**4:30 p.m.-5:00 p.m.**

# TAILORING SUPPORTED HOUSING FOR THE HOMELESS

Marianne L. Smith, M.D., *Assistant Professor of Psychiatry, University of Massachusetts Medical Center, 55 Lake Avenue, North, Worcester, MA 01655*

## EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to understand how an integrated model of treatment and housing can be successfully used to result in a better quality of life for homeless individuals with multidisciplinary problems.

## SUMMARY:

Homeless persons frequently cycle from housing to homelessness again. Problems that resulted in homelessness resurface, and an individual is on the street once more. Those with psychiatric, addiction, and medical problems (especially HIV/AIDS) are at high risk for relapse, which may lead to relapse into homelessness.

Just as traditional models of treatment often do not work, traditional housing often does not work for homeless individuals either. Individuals who are able to live independently are often in need of much more than housing to be stably housed. Continuity of care is paramount in avoiding homeless recidivism. The psychiatric, medical, and case management services that began during homelessness need to continue, ideally by the same providers, once an individual is housed.

One solution is to create supported permanent housing designed for, and tailored to needs of formerly homeless individuals. Several supported housing programs have been created in Worcester, Massachusetts, *within* a health care for the homeless project that is itself *within* a large community mental health agency.

The objective of this presentation is to illustrate, through case examples, how these supported housing programs, designed for previously homeless individuals with mental health, health, and addiction issues, can lead to stable, permanent housing.


## REFERENCES:

1. Lamb HR, Bachrach LL, Goldfinger SM, Kass FI: Summary and recommendations. In: Lamb HR, Bachrach LL, and Kass FI (eds.): *Treating the Homeless Mentally Ill.* Washington, D.C.: American Psychiatric Association, pp. 1–10, 1992.
2. Bennett MI, Gudeman JE, Jenkings L, et al: The value of hospital-based treatment for the homeless mentally ill. *American Journal of Psychiatry* 145 (10):1273–1276, 1988.

**Lecture 1** **Friday, October 24**
**8:00 a.m.-9:30 a.m.**

## THE TREATMENT OF SCHIZOPHRENIA: INTERVENTIONS AND OUTCOMES

Anthony F. Lehman, M.D., M.S.P.H., *Professor of Psychiatry and Director, Center for Mental Health Services Research, University of Maryland School of Medicine, 645 West Redwood Street, Baltimore, MD 21201*

### SUMMARY:

The time has come for the development of standards to ensure quality and cost-effective care for the treatment of persons with schizophrenia. Advances in understanding the efficacy of treatments for schizophrenia, the promise of new treatment advances derived from a rapidly evolving neuroscience, pressure to contain health care costs while maintaining or increasing quality, and the growth of advocacy on behalf of persons with schizophrenia are driving this need. The evidence for the efficacy of pharmacotherapies, psychological interventions, family interventions, vocational rehabilitation, and case management and assertive community treatment is summarized. Implications of this evidence for instituting "disease management" for schizophrenia are presented. Such disease management programs must ensure that efficacious treatments are available, that both effectiveness and costs are considered in the allocation of resources, and that procedures are in place to evaluate ongoing effectiveness and promote service improvement.

### REFERENCE:

1. Lehman AF, Carpenter WT, Goldman HH: Treatment outcomes in schizophrenia: implications for practice, policy, and research. *Schizophrenia Bulletin* 21:669–675, 1995.

**Lecture 2** **Friday, October 24**
**3:30 p.m.-5:00 p.m.**

## REDUCTION AND REDUCTIONISM: A DILEMMA FOR PSYCHIATRY

James H. Scully, Jr., M.D., *Professor and Chair, Department of Neuropsychiatry and Behavioral Science, University of South Carolina School of Medicine, and Director, William S. Hall Psychiatric Institute, 3555 Harden Street, Room 104A, Columbia, SC 29203*

### SUMMARY:

Psychiatry has long struggled with the problem of reductionism. Both psychological and biological theories have been proposed to explain all psychiatric illness. Reductionism has its uses as well. For example: Biological reductionism has helped decrease stigma. Economic forces are now also acting to promote reductionism in the role of psychiatry. We must not as a profession fall into this trap but must continue to work to develop an integrated biopsychosocial model.

### REFERENCE:

1. Gabbard GO: Mind and brain in psychiatric treatment. *Bulletin of the Menninger Clinic*, 58(4):427–446, 1994.

**Lecture 3** **Saturday, October 25**
**8:00 a.m.-9:30 a.m.**

## PRODROMAL SYMPTOMS AND RELAPSE PREVENTION IN SCHIZOPHRENIA

Marvin I. Herz, M.D., *Professor of Psychiatry, University of Rochester, 300 Crittenden Blvd., Rochester, NY 14642-1018*

### SUMMARY:

Schizophrenia is usually a long-term disorder characterized by relapses alternating with periods of full or partial remission. Studies have shown that many patients demonstrate prodromal symptoms prior to full relapse. This paper will discuss what is known about the process of relapse and will focus on the significance of monitoring for prodromal symptoms and early intervention with increased medication and clinical contacts when these symptoms are detected.

Early intervention was first used in studies where patients were taken off maintenance antipsychotic medication and given it only when prodromal symptoms appeared. Maintenance medication proved superior in prevention of relapse and rehospitalization. However, if patients are off maintenance medication, early intervention improves outcome when compared with treatment not using an early intervention approach.

There have been no studies reported involving early intervention for patients who are maintained on antipsychotic medication. This paper will present results of a controlled study comparing early intervention with no early intervention for patients maintained on antipsychotic medication. Results of this study, including relapse and rehospitalization rates as well as costs, will be reported, and the implications for clinical practice will be discussed.

### REFERENCE:

1. Herz MI: Early Intervention in Schizophrenia, in Psychosocial Treatment of Schizophrenia, Vol. 4 of *Handbook of Schizophrenia*, Herz MI, Keith S, Docherty J (eds.). Amsterdam: Elsevier Science Publishers, pp. 25–44, 1990.

**Lecture 4** **Saturday, October 25**
**10:00 a.m.-11:30 a.m.**

## THE FALSE MEMORY SYNDROME

Paul R. McHugh, M.D., *Department of Psychiatry, Johns Hopkins Hospital, 600 North Wolfe Street, Baltimore, MD 21205-2110*

### SUMMARY:

In this lecture the concept of repressed or recovered memories and of severe and repeated abuse will be discussed in relationship to what would seem to be cautious practices in the therapy. The many pitfalls that have led to embarrassing positions of psychiatrists will be described and a process of clear do's and don't's in practice to avoid being entrapped in the false memory problem will be outlined. Clinical experience, case examples, and outcomes will be reviewed as will the capacity of this problematic issue to lead to obviously artifactual memories. The problems based on research and on published work will be reviewed as will suggestions to correct the errors and plan for the future.

### REFERENCE:

1. Dishion T, French D, Patterson G: Treatment of patients with recovered memories. *New England Journal of Medicine.* 335:281–283, 1996.

**Lecture 5** **Saturday, October 25**
**1:30 p.m.-3:00 p.m.**

## ANTI-GAY VIOLENCE AND HATE CRIMES: PSYCHIATRIC PERSPECTIVES

Jeffrey S. Akman, M.D., *Assistant Dean for Student Educational Policies, and Associate Professor of Psychiatry and Behavioral Sciences, George Washington University, 2150 Pennsylvania Avenue N.W., Washington, DC 20037*

### SUMMARY:

Recent reports document increasing rates of anti-gay violence and hate crimes in the United States and throughout the world. Ranging from verbal and physical harassment to assault, torture, and murder, the mental health implications of this problem have only recently come under scrutiny. In this presentation, Dr. Akman will review the recent data on gay and lesbian hate crimes, address the roots of anti-gay attitudes and homophobia, discuss the implications of anti-gay violence on gay and lesbian identity development, and review research on the psychiatric consequences of anti-gay violence. Recommendations for the role of mental health professionals in treatment and policy-making will be discussed.

### REFERENCE:

1. Otis MD, Skinner WF: The prevalence of victimization and its effect on mental well-being among lesbian and gay people. *Journal of Homosexuality.* 1996; 30 (3):93–121.

**Lecture 6** **Saturday, October 25**
**1:30 p.m.-3:00 p.m.**

## ADVOCACY AS A THERAPEUTIC MODALITY

Harriet Lefley, Ph.D., *Professor, Department of Psychiatry, University of Miami School of Medicine, D-29, P.O. Box 016960, Miami, FL 33101*

### SUMMARY:

This presentation discusses therapeutic aspects of advocacy for persons with severe and persistent psychiatric disorders and for the families whose lives are affected by their illness. We trace the development and current status of family and consumer advocacy organizations, including research findings. These movements generally have been welcomed by the psychiatric community, but their activities have been viewed as an adjunctive political resource and as ancillary to clinical interventions. Clinical interventions for serious mental illness, however, are generally palliative rather than curative, and our research and evaluation designs acknowledge the modesty of expected effects. Outcome studies generally focus on avoidance of relapse or on symptom reduction rather than hard-to-operationalize variables such as identity change.

In this presentation, we talk about the subjective experience of mental illness for patients and family members, and the dynamics of therapeutic change in persons who existentially have suffered loss of control over the events and systems that rule their lives. Clinical, psychoeducational, and rehabilitative interventions offer the groundwork but not the end of the therapeutic process. Advocacy movements provide mutual support, experiential sharing, productive roles that enhance self-esteem, social and instrumental learning, and role modeling from successful peers. For both patients and families, they offer empowerment to affect the political process and a means of controlling one's personal destiny. Research directions will be suggested for studying the effects of the family and consumer movements on course of illness.

### REFERENCE:

1. Lefley HP: Advocacy, self-help, and consumer-operated services. In, A Tasman, J Kay, JA Lieberman, eds. *Psychiatry*, Vol. 2, pp. 1770-1780. Philadelphia: Saunders, 1997.

**Lecture 7** **Saturday, October 25**
**3:30 p.m.-5:00 p.m.**

## MENTAL HEALTH CARE IN THE 21ST CENTURY

*American Hospital Association*

Steven M. Mirin, M.D., *Medical Director, American Psychiatric Association, 1400 K Street, N.W. Washington, DC 20005*

### SUMMARY:

As we approach the next millennium, the financing and delivery of mental health care is undergoing enormous change. With the growth of managed care, capitated reimbursement, and integrated delivery systems, psychiatrists and other mental health professionals are appropriately anxious about their role in the mental health care delivery system of the future. Moreover, as pressure to reduce the costs of care has accelerated, payers have attempted to shift the bulk of clinical responsibility to allegedly lower-cost providers, and disputes over therapeutic territory have impaired the ability of mental health caregivers to advocate on behalf of the mentally ill.

Looking to the future, it is clear that competitive pressures will continue. Groups and networks of mental health care providers will seek to contract directly with employers, purchasing alliances, and state and federal governments, raising economic and ethical issues, while also changing the nature of the clinician/patient relationship. Research advances will continue to improve the delivery of care, but debate about the size and composition of the mental health workforce will continue. This lecture will address these and other trends that will affect mental health caregivers in the next century.

### REFERENCE:

1. Mirin SM, Sederer LI: Mental health care: current realities, future directions. *Psychiatric Quarterly*, 1994; 65(3).

**Lecture 8** **Saturday, October 25**
**3:30 p.m.-5:00 p.m.**

## DRADA: A CLINICAL, EDUCATIONAL, AND RESEARCH COLLABORATION WITH FAMILIES AFFECTED BY MOOD DISORDERS

J. Raymond DePaulo, Jr., M.D., *Professor of Psychiatry, and Director of the Affective Disorders Clinic, Johns Hopkins School of Medicine, 600 North Wolfe Street, Baltimore, MD 21287*

### SUMMARY:

DRADA, the Depression and Related Affective Disorders Association, is a voluntary health organization incorporated in the state of Maryland in 1986 for the purposes of educating the public about the medical/biochemical nature of clinical depression and manic depressive illness, to offer support to those affected by the illness, and to promote research into their causes and treatments. DRADA was modeled after similar not for profit voluntary organizations in the medical field including Alzheimer's disease, Huntington's disease, breast cancer, and Retinitis Pigmentosa. These disease-specific organizations are organized quite differently from the National Mental Health Association, the National Alliance for the Mentally Ill, On Our Own, Recovery Incorporated, and Alcoholics Anonymous, the best known and largest voluntary organizations related to psychiatric disorders. DRADA is also quite different from all of the psychiatric and medical disease-related groups. The differences include naming a particular disease or set of diseases as the focus of activity and the absence of lobbying. A brief review of these differences, as well as a discussion of accomplishments and the current goals of DRADA will be discussed in the context of an evolution of voluntary health organizations in psychiatry at the end of the 20th century.

### REFERENCES:

1. Frank JB and Frank JD: Persuasion and Healing: A Comparative Study of Psychotherapy, The Johns Hopkins University Press, Baltimore, 1991.
2. Resnick, WM: Nursing and the voluntary association: origin, development and collaboration. *Nursing Clinics of North America* 21:515–525.

**Lecture 9** **Sunday, October 26**
**8:00 a.m.-9:30 a.m.**

## PSYCHIATRIC DISORDERS IN PRIMARY CARE

Javier I. Escobar, M.D., *Professor and Chair, Department of Psychiatry, Robert Wood Johnson Medical School, 675 Hoes Lane, Piscataway, NJ 08854-5635*

### SUMMARY:

The general health sector has been traditionally dubbed the "de facto" mental health system in the United States. Nowadays, a number of factors including stigma, changes in health care reimbursement, and the tendency to move away from speciality care perpetuate or even strengthen this trend. Thus, a large segment of patients using primary care services suffer from major mental disorders. In this presentation, the literature on prevalence of specific psychiatric disorders in primary

care will be briefly reviewed. Next, the author will present data from a study recently completed in which he participated as coinvestigator. That study assessed more than 1500 users of primary care services with the CIDI, a highly standardized psychiatric interview that makes DSM-IV diagnoses.

This study found a high prevalence of somatizing syndromes, post-traumatic stress disorders, and major depression in this sample and pointed to specific risk factors to explain these diagnoses. The discussion will elaborate on strategies to enhance the assessment and management of these patients in the primary care setting.

## REFERENCE:

1. Barrett J, Oxman T, et. al: The prevalence of psychiatric disorders in primary care practice. *Arch Gen Psych*, 45:1100–1106, 1988.

**Lecture 10** **Sunday, October 26**
**10:00 a.m.-11:30 a.m.**

## A SHORT HISTORY OF PARITY: WHAT DO WE REALLY WANT?

Howard H. Goldman, M.D., M.P.H., Ph.D., *Professor of Psychiatry, and Director of Mental Health Studies, University of Maryland School of Medicine, 685 W. Baltimore Street, Baltimore, MD 21201*

## SUMMARY:

The recent passage of the Domenici-Wellstone mental illness parity provision, an amendment to the FY 1997 VA, HUD Appropriations bill signed into law in September 1996 by the President, is a milestone in mental health policy. It has occasioned considerable commentary. The accomplishments and limitations have been described; the politics have been analyzed. Perhaps everything that needs to be said has been said already. Having studied this issue for more than a decade, however, I could not resist an invitation to add a few comments of my own.

This presentation will review the pros and cons of the story of "parity" in mental health insurance benefits—from the conceptual work in the early 1980's through the expansion of Medicare to attempts at national health care reform and the current policy debate. "Parity" means different things to different people. It has re-emerged with new valence, embodying two related concepts: *fairness* and *nondiscrimination*. The recent debate suggests that whatever the meaning of parity comes to be and whatever concerns about equity may remain, the focus of further policy should be on fairness and an end to discrimination in coverage policy.

## REFERENCE:

1. Hennessy KD, Stephens S: Mental health parity. *Psychiatric Services* 48:161–164, 1997.

**Lecture 11** **Sunday, October 26**
**1:30 p.m.-3:00 p.m.**

## THE CRIMINALIZATION OF THE MENTALLY ILL IN THE PUBLIC SECTOR

John M. Oldham, M.D., *Director, New York State Psychiatric Institute, and Chief Medical Officer, New York State Office of Mental Health, 722 West 168th Street, New York, NY 10032*

## SUMMARY:

Much has been written about the nationwide steady decline in state hospital populations and the efforts to reinvest recovered resources in community-based care, many examples of which have been innovative and successful. Patients remaining in state hospital beds, however, include those who are severely disabled and have not sufficiently responded to available treatments; these patients frequently have multiple diagnoses (often including substance abuse) and are, in increasing percentages, deemed to be dangerous. Thus the state hospitals, always at risk of being stigmatized along with their patients, are increasingly seen as secure asylums mandated to contain their patients to protect society, rather than as locations where humane treatment and rehabilitation occur. Data will be presented from New York indicating these changing characteristics of patients in its state hospitals.

As state hospital populations are decreasing, prison populations are increasing and include large numbers with psychiatric disabilities. Coordination between criminal justice and mental health systems has been spotty and uneven, and several thorny dilemmas remain unresolved. For example, are conditions such as pedophilia and antisocial personality disorder truly mental illnesses (*DSM-IV* notwithstanding), or do they fundamentally represent criminal behavior and social deviance? Or both? In turn, do patients with these conditions belong in prison or in the hospital? Several highly publicized cases will be reviewed that illustrate the complexities of these situations. The recent Supreme Court decision ( *Kansas v. Hendricks*) has created an added challenge, since offenders with conditions now court-designated as "mental abnormalities" can be remanded after sentence completion for unlimited "treatment" in civil settings.

In spite of these complex political/social/legal/ethical/fiscal/clinical situations, for which there are no easy solutions, we must not lose our clinical perspective. Many of the individuals with recidivistic criminal histories and *DSM-IV* diagnoses, whether located in the criminal justice or the mental health system, are victims of years of abuse and neglect, and they are extremely disabled. New findings will be reviewed, such as the emerging results of the MacArthur Risk Assessment Study, that are informing us about those patients at highest risk for violence. New prevention techniques are being

developed to "immunize," early in life, high-risk children whose lives would otherwise inevitably unfold into crime and disability. But greater efforts are needed to fund research, and to develop better prevention and treatment strategies for these severely dysfunctional individuals, rather than channeling all resources into low-cost containment reminiscent of the warehousing practices of the past.

## REFERENCE:

1. Hodgins S (ed.): Mental Disorder and Crime, Sage Publications, Newbury Park, 1993.

**Lecture 12** **Sunday, October 26**
**3:30 p.m.-5:00 p.m.**

## LONGITUDE, THE MILLENNIUM, AND THE FUTURE OF PSYCHIATRY

Bernard S. Arons, M.D., *Director, Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 5600 Fishers Lane, Rockville, MD 20857*

## SUMMARY:

Over the past decade, much progress has been achieved in conceptualizing and designing comprehensive, coordinated, community-based systems of care for adults with severe mental illnesses and for children and adolescents with serious emotional disorders and their families. These systems of care emphasize a broad array of flexible and individualized services, coordination across agencies and systems, the full involvement of consumers and families in all aspects of the planning and delivery of services, and providing services that are responsive to culturally and ethnically diverse populations.

This lecture will address the changing trends in mental health service delivery, the lessons learned from the past, and the challenges of the future. All of these must be addressed with care to preserve the progress that has been made and build on existing strengths. There also are several issues to be covered, including efficacy of treatment, stigma, and the service delivery models already in place. Recipients of treatment have shown significant improvements in many outcome measures. The continuation of the delivery of effective services along with the outcomes of new and advanced treatment models will ensure that mental health services continue to provide needed treatment to its customers into the 21st century.

## REFERENCE:

1. Center for Mental Health Service: *Mental Health, United States, 1996.* Manderscheid RW, and Sonnenschein MA, (eds.) DHHS Pub No. (SMA) 96-3098. Washington, D.C.: U.S. Govt. Print. Off., 1996.

**Lecture 13** **Sunday, October 26**
**3:30 p.m.-5:00 p.m.**

## CONFIDENTIALITY AND COMPUTERS

Harold I. Eist, M.D., *Medical Director, Montgomery Child and Family Health Services, Department of Psychiatry, Howard University, and Past President, American Psychiatric Association, 5705 Rossmore Drive, Bethesda, MD 20814-2227*

## SUMMARY:

This lecture will address the importance of confidentiality to the establishment and maintenance of the doctor/patient relationship. Physicians have been traditional guardians of patient information, and patients reveal information to their physicians in the service of recovery and healing. The commercial uses of information are generally exploitative and profit driven. Patients have a right to confidentiality. Computers and central data banks create unprecendented hazards for the maintenance of confidentiality and threaten the sanctity of the doctor/patient relationship. Examples of the destructive commercial use of information will be included.

## REFERENCE:

1. *Statement of the APA on the Medical Records Confidentiality Act of 1995 to Senate Labor & Human Resources Committee*, 11/17/95.

**Lecture 14** **Monday, October 27**
**8:00 a.m.-9:30 a.m.**

## ENSURING CHILDREN'S MENTAL HEALTH

Mary Jane England, M.D., *President, Washington Business Group on Health, 777 N. Capitol Street NE, #800, Washington, DC 20002-4239*

## SUMMARY:

An estimated 20% or 11 million American children and adolescents have serious and diagnosable emotional health disorders; less than one third receive appropriate treatment. The prevalence varies by income. Disorders are more prevalent among children who are covered under Medicaid or who are uninsured. Models of programs that blend funding at the community level will be discussed. These systems of care serve all children's health needs and are accountable for cost, quality, and improved outcomes. Best practices in the private sector

and demonstration projects in the public sector are models for improving the health status of all children.

## REFERENCES:

1. Glied S, Hoven CW, Moore RE, et al: Children's access to mental health care: does insurance matter? *Health Affairs* January-February 1997 Vol 16 #1; 167–174.
2. England MJ, "Meeting the Mental Health Needs of Children." Testimony before Senate Committees on Labor and Human Resources, April 18, 1997.
3. GAO Report Health Insurance for Children - Private Insurance Coverage Continues to Deteriorate - June 1996.

**Lecture 15** **Monday, October 27**
**10:00 a.m.-11:30 a.m.**

## GENDER DIFFERENCES IN MOOD DISORDERS

Ellen Leibenluft, M.D., *Chief, Unit on Rapid Cycling Bipolar Disorder, Clinical Psychobiology Branch, National Institutes of Health, and Associate Professor of Psychiatry, Georgetown Universiy, 7103 Ridgewood Avenue, Chevy Chase, MD 20815*

## SUMMARY:

Until recently, the topic of gender was relatively neglected by psychiatric researchers. In older studies and case reports, it is not uncommon for authors to describe patients in great detail, but to omit mention of their sex. This trend has been reversed in recent years as political forces and an awareness of the scientific importance of gender-related issues have caused a marked increase in research on the topic.

In the case of mood disorders, the fact that women are at higher risk than men to develop depressive disorders has now been demonstrated by several epidemiological studies in a number of countries. The reasons for this gender difference in prevalence, however, are still poorly understood. Recent advances in neuroscience demonstrate that environmental influences can affect biological processes in the central nervous system; these findings render the old debate about whether women's increased risk for depression is "biological" rather than "psychological" or "social" largely moot. Further research on gender differences in central nervous system function and on the effects of stress on the brain may increase our understanding of women's increased risk for depression.

While gender differences in the prevalence of mood disorders are well-documented, less is known about possible gender differences in symptomatology, course, and treatment response. The literature indicates that men and women with major depression may differ little on these variables, although a number of such differences may exist between male and female patients with bipolar illness. In addition, the interaction between reproductive transitions and the course of mood disorders in women is poorly understood, although research on this topic has increased.

## REFERENCE:

1. Leibenluft E: Women with bipolar illness: clinical and research issues. *Am J Psychiatry* 153:163–173, 1996.

**Lecture 16** **Monday, October 27**
**1:30 p.m.-3:00 p.m.**

## WRITING A NEW NATIONAL PRESCRIPTION TO IMPROVE WOMEN'S MENTAL HEALTH

*American Hospital Association*

Susan J. Blumenthal, M.D., M.P.A., *U.S. Deputy Assistant Secretary for Health (Women's Health), U.S. Assistant Surgeon General, U.S. Department of Health and Human Services, and Clinical Professor of Psychiatry, Georgetown School of Medicine, 5600 Fishers Lane, Room 10-104, Rockville, MD 20857*

## SUMMARY

Over the past seven years, the United States has witnessed the greatest focus on women's health in its history. The year 1990 marked the beginning of a decade when our country began to focus national attention on gender differences and their implications for the clinical care of women patients. Well-documented gender differences exist in incidence and prevalence of specific mental disorders. Women experience significantly higher rates of eating disorders, panic disorders, and mood disorders than do men.

This presentation will review the events that have placed women's health issues at the forefront of our nation's health care agenda. It will explore sex differences in the incidence and prevalence of mental disorders, will discuss biological and behavioral factors that may contribute to gender differences in rates, and will examine emerging issues affecting women's mental health. The talk will conclude with a description of federal initiatives that should improve women's mental health in this decade and into the 21st century.

## REFERENCE:

1. Chiles, Strosahl, Zheng, et. al., Improving the mental health of women, *Am J Psychiatry* 146:3, 339–344, 1995.

**Lecture 17** **Monday, October 27**
**3:30 p.m.-5:00 p.m.**

## THE EMPEROR'S NEW CLOTHES: PRIMARY CARE VERSUS MENTAL ILLNESS

Jerry M. Wiener, M.D., *Leon Yochelson Professor and Chairman, Department of Psychiatry, George Washington University, and Past President, American Psychiatric Association, 2150 Pennsylvania Avenue, N.W., Washington, DC 20037-2396*

### SUMMARY:

For about 40 years, since the end of World War II, American medical education, residency training, practice, credentialing, and reimbursement have focused on specialist rather than generalist training. This also coincides with the enormous growth over this same period in research, technology, and health care costs.

By the mid-1980's, two important trends came together: serious efforts to curb rising health care costs and concerns about the increasing mechanization of patient care and the doctor-patient relationship. Both of these have led to a renewed interest in generalist or primary care training as an alternative to specialist training and as a way of restoring the role of the doctor-patient relationship. For purposes of controlling costs, access, and utilization, the managed care industry, along with other contributors to health care policy, established primary care (family practice, general internal medicine, pediatrics, and ob/gyn) as both the front line of care and the gatekeepers controlling access to specialist care, principally by the use of reverse financial incentives. An absolutely key assumption in general, and in regard to mental health care in particular, is that primary care is prepared and expected to provide initial diagnosis and treatment—primarily medications—for the majority of psychiatric problems, referring on to specialty care only the more difficult and complicated. In order for this expectation to be realistic there should be reason to believe that primary care physicians are knowledgeable in the diagnosis and treatment of "uncomplicated" psychiatric disorders, that they are motivated, i.e., interested, to provide such care, and that in their practice structure they are able to provide such care. This presentation will discuss all three of these assumptions with the concern that none of them are justified by current training, data on identification of disorders, or practice structure.

### REFERENCE:

1. De Gruy F: *Mental Health Care in the Primary Care Setting.* A paper commissioned by the Committee on the Future of Primary Care, Institute of Medicine, Washington DC, September 1995.

**Lecture 18** **Tuesday, October 28**
**8:00 a.m.-9:30 a.m.**

## OVERCOMING DISABILITY IN SCHIZOPHRENIA BY GAINING SOCIAL AND INDEPENDENT LIVING SKILLS

Robert Paul Liberman, M.D., *Professor of Psychiatry, University of California at Los Angeles School of Medicine, 528 Lake Sherwood Drive, Thousand Oaks, CA 91361*

### SUMMARY:

Social skills training, a modality validated for its therapeutic effects in schizophrenia and other major mental disorders, has been packaged into user-friendly and video-assisted modules to spur widespread dissemination and adoption of this rehabilitation innovation by practitioners. Each module is a highly specific and structured series of skill areas, each of which targets educational objectives at the cognitive and behavioral levels using seven learning activities. The learning activities comprise principles of human learning, including modeling, reinforcement, behavioral rehearsal, problem solving, and in vivo and homework exercises.

Controlled clinical research, as well as field trials in hospital and community-based treatment facilities, has documented the 1) efficacy of the modules in promoting significant and durable learning of social and independent living skills in a wide spectrum of mentally disabled individuals, even when moderately severe symptoms were present; 2) generalizability of skills learned in training sessions into real-life situations; 3) improved quality of life reported by the participants in skills training; and 4) positive impacts of training when conducted by a broad array of professionals and paraprofessionals in the USA, Canada, Europe, and Asia. The lecture will be illustrated by video demonstrations of modules in action, which cover such topics as basic conversation skills, community re-entry, recreation for leisure, medication self-management, and symptom self-management.

Since neurocognitive deficits shown by persons with schizophrenia (verbal learning, working memory, attention, and vigilance) appear to serve as "rate-limiting" factors in the acquisition of instrumental and social role skills, the lecture will also include current research at the Clinical Research Center for Schizophrenia & Psychiatric Rehabilitation that is probing the boundaries between the brain and behavior to determine whether the brain can be trained to improve its information-processing capacity and thereby facilitate rehabilitation readiness and the learning and utilization of social and independent living skills. If time allows, the lecture will include experiential role plays for the audience to practice the learning activities in a module and to plan how to overcome organizational and personal obstacles to

the implementation of the modules in real-life clinical settings.

## REFERENCES:

1. Liberman RP, et al: Innovations in skills training for the seriously mentally ill: the UCLA Social & Independent Living Skills Modules. *Innovations & Research*, 2:43–60, 1993.
2. Liberman RP, Corrigan PW: Designing new psychosocial treatments for schizophrenia. *Psychiatry*, 56:238–248, 1993.

**Lecture 19** **Tuesday, October 28**
**10:00 a.m.-11:30 a.m.**

## A SYSTEMS APPROACH TO CARING FOR PERSONS WITH SEVERE AND PERSISTENT MENTAL ILLNESS

Leonard I. Stein, M.D., *Professor Emeritus, Department of Psychiatry, University of Wisconsin Medical School, 600 Highland Avenue, Madison, WI 53792-2475.*

## SUMMARY:

In planning mental health services for persons with severe and persistent mental illness, it is important to go beyond the program level and to think in system terms. This includes an array of services of varying intensity, funding strategies, gate keeping, hospital monitoring, and methods of coordinating service elements to ensure they operate in an integrated manner.

Dane County, Wisconsin has been operating a managed care public mental health system for over two decades. The primary locus of care for persons with severe and persistent mental illness was shifted from the hospital to the community, utilizing community-based programs that serve as fixed points of responsibility for the seriously ill consumer. Dane County's public mental health system operates on less money than the national average. However, it is able to serve its consumers well by reallocating hospital dollars to community services. Over the past 20 years, it has shifted the ratio of dollars from 70% hospital and 30% community, to what it now spends: 80% community and 20% hospital.

This presentation will discuss the clinical, organizational, strategic, and economic principles that guide the Dane County service system.

## REFERENCE:

1. Stein LI, Diamond RJ, Factor RM: A system approach to the care of persons with schizophrenia. *Handbook of Schizophrenia, Vol. 4: Psychosocial Treatment of Schizophrenia.* Eds. Herz MI, Keith SJ, Docherty JP. Elsevier Science Publishers B.V, (Biomedical Division), 1990.

**Multimedia Session 1** **Friday, October 24**
**8:00 a.m.-9:30 a.m.**

## VIDEO WORKSHOP: DUAL DIAGNOSIS DISORDERS

H. James Lurie, M.D., *Clinical Professor of Psychiatry, University of Washington, 1417 East Aloha Street, Seattle, WA 98112-3931*; John M. Dluhy, M.D.

### EDUCATIONAL OBJECTIVES:

The participant will be able to observe 1) various group therapy techniques for different types of dually diagnosed patients, 2) phases of treatment that are appropriate for dual diagnosis programs that treat both mental illness and substance abuse are also described.

### SUMMARY:

The tape demonstrates principles used to select dually diagnosed patients for different types of therapy groups, as well as shows and discusses specific interventions used by therapists in these groups. The groups range from "pre-phase" (both minimal sobriety and/or minimal mental illness stabilization) to "phase 2" (much greater stability of symptoms of both addiction and mental illness). The tape is narrated by Richard Ries, M.D., director of the Dual Diagnosis Program of Harborview Medical Center, University of Washington School of Medicine, Seattle, and uses actual patients and therapists from this program.

The tape is appropriate for mental health center clinicians dealing with these populations, as well as for medical students, psychiatric and primary care residents, and psychiatrists, psychologists, and social workers who do group therapy with dual diagnosis populations.

### REFERENCES:

1. Drake RE, Mueser KT, (eds.): *Dual Diagnosis of Major Mental Illness and Substance Disorders.* Recent Research and Clinical Implications. San Francisco. Josey-Boss, 1996.
2. *Assessment and Treatment of Patients with Coexisting Mental Illness and Alcohol and Other Drug Abuse.* Center for Substance Abuse Treatment. Treatment Impact Protocol #9. Washington, DC. DHHS Publications. No.SMA-2078, Ries R, Chair. 1994.

**Multimedia Session 2** **Friday, October 24**
**8:00 a.m.-9:30 a.m.**

## COMPUTER WORKSHOP: HOW TO OBTAIN PSYCHIATRIC INFORMATION USING THE COMPUTER

R. Bhawani Prasad, M.D., *Department of Psychiatry, Veterans Affairs West Side Hospital, 9250 Columbia Ave # 1, Munster, IN 46321-3538*; Donald A. Elliott, M.D.

### EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to use search-utilities to find psychiatric information on the Internet, on the Medline, and on their personal computers.

### SUMMARY:

As more and more psychiatrists become familiar with computers, it becomes necessary for them to know how to search for information. There are three locations where information is stored. One is an individual's personal computer, where information is stored as files in various directories (also called folders). The second is a dedicated computer ("server") like the National Institutes of Health's Medline database where information is stored as "records," each record being a citation of an article published in a medical journal. The third is the Internet. Each of these three locations has its own searching technique. In this presentation, the ability of Quick-Finder, a Windows-based utility, to search for files stored in a personal computer will first be shown. The NIH-Medline database's methods for searching will be explored by means of software like Grateful Med, Paper Chase, and Silver Platter. The Internet requires what are called search engines and directories (Yahoo, Lycos, etc.) and these will be discussed in detail. (The Medline database can be accessed via the Internet also). What is common to all these three seemingly different searching techniques are Indexing and Boolean logic (which uses operators like AND, OR, LIKE, etc). These concepts will be explored.

### TARGET AUDIENCE:

Psychiatrists.

### REFERENCES:

1. McKibbon KA, Walker-Dilks CJ: The quality and impact of MEDLINE searches performed by end user *Health Libr Rev*, 12(3):191-200, Sept 1995.
2. Horton RM: Internet on-ramp. searching the Internet. *Biotechniques* 20(3):406-8, 1996.
3. QuickFinder: *Word Perfect Magazine*, April 1994.

**Multimedia Session 3** **Friday, October 24**
**10:00 a.m.-11:30 a.m.**

## VIDEO WORKSHOP: *DSM-IV*: NEW DIAGNOSTIC ISSUES

Harvey Bluestone, M.D., *Member, APA Institute Scientific Program Committee, and Professor of Psychiatry, Albert Einstein College of Medicine, 1285 Fulton Avenue, Bronx, NY 10456-3401*; John A. Talbott, M.D.

## EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to identify and discuss the new diagnostic issues related to the three psychiatric diagnoses presented in the videotapes.

## SUMMARY:

This series of three clinical programs reveals additions and changes from *DSM-III-R* to *DSM-IV* for mood, psychotic, and anxiety disorders. Each videotape focuses on a particular area of psychiatric diagnosis and contains enactments of three outstanding clinicians' actual patient interviews. Nancy C. Andreasen, M.D., Andrew H. Woods Professor of Psychiatry, University of Iowa College of Medicine, is the interviewer for *Psychotic Disorders*; Andrew E. Skodol II, M.D., Associate Professor of Clinical Psychiatry at the College of Physicians and Surgeons of Columbia University, is the interviewer for *Anxiety Disorders*; and Ellen Frank, Ph.D., Professor of Psychiatry and Psychology at the University of Pittsburgh School of Medicine, is the interviewer for *Mood Disorders*. Each videotape begins with an introductory discussion between the clinician and the moderator. The clinician then conducts three 10-minute psychiatric diagnostic interviews. Following each interview, the clinician and the moderator discuss the taped segments and comment on issues illustrated during the interviews, including how the *DSM-IV* diagnostic criteria were utilized in the interview, how diagnostic markers were elicited, and how interpersonal issues and diagnostic markers were identified. The interviews use reference data to examine conclusions reached during the patient interviews. Each tape also demonstrates good interviewing techniques and highlights the development of a positive doctor/patient relationship.

**Multimedia Session 4** **Friday, October 24**
**10:00 a.m.-11:30 a.m.**

# COMPUTER WORKSHOP: PSYCHIATRY RESIDENTS AND COMPUTERS

Waguih W. Ishak, M.D., *Clinical Instructor in Psychiatry, New York University Medical Center, 564 First Avenue, Apt. 16X, New York, NY 10016*

## EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to recognize 1) residents' attitudes toward computers, 2) use of interactive patient records, 3) use of online computers, 4) uses for residency education, and for research purposes, and reverse mentoring.

## SUMMARY:

In recent years the medical profession has witnessed a significant increase in computer use and a parallel increase in demand for computerized products and services. Computers can reduce the time spent on paperwork, retrieval of information, and communication among professionals. They increase the accessibility of reference material, research data, and innovative discoveries. Residents' attitudes toward computers fall within a wide range between avoidance and overuse. Both extremes can affect professional efficiency as well as personal lives. Computer literacy can be a great tool in the professional arena. As in every other profession in times of change the junior professionals are often the first to pick up a new skill. When they proceed to teach this skill to the more senior against the formal flow of information in professional hierarchies, the process is named "reverse mentoring." Consistent with this annual meeting's theme, this symposium will focus on the psychiatry residents' opportunity to enhance patient care, education, and research using the appropriate computerized technology. In the symposium all these aspects of psychiatry residents' use of computers will be discussed in detail with the audience.

## TARGET AUDIENCE:

Psychiatry educators and Residents.

**Multimedia Session 5** **Friday, October 24**
**1:30 p.m.-3:00 p.m.**

# VIDEO WORKSHOP: COLLABORATIVE HEALTH CARE, PART I: COPING WITH ANTICIPATED LOSS IN LIFE-THREATENING ILLNESS

Anita Menfi, R.N., M.Ed., *Department of Psychiatry, New York Hospital-Cornell Medical College, 15 East 94th Street, New York, NY 10028*; Deanna R. Pearlmutter, R.N., Ed.D., Randi Cohen, R.N.,C.N.S.

## EDUCATIONAL OBJECTIVES:

Through the use of videotape and discussion, participants will identify issues that influence critical end-of-life decision making for patients and their families. At the end of this session participants will understand ways to help patients and their families deal better with their fears about death and dying.

## SUMMARY:

Using segments depicting several real family situations from the videotape, "Whose Death Is It Anyway?", this workshop will provide the opportunity to discuss the significant issues that impact families during illness. The chairperson and panel will join with the

audience in discussing family conflicts about "end-of-life" decisions, as well as issues related to palliative care, advanced directives, and legal rights of patients.

The group will interact in sharing their collective experience in this important field where ethics and medicine seek to inform family and professional collaboration.

## REFERENCES:

1. Walsh F, McGoldrick M: *Living Beyond Loss: Death in the Family*. Norton, New York, 1991.
2. Wright LM, Leahey M: *Families and Chronic Illness*. Springhouse Corporation, Springhouse, PA

**Multimedia Session 6** **Friday, October 24**
**1:30 p.m.-3:00 p.m.**

## VIDEO WORKSHOP: INTERACTIVE MULTIMEDIA: INPATIENT APPLICATIONS

Gene Kaplan, C.S.W., *Director, Quality Management, South Beach Psychiatric Center, 777 Seaview Avenue, Staten Island, NY 10305;* Francine R. Goldberg, Ph.D., Joel S. Feiner, M.D.

## EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation the participant should be able to 1) identify the cognitive, social, and communications skill-building benefits for intermediate and long-stay inpatients of using current interactive multimedia tools in the treatment process, and 2) summarize how a virtual exploration via CD-ROM of typical residential placements leads to improved discharge planning and consumer satisfaction.

## SUMMARY:

This presentation is designed for clinicians who work in public sector inpatient settings. It will help them understand the importance of employing engaging, clinically powerful, and cost-effective interactive multimedia modalities in their work with the growing numbers of patients whose access to off-unit programming is restricted by the clinical, medical, and/or security risk profiles they present.

The session will demonstrate two "best practice" applications at South Beach Psychiatric Center of telemedicine and the CD-ROM to cognitive, social, and communication skill remediation with dually diagnosed patients, patients transferred from the criminal justice system, and others. South Beach Interactive TV (SBTV) provides 14 inpatient units with eight to 10 weekly interactive programs, which are cablecast live via CCTV from a central video studio. Initial data suggest that consumers can be engaged in, and offer input into, interesting and helpful enrichment, rehabilitative, and informational programming with a centrally located "master" therapist through the use of teleconferencing technology.

The self-authored, decision-tree CD-ROM, "Making Choices: Choosing the Right Place to Live," makes the complex New York State residential treatment system more comprehensible to consumers and offers them the flavor of a residential experience in a low-stress environment. Initial data indicate that it is enjoyable, consumer-friendly, helpful, and has influenced discharge planning.

## TARGET AUDIENCE:

Inpatient clinicians.

## REFERENCES:

1. Lieberman HJ, Goldberg F, Kaplan G: The CD-ROM as a multi-purpose clinical and management tool. *Psychiatric Services* (Accepted for publication).
2. Zarr M: Computer-aided psychotherapy: machine helping therapist. *Psychiatric Annals* 24:42–46, 1994.

**Multimedia Session 7** **Friday, October 24**
**3:30 p.m.-5:00 p.m.**

## COMPUTER WORKSHOP: THE COMPREHENSIVE CLINICIAN'S DESKTOP

Tal Burt, M.D., *Chief Resident, Department of Psychiatry, New York University Medical Center, 120 East 37th Street, Apt. 3F, New York, NY 10016-3024*; Donald A. Elliott, M.D.

## EDUCATIONAL OBJECTIVES:

The participants will acquire knowledge about all-in-one computer applications in psychiatric practice. They will recognize the role of these systems in improving patient care, diagnostic and management skills, and documentation in addition to access to references and communication.

## SUMMARY:

The ultimate goal of medical practice, including psychiatry, is to alleviate patient suffering. The introduction of computers in the second half of the 20th century has led to the development of tools that can help achieve this goal by optimizing patient care, enhancing psychiatric education, and promoting meaningful research. The presentation will demonstrate the Comprehensive Clinician's Desktop that provides an all-in-one tool of charting, reference, and communication, reducing the time spent on paperwork and repetitive tasks, and improving diagnostic and management skills in addition to billing

functions. The presentation will demonstrate making use of stored data in generating information useful for administrative decision making, meeting educational requirements in training, and simplifying managed care demands. The participants will have the opportunity to learn about the use of computers in education and training, with its promises and limitations. They will have the opportunity to participate in live debate over the future of such systems and their benefits and limitations, including, but not limited to, confidentiality.

## REFERENCES:

1. Williams TA, Johnson JH, Bliss EL: A computer-assisted psychiatric assessment unit. *Am J Psychiatry*, 132:1074–6, 1975.
2. Modai I, Rabinowitz J: Why and how to establish a computerized system for psychiatric case records. *Hosp Community Psychiatry*, 44(11):1091–5, 1993.

**Multimedia Session 8** **Friday, October 24**
**3:30 p.m.-5:00 p.m.**

## COMPUTER WORKSHOP: THERAPY ON THE INTERNET

Russell F. Lim, M.D., *Clinical Instructor, Department of Psychiatry, University of California at Los Angeles, 11080 Olympic Boulevard, Los Angeles, CA 90064*; Ian E. Alger, M.D.

## EDUCATIONAL OBJECTIVES:

At the conclusion of this session, participants will be able to: 1) describe the Internet, the equipment necessary to connect to the Internet, the World Wide Web, Web browsers, 2) explain how Internet Relay Chat (IRC), USENET newsgroups, and electronic mail can be used to augment or provide individual and group psychotherapy.

## SUMMARY:

The Internet is a dynamic, rapidly evolving and enlarging international computer network that enables the exchange of most forms of data, including text, graphics, audio, and video among geographically distant mental health clinicians and their patients. The recent development of graphical interfaces to the Internet has made access to its resources much easier to individual users. In addition, the Internet's explosive growth has given consumers and mental health service providers greater access to its resources and capabilities. In this presentation, the Internet and how it can be used to provide treatment to patients will be described and demonstrated, as well as how hypertext network browsers, such as Netscape and Internet Explorer, allow clinicians and patients to use a mouse pointing device to quickly locate and retrieve information from a remote site.

The use of electronic support groups on the USENET and the use of Internet Relay Chat (IRC) for real time support groups run by consumers, as well as applications for electronic mail in the treatment of specific groups of patients will be emphasized. In addition, consultation is available on the Internet; Websites for these will be demonstrated.

## TARGET AUDIENCE:

1) Mental health professionals who want to learn how to use the Internet to treat their patients. 2) Consumers who want to know more about treatment options.

## REFERENCES:

1. Engst AC: *Internet Starter Kit for Macintosh*, Hayden Books, Indianapolis, 1993.
2. Hafner K: Making sense of the Internet, *Newsweek*, pp. 46–48, October 24, 1994.
3. Illingworth M: Surf's Up, *Hemispheres*, pp. 86–98, October 1995.
4. Cutter F: Virtual psychotherapy?, *Psychnews International*, 1:3, 1996.
5. Lim RF: The Internet: applications for mental health clinicians in clinical settings, training, and research, *Psychiatric Services* 47:6,597–9, 1996.

**Multimedia Session 9** **Saturday, October 25**
**8:00 a.m.-9:30 a.m.**

## COMPUTER WORKSHOP: MULTIMEDIA AUTHORING FOR EDUCATION

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

## EDUCATIONAL OBJECTIVES:

Participants in this advanced technology workshop will learn about organizing and producing their own multimedia educational materials for computer. At the conclusion of this presentation participants will learn about the hardware and software needed to begin to create multimedia materials, see a demonstration of various types of teaching materials, understand the problems and issues that need to be considered in creating educational programs.

## SUMMARY:

This multimedia workshop is designed to jump start the participants into the world of creating interactive multimedia computer programs for psychiatric education. From brainstorming to design to implementation to the final CD mastering, this session will explore both

the excitement and difficulties of developing interactive educational materials.

Discussion will include: a review of the planning and design phase, organization of data, layout and interactive interface implementation, structure, hyperlinks, and sequencing. Various elements of the necessary hardware will be reviewed as well as the software necessary to produce a program. Demonstrations will highlight the important aspects of multimedia authoring. Although the novice computer user will learn and explore new innovations, this workshop is designed for the computer literate or computer "comfortable" psychiatric/mental health educator who wishes to take on the challenge of multimedia as the academic tool of the present and future.

## REFERENCES:

1. Miller PR, Tupin JP: Miltimedia teaching of introductory psychiatry, *Amer J Psych* 128(10):1219–23, 1972.
2. Baskett SJ: Teaching psychiatry in a new medical school: a multimedia approach. *So Medical J.* 71(12): 1507–10, 1978.

**Multimedia Session 10 Saturday, October 25 8:30 a.m.-11:30 a.m.**

## COMPUTER WORKSHOP: VIRTUAL REALITY AND MENTAL HEALTH

Ian E. Alger, M.D., *Multimedia Consultant, APA Institute Scientific Program Committee, and Clinical Professor of Psychiatry, New York Hospital-Cornell Medical Center, 500 East 77th Street, New York, NY 10162-0025*; Larry F. Hodges, Ph.D., *Associate Professor, College of Computing, and Associate Director for Industrial Relations, Georgia Institute of Technology, 801 Atlantic Avenue, Atlanta, GA 30332-0280*

## EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to understand the basic technological and theoretical issues involved in the development and application of some of the newer virtual reality clinical applications. They should also have a knowledge of the current state of the art, of the variety of clinical applications being considered and tested, and an awareness of the practical issues and unintended consequences affecting the further development of these new approaches.

## SUMMARY:

The virtual reality workshop will include discussion of the following topics, each including a segment for discussion and questions and answers: a) these technologies are being applied in psychiatry, psychology, rehabilitation medicine as well as for training in government, academia, and business and the unintended consequences such as emotional and physical sequelae, and the social concerns of influence and control are among the many issues which need to be assessed; b) virtual reality "exposure" therapy is under increasing development, and programs for the reduction of fear of spiders, heights, and flying are among the many therapeutic applications that will be described; c) the development of multisensory communications for children with autism; with blind users in image worlds; and with recovering stroke patients will be explored through the work from the NSA SHARK National Laboratory in defining how practitioners, patients, and learners might benefit from using their dominant audio, visual, and kinetic "feeling" senses in virtual reality perceptual worlds.

## REFERENCES:

1. Hodges L, Kooper IR: Virtual reality exposure therapy. *J. Psychotherapy Practice and Research* 6:219–226, 1997.
2. Strickland D: A virtual reality application with autistic children. *Presence: Teleoperators and Virtual Environments* 5:319–325, 1996.

**Multimedia Session 11 Saturday, October 25 10:00 a.m.-11:30 a.m.**

## COMPUTER WORKSHOP: DATABASES IN MENTAL HEALTH

H. Rowland Pearsall, M.D., *Associate Professor and Director of Inpatient Services, Yale University School of Medicine, 34 Park Street, P.O. Box 1842, New Haven, CT 06508-1842*; Zebulon C. Taintor, M.D.

## EDUCATIONAL OBJECTIVES:

Participants will learn the basic concepts of computer database programs and will be able to think about possible uses for such programs in their own clinical practice settings; participant will learn the basic elements of database programs and have an opportunity to participate in the construction of a sample database program using these basic elements.

## SUMMARY:

This workshop is designed to demonstrate the use of a computer that database program assists with information tracking and treatment planning. The program is designed for use in a community mental health center setting. In addition to demonstrating this already functioning database program, the workshop intends to provide basic information to participants on the use of database-type computer programs in mental health settings, as well as a demonstration of some of the basic principles in constructing such databases. The audience will have the opportunity to participate interactively in the con-

struction of a sample database and to see how such computer programs might be tailored to meet the individual needs of a particular practice setting.

## TARGET AUDIENCE:

Mental health professionals with a very basic understanding of using computers and an interest in extending their knowledge.

## REFERENCES:

1. Weaver RA, Christensen PW, Sells J, et al: Computerized treatment planning. *Hospital and Community Psychiatry* 45:825–827, 1994.
2. Modai I, Rabinowitz J: Why and how to establish a computerized system for psychiatric case records. *Hospital and Community Psychiatry* 44:1091–1099, 1993.

**Multimedia Session 12 Saturday, October 25 1:30 p.m.-3:00 p.m.**

## VIDEO WORKSHOP: COLLABORATIVE HEALTH CARE, PART II: CHILDRENS' STORIES OF ILLNESS

Anita Menfi, R.N., M.Ed., *Department of Psychiatry, New York Hospital-Cornell Medical College, 15 East 94th Street, New York, NY 10028*

## EDUCATIONAL OBJECTIVES:

At the conclusion of this video session, participants will understand how children experience their own medical illnesses. Participants will understand how the Child Life Program provides outlets for children to process their memories and questions in the face of illness.

## SUMMARY:

The diagnosis and treatment of childhood illnesses and the resulting medical interventions are often experienced as traumatic by children and their parents. Using several videotape segments representing the work of innovative children's programs, this video workshop will provide an opportunity to dicuss how children can find outlets to process their feelings, memories, and questions in the face of illness.

## REFERENCES:

1. Hobbes N, Perrin JN, eds: *Stories in the Care of Children with Chronic Illness*. Jossey-Bass. San Francisco, 1985.
2. Robert MC, Wallender JL, eds: *Family Issues in Pediatric Psychology*. Earlbaum, NY, 1992.

**Multimedia Session 13 Saturday, October 25 3:30 p.m.-5:00 p.m.**

## VIDEO WORKSHOP: FAMILIES COPING WITH ALZHEIMER'S DISEASE

***American Occupational Therapy Association***

Anne L. Morris, Ed.D., *Geriatric Program Manager, American Occupational Therapy Association, Inc., 4720 Montgomery Lane, Box 31220, Bethesda, MD 20824*; Marian K. Scheinholtz, M.S., O.T., *Mental Health Program Manager, American Occupational Therapy Association, Inc., 4720 Montgomery Lane, Box 31220, Bethesda, MD 20824*

## EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to engage a person with cognitive loss in meaningful activity using task simplification, recognize and converse in easily understood conversation style, and identify home-modification ideas that simplify daily activity routines.

## SUMMARY:

The family caregivers you meet in the videotape share solutions that enable the person with Alzheimer's to be successful and feel useful in doing daily tasks. This video shows ways that the role of the caregiver can be made easier, while improving the quality of life for the person with cognitive loss. These include doing familiar activities that are broken down in smaller, manageable steps, improving communication by using short sentences, and making small modifications to the home to make it more safe and workable.

The resource booklet contains suggestions, review sheets, and worksheets for caregivers that expand upon the video and focus on ways to improve quality of life for the person with cognitive loss. The resource section includes a bibliography and complete listing of organizations whose members might facilitate consumer/caregiver discussions.

This package is the winner of five awards for excellence in consumer education! It is currently under review for foreign language transcription by the Technology Initiative for the Disabled and Elderly (TIDE), European Community.

## REFERENCES:

1. Carly H: *Activity Focused Caregiving*. New York, NY: Butterworth Press, 1994.
2. Canadian Mortgage and Housing Corp. *At Home with Alzheimer's Disease*. Ottawa, Canada: 1990.

**Multimedia Session 14** **Sunday, October 26**
**8:00 a.m.-9:30 a.m.**

## VIDEO WORKSHOP: COPING WITH DELUSIONS

Mary D. Moller, A.R.N.P., *Administrator, Suncrest Wellness Center, 12204 W. Sunridge Drive, Nine Mile Falls, WA 99026*; Ann-Louise S. Silver, M.D.

### EDUCATIONAL OBJECTIVES:

At the conlusion of this presentation, the participant should be able to examine individuals' descriptions, lived experiences, and their understanding of the internal ordeal of living with delusions, and discuss strategies identified by individuals that are most helpful to them before, during, after experiencing delusional thoughts.

### SUMMARY:

Delusions—personal beliefs based on incorrect inference about reality—often involve themes such as loss of control, insecurity, restriction of freedom, isolation, and injury to self. These uncomfortable and often intolerable feelings usually promote further strange and bizarre thoughts, depression, loneliness, and behaviors that are disturbing to others. Ultimately a loss of control can occur.

In this program, the fourth in the NurSeminars Series, Mary D. Moller A.R.N.P., takes an honest look at managing delusions as a symptom of brain disease, not as a behavior. In easy to understand language, she explains the keys to understanding and communicating with individuals who have delusions. She will share intervention steps that lead to empowerment for the person who lives with delusions. The program also includes poignant testimony from individuals and family members who are struggling to manage daily lives with the specter of delusions. They share their frustrations and concerns and offer valuable insights to other consumers, family members, and psychiatric care providers into this serious and lonely symptom.

This video won a 1996 Silver Telly Award for Health and Medicine.

### REFERENCES:

1. Butler RW, Braff DL: Delusions: a review and integration. *Schizophrenia Bulletin*, 17: 633–647, 1995
2. Walkup J: A clinically based rule of thumb for classifying delusions. *Schizophrenia Bulletin* 21: 323–331, 1995

**Multimedia Session 15** **Sunday, October 26**
**8:30 a.m.-5:00 p.m.**

## COMPUTER WORKSHOP: HANDS-ON LEARNING

*Supported by Pfizer U.S. Pharmaceuticals*

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

### EDUCATIONAL OBJECTIVE:

At the conclusion of this workshop participants should be familiar with the basic computer technologies and programs to understand assembling hardware, installing programs, and utilizing computers to search databases, communicate through the Internet, access programs, and apply various therapeutic programs.

### SUMMARY:

In the morning, a special "sign-up" tour will enable participants to observe the steps in setting up the various programs being demonstrated later in the day. In the second portion of the day-long program, participants will be able to observe and operate computer programs ranging from informational searches to finding mental health software on the Internet, to accessing psychopharmacology programs and programs to assist in psychotherapeutic treatment planning, as well as to administer computer-assisted treatment. Additionally, there will be the opportunity to discuss directly with program developers and operators the innovations and modifications that can be made to existing programs for specific at-home applications.

**Multimedia Session 16** **Sunday, October 26**
**10:00 a.m.-11:30 a.m.**

## VIDEO WORKSHOP: DEPRESSION IN CHILDREN IN GRADES SIX THROUGH TEN

*National Alliance for the Mentally Ill*

Laurie M. Flynn, M.A., *Executive Director, National Alliance for the Mentally Ill, 200 N. Glebe Road, Suite 1015, Arlington, VA 22203*; Carolyn B. Robinowitz, M.D.

### EDUCATIONAL OBJECTIVES:

The objectives of the video are to:
Define major depression in children,
Outline the neurobiological basis of major depression,

Define the eight signs of major depression,

Demonstrate ways friends and family members can help the depressed child,

Review resources that can assist the depressed child,

Find appropriate assistance for the depressed child: parents, teachers, counselors, mental health professionals,

Three components of treatment: pharmacology, psychotherapy, family education,

Four challenges that depression poses for the child: bad feelings, side effects of medication, worrying, being different,

Five rewards for the child who deals with depression: deepening friendships, increasing family understanding, learning tricks for self-management, feeling good, and helping others.

## SUMMARY:

The video was designed especially for classroom use in the middle school but is also appropriate for students in the first years of high school (grades 6–10). The handbook/curriculum contains specific directions and materials for the teachers. It is organized in three modules.

Part I, Diagnosis and Symptoms of Depression:

Claire introduces herself, family, and friends. She narrates her experience with the disorder up to the point of seeking treatment.

An adult narrator amplifies Claire's remarks explaining what is now known about depression. While easy to miss, depression in childhood and adolescence has identifiable symptoms. Eight symptoms are reviewed.

Part II, Treatment:

Claire was diagnosed by a pediatrician, assessed by a psychologist, and prescribed medication by a psychiatrist who monitored her progress. Treatment consists of medication, psychotherapy, and education.

Part III: Living with Depression:

Claire discusses the problems she has encountered and strategies she has developed to deal with her disorder. She also talks about the support she has received from her friends. She outlines the challenges of living with depression. Claire feels closer to her family and friends because of their support.

## REFERENCES:

1. Alpern L, Lyons-Ruth K: School children at social risk: chronicity and timing of maternal depressive symptoms. *Development and Psychopathology* 5:371–387, 1993.
2. Roy A, Brier A, Doran AR, et al: Depression in school classrooms. caning children *Journal of Effective Disorders* 9:143–148, 1993.

**Multimedia Session 17** **Sunday, October 26**
**1:30 p.m.-3:00 p.m.**

## VIDEO WORKSHOP: CONSUMERS AND SURVIVORS OF PSYCHIATRIC SERVICES

*Winner of the 1997 Psychiatric Services Video Award*

Peter Stastny, M.D., *New York State Office of Mental Health, 55 Hudson Street #2D, New York, NY 10013*; Laura Van Tosh

## EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, participants should be able to identify and better understand the nature of patients' subjective experiences of their illnesses and should be able to facilitate patients' developing empowering strategies in their own recovery.

## SUMMARY:

This workshop will feature the videotape *NERVE*, which features four individuals living in Vienna and New York who define themselves as "consumers" or "survivors" of psychiatric services. The protagonists are involoved in the international self-help movement, which is focused on individuals recovering from mental illnesses who undertake to organize their own self-help organizations, establishing new relationship contracts with both care providers and mental health institutions, and with other family members. In the film, these patients discuss their experiences in the mental health system in both Europe and the United States, as well as describing their emotional crises. They demonstrate that subjective perspectives are valuable and that empowering activities are crucial to recovery.

**Multimedia Session 18** **Sunday, October 26**
**3:30 p.m.-5:00 p.m.**

## VIDEO WORKSHOP: *DSM-IV*: NEW DIAGNOSTIC ISSUES

H. James Lurie, M.D., *Clinical Professor of Psychiatry, University of Washington, 1417 East Aloha Street, Seattle, WA 98112-3931*; Brian B. Doyle, M.D.

See Multimedia Session 3 beginning on page 75 for the Educational Objectives, Summary and References for this session.

**Multimedia Session 19** **Monday, October 27**
**8:00 a.m.-9:30 a.m.**

## VIDEO WORKSHOP: FAMILY INTERVENTIONS AND CONSULTATION FOR AIDS PATIENTS

Lawrence B. Jacobsberg, M.D., Ph.D., *Psychiatrist, AIDS Mental Health Team, Community Mental Health Services, Visiting Nurse Service, 2170 McDonald Avenue, Brooklyn, NY 11229*; Jeffrey S. Akman, M.D.

### SUMMARY:

As part of a program doing psychiatric consultation to medical services for homebound AIDS patients, individual psychotherapy frequently needs to be supplemented by family interventions. Uninfected children present a particularly poignant task for both patient and therapist, because, even after settling the anguishing and potentially explosive issues of their custody, the children need to be prepared for the death of one or both of their parents.

We have implemented a program of videotape Legacy Recordings to provide a framework for this emotionally searing task. Patients record material of their choice, sometimes involving the children themselves in the video. Although demanding of caregivers, the work is appreciated by the patient and often furthers psychotherapy by providing a focus for introspection.

Selections from three tapes will be shown to illustrate a variety clinical scenarios. Each 15-minute tape will be preceded by a 5-minute summary from the patient's clinician, to put the piece in context and highlight unique aspects of the selection. Following the video, there will be a 10-minute discussion period, during which the audience will be encouraged to share their reactions to the tape and extend the dialogue from their own clinical experience. By engaging a varied audience of caregivers, each of whom has unique clinical experiences, the presentation will expand the treatment repertoires of all participants.

### TARGET AUDIENCE:

Psychiatrists, psychiatric nurses, and clinical social workers who treat AIDS patients and their children.

### REFERENCES:

1. Hurley PM, Ungavarski PJ: Mental health needs of adults with HIV/AIDS referred for home care. *Psychosocial Rehab J* 17:117–126, 1994.
2. Levine C: Orphans of the HIV epidemic: unmet needs in six US cities. *AIDS Care Suppl* 1:S57–62, 1995.

**Multimedia Session 20** **Monday, October 27**
**10:00 a.m.-11:30 a.m.**

## FILM WORKSHOP: SCHIZOPHRENIA: PSYCHIATRIC REHABILITATION

Stephen M. Goldfinger, M.D., *Consultant, APA Institute Scientific Program Committee, and Vice Chairman, Department of Psychiatry, State University of New York, Downstate Medical Center, 450 Clarkson Avenue, Brooklyn, NY 11203*; Marvin I. Herz, M.D.

### EDUCATIONAL OBJECTIVES:

At the conclusion of this session, participants should have an increased awareness of the reality of life as a schizophrenic person and should be able to understand in a very personal way the actual experience of the illness.

### SUMMARY:

The film *"I'm Still Here: The Truth About Schizophrenia,"* documents in compelling cinematic style the experiences and lives of individuals families, professionals, and others throughout the United States who have had experience with schizophrenia, a highly misunderstood psychiatric disorder. The film is created in a *cinema verité* mode, which enhances the immediacy and enlarges the understanding of the many people who actually have lived through the challenges and the successes and disappointments in living with this disorder.

All professionals, patients, and their families would find this film personally valuable and could also use it as an exciting addition to any educational programs.

### REFERENCES:

1. Rappaport JT, et al: Collaborative research with a mutual help organization. *Social Policy* 15:12–24, 1985.
2. Test MA: Training in community living, in RP Liberman (ed). *Handbook of Psychiatric Rehabilitation*, pp. 153–170, MacMillan, New York, 1992.

**Multimedia Session 21** **Monday, October 27**
**1:30 p.m.-3:00 p.m.**

## VIDEO WORKSHOP: TRAUMA DISORDERS

Colin A. Ross, M.D., *President, Ross Institute, 1701 Gateway Ste 349, Richardson, TX 75080*; Pedro E. Martinez, M.D.

### EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to demonstrate an understanding of two core aspects of the therapy of survivors of severe child-

hood trauma: the problem of attachment to the perpetrator and the locus of control shift. The participant will be able to implement these principles in treatment.

## SUMMARY:

The video teaches advanced techniques for treating dissociative identity disorder, post-traumatic stress disorder, and trauma-related depression, anxiety, addictions, and borderline personality.

It explains two fundamental principles of treating severe childhood trauma: the problem of attachment to the perpetrator and the locus of control shift. These two core aspects of therapy are essential for therapists to understand in order to treat their clients in an effective and timely manner. The program follows the case histories of two women who suffer from childhood trauma. The video uses interviews with Dr. Colin A. Ross, M.D., narrator discussion, and dramatic reenactments to clearly illustrate proven techniques for treating trauma-based disorders.

April, a 31-year-old computer analyst, comes in for therapy complaining of amnesic spells. She cannot remember an entire evening with her father and his new girlfriend.

Kari, a 25-year-old college student, is the victim of a recent rape. She is admitted to a psychiatric hospital for severe depression and amnesic spells.

The trauma field is undergoing a major fundamental shift. The abreactive model of therapy that dominated in the 1980's is being replaced by a focus on the attachment to the perpetrator. This new approach promotes therapeutic neutrality while fostering higher functioning and recovery. This training video is an excellent tool for therapists as well as the general public, because it clearly illustrates two fundamental treatment principles within this new therapeutic model.

## TARGET AUDIENCE:

Psychiatrists, psychologists, social workers and psychotherapists

## REFERENCES:

1. Ross CA: *Dissociative Identity Disorder*, Second Edition. New York, Wiley, 1997
2. Ross CA: *The Osiris Complex.* Toronto, University of Toronto Press, 1994

**Multimedia Session 22** **Monday, October 27**
**3:30 p.m.-5:00 p.m.**

## VIDEO WORKSHOP: *DSM-IV:* NEW DIAGNOSTIC ISSUES

Troy L. Thompson II, M.D., *Member, APA Institute Scientific Program Committee, and The Daniel Lieberman Professor, Department of Psychiatry and Human Behavior, Jefferson Medical College and Hospital, 1025 Walnut Street, Room 320, Philadelphia, PA 19107-5005*; Brian B. Doyle, M.D.

See Multimedia Session 3 beginning on page 75 for the Educational Objectives, Summary and References for this session.

**Poster 1** **Saturday, October 25**
**10:00 a.m.-11:30 a.m.**

## ASSESSMENT OF UTILIZATION MANAGEMENT IN THE IOWA MEDICAID MANAGED MENTAL HEALTH ACCESS PLAN

Barbara M. Rohland, M.D., *Assistant Professor of Psychiatry, University of Iowa College of Medicine, Psychiatry Research 1-400 MEB, Iowa City, IA 52242-1000*

### SUMMARY:

The definition and measurement of quality in managed mental health care plans is often ill defined, and performance indicators used often do not address cl,inical appropriateness and efficacy. The present study describes the assessment of the utilization management program used by the contractor for the statewide Medicaid managed mental health care carve-out program in Iowa. The mechanism used by the contractor to measure and document quality focused almost exclusively on administrative process indicators. There were no data to demonstrate that utilization management by the contractor was either clinically appropriate or effective in maintaining acceptable standards of clinical care. Furthermore, four problem areas were identified: (1) utilization managers did not appear to be qualified to perform utilization management of somatic therapies due to their limited medical training and experience, (2) a mechanism by which the continuity of care for patients discharged from inpatient or other high-intensity services was assured was not in place, (3) the process by which care managers made determinations of the appropriateness of care could not be distinguished from direct recommendations for treatment, and (4) a mail-out survey of self-reported satisfaction was used as the primary measure of patient outcome in populations with affective and cognitive disorders.

### REFERENCES:

1. Donabedian A: *The Definitions of Quality and Approaches to its Assessment.* Ann Arbor Health Administration Press, 1980.
2. Rohland BM and Rohrer JE: Evaluation of managed mental health care for Medicaid enrollees in Iowa. *Psychiatric Services* 47:1185–1187, 1996.

**Poster 2**

**WITHDRAWN**

**Poster 3** **Saturday, October 25**
**10:00 a.m.-11:30 a.m.**

## MULTIMEDIA PROGRAMS IN PRIMARY CARE EDUCATION

Sheila M. Marcus, M.D., *Department of Psychiatry, University of Michigan, 1500 East Medical Center Drive, Ann Arbor, MI 48109*; Karen K. Milner, M.D., *Clinical Instructor, Department of Psychiatry, University of Michigan Medical Center, 1500 East Medical Center Drive, Ann Arbor, MI 48109*; Kevin B. Kerber, M.D., Duane J. DiFranco, M.D.

### SUMMARY:

The dissemination of high-quality and timely medical information is one of the most critical elements in a good health care delivery system. Increasingly, the role of the psychiatrist will be to inform primary care practitioners about mental and emotional conditions and to co-manage these illnesses in the primary care settings. Additionally, the role of psychiatrist as educator through a variety of multimedia materials will provide the information necessary for patients to access appropriate treatments.

In this project, the authors describe the development of a multimedia product to educate primary care providers about mood disorders in women. The role of sound, graphics, and color to engage audiences effectively and the use of quicktime movies and audio to enhance the educational experience with live clinical information is demonstrated. The differences between those programs where multimedia elements enhance a lecture that is being delivered by a physician and those that "stand alone" to be processed directly by a patient or practitioner are described.

Finally, the use of the Internet to disseminate educational materials, including use of the Intranet to protect patient confidentiality, is explored. The potential ability of such programs to provide outcomes information about the patients who use them through their linkages to databases is examined.

### TARGET AUDIENCE:

Primary care clinicians, female patients, and patients' families.

### REFERENCES:

1. Huang M, Alessi N: The Internet and the future of psychiatry; *Am J Psychiatry* 153:861–869, 1996.
2. Marcus S, Quinlan P, DiFranco D, et al. The use of a web based "Intranet" system for institutional dissemination of multimedia information about postpartum depression; *Am J Psychiatry* 121:569–571, 1995.

**Poster 4** **Saturday, October 25 10:00 a.m.-11:30 a.m.**

## TELEMEDICINE IN PSYCHIATRIC PRIMARY CARE

Jean G. Shelor, C.S., *Associate Chief of Nursing for Psychiatry, Veterans Affairs Medical Center, 1970 Roanoke Boulevard, Salem, VA 24153*

### SUMMARY:

A Mid-Atlantic Veterans Affairs medical center is experiencing downsizing of its acute psychiatric inpatient population. With the downsizing of inpatient services comes an emphasis on outpatient services. One of the outpatient areas the VAMC is providing care for is a rural area one hundred miles from the facility. Services are provided for the psychiatric patients through telemedicine services in the psychiatric primary care clinic. The poster presentation depicts the need for telemedicine services, the staff involved with the psychiatric primary care team that encompases these services, and how the interviews are conducted. A special patient satisfaction survey has been developed as a quality-management tool for the new service provided by the psychiatric interdisciplinary team involved with the telemedicine project. Telepsychiatry is being utilized for clinical support and improved patient management. It is providing mental health services through video conferences, and conducts concise and objective clinical evaluation of the quality of delivered services.

### TARGET AUDIENCE:

Physicians, nurses, social workers, psychology.

### REFERENCES:

1. Inward nurture rural health networks *Telemedicine and Telehealth Networks* 2:14–15, 40, 1996.
2. Using telemedicine to improve health care in distant areas. *Hosp & Community Psychiatry*, 43:25–31, 1992.

**Poster 5** **Saturday, October 25 10:00 a.m.-11:30 a.m.**

## DEPRESSION AND DEMORALIZATION AMONG RUSSIAN-JEWISH IMMIGRANTS IN PRIMARY CARE

Zinoviy Gutkovich, M.D., *Senior Resident, Department of Psychiatry, Beth Israel Medical Center, 68-12 Burns Street, Apartment D-1, Forest Hills, NY 11375-5078*; Richard N. Rosenthal, M.D., *Associate Chairman, Department of Psychiatry, Beth Israel Medical Center, First Avenue at 16th Street, New York, NY 10003*; J. Christopher Muran, Ph.D., Igor I. Galynker, M.D., Ph.D.

### SUMMARY:

Somatization, depression, and demoralization are elevated in Russian-Jewish emigres within the community. It is important to distinguish endogenomorphic depression from demoralization, which is a combination of distress and subjective incompetence and characterized by preserved hedonic capacity. The purpose of this study was to examine the levels and nature of psychological distress and depression among Russian-Jewish emigres in primary care. Fifty-seven consecutive patients at the primary care clinic were assessed with the Hamilton Depression Scale (HAM-D). Subjects completed self-rating scales, including the Beck Depression Inventory (BDI), Life Orientation Test, Beck Hopelessness Scale, Attributional Style Questionnaire, and Sneith-Hamilton Pleasure Scale. Data on demographics and physical complaints were collected and analyzed. A total of 82.5% of the patients experienced psychological distress (BDI>= 10); 43.9% had clinically significant depressive symptoms (HAM-D>=17). BDI and HAM-D scores correlated with the number of psychosomatic complaints ($p<.005$), with hopelessness ($p<.001$), lack of optimism ($p<.001$), anhedonia ($p<.001$), and dysfunctional attributional style ($p<.05$). Distressed but not depressed patients had preservation of hedonic capacity. We suggest that the high rate of depression among Russian-Jewish emigres in primary care is attributable to a culturally specific tendency to express distress in somatic terms. The nature of distress was phenomenologically similar to demoralization.

### REFERENCES:

1. Kohn R, Flaherty JA, Levav I: Somatic symptoms among older Soviet immigrants: an exploratory study. *Int J Soc Psychiatry* 35:350–360, 1989.
2. de Figueiredo JM: Depression and demoralization: phenomenologic differences and research perspectives. *Compr Psychiatry* 34:308–311, 1993.

**Poster 6** **Saturday, October 25 10:00 a.m.-11:30 a.m.**

## CITALOPRAM VERSUS AMITRIPTYLINE IN THE TREATMENT OF THE DEPRESSED ELDERLY IN A GENERAL PRACTICE SETTING

Kerstin Overo, Sc.D., Pharm.D., *Department of Marketing, Forest Laboratories, 909 Third Avenue, New York, NY 10022*

### SUMMARY:

The enhanced sensitivity of the elderly to side effects (e.g., anticholinergic effects) of tricyclic antidepressants (TCA's) has made treating depression in this group prob-

lematic. The selective serotonin reuptake inhibitors (SSRI's) have been reported to produce fewer such side effects than TCA's. The therapeutic actions and safety of citalopram, the most selective of the SSRI's, were investigated in a group of 365 elderly patients (age≥65) diagnosed with major depression (MADRS≥22) in a double-blind, parallel group, multicenter comparison of citalopram (n=179, 20 or 40 mg once daily) and amitriptyline (n=186, 50 or 100 mg/day). Patients who did not respond to placebo during a one-week, single-blind phase were randomized to receive citalopram or amitriptyline for eight weeks. Both treatments produced equivalent time-related declines in severity of depression so that by eight weeks slightly more that 50% of patients completely recovered (MADRS≥12). By contrast, patients receiving amitriptyline had a greater incidence of anticholinergic effects, including a greater ($p<.001$) percentage of patients reporting dry mouth (34% vs. 7%), as well as a higher ($p<.03$) incidence of somnolence (16% vs. 8%). Based on these results, citalopram is an effective antidepressant with potential advantages over amitriptyline in the treatment of the depressed elderly.

## REFERENCES:


1. Halaris A: Antidepressant drug therapy in the elderly: enhancing safety and compliance. *Intl J Psychiatry in Medicine* 1986–1987; Vol. 16 (1).
2. Nyth AL, Gottfries CG, et. al: A controlled multicenter clinical study of citalopram and placebo in elderly depressed patients with and without concomitant dementia. *Acta Psychiatr Scand* 86:138–145, 1992.


**Poster 7** **Saturday, October 25**
**10:00 a.m.-11:30 a.m.**

## FUNCTIONAL CAPACITY AND HOSPITAL COURSE


Geetha Jayaram, M.D., *Assistant Professor, Department of Psychiatry, Johns Hopkins University School of Medicine, 600 N. Wolfe Street/Meyer 101, Baltimore, MD 21237*; Russell L. Margolis, M.D., *Assistant Professor, Department of Psychiatry, Johns Hopkins University School of Medicine, 600 N. Wolfe Street/Meyer 101, Baltimore, MD 21287*


## SUMMARY:


The current climate of capitated resources for the chronically mentally ill requires the identification of patient populations that need intense or specialized psychiatric services to 1) minimize length of stay, and 2) maximize functional outcome. To identify these patients, we assessed a series of 109 consecutive patients admitted to a short-stay community psychiatry inpatient service with a battery of cognitive, functional, and demographic measures (Jayaram, 1996). Scores from OTTOS (Occupational Therapy Task Observation Scale), a rapid method for evaluating functional capacity (Margolis, 1996), were compared with an index of events impeding treatment and with psychiatric diagnosis. The data indicate that (1) lower function significantly correlates with treatment impediments, and (2) patients with schizophrenia are more functionally impaired than other patients and experience a more difficult hospital course. These results suggest that functional assessment is essential to defining service needs and predicting hospital course.


## TARGET AUDIENCE:

Psychiatrists, occupational therapists, health care managers.

## REFERENCES:


1. Margolis RL, Harrison SA, Robinson HJ, Jayaram G: Occupational Therapy Task Observation Scale (OTTOS): a rapid method for rating task group function of psychiatric patients. *The American Journal of Occupational Therapy* Vol. 50 Number 5, 1996.
2. Bradlee L: The use of groups in short-term psychiatric settings. In Cottrell RPF (Ed.): *Psychosocial occupational therapy proactive approaches* (pp 93–98). Rockville, MD: American Occupational Therapy Association, 1993.


**Poster 8** **Saturday, October 25**
**10:00 a.m.-11:30 a.m.**

## PSYCHIATRIST-PROGRAMMED COMPUTER SYSTEM ENHANCES QUALITY CARE IN INPATIENT AND OUTPATIENT PRACTICE


Daniel A. Deutschman, M.D., *Medical Director of Behavioral Health, Southwest General Health Center, 18697 Bagley Road, Middleburg Heights, OH 44130*


## SUMMARY:


*Purpose:* 1) Describe a relational database program developed and continually updated by a practicing psychiatrist. 2) Assess its costs and impact on quality of care. 3) Review the features that have been added most recently.

*Content:* Data entry by the psychiatrist is done in real time during the interview, replacing note taking. The software guides and prompts the clinician in re-diagnostic inclusion/exclusion criteria and treatment algorithms. Clicking on look-up tables does most of the data entry. Rating scales will soon be scanned directly into the database to track outcomes.

*Methodology:* Software was developed in Microsoft Access and requires at least a 486 IBM PC with 16 meg of RAM.

*Results:* A total of 2,000 patients with 5,000 visits have been seen since February 1995. Records can be reviewed at home when making medication decisions on weekends. Prescriptions are computer generated. Medication/patient response reports are preprogrammed. Cost per clinician=$1,500 to $3,500 for hardware and software plus the psychiatrist-programmer's time.

*Summary:* Practicing psychiatrists can enhance the quality of their work through the use of computer programs that they develop and continually upgrade without major expense.

## TARGET AUDIENCE:

Practicing psychiatrists.

## REFERENCES:

1. Hammer JS, et. al: Operationalizing a bedside pen entry notebook clinical database systems in consultation-liaison psychiatry. *General Hospital Psych* 17:165–172, 1995.
2. Seeman D: Log on: automation trends in medicine. *American Medical News*, December 11, 21, 1995.

**Poster 9** **Saturday, October 25 10:00 a.m.-11:30 a.m.**

## SOCIAL SUPPORT AND PRESENTATION TO OUTPATIENT TREATMENT: PILOT DATA

Patrick J. Raue, Ph.D., *Postdoctoral Fellow, Department of Psychiatry, Cornell Medical Center, 21 Bloomingdale Road, White Plains, NY 10605*; Martha L. Bruce, Ph.D., M.P.H., Deborah A. Perlick, Ph.D.

## SUMMARY:

The role of psychosocial variables such as perceived support and negative family interactions has been examined among depressed patients, but little is known about how these factors influence the point at which clients seek help or how duration of depression affects the social network. We examined the association among depressed patients between different aspects of social support and length of time to seek psychiatric help at an outpatient clinic. All patients presented at one of eight different outpatient clinics and received a SCID diagnosis of major depression lasting less than one year (N=119). Controlling for previous psychiatric treatment, multiple regression indicated that better perceived physical health was the only demographic or clinical variable associated with quicker presentation ($p$=.02). Beyond this effect, more frequent interaction with family members was marginally associated with quicker presentation ($p$=.07). These findings hold up regardless of whether or not patients used recent previous treatment. The results suggest two explanations that will be explored in future research. The first explanation is that some psychosocial factors can influence how quickly depressed patients seek outpatient help. Alternatively, the longer the depressive episode, the more negatively the patient's social network may be affected.

## REFERENCES:

1. Rogler LH, & Cortes DE: Help-seeking pathways: a unifying concept in mental health care. *Am J Psychiatry*, 150, 554–561, 1993.
2. Birkel RC, & Reppucci ND: Social networks, information-seeking, and the utilization of services. *Am J Community Psychology*, 11, 185–205, 1983.

**Poster 10** **Saturday, October 25 10:00 a.m.-11:30 a.m.**

## IMPLEMENTATION OF A PSYCHOTROPIC DRUG REDUCTION PROGRAM IN A PUBLIC NURSING HOME USING EDUCATIONAL AND BEHAVIORAL MANAGEMENT TECHNIQUES

Jeffrey C. Wilson, M.D., *Chair, Department of Psychiatry, Forbes Hospital, and Former APA Mead Johnson Fellow, 221 Pennsylvania Avenue, Suite 1100, Pittsburgh, PA 15217*; Victor G. Stiebel, M.D., *Clinical Assistant Professor, Department of Psychiatry, University of Pittsburgh, 6350 Phillips Avenue, Pittsburgh, PA 15217*; Wayne Hoover, Ph.D., Sarah Frank, M.S.W.

## SUMMARY:

The Omnibus Budget Reconciliation Act of 1987 included provisions regulating psychotropic usage in long-term facilities. Nursing homes have been scrutinized lately because many failed to comply. A MEDLINE search found no studies showing that compliance does not sacrifice patient care.

A 360-bed public nursing home was chosen for this ongoing program evaluation. A total of 120 patients have been enrolled in a psychotropic drug reduction program targeted at antidepressants, benzodiazepines, and neuroleptics. The program consists of staff education, psychiatric evaluation and baseline rating scales, educational handouts for attending physicians explaining the program and alternatives to medications, monthly monitoring of rating scales, and the implementation of a behavioral management program. Board-certified psychiatrists practicing full-time geriatrics attempted to reduce or change medications according to the patient's condition. If deterioration was noted, previous medications were resumed and no further changes were made.

Based on results to date we have found that targeted medications can be safely reduced in a subset of patients in this setting. No significant increase in restraints and injuries to patients or staff have been noted. For other patients alternative non-targeted medications have been substituted. We conclude that nursing homes can comply with governmental regulations for most patients without compromising patient care.

## TARGET AUDIENCE:

Consultation-Liaison, Geriatrics.

## REFERENCES:

1. Lantz MS: A Ten year review of the effect of OBRA-87 on psychotropic prescribing practices in an academic nursing home. *Psych Serv* 47(9):951–5, 1996.
2. Shorr RI: Changes in antipsychotic drug use in nursing homes during implementation of the OBRA-87 regulations. *JAMA* 271(5):358–62, 1994.

**Poster 11** **Saturday, October 25 10:00 a.m.-11:30 a.m.**

## MANAGED CARE IN A COMMUNITY MENTAL HEALTH CENTER

Sandra Freeman, M.D., *Psychiatry Fellow, Department of Psychiatry, University of North Carolina Hospitals, 316 Tenney Circle, Chapel Hill, NC 27516*; Marcia A. Maury, M.Ed., John J. Haggerty, Jr., M.D.

## SUMMARY:

In keeping with the national trend of health care cost reduction through managed care programming, on July 1, 1997, the North Carolina Division of Mental Health Services designated a predetermined number of bed days per diagnostic category, and commissioned each of its 41 area programs to assume responsibility for state hospital utilization. Fraught with technical and administrative obstacles, the pros and cons of this plan have been difficult to determine. The data presented here reflect one local area program's attempt to sort out the short-term and yet evolving long-term consequences of such an arrangement.

The Alamance-Caswell Area Program reviewed individual admissions to John Umstead Hospital from July 1996 through April 1997 to compare hospital admission rates before and after policy implementation. Demographic and medical indexes were examined to establish a patient profile that could be used to identify patients at risk for needing state hospital care.

Despite a concerted effort on the part of the local area authorities to limit the number of referrals to the state hospital, the total number of admissions rose from 336 (FY '96) to 484 during the initial 10 months of FY '97. The typical state hospital referral was a white male, mean age of 40–42 years, with a greater than 50% chance of having substance-related comorbidity, and most likely to require 0–7 days hospitalization.

*Conclusion:* In order for area mental health programs to contain inpatient costs, they must evaluate existing services, and perhaps develop more innovative, expansive programs for dealing with acutely disturbed patients—especially in the area of substance abuse.

## REFERENCES:

1. Goldman W, Feldman S (eds.): Managed mental health care, *New Directions in Mental Health Services*, 59; 1993.
2. Croze C, ed: Public mental health systems, Medicaid re-structuring, and managed behavioral healthcare; *Behavioral Healthcare Tomorrow*, Sept./Oct. '95.

**Poster 12** **Saturday, October 25 10:00 a.m.-11:30 a.m.**

## CREATIVE ALTERNATIVES IN MANAGED CARE

Wendy Shepard, M.S.N., *Clinical Nurse Specialist, Department of Community Psychiatry, Johns Hopkins Bayview, 2400 Broening Highway, Suite 180, Dundalk, MD 21224*

## SUMMARY:

This five-year demonstration project provides a comprehensive continuum of individualized case management services for severely and persistently mentally ill persons. Members enroll voluntarily into the program, which will serve 150 people in the Baltimore metropolitan area. Through capitated funding, we become the managed care agency and must pay for all inpatient or outpatient psychiatric services. The goal is to use the least restrictive appropriate service available. Key values include normalization, community reintegration, natural consequences, and a focus on personal strengths versus symptoms. Our goal is to assist each member in finding "creative alternatives" to real-life situations, while supporting them within the community. Continuous quality improvement is monitored through ongoing evaluation of staff roles and functions, member satisfaction, and outcome measures.

## REFERENCES:

1. Shepard W: Creative alternatives in mental health, *Caring Magazine*, July, 16–22, 1995.
2. Shepard W: Intensive case management keeps psychiatric patients in the community, *Case Management Advisor*, 8:56–58, 1997.

**Poster 13** **Saturday, October 25 10:00 a.m.-11:30 a.m.**

## CHARACTERISTICS OF MEDICAID MANAGED CARE INPATIENTS

Ali Khadivi, Ph.D., *Associate Chief Psychologist, Department of Psychiatry, Bronx-Lebanon Hospital Center, 1276 Fulton Avenue, 6th Floor, Bronx, NY 10456*; Adedapo M. Oduwole, M.D., *Psychiatric Resident, Department of Psychiatry, Bronx-Lebanon Hospital Center, 1276 Fulton Avenue, 4th Floor, Bronx, NY 10456*; Raman C. Patel, M.D.

### SUMMARY:

This study was undertaken to examine the characteristics Medicaid managed care mentally ill patients. The sample was selected (N=81) from a retrospective chart review of all 1995 consecutive inpatient admissions to a major inner-city hospital. Forty-two nonoverlapping Medicaid managed care inpatients who constituted all the managed care admissions were compared with 41 randomly selected non-managed-care inpatients. In addition to obtaining demographics, diagnoses, and length of stay, each chart was rated using the Severity of Psychiatric Illness (SPI) Scale, which measures the following clinical characteristics: reason for admission, complication to psychiatric illness and treatment, and severity and persistence of symptoms. These dimensions are rated on a four-point scale.

Demographically, the managed care group was younger and had higher proportion of African Americans. The managed care group had significantly shorter lengths of stay than the comparison group. On the SPI, the managed care group scored significantly lower on the total severity score than did the comparison group. Although no significant differences emerged on danger to self or others, or substance abuse, the comparison group had significantly more difficulty with self-care, more medical complications, and had a higher premorbid level of dysfunction than the Medicaid managed care sample.

Results indicate that the managed care group was less severely impaired than the comparison group.

### REFERENCES:

1. Lyons JS, Colletta J, Devens M, Finkel S: Validity of the Severity of Psychiatric Illness Rating Scale in a sample of inpatients on a psychiatric unit, *International Psychogeriatrics*, 7:407–416, 1995.
2. Stroup ST, Dorwart R: Impact of a managed mental health program on Medicaid recipients with severe mental illness, *Psychiatric Services*, 46:885–889, 1995.

**Poster 14** **Saturday, October 25 10:00 a.m.-11:30 a.m.**

## PSYCHOTHERAPY OF CHRONIC DEPRESSION

Robert H. Howland, M.D., *Assistant Professor of Psychiatry, Department of Psychiatry, University of Pittsburgh, 3811 O'Hara Street, Pittsburgh, PA 15213*; Michael E. Thase, M.D.

### SUMMARY:

*Objective:* Psychotherapy is often advocated for chronically depressed patients because they are viewed as having personality disorders, although studies support the efficacy of antidepressants for these patients. This study reviews the literature on psychotherapy in chronic depression.

*Method:* The literature was searched using MEDLINE and by reviewing the bibliographies of recent publications. Forty psychotherapy studies including patients with DSM-III or DSM-III-R chronic depression, or patients described as having persistent depression, were reviewed.

*Results:* Cognitive behavior therapy is the best-studied psychotherapy in chronic depression. It has comparable or greater efficacy than antidepressants and other psychotherapies, even among medication-refractory patients, but is less effective in the treatment of chronic depression than in the treatment of nonchronic depression. Other psychotherapies have not been well studied, although practical psychosocial services and behaviorally oriented interventions such as social skills training may be more useful than passive psychotherapeutic approaches. Some evidence suggests that maintenance treatment and combined pharmacotherapy-psychotherapy may be necessary in chronic depression, but they have not been well studied.

*Conclusions:* There is some support for the efficacy of psychotherapy in chronic depression. Future research should investigate other standard psychotherapies, such as interpersonal psychotherapy, and maintenance and combined treatment in different subtypes of chronic depression.

### TARGET AUDIENCE:

Psychiatrists, psychologists, psychotherapists.

### REFERENCES:

1. Markowitz JC: Psychotherapy of dysthymia. *Am J Psychiatry* 151:1114–1121, 1994.
2. Howland RH: Psychosocial therapies for dysthymia. *The Hatherleigh Guide to Managing Depression.* New York, NY: Hatherleigh Press, pp. 225–241, 1996.

**Poster 15** **Saturday, October 25 10:00 a.m.-11:30 a.m.**

## PSYCHIATRY'S ROLE IN THE CARE OF THE BEREAVED ELDERLY

Daniel P. Chapman, Ph.D., M.S., *Psychiatric Epidemiologist, Department of Health Care, Centers for Disease Control and Prevention, 4770 Buford Highway, NE/MS K-51, Atlanta, GA 30341*; J. Patrick Moulds, M.D., *Resident and Visiting Scientist, Department of Preventive Medication, University of Maryland, 660 West Redwood Street, Baltimore, MD 21201*

### SUMMARY:

Spousal loss has been identified as one of the most significant life stressors and is experienced by approximately 800,000 older adults in the U.S. annually. A MEDLINE search identified empirical studies published since 1986 referenced to psychiatric disorders and bereavement in older adults (N=39). With an estimated lifetime prevalence of between 10%–20%, bereavement complicated by psychiatric symptoms poses serious implications for the health of older adults. Depressive reactions occur frequently among the bereaved, but characteristically do not feature the psychomotor retardation and active suicidal ideation common in major depression. Anxiety symptoms are often pronounced among bereaved older adults and may precipitate increased use of alcohol and hypnotics. Depressive symptoms are more likely to persist in younger-old (ages 65–74) bereaved adults than among persons in older age strata. The efficacy of psychosocial interventions for older bereaved adults appears to be mediated by intrapersonal resources (self-esteem, self-perceived competence, and life satisfaction). Initiation of pharmacotherapy with desipramine or nortriptyline early in the course of bereavement reduces depressive symptoms and sleep disturbance in older adults. However, the efficacy of serotonin reuptake inhibitors in this population has not yet been empirically verified and merits further investigation.

### TARGET AUDIENCE:

Psychiatrists, primary care MDs, nurses, psychologists, soc. wrkrs.

### REFERENCES:

1. Clayton PJ: Bereavement and depression. *J Clin Psychiatry* 51:7(suppl), 34–38, 1990.
2. Pasternak RE, Reynolds CF, Schlernizauer M: Acute open-trial nortriptyline therapy of bereavement-related depression in late life. *J Clin Psychiatry* 52:307–310, 1991.

**Poster 16** **Saturday, October 25 10:00 a.m.-11:30 a.m.**

## MEDICAL PROBLEMS IN PATIENTS WITH SEVERE MENTAL ILLNESS

Varsha M. Vaidya-Kunnirickal, M.D., *Instructor and Assistant Director for Creative Alternatives, Department of Psychiatry, Johns Hopkins Bayview Medical Center, 2400 Broeing Highway, Suite 180, Baltimore, MD 21224*; Gerard Gallucci, M.D., *Assistant Professor and Director of Creative Alternatives, Department of Psychiatry, Johns Hopkins Bayview Medical Center, 2400 Broeing Highway, Suite 180, Baltimore, MD 21224*

### SUMMARY:

Medical illness is almost twice as common in patients with severe and persistent mental illness. Major medical illnesses remain undiagnosed, and patients are being labelled "psychosomatic" at an alarming rate. Studies have shown that 53% of chronic psychiatric patients had chronic medical problems that interfered with daily activity/functioning (McCarrick et al.). Koranyi found that 43% of patients referred to a Canadian psychiatric clinic had major medical illnesses and 46% of these illnesses had been unknown to the referring physicians. Morbidity and mortality is higher in this population.

These studies suggest that medical illness is common among psychiatric outpatients, and almost half of these patients are undiagnosed and, therefore, untreated at the time of referral. Contributing factors may include problems of patients effectively verbalizing their symptoms and mental health professionals focusing primarily on "psychiatric symptoms."

Creative Alternatives is a capitated mental health rehabilitation program that serves a population with severe and persistent mental illness. Patients had previously been hospitalized in a state psychiatric facility for more than seven years and/or had multiple psychiatric hospitalizations at local hospitals (greater than four admissions/two years). Case management has helped to identify the medical needs of these patients and has provided follow-up for their multiple somatic problems. We will provide information about the medical problems of this patient group and the extensive case management services that are necessary for them.

### REFERENCES:

1. Bruce HS, Leaf PJ, Rozal GP, et al: Psychiatric status and 9-year mortality data in the New Haven Epidemiologic Catchment Area Study. *American Journal of Psychiatry* 151:716–721, 1994.
2. Karasu TB, Waltzman S, et al: The medical care of patients with psychiatric illness. *Hospital and Community Psychiatry* v.31, 1980.

**Poster 17** **Saturday, October 25**
**10:00 a.m.-11:30 a.m.**

## THE EFFECT OF A COPING-WITH-LOSS GROUP ON GRIEVING INDIVIDUALS' LEVELS OF STRESS

Gerard Gallucci, M.D., *Assistant Professor and Director of Creative Alternatives, Department of Psychiatry, Johns Hopkins Bayview Medical Center, 2400 Broeing Highway, Suite 180, Baltimore, MD 21224*; Bruce Singley, M.S.N., *Nurse Therapist, Department of Community Psychiatry, Johns Hopkins Bayview Medical Center, 4940 Eastern Avenue, Baltimore, MD 21224*

### SUMMARY:

Evaluating the effect of a coping-with-loss group on 30 grieving individuals' level of stress over a 10-week timeframe and post group constituted the purpose of this study. Two groups of 30 individuals involved in the Community Psychiatric Program at Johns Hopkins Bayview Medical Center were the subjects. One group of 30 individuals comprise the members of the 10-week coping-with-loss group. The other 30 individuals, who may be involved individual treatment or other support, comprise the control group.

Initially, both groups were interviewed and, after giving consent, were given a self-report interview schedule that collected data reflecting their race, age, marital status, living arrangements, education, income, culture and ethnic group, and religious preference, factors that can affect their response to loss. Then each individual in each group will complete a self-report assessment inventory the BSI (Brief Symptom Inventory) and their social/personal status by completing the QOLI inventory. The BSI is a 53-item instrument with five-point rating scales that has nine primary symptom dimensions and three global indices. The QOLI is a 16-item self reporting inventory to measure social adjustment and quality of life.

After 10 weeks, whether the individual participated in the coping-with-loss group or the control group, they were reassessed by utilizing the BSI and QOLI. The individuals who participated in the coping-with-loss group did complete a questionnaire looking at their response to participating in the group and whether this participation helped them cope better with their loss. Finally, the BSI and QOLI were administered to both groups after a six-month period to assess whether the benefit of the group was maintained and their response to coping with loss.

Hypothesis 1, which predicted that there would be a greater outcome in the areas of psychological status, self-esteem, and interpersonal functioning in the grieving individuals who participated in the coping-with-loss group than those individuals who were part of the control group was not rejected, because the mean score of the BSI inventory was lower for the coping-with-loss group than the control group on a significant basis.

Hypothesis 2, which predicted that those individuals who participated in the coping-with-loss group would report at completion of the group that the support of group helped them cope better with the grief process in dealing with their loss was not rejected, because the mean scores on this questionnaire showed a significant different outcome indicating that individuals did cope better with their loss.

Hypothesis 3 predicted that benefits of the group would be maintained after six months and was not rejected because results of the reassessment demonstrated a significantly different outcome indicating that individuals were coping with their loss even after six months than were the control group.

### REFERENCES:

1. Babney F, et al: A merger of themes and roles in a short-term loss group. *International Journal of Group Psychotherapy* 1993.
2. Horowitz et al: Brief psychotherapy of bereavement reactions. *Archives of General Psychiatry* 1984.

**Poster 18** **Saturday, October 25**
**10:00 a.m.-11:30 a.m.**

## PERCEPTIONS OF COLLABORATION AND REFERRAL RELATIONSHIPS BETWEEN PRIMARY CARE PROVIDERS AND MENTAL HEALTH SPECIALISTS

Shimon Waldfogel, M.D., *Department of Psychiatry, Jefferson Medical College, 1020 Sansom Street, Room 1651, Philadelphia, PA 19107*; Elaine Yuen, A.B.D., *Research Associate, Jefferson Medical College, 1025 Walnut Street, Suite 119, Philadelphia, PA 19107*

### SUMMARY:

The objective of this study was to enhance understanding of collaborative and referral relationships between primary care physicians and mental health providers by examining structural and process characteristics of these relationships. Primary care physicians affiliated with Jefferson Medical College were surveyed on their perceptions of consultation practices and referral practices with mental health providers. Ninety-nine attending physicians responded to the survey. Physicians trained in family medicine ranked their ability to recognize and treat mental illness higher than those trained in general internal medicine. Overall, respondents reported that an average of 30% of their patients had mental health problems. Family practice physicians referred more often to nonphysician mental health providers than did general

internists. In communicating with mental health providers, 48.5% of physicians often or always provided patient information to individual mental health providers, but only 25.0% often received patient information in return. Also, 65.2% of the respondents were satisfied with their relationships with individual mental health providers, but only 33.3% were satisfied with their relationships with mental health carveout programs. Quality of mental health care was perceived to be lower for patients who were referred to mental health carveout programs compared with individual mental health providers. Primary care physicians felt that the quality of collaboration and referral relationships for mental health problems with individual providers was markedly better than with managed care carveout programs. These differences point to the necessity for increased communication between primary care and mental health providers, especially when primary care providers refer to the carveout programs that are often found in managed care settings.

## REFERENCES:

1. Pincus HA: Patient-oriented models for linking primary care and mental health care. *Gen. Hosp. Psych.* 9:95–101, 1987.
2. Doherty WJ: The why's and levels of collaborative family health care. *Family Systems Medicine* 13:275–281, 1995.

**Poster 19** **Saturday, October 25**
**10:00 a.m.-11:30 a.m.**

## PROVIDER-BASED MEDICAL GROUP DELIVERY SYSTEMS IN MANAGED CARE THAT IMPROVE ACCESS, PATIENT OUTCOME, MEDICAL OFFSET AND SERVICES

Stuart H. Levine, M.D., M.H.A., *Chief Executive Officer, PsychCare Alliance, Topaz Health, 423 S. Pacific Coast Highway, #101, Redondo Beach, CA 90277*; Morris Gelbart, Ph.D., *Director, Clinical Operations, PsychCare Alliance, Topaz Health, 423 S. Pacific Coast Highway, #101, Redondo Beach, CA 90277*; Peter B. Hirsch, M.D., Ph.D., Daniel D. Anderson, M.D.

## SUMMARY:

Managed care continues to receive constant criticism, both in popular and professional media. Critics describe it as "mangled" or "unmanaged" care, and cite horror stories describing impossible access, denial of services, and physician decisions motivated by financial greed rather than professional judgment.

In our staff-model and network IPA, we at PsychCare Alliance have developed a system free from any of the major criticisms. Unique to our system is a provider-owned and provider-driven organization, which strives to provide excellent service while still maintaining a business where profit is essential to operating. In servicing more than 600,000 contracted lives, we have developed an infrastructure that provides increased access to a multidisciplinary team of providers, which provides greater number and degrees of services to the patients and which trains therapists in leading-edge methods to provide cost-effective, well-documented, yet all necessary services. Capitation for services is a cornerstone of our organization. Rather than serving as a basis for financially motivated treatment decisions, capitation has enabled us to develop creative and meaningful modalities, via groups, education, wellness activities, etc., thereby allowing us to provide an even greater range of services than the traditional model. In making providers accountable, via information systems that provide a wide range of data, case management and utilization review by peers, and analysis of medical cost offset, we are able to provide superior, rather than inferior services.

## TARGET AUDIENCE:

Mental health professionals, mental health administrators.

## REFERENCES:

1. Furchner RS: Behavioral health care risk-sharing and medical cost of treatment. *JAMA* 405:34–38, 1996.
2. Lasmar, JL: Ethical Issues in Managed Care. *JAMA* 273:307–310, 1995.

**Poster 20** **Saturday, October 25**
**10:00 a.m.-11:30 a.m.**

## PSYCHIATRIC PATIENTS TREATED IN GENERAL PRACTICE

F. Michael Stark, M.D., Ph.D., *Professor of Psychiatry, University of Hamburg, Martinistrasse 52, Hamburg, Germany 20246*

## SUMMARY:

This presentation reports on a comprehensive survey about the involvement of primary care physicians (GPs) in the treatment of psychiatric patients. A short questionnaire was devised for this purpose. GPs were asked to rate the psychiatric morbidity among their patients during the previous three months. In addition, they were asked about their knowledge concerning etiology of specific psychiatric disorders, their subjective expertise to treat patients with psychiatric disorders, and their level of cooperation with psychiatrists and other psychiatric services such as psychiatric hospitals and community-based services. During the last five years, the questionnaire was sent several times to the about 1000 general medical practices in Hamburg, the second biggest city

in Germany, with approximately 1.7 million inhabitants. Each time a different psychiatric disorder was surveyed.

The proportion of patients suffering from psychiatric disturbances reported by the GPs was in the lower range of those stated in the numerous international studies, e.g., 0.45% for schizophrenic patients and 8.6% for depression. The survey demonstrates that the self-assessed level of competence showed significant correlation with treatment regime and number of psychiatrically ill patients. In spite of the sharp rise in the number of practicing psychiatrists during the past 20 years, GPs remain an important element in the care of psychiatric illness. The study established the necessity of improved psychiatric training for GPs, as well as the need for increased cooperation among GPs, practicing psychiatrists, psychologists, hospitals, and outpatient facilities.

## REFERENCES:

1. Schreter RK: Earning a living: a blueprint for psychiatrists. *Psychiatric Services* 46:1233–35, 1995.
2. Dorwart RA, Chartock LR, Dial T, et al: A national study of psychiatrists' professional activities. *Am J Psychiatry* 1499:1499–1505, 1992.

**Poster 21** **Saturday, October 25**
**10:00 a.m.-11:30 a.m.**

## OUTCOME AND UTILIZATION OF AN OVERNIGHT PSYCHIATRIC OBSERVATION PROGRAM

Marlene P. Hart, M.D., M.P.H., *Chief Resident in Psychiatry, University of South Florida, 9119 Cypresswood Circle, Tampa, FL 33647*; Alan D. Feldman, M.D., *Resident in Psychiatry, University of South Florida, 3515 E. Fletcher Avenue, Tampa, FL 33613*; William R. Marchand, M.D., Elie M. Francis, M.D.

## SUMMARY:

In February, 1996, an overnight psychiatric evaluation program was implemented at the Veterans Administration Hospital in Tampa, Florida. The purpose of this program is to provide brief care to stabilize patients before outpatient referrals or admission to the inpatient unit. Medically stable patients with suicidal or homicidal ideation, substance abuse, or unstable living arrangements could be admitted. The present study was done to evaluate the outcomes of patients admitted in the first six months of the program. Retrospective chart audits were completed for the 103 patients with 127 admissions from 2/96–7/96. Demographics, the number of hospitalizations, suicide attempts, and outpatient follow-up visits were compared for the six months before and after the initial overnight stay.

Results showed that 89% of the patients were stable for discharge after the overnight stay, 55% were homeless, and 65% were admitted for suicidal or homicidal ideation with substance abuse. The outcomes were comparable before and after admission. This study indicates that an overnight program can be an effective alternative to inpatient care in a VA hospital.

## TARGET AUDIENCE:

Emergency room clinicians, administrators.

## REFERENCES:

1. Jayaram G, Tien A, Sullivan P: *Psychiatric Services,* Vol 47, No 5, May, 1994
2. *Psychiatric Services,* Vol 47, No 2, Feb, 1994

**Poster 22** **Saturday, October 25**
**10:00 a.m.-11:30 a.m.**

## UTILIZATION OF CONTINUOUS QUALITY IMPROVEMENT METHODOLOGY TO ADDRESS PROVIDER SATISFACTION WITH A MANAGED BEHAVIORAL HEALTHCARE ORGANIZATION

Jonathan Book, M.D., *Chief Medical Officer, Green Spring Health, 5565 Sterrett Place, #500, Columbia, MD 21044;* Paul R. McCarthy, Ph.D., Alan M. Elkins, M.D., Suzan Lumpkin, M.P.H., Claressa C. Marqus, Ph.D.

## SUMMARY:

The information summarized in this poster includes the results from a multiple-year provider satisfaction surveying effort. These data have been used to drive an ongoing quality improvement effort to identify opportunities for improvement, addressing provider issues and concerns with the operation of a managed behavioral healthcare organization.

The data used in this ongoing study reflects psychiatrist satisfaction with a large, national MBHO. Consecutive satisfaction surveys spanning a 3-year period are analyzed and presented. Self-reported provider satisfaction is assessed across multiple domains including satisfaction with such areas as: treatment standards and medical necessity criteria, reimbursement rates, paperwork volume, procedural clarity, access to care management review services, timeliness of treatment plan review, appeal process, overall satisfaction with the MBHO, and satisfaction relative to other MBHOs.

These findings are evaluated using a continuous quality improvement framework, areas of improvement and opportunities for improvement are identified. Action

plans addressing specific improvement opportunities are discussed.

## TARGET AUDIENCE:

Providers, administrators, managers having involvement with managed behavioral health care.

## REFERENCES:

1. Weinstein ME: Network development: building a managed care competent organization. Pollack D., Minkoff, K. (eds) *Managed Mental Health Care in the Public Sector: A Survival Manual.*
2. Zieman GL (ed): *The Complete Capitation Handbook—How to Design and Implement Quality Improvement Methods in Managed Behavioral Healthcare.* CentraLink Publications, 1995.

**Poster 23** **Saturday, October 25 4:00 p.m.-5:30 p.m.**

## LITHIUM, HYPERCALCEMIA AND ARRHYTHMIA

Marion E. Wolf, M.D., *Clinical Professor of Psychiatry, Veterans Affairs Medical Center, 3001 Green Bay Road, North Chicago, IL 60064*; Aron D. Mosnaim, Ph.D., *Professor of Pharmacology, Chicago Medical School, 3333 Green Bay Road, North Chicago, IL 60064*; Raul Gazmuri, M.D., Merle Moffat, Psy.D.

## SUMMARY:

Considerable evidence supports an association between lithium, hypercalcemia, and hyperparathyroidism although the nature of this association is not clear. The clinical records of ten patients with lithium-induced hypercalcemia were reviewed. All subjects had laboratory results consistent with those of the late-onset lithium-induced hyperparathyroidism syndrome. It was found that five patients had hypertension and eight of the ten subjects had abnormal EKGs. Excluding the two patients who had nonspecific EKG changes, the remaining six subjects had bradyarrhythmias, with sinus bradycardia and/or AV block, and/or bundle branch block. The arrhythmia constituted a major clinical problem in two patients. Calcium and lithium are known to play an important role in the development of arrhythmias, and our preliminary data suggest that hypercalcemia potentiates lithium-induced bradyarrhythmias, and/or that lithium potentiates the calcium-induced arrhythmias. These findings emphasize the need for regular laboratory and electrocardiographic monitoring of patients on maintenance lithium therapy.

## REFERENCES:

1. Kingsbury S, Salzman: Lithium's role in hyperparathyroidism and hypercalcemia. *Hospital and Community Psychiatry* 44:1047–1048, 1993.
2. Ranade V, Wolf ME, Mosnaim AD: Development of antiarrhythmic drugs: an overview. *Expert Opinion In Investigational Drugs* 4:1–29, 1995.

**Poster 24** **Saturday, October 25 4:00 p.m.-5:30 p.m.**

## PREVALENCE AND SIGNIFICANCE OF CATATONIC SYMPTOMS IN MANIA

Stephanie Kruger, M.D., *Research Fellow, Department of Psychiatry, University of Bochum, Alexandrinenstr 1, Bochum, Germany 44791*; Peter Braunig, M.D., *Chief of Service, Geuenae Psychiatric Division, Department of Psychiatry, University of Bochum, Germany, Alexandrinenstr 1, Bochum, Germany 44791*; Gerald Shugar, M.D.

## SUMMARY:

*Objective:* This study investigates the prevalence and clinical significance of catatonic symptoms in mania.

*Methods:* Sixty-one German inpatients with *DSM-III-R* bipolar disorder, manic or mixed episode, were divided into catatonic (19, 31%) and non-catatonic (42, 69%) groups using the Bräunig Catatonia Rating Scale. The groups were compared for demographic and course parameters and pre-admission level of functioning. Current comorbidity was assessed using the SCID for *DSM-III-R* criteria. Manic symptoms were measured by the Young Mania Rating Scale and the Self Report Manic Inventory. General pathology was measured by the Brief Psychiatric Rating Scale after admission and again before discharge.

*Results:* Catatonic manics had lower pre-admission functioning. Mixed mania was more frequent (18; 95% vs. 28; 67%). Hospitalization was longer (mean days 112 vs. 64, p=.002). The YMRS, the SRMI, and the BPRS were significantly higher on admission and the BPRS remained significantly higher on discharge. There was a higher frequency of anxiety disorder (4; 21% vs. 1; 2.6%, p=.005), dysthymia (7; 37% vs. 3; 8%, p=.005), prior suicide attempts (12; 63% vs. 7; 18%, p=.006), binge eating behavior (11; 58% vs., 4; 10%, p=.000), intermittent explosive disorder (4; 21% vs. 1; 3%, p=.018) and polydipsia (2; 11% vs. 0; 0%, p=.039).

*Conclusions:* Almost one third of hospitalized manics had significant catatonic symptoms associated with more severe mania, more comorbid pathology, and poorer outcome.

**REFERENCES:**

1. Abrams R, Taylor MA: Catatonia: a prospective study. *Arch Gen Psychiatry* 33:579–581, 1976.
2. Fein S, McGrath MG: (1990) Problems in diagnosing bipolar disorder in catatonic patients. *J Clin Psychiatry* 51:203–205, 1990.

**Poster 25** **Saturday, October 25**
**4:00 p.m.-5:30 p.m.**

## CITALOPRAM VERSUS PLACEBO IN THE TREATMENT OF OUTPATIENTS WITH MODERATE TO SEVERE DEPRESSION

Joseph Mendels, M.D., *Consultant to Forest Laboratories, 909 Third Avenue, New York, NY 10022*; Ari Kiev, M.D., *Lieu Research Laboratories, New York, NY*; Louis F. Fabre, Jr., M.D.

**SUMMARY:**

Citalopram is the most selective serotonin reuptake inhibitor available, marketed in 48 countries, with worldwide exposure estimated at over 4,000,000 patients. The present study is one of two completed placebo-controlled trials, which were conducted in the U.S. to establish the efficacy and safety of citalopram in the treatment of outpatients with major depression. This multicenter study used a fixed-flexible, parallel group design where patients were titrated from 20 to 80 mg in a two-week period. After a one-week washout, eligible patients were randomized to receive either citalopram (n=89) or placebo (n=91) in a double-blind manner for four weeks. The citalopram group (average daily dose at endpoint, 52 mg/day) showed clinically and statistically significant improvement compared with the placebo group by trial weeks one or two, and at endpoint based on both HAMD (mean change from baseline) and CGI scores. The citalopram treated patients had elevated incidences of nausea, insomnia, and dry mouth compared with placebo. Based on these results, citalopram can be judged effective and well tolerated for the treatment of major depression, with a possible rapid onset of effect.

**REFERENCES:**

1. Hytell J: Citalopram: pharmacological profile of a specific serotonin uptake inhibitor with antidepressant activity. *Prog Neuro-Psychopharm,* and *Biol. Psychiatry* 6:277–295, 1982.
2. Milne RJ, Goa KL: Citalopram: a review of its pharmacodynamic and pharmacokinetic properties and therapeutic potential in depressive illness. *Drug* 41:451–477, 1991.

**Poster 26** **Saturday, October 25**
**4:00 p.m.-5:30 p.m.**

## FIXED-DOSE COMPARISON OF CITALOPRAM VERSUS PLACEBO IN THE TREATMENT OF OUTPATIENTS WITH MODERATE TO SEVERE DEPRESSION

John P. Feighner, M.D., *Department of Marketing, Forest Laboratories, 909 Third Avenue, New York, NY 10022*; Ronald R. Fieve, M.D., *Department of Psychiatry, Columbia University, New York, NY*

**SUMMARY:**

Citalopram, the most selective serotonin reuptake inhibitor available, is approved in Europe at single daily doses of 20 to 60 mg/day. The present study is one of two completed placebo-controlled trials, which were conducted in the U.S. to confirm the efficacy and safety of citalopram in the treatment of patients with moderate to severe depression. In this multicenter, randomized trial, patients who were nonresponsive to placebo treatment during the initial one-week, single-blind phase were randomized to citalopram 10 (n=131), 20 (n=130), 40 (n=131), or 60 (n=129) mg/day q.d. or placebo (n=129) treatment for up to six weeks. Both the 40 and 60 mg/day citalopram groups demonstrated significant ($p<0.05$) improvements in HAMD, MADRS, and CGI endpoint scores compared with placebo. Citalopram was well tolerated with a safety profile similar to that of other SSRIs. Based on these results, both the 40 and 60 mg/day doses of citalopram are effective and well tolerated for the treatment of patients with moderate to severe depression.

**REFERENCES:**

1. Milne RJ, Goa KL: Citalopram: a review of its pharmacodynamic and pharmacokinetic properties and therapeutic potential in depressive illness. *Drug* 41:451–477, 1991.
2. Montgomery SA, Rasmussen JGC, Lyby K, et al: Dose response relationships of citalopram 20 mg/day, citalopram 40 mg/day and placebo in the treatment of moderate and severe depression. *Int Clin Psychopharmacol* 6 suppl 5:65–70, 1992.

**Poster 27** **Saturday, October 25**
**4:00 p.m.-5:30 p.m.**

## POSTULATED MODEL OF PANIC DISORDER

Tibor Szekely, B.S., *Chemical Engineer, 39-30 59th Street, #B3, Woodside, NY 11377*

## SUMMARY:

*Hypothesis:* Biogenic amines (BA) form loose bonds to immunoglobulins (Ig) in cerebrospinal fluid (CSF), maintaining a dynamic equilibrium. Any decrease in CSF pH results in allosteric changes, producing free BA's. An increase in the level of free BA in the brain reaction kinetically slows down the metabolism of the neurotransmitters (dopamine, serotonin, norepinephrine) resulting in a rapid increase of neurotransmitter level.

*Discussion:* The physiological pH range of CSF overlaps with the normal range of isoelectric points (pI) of Ig's. The buffer capacity of CSF is significantly lower than of plasma. That is why panic regulation presumably takes part in CSF. Stress induces a drop in CSF pH by altered breathing. In isoelectric range, consecutive small decrements in pH can liberate disproportionately large amounts of BA's. The described biochemical kinetics shows resemblance to the physiological kinetics of panic. Pathologic reaction during a panic challenge could be explained with an altered isotype composition (IgA, IgG, IgM) and molecular weight distribution of Ig. The described model fits into Klein's false suffocation theory and could have genetic and psychoneuroimmunologic aspects.

*Testing the hypothesis:* 1. Test variously affected panic patient's CSF Ig isotype composition and molecular weight distribution against normal control. 2. Correlate various immunological markers in CSF and plasma against various anxiety and impulsivity assessment scores.


**Poster 28** **Saturday, October 25 4:00 p.m.-5:30 p.m.**

## CHANGES IN INSOMNIA DURING TREATMENT OF DEPRESSION: ANALYSIS FROM FLUOXETINE DOUBLE-BLIND, PLACEBO-CONTROLLED TRIALS

Steven J. Romano, M.D., *Clinical Research Physician, Neuroscience Department, Eli Lilly and Company, Lilly Corporate Center/DC 1046, Indianapolis, IN 46285*; Rosalinda Tepner, R.Ph., Bruce Basson, M.S.


## SUMMARY:

*Introduction:* Sedating antidepressants are often recommended for patients presenting with insomnia. We examine the effects of fluoxetine (''nonsedating'') treatment on insomnia symptoms in patients characterized as having high or low baseline insomnia.

*Method:* We analyzed data from seven double-blind clinical trials including 2,456 patients with major depression randomly assigned to fluoxetine or placebo treatment. Baseline HAMD insomnia score (total of Items 4, 5, and 6) was used to categorize patients as having low insomnia (<4) or high insomnia (≥4). Baseline-to-endpoint reduction in insomnia score was used as a measure of improvement. The frequency of treatment-emergent insomnia (appeared or worsened during treatment) was also determined.

*Results:* Compared with placebo, fluoxetine-treated patients with high baseline insomnia experienced significant reductions in insomnia score (fluoxetine, −2.132; placebo, −1.632; $p<.05$). Patients with low baseline insomnia showed a slightly decreased insomnia score in both treatment groups (fluoxetine, −0.243 and placebo, −0.272). Frequency of treatment-emergent insomnia was greater in fluoxetine- vs. placebo-treated patients in both insomnia categories (low insomnia; 15.7% vs 5.8%, $p<.001$ and high insomnia; 16.0% vs 11.5%, $p=.02$).

*Conclusion:* Compared with placebo, fluoxetine-treated patients with high baseline insomnia showed significant improvement in insomnia and patients with low baseline insomnia evidenced numerical improvement from baseline in both treatment groups. Treatment-emergent insomnia for fluoxetine-treated patients was virtually identical in high and low baseline insomnia groups.


## TARGET AUDIENCE:

Primary care physicians.

## REFERENCES:


1. Mellinger GD, Balter MB, Uhlenhuth EH. Insomnia and its treatment. *Arch Gen Psych;* 42:225–232: 1985.
2. Breslau N, Roth T, Rosenthal L, Andreski P: Sleep disturbance and Psychiatric disorders: a longitudinal epidemiological study of young adults. *Biol Psychiatry*; 39:411–418, 1996.


**Poster 29** **Saturday, October 25 4:00 p.m.-5:30 p.m.**

## RISK OF ADVERSE EVENTS AND DEPRESSIVE SYMPTOM BREAKTHROUGH FOLLOWING BRIEF INTERRUPTION OF SSRI THERAPY

Sharon L. Blomgren, M.D., *Senior Clinical Research Physician, Neuroscience Department, Eli Lilly and Company, Lilly Corporate Center/DC 1046, Indianapolis, IN 46285*; Jerrold F. Rosenbaum, M.D., Maurizio Fava, M.D.


## SUMMARY:

*Objective:* To assess somatic distress and stability of antidepressant response following a brief placebo substitution, mimicking noncompliance, in patients with

remitted depression receiving maintenance therapy with open-label fluoxetine, sertraline, or paroxetine.

*Method:* Patients successfully treated for major depressive disorder with fluoxetine, sertraline, or paroxetine for four to 24 months were recruited. During this four-week study, therapy was interrupted in a randomized, double-blind fashion. Active drug therapy was resumed and patients were followed for an additional one to two weeks. Somatic distress was assessed using the Symptom Questionnaire (SQ) and the Discontinuation-Emergent Signs and Symptoms (DESS) Checklist. Changes in severity of depressive symptoms were assessed using the Montgomery-Asberg Depression Rating Scale (MADRS) and the 28-Item Hamilton Depression Rating Scale (HAMD-28).

*Results:* Following placebo substitution, fluoxetine-treated patients reported a mean number of DESS and a mean score on the SQ somatic symptom scale significantly lower than the mean number/score of either sertraline- or paroxetine-treated patients (both, $p<.001$). Also, mean increases in HAMD-28 and MADRS scores were significant in the sertraline- and paroxetine-treated patients (both, $p<.001$) but not in the fluoxetine-treated patients ($p=.616$).

*Conclusion:* Abrupt interruption of fluoxetine treatment is much less likely to produce discontinuation-emergent somatic distress or depressive symptom increase than interruption of sertraline or paroxetine treatment.

## TARGET AUDIENCE:

Research issues/primary care.

## REFERENCES:

1. Lazowick AL, Levin GM: Potential withdrawal syndrome associated with SSRI discontinuation. *Annals of Pharmacotherapy*. 29(12):1284–85, 1995.
2. Coupland NJ, Bell CJ, Potokar JP: Serotonin reuptake inhibitor withdrawal. *J Clin Psychopharmacol*: 16:356–362, 1996.

**Poster 30** **Saturday, October 25 4:00 p.m.-5:30 p.m.**

## TELEMEDICINE RATINGS OF GERIATRIC DEPRESSION

Beverly N. Jones, M.D., *Assistant Professor, Department of Psychiatry, Bowman Gray School of Medicine, Medical Center Boulevard, Winston-Salem, NC 27103-3536*; W. Vaughn McCall, M.D., *Associate Professor, Department of Psychiatry, Bowman Gray School of Medicine, Medical Center Boulevard, Winston-Salem, NC 27157*; Beth A. Melton, Ph.D., Deirdre M. Johnston, M.B.

## SUMMARY:

*Objective:* Determine reliability of telemedicine assessments of geriatric depression.

*Method:* Ten geriatric patients were interviewed using videoconferencing equipment. A geriatric psychiatrist administered the HDRS and the BPRS using videoconferencing equipment to see and hear the participant while a second rater simultaneously completed HDRS and BPRS ratings while observing the participant face-to-face. Reliability was assessed using Pearson's correlation for total scale scores and Cohen's Kappa for individual items. The BPRS was divided into two subscales, subjective ratings and observation ratings. A satisfaction questionnaire compared the telemedicine interview to traditional face-to-face interview.

*Results:* Correlations between the telemedicine ratings and face-to-face ratings were significant for all scores: Total BPRS $r=.82$ ($p=.0039$); BPRS Subjective $r=.96$ ($p=.0054$); BPRS Observation $r=.65$ ($p=.0001$); Total HDRS $r=.90$ ($p=.0399$). These results were comparable to face-to-face interrater correlations: Total BPRS $r=.97$ ($p=.1544$); Subjective BPRS $r=1.0$ ($p=.0001$); Observation BPRS $r=.97$ ($p=.1544$). Satisfaction ratings for the telemedicine interview indicated comfort, acceptance and confidence equivalent or better than traditional face-to-face interview.

*Conclusions:* Preliminary results indicate high reliability between telemedicine and face-to-face ratings of geriatric depression. Correlation scores were higher for BPRS subjective items than for BPRS observation items. Participants' ratings of satisfaction and comfort indicate that telemedicine assessment of geriatic depression is acceptable to patients.

## TARGET AUDIENCE:

Geriatric mental health workers.

## REFERENCES:

1. Jones B: Telemedicine and long-term care. *Nursing Home Economics* 3–17, 1996.
2. Jones B: Colenda C. Telemedicine and geriatric psychiatry: progress and potential. *Psychiatric Services* 48(6):783–786, 1997.

**Poster 31** **Saturday, October 25 4:00 p.m.-5:30 p.m.**

## ABRUPT DISCONTINUATION OF FLUOXETINE: A RANDOMIZED, PLACEBO-CONTROLLED STUDY

David Michelson, M.D., *Clinical Research Physician, Department of Neuroscience, Eli Lilly and Company, Lilly Corporate Center/DC 1046, Indianapolis, IN*

*46285*; Michael G. Wilson, M.S., Charles M. Beasley, Jr., M.D.

## SUMMARY:

*Introduction:* Shorter acting SSRI's are associated with more treatment-interruption-related symptoms than fluoxetine. To rule out the possibility that fluoxetine's longer half-life is associated with late occurring events, we studied adverse events over six weeks following abrupt discontinuation of fluoxetine.

*Method:* A total of 395 fluoxetine-treated (20mg/day for 12 weeks) patients in a double-blind, placebo-controlled study of maintenance treatment of depression were randomized in a double-blind fashion to continued fluoxetine (N=299) or abrupt substitution of placebo (N= 96). Patients were seen one, two, four and six weeks following randomization and reports of adverse events (AE's) were systematically collected.

*Results:* Overall new or worsened AE's and patient discontinuations related to AE's were similar for both groups at each visit before and after randomization. Several mild common events were slightly more frequent at individual visits.

*Conclusion:* Abrupt discontinuation of fluoxetine is not associated with increased number of AE's over a six-week period. Several mild, common symptoms occurring only in small numbers of patients were slightly more frequent at individual visits, but were not clinically significant and may overstate statistical significance since a conservative approach not correcting for multiple comparisons was employed. These data suggest fluoxetine discontinuation is not associated with the emergence of clinically significant symptoms over a six-week period.

## TARGET AUDIENCE:

Primary care.

## REFERENCES:

1. Coupland NJ, Bell CJ, Potokar JP: Serotonin reuptake inhibitor withdrawal. *J Clin Psychopharmacol*; 16:356–362, 1996.
2. Dilsaver SC: Withdrawal phenomena associated with antidepressant and antipsychotic agents. *Drug Saf*; 10:103–114, 1994.

**Poster 32** **Saturday, October 25 4:00 p.m.-5:30 p.m.**

## EARLY AND LATE ADVERSE EVENT PROFILES ASSOCIATED WITH FLUOXETINE TREATMENT

David Michelson, M.D., *Clinical Research Physician, Department of Neuroscience, Eli Lilly and Company, Lilly Corporate Center/DC 1046, Indianapolis, IN 46285*; Michael G. Wilson, M.S., Charles M. Beasley, Jr., M.D.

## SUMMARY:

*Introduction:* We examined the safety of fluoxetine 20 mg/day in long-term treatment in a large, prospective trial and report a comparison of early and late adverse events (AE's) and the course of AE's over time.

*Method:* AE's were recorded at each visit in a uniform format by open-ended questioning, regardless of perceived causality. The frequencies of 18 new/worsened AE's reported in the first four weeks (early) or the 22$^{nd}$-26$^{th}$ weeks of treatment (late) were compared using a chi square analysis.

*Results:* A total of 299 patients with 12 weeks of fluoxetine treatment entered continuation therapy and 174 completed 26 weeks of therapy. All early events, which occurred in ≥5% of patients, declined significantly ($p<05$) over time and no events occurred significantly more frequently during continuation therapy.

*Discussion:* Adverse events associated with initiating fluoxetine in depressed patients resolve in the majority of patients and are significantly less frequent with ongoing treatment. Overall, therapy with fluoxetine 20 mg daily is well tolerated over a six-month period.

## TARGET AUDIENCE:

Research issues/primary care.

## REFERENCES:

1. Pande AC, Sayler ME: Adverse events and treatment discontinuations in fluoxetine clinical trials. *Int Clin Psychopharmacology*, 8(4):267–9, 1993.
2. Tollefson GD: Adverse drug reactions/interactions in maintenance therapy. *J Clin Psych;* 34 Suppl.48–60, 1993.

**Poster 33** **Saturday, October 25 4:00 p.m.-5:30 p.m.**

## OPTIMAL LENGTH OF CONTINUATION THERAPY: A PROSPECTIVE ASSESSMENT DURING FLUOXETINE LONG-TERM TREATMENT OF MDD

David Michelson, M.D., *Clinical Research Physician, Department of Neuroscience, Eli Lilly and Company, Lilly Corporate Center/DC 1046, Indianapolis, IN 46285*; Michael G. Wilson, M.S., Charles M. Beasley, Jr., M.D.

## SUMMARY:

*Objectives:* To prospectively determine optimal length of fluoxetine continuation therapy following successful acute treatment of major depressive disorder.

*Methods:* Outpatients were treated for 12 to 14 weeks with fluoxetine (20 mg/day). Patients meeting response criteria were randomized to 50 weeks of double-blind continuation therapy comprised of placebo crossover periods as follows:

- immediate placebo crossover for 50 weeks (crossover group-1);
- fluoxetine for 14 weeks followed by placebo crossover for 36 weeks (crossover group-2);
- fluoxetine for 38 weeks followed by placebo crossover for 12 weeks (crossover group-3);
- fluoxetine for 50 weeks (no crossover).

Actual relapse rates and Kaplan-Meier estimates were determined during three fixed 12-week time intervals following each placebo crossover.

*Results:* Relapse rates were statistically significantly higher in patients initiating placebo in crossover group-1 (48.6% vs. 26.4% $p<0.001$) and crossover group-2 (23.2% vs. 9.0% $p=0.027$) than in patients remaining on fluoxetine. Relapse rates were not statistically significantly higher in patients initiating placebo in crossover group-3 than in patients remaining on fluoxetine (16.2% vs. 10.7% $p=0.717$).

*Conclusions:* These data suggest that following a successful 12-week course of acute therapy, additional protection against relapse is associated with continuation therapy of at least 26 additional weeks (38 weeks total).

## TARGET AUDIENCE:

Psychiatric education/primary care/research issues.

## REFERENCES:

1. Keller MB, Klerman GL, Lavori PW, et al: Long-term outcome of episodes of major depression: clinical and public health significance. *JAMA*; 252:788–792, 1984.
2. Prien RF, Kupfer DJ: Continuation drug therapy for major depressive episodes: how long should it be maintained? *Am J Psychiatry*; 143:18–23, 1986.

**Poster 34** **Saturday, October 25 4:00 p.m.-5:30 p.m.**

## MANAGEMENT OF BIPOLAR DISORDER IN THE INDIGENT

Ramaswamy Viswanathan, M.D., *Associate Professor of Clinical Psychiatry, Department of Psychiatry, SUNY Health Science Center at Brooklyn, 450 Clarkson Avenue/Box 127, Brooklyn, NY 11203-2012*; Rafael B. Durango, M.D., *Staff Psychiatrist, Department of Psychiatry, St. Joseph's Medical Center, 127 South Broadway, Yonkers, NY 10701*

## SUMMARY:

The importance of doing research on clinical practice has been gaining recognition recently. We did a retrospective chart review study of 54 randomly chosen patients who were discharged with a diagnosis of bipolar disorder in the period 7/95 to 1/96 from an inner-city hospital serving indigent patients. On admission the diagnosis of bipolar disorder had been recognized in 65% of these patients. At discharge 89% were on a mood stabilizer, 91% on a neuroleptic, and 20% on a benzodiazepine. Number of days before a mood stabilizer was started (mean $4.7\pm8.3$) correlated with length of hospital stay (LOS) (mean $30.6\pm14.7$ days, $r=.3789$, $p<.01$). The type of mood stabilizer used (lithium, valproate, carbamazepine), prior hospitalizations, family history, gender, and history of substance abuse were not related to LOS. There was a trend for patients compliant with psychotropic medication during hospitalization to have shorter LOS (mean $26.5\pm13.1$, $n=25$) than noncompliant patients (mean $34 \pm 15.3$, $n=29$, $p=.056$ by ANOVA). We conclude that bipolar disorder is not readily recognized at initial evaluation, delay in starting mood stabilizer and noncompliance seem to be associated with increased LOS, and LOS seems to be longer in these indigent patients compared to LOS in published psychopharmacological studies. Why neuroleptics tend to be used heavily in this patient population even at discharge needs to be explored in further studies.

## TARGET AUDIENCE:

Inpatient psychiatrists, quality assurance, hospital administrators.

## REFERENCES:

1. American Psychiatric Association: Practice Guidelines for the Treatment of Patients With Bipolar Disorder. *Am J Psychiatry* 151 (Dec suppl), 1994.
2. Frye MA, Altshuler LL, Szuba MP, et al: The relationship between antimanic agent for treatment of classic or dysphoric mania and length of hospital stay. *J Clin Psychiatry* 57:17–21, 1996.

**Poster 35** **Saturday, October 25 4:00 p.m.-5:30 p.m.**

## ONE-MONTH USE OF SSRIs WITH OTHER CYTOCHROME P450, 2D6 OR 3A4 MEDICATIONS: HOW OFTEN DOES IT REALLY HAPPEN?

Karen Way, Ph.D., *Researcher, Outcomes Research, PCS Health Systems, 9501 East Shea Boulevard/MC034, Scottsdale, AZ 85260*; Karl J. Gregor, Pharm.D., *Team Leader, Outcomes Research, PCS Health Systems, 9501 East Shea Boulevard/MC034, Scottsdale, AZ 85260*;

Christopher H. Young, Ph.D., Steven P. James, M.D., M.B.A.

## SUMMARY:

This study described the one-month concomitant use of cytochrome P450 2D6 or 3A4 metabolized medications in 544,309 patients who were also receiving selective serotonin reuptake inhibitors (SSRI's). Overall, 25.53% of SSRI patients experienced concomitant use with at least one of the 33 studied CYP 2D6 or 3A4 metabolized medications. Certain drugs and drug classes were more likely to be used concurrently among SSRI patients (e.g., benzodiazepines, tricyclic antidepressants, calcium channel blockers). Similarly, of the SSRI patients experiencing concomitant use, this concurrent use was twice as likely with cytochrome P450 medications metabolized by the 3A4 isoenzyme as with those metabolized by the 2D6 isoenzyme. Finally, the vast majority (90.9%) of SSRI patients experiencing concomitant use did so with one CYP 2D6 or 3A4 metabolized medication. In sum, concomitant use was not extensive and did not appear to be differential among the fluoxetine, paroxetine, or sertraline patient comparison groups.

## TARGET AUDIENCE:

Psychiatrists and other prescribers of antidepressants.

## REFERENCES:

1. *Depression in Primary Care: Volumes 1–2*, AHCPR, 1993.
2. Farris KB, et al: Examination of days supply in computerized prescription claims. *J Pharmcoepi*, 2(1), 63–76, 1994.

**Poster 36** **Saturday, October 25 4:00 p.m.-5:30 p.m.**

# NEFAZODONE THERAPY IN REFRACTORY DEPRESSION

Martha Sajatovic, M.D., *Associate Chief of Psychiatry, Department of Psychiatry, Cleveland VA Medical Center, 10000 Brecksville Road, Brecksville, OH 44141*; Sue DiGiovanni, M.D., Matthew Fuller, Pharm.D.

## SUMMARY:

Approximately 30% of depressed patients fail to respond to antidepressant medication. Risk factors for treatment resistance include inadequate pharmacologic treatment, treatment noncompliance, and comorbid psychiatric conditions. This is an analysis of our experience with nefazodone therapy in treatment resistant depression. Documentation of failure with previous antidepressant trial, DSM-IV diagnoses, and completion of a Beck Depression Inventory (BDI) were obtained prior to nefazodone initiation. Follow-up BDI was obtained after at least four weeks of nefazodone therapy. Twenty patients with treatment refractory or intolerant major depression received nefazodone therapy. Mean age of the group was 48.1, SD ± 9.35 years. Psychiatric comorbidity in this group was substantial, with post-traumatic stress disorder (PTSD) found in 11 (55%) patients, substance abuse in three (15%) patients, and personality disorder in two (10%) patients. This group was generally refractory to multiple previous antidepressant regimens. The mean number of previously failed antidepressant trials was 1.9 ± 0.6, range one to three trials. The largest percentage of patients (N=9, 45%) had substantial clinical improvement, defined as greater than 20% improvement on the BDI. A smaller proportion of patients (N= 3, 15%) had more modest improvement, defined as between 10% and 20% improvement on the BDI. There were six patients (30%) with minimal change in clinical status, defined as ± less than 10% change on the BDI. Two patients (10%) discontinued nefazodone due to adverse effects. Nefazodone therapy may be an important therapeutic option for patients with treatment refractory depression. Of particular interest is positive response among individuals with depression and PTSD.

## TARGET AUDIENCE:

Physicians, mental health clinicians.

## REFERENCES:

1. Nierenberg AA, White K: What next? a review of pharmacologic strategies for treatment resistant depression. *Psychopharmacology Bulletin* 26:429–460, 1991.
2. Quitkin FM, McGrath PJ, Stewart JW, et al: Chronological milestones to guide drug change: when should clinicians switch antidepressants? *Archives of General Psychiatry* 53:785–792, 1996.

**Poster 37** **Saturday, October 25 4:00 p.m.-5:30 p.m.**

# ANTIDEPRESSANT USE IN COMMUNITY TREATMENT OF DEPRESSION

JoAnne Sirey, Ph.D., *Department of Psychology in Psychiatry, New York Hospital-Cornell Medical Center, 21 Bloomingdale Road, White Plains, NY 10605-1504*; Barnett S. Meyers, M.D., *Professor of Psychiatry, New York Hospital-Cornell Medical Center, 21 Bloomingdale Road, White Plains, NY 10605*; Martha L. Bruce, Ph.D., M.P.H., Brooke Myers, M.A., Lauren Picone, B.A.

## SUMMARY:

*Objective:* Antidepressants are effective treatments for depression but are underprescribed and underused. This study identifies the demographic and clinical factors

predictive of provider referral for medication and antidepressant use among persons seeking mental health care.

*Methods:* Consecutive admissions to five community mental health clinics were screened for depression with the CES-D. Persons with CES-D<15 were administered the SCID. A total of 98 SCID depressives were reinterviewed three months after intake and information was collected on treatment prescribed and used.

*Results:* A total of 74% of depressed patients were referred for medication evaluation; of those referred, 95% had antidepressants recommended. Depression severity, early morning awakening, and anxiety were significantly associated with referral for medication. Minority status predicted referral such that Hispanic and black patients were less likely to be referred for medication than whites ($p<.005$).

A total of 62% of patients recommended medication took an antidepressant during the follow-up period. Patients who took antidepressant medication had higher levels of psychomotor retardation at intake ($p<.05$), prior antidepressant use ($p<.0001$), and were more likely to be married ($p<.05$). In a logistic regression analysis, the only variable that significantly predicted antidepressant use among those recommended medication was a recent history of antidepressant use.

*Conclusions:* In community mental health settings, different factors contribute to (1) provider referral for antidepressant medication, and (2) medication use among individuals with depression. Sociodemographic and clinical patient characteristics influence medication treatment planning and patient use of antidepressants.

## REFERENCES:

1. Hirschfeld R, et al: *The National Depressive and Manic-Depressive Association Consensus Statement on the Undertreatment of Depression.*
2. Kell MB, et al: Low levels and lack of predictors of somatotherapy and psychotherapy received by depressed patients. *Arch Gen Psychiatry,* 43:458–466, 1996.

**Poster 38** **Saturday, October 25 4:00 p.m.-5:30 p.m.**

## PATIENT AND SERVICE USE PREDICTORS OF RECOVERY FROM DEPRESSION

JoAnne Sirey, Ph.D., *Department of Psychology in Psychiatry, New York Hospital-Cornell Medical Center, 21 Bloomingdale Road, White Plains, NY 10605-1504*; Barnett S. Meyers, M.D., *Professor of Psychiatry, New York Hospital-Cornell Medical Center, 21 Bloomingdale Road, White Plains, NY 10605-1504*; Martha L. Bruce, Ph.D., M.P.H., Patrick J. Raue, Ph.D., Claire Mackay, B.A.

## SUMMARY:

*Objective:* Predictors of early recovery can guide and promote effective treatment in community settings. This study investigated patient sociodemographic, clinical characteristics, and service use associated with improvement.

*Method:* A total of 98 SCID-diagnosed depressives seeking treatment at five outpatient mental health clinics were evaluated at intake and reassessed three months later. Treatment with medication and service utilization were recorded. Recovery was defined as the absence of *DSM-IV* criteria for MDD at follow-up.

*Results:* Three months after intake, 54% of patients met recovery criteria. Improvement was associated with being employed, married, and better educated. Although only weakly related to severity of depression, nonrecovery was associated with anxiety, suicidal ideation, and concurrent dysthymia. Medication treatment per se was not related to recovery; however, patients with psychomotor retardation were more likely to take medication and show early recovery. Patients who recovered did not use more outpatient services, but service use prior to intake and adherence to nonmedication regimen was associated with recovery.

*Conclusion:* Recovery from depression is predicted by a complex relationship among psychosocial factors, clinical characteristics, and service utilization. Level of functioning and symptom profile can identify patients at community clinics who may recover quickly. Previous service use and adherence are associated with improvement. Future work will further pursue the interaction of patient and treatment predictors of early recovery.

## REFERENCES:

1. Keller MB, et al: Time to recovery, chronicity, and levels of psychopathology in major depression. *Arch Gen Psychiatry,* 49:809–816, 1992.
2. Wells B, et al: The course of depression in adult outpatients. *Arch Gen Psychiatry* 49:788–794, 1992.

**Poster 39** **Saturday, October 25 4:00 p.m.-5:30 p.m.**

## MOOD STABILIZER COMBINATIONS: A REVIEW OF SAFETY AND EFFICACY

Marlene P. Freeman, M.D., *Department of Psychiatry, Brigham and Women's Hospital, 221 Longwood Avenue, 4th Floor, Boston, MA 02115;* Andrew L. Stoll, M.D.

## SUMMARY:

*Objective:* Polypharmacy is common in the treatment of refractory bipolar disorder. The purpose of this poster

is to review the safety and efficacy of mood stabilizers in combinations.

*Method:* A manual and computer (Medline) search was performed for combinations of the most commonly used mood stabilizing agents.

*Results:* Safety and efficacy data are reviewed regarding the more frequently encountered combinations of established and putative mood stabilizers.

*Conclusions:* There are few controlled data on the use of combinations of mood stabilizers. However, mood stabilizer polypharmacy is standard practice in many centers. Based mainly on open-label data, the safest and most effective mood stabilizer combinations appear to be the mixtures of anticonvulsants and lithium, particularly valproate and lithium. As described, the interactions of combinations of mood stabilizers are sometimes complex, often useful, and potentially dangerous. More systematic and controlled studies are indicated in the use of polypharmacy in bipolar disorder.

## TARGET AUDIENCE:

Psychiatrists.

## REFERENCES:

1. The Expert Consensus Guideline Series, Treatment of Bipolar Disorder. Steering committee: Frances A, Doherty J, Kahn D. *J Clin Psych* 57(suppl 12):48, 1996.
2. Schaff M, Fawcett J, Zajecka J: Divalproex sodium in the treatment of refractory affective disorders. *J Clin Psych* 54:380–84, 1993.

**Poster 40** **Saturday, October 25 4:00 p.m.-5:30 p.m.**

## PERSONALITY AND SSRI TREATMENT

Lee A. Kelley, M.D., *Assistant Professor of Psychiatry, Department of Psychiatry, University of Missouri, 1 Hospital Drive, Columbia, MO 65212*; Marian Hjelmfelt, Ph.D., R.N., Arthur Goodwin, M.A.

## SUMMARY:

*Introduction:* A growing body of evidence suggests some patients report personality changes following treatment with psychotropic medications. Previous studies have not addressed treatment with selective serotonin reuptake inhibitors (SSRI's).

*Purpose:* To determine the kinds of personality changes that may occur with SSRI treatment.

*Hypothesis:* Patients receiving SSRI's would show decreases on personality disorder scales and would exhibit increased extroversion and change-oriented personality characteristics.

*Method:* 31 students receiving SSRI treatment for various mental health problems at a university student clinic completed the Millon Clinical Multiaxial Inventory-III (MCMI-III) and the Personality Styles Inventory (PSI) prior to SSRI treatment, and again after two months and four months of treatment. A comparison group of 23 student volunteers completed the same inventories at baseline, two months, and four months.

*Results:* Compared with the volunteers, the SSRI group showed statistically significant decreases on a number of MCMI-III personality scales and significant increases on histrionic and narcissistic scales. On the PSI, the SSRI group showed a trend toward increased extroversion but did not become more change-oriented over time.

*Conclusions:* The benefits of SSRI's may extend beyond treatment of Axis I disorders, possibly changing our view of personality and treatment approaches.

## REFERENCES:

1. Bronisch T, Klerman GL: Personality functioning. *Journal of Personality Disorders,* 5:307–317, 1991.
2. Cornelius JR, et al: A preliminary trial of fluoxetine. *Journal of Clinical Psychopharmacology,* 11:116–120, 1991.

**Poster 41** **Saturday, October 25 4:00 p.m.-5:30 p.m.**

## PERSONALITY TRAITS AND PREMATURE TERMINATION FROM MEDICATION TREATMENT STUDIES

Lee A. Kelley, M.D., *Assistant Professor of Psychiatry, Department of Psychiatry, University of Missouri, 1 Hospital Drive, Columbia, MO 65212*; Marian Hjelmfelt, Ph.D., R.N., Arthur Goodwin, M.A.

## SUMMARY:

Dropout from medication treatment studies is common (about 50%). Few studies have investigated patient characteristics contributing to dropout. This study examined the contribution of personality factors to patient dropout from a medication treatment study.

Participants were 61 patients receiving selective serotonin reuptake inhibitor (SSRI) treatment for various psychiatric disorders at a university student health center. Patients were to complete the Millon Clinical Multiaxial Inventory-III (MCMI-III), a self-report inventory of 14 personality and 10 syndrome scales, at three points: prior to beginning treatment (Time 1), after two months of treatment (Time 2), and after four months (Time 3) of treatment. Thirty patients (49%) did not return for one or both of the follow-up assessments. Baseline scores of completers, compared with those of dropouts (using t-test), showed significantly higher (more pathological) scores for dropouts on dependent,

antisocial, aggressive, passive-aggressive, schizotypal, borderline, and paranoid scales, and lower scores on the compulsive scale. Dropouts were more likely (on chi-square analysis) to be diagnosed with dependent, passive-aggressive, or borderline personality disorder. They scored higher on several syndrome (Axis I) scales.

These findings, although exploratory, suggest the MCMI-III may be a useful tool for identifying patients at high risk for premature termination in studies and possibly from pharmacotherapy as well.

## REFERENCES:

1. Millon T: *MCMI-III Manual.* Minneapolis, MN: National Computer Systems, 1994.
2. Libb JW, et al: Personality disorder among depressed outpatients. *Journal of Clinical Psychology,* 46:277–284, 1990.

**Poster 42** **Saturday, October 25 4:00 p.m.-5:30 p.m.**

## OUTCOMES OF HOUSING IN PERSONS WITH MENTAL ILLNESS AND SUBSTANCE USE DISORDERS

Niamh M. Holohan, M.D., *Department of Psychiatry, University of Maryland, 1833 Gramercy Place, Hummelstown, PA 17036*; Lisa B. Dixon, M.D., M.P.H., *Associate Professor of Psychiatry, Center for Mental Health Services Research, University of Maryland, 645 West Redwood Street, Baltimore, MD 21201*; Nancy Krauss, L.C.S.W.

## SUMMARY:

*Objectives:* This study assessed the impact of dual diagnosis (DD) of substance use on housing outcomes in persons with severe mental illness (SMI) receiving Assertive Community Treatment (ACT).

*Methods:* Clinical staff recorded each patient's nightly housing location and reasons for moves in 70 ACT patients. DD and non-DD patients were compared on total and quarterly summaries of number and types of housing moves and locations.

*Results:* DD patients had significantly more total moves ($p<0.05$) and more moves in the first ($p<0.05$) and second ($p<0.02$), but not third and fourth quarters. Moves for DD patients were less likely to be in the direction of permanent housing ($p<0.05$). DD patients spent more days on the street ($p<0.05$) but did not differ from non-DD patients in other types of housing used. Moves for DD patients were more likely to originate or end in independent community settings.

*Conclusions:* A baseline substance abuse disorder had an adverse impact on housing stability, but this effect seemed to diminish with time and treatment with ACT.

## TARGET AUDIENCE:

General.

## REFERENCES:

1. Stein LI, Test MA: Alternative to mental hospital treatment: I. conceptual model, treatment program and clinical evaluation. *Archives of General Psychiatry* 37:392–397, 1980.
2. *Making A Difference: Interim Report of the McKinney Demonstration Program for Homeless Adults with Serious Mental Illness*, Center for Mental Health Services, DHHS Publication No. 94-3014.

**Poster 43** **Saturday, October 25 4:00 p.m.-5:30 p.m.**

## CLIENT SATISFACTION ON AN ASIAN-FOCUS INPATIENT UNIT

Kenneth K. Gee, M.D., *Assistant Clinical Professor of Psychiatry, Department of Psychiatry, University of California at San Francisco, 1001 Potrero Avenue, San Francisco, CA 94110*; Francis G. Lu, M.D., *Clinical Professor of Psychiatry, Department of Psychiatry, University of California at San Francisco, 1001 Potrero Avenue, San Francisco, CA 94110-3518*; Amy Y. Zhang, Ph.D., Cecile Schwanke, M.S.N.

## SUMMARY:

Language match between therapists and patients is a crucial factor for improving treatment outcome among minority patients. This study examined how language match affected severely mentally ill patients' satisfaction with a culturally focused inpatient psychiatric program: the Asian Focus Inpatient Unit at San Francisco General Hospital, which specializes in treating Asian or Asian-American patients. Its staff are predominately Asians or Asian-Americans who speak 10 Asian languages or dialects of Chinese. The study examined 36 Chinese inpatients, most of whom were diagnosed with either severe psychotic or mood disorders. A client satisfaction questionnaire developed on the unit was administered by a research staff. Twenty-seven subjects were identified as Chinese speakers while nine subjects were English speaking. Descriptive statistics were obtained for patients' responses from each language group. Our results showed that a higher percentage of Chinese-speaking patients than English-speaking patients felt it helpful to interact with Chinese staff (89% versus 33%) or with Asian staff (81.5% versus 44%); considered Chinese staff helpful because they spoke the patients' language

(93% versus 67%); understood the patients' culture (100% versus 44%); or showed respect to the patients (92.6% versus 67%).

## REFERENCES:

1. Lee E, (ed.): *Clinical Care of Asian Americans.* New York: Guilford, in press.
2. Uba L: *Asian Americans.* New York: Guilford, 1994.

**Poster 44** **Saturday, October 25 4:00 p.m.-5:30 p.m.**

## EFFECT OF FLUOXETINE ON INTERPERSONAL SENSITIVITY IN DEPRESSED OUTPATIENTS

Paul Sandor, M.D., *Department of Psychiatry, The Toronto Hospital, 399 Bathurst Street, Toronto, ONT, Canada M5T 2S8*; Brian Baker, M.D., David Newman, M.D.

## SUMMARY:

*Objective:* Fluoxetine is the most widely prescribed antidepressant. There has been speculation that it could affect personality, but besides aggression and impulsivity, this has not been systematically evaluated.

*Method:* In a randomized, double-blind, parallel group, six-week study, patients diagnosed with major depressive disorder (MDD) by independent SCID, after one week placebo, received fluoxetine or doxepin; mood was reassessed every two weeks (in a reported cardiac study) by HAM-D, Montgomery Asberg, Beck Depression Inventory, and Symptom Checklist 90R(SCL90R).

*Results:* 39 patients were available for analysis; there was complete data for 36. Patients on fluoxetine (N= 20) (mean daily dose 37 ± 18 mg) were similar to those on doxepin (N=19) (169 ± 42 mg) on demographic variables and all scales and SCL-90R subscales. The only difference in drug effect was in the Interpersonal Sensitivity subscale of the SCL-90R, where the magnitude of improvement over time was greater for fluoxetine than doxepin ($p<.02$). Internal consistency measures of the subscale revealed Cronbach's alpha values ranging from 0.73 to 0.81.

*Conclusion:* Interpersonal sensitivity may be more positively affected by fluoxetine than doxepin in outpatients with MDD, but more extensive investigation is required.

## TARGET AUDIENCE:

Psychiatrists, psychologists, social workers.

## REFERENCES:

1. Derogatis L: *The SCL90R Administration, Scoring and Procedures Manual II,* Towson MD, Clinical Psychometric Research, 1983.
2. Gram LF: Fluoxetine. *N Engl J Med* 1994; 881, 1354–61.

**Poster 45** **Saturday, October 25 4:00 p.m.-5:30 p.m.**

## ANGER ATTACKS IN FRENCH DEPRESSED PATIENTS

Pauline Morand, M.D., *Department of Psychiatry, Paris 6 University, 84 Rue Du FBG St, Antoine, Paris, France 75012*; Guy Thomas, Ph.D., *Department of Psychiatry, Paris 6 University, 84 Rue Du FBG St, Antoine, Paris, France 75012*; Roland Jouvent, Ph.D., Maurice Ferreri, M.D.

## SUMMARY:

The occurrence of anger attacks in depressed patients was first investigated by Fava and coworkers, who developed a self-rating evaluation instrument, the Anger Attacks Questionnaire. Here, we present the results of a study conducted on 103 depressed French patients who were evaluated with a French translation of the Anger Attacks Questionnaire. The prevalence of anger attacks during the previous month was 46.7%, and the most frequently reported symptoms were feeling of panic (85.1%), tachycardia (83.7%), and feeling out of control (81.3%). Anger attacks were not significantly associated with either age, gender, severity of depression or anxiety, history of suicidal attempts, or mood disorder, but were significantly related to loss of control. Interestingly, a significant association was also observed with history of panic attacks—while not reported previously, this association is striking in the light of Fava's early hypothesis that anger attacks might be a variant of panic attacks.

Three-week treatment with serotoninergic antidepressants induced a significant decrease in prevalence of anger attacks. Overall, our findings are in close agreement with those of Fava and coworkers, thus confirming the clinical relevance of anger attacks in depressed patients.

## REFERENCES:

1. Fava M, et al: *Am J Psychiatry* 1990; 147:867–870.
2. Fava M, et al: *Am J Psychiatry* 1993; 150:1158–1163.

**Poster 46** **Saturday, October 25**
**4:00 p.m.-5:30 p.m.**

## A DOUBLE-BLIND COMPARISON OF INTRAVENOUS INFUSION OF CITALOPRAM AND VILOXAZINE IN THE TREATMENT OF SEVERE DEPRESSION

Charles Flicker, Ph.D., *Senior Medical Director, Forest Laboratories, 909 Third Avenue, New York, NY 10022*

### SUMMARY:

Antidepressant efficacy and tolerability of citalopram (n=30) and viloxazine (n=32) were compared under double-blind conditions during the first two weeks of treatment with slow drop infusion, followed by oral administration for the rest of the six-week trial period.

The 62 severely depressed and hospitalized patients included in the intention-to-treat analysis had a mean age of 45 years (range 23 to 70 years). About two thirds of the patients were female. Baseline mean MADRS total score was 34 in both groups. After 14 days of infusion, the MADRS total score had decreased to 12.3 in the citalopram group and to 16.9 in the viloxazine group, a significant difference ($p<0.05$). On day 42 (end point), the scores had dropped to 6.7 in the citalopram group and to 13.1 in the viloxazine group, ($p<0.05$). The Clinical Global Improvement score revealed a significantly greater improvement ($p<0.05$) in the citalopram group as early as day 7 of double-blind treatment.

Analysis of treatment-emergent adverse events based on the UKU scale showed a significantly ($p<0.05$) higher frequency of constipation at study end in the viloxazine group than in the citalopram group. Nausea was reported more frequently in the viloxazine group on day 14, whereas weight gain and difficulty in concentration were reported more frequently in the citalopram group on day 21 and day 7, respectively. Standard laboratory investigations and ECG analyses did not show clinically relevant abnormalities. In summary, relative to the viloxazine active control group, this study demonstrated the antidepressant efficacy of a two-week infusion of citalopram and of a six-week combined intravenous and oral regimen in the treatment of severe depression. The results support the conclusion that antidepressant treatment with citalopram infusion followed by oral citalopram may be more efficacious than a corresponding treatment schedule with viloxazine.

### TARGET AUDIENCE:

Psychiatrists.

### REFERENCES:

1. Baldwin DS, Johnson FN: Tolerability and safety of citalopram. *Rev Contemp Pharmacother* 1995; 6:315–325.
2. Bech P, Ciadella P: Citalopram in depression: meta-analysis of intended and unintended effects. *Int Clin Psychopharmacol* 1992; 6(suppl 5):45–54.

**Poster 47** **Saturday, October 25**
**4:00 p.m.-5:30 p.m.**

## A DOUBLE-BLIND COMPARISON OF INTRAVENOUS AND ORAL CITALOPRAM IN THE TREATMENT OF INPATIENT DEPRESSION

Charles Flicker, Ph.D., *Senior Medical Director, Forest Laboratories, 909 Third Avenue, New York, NY 10022*

### SUMMARY:

Antidepressant efficacy and tolerability of identical doses of citalopram (40 mg/day), administered for 10 days as either once-daily tablets or slow drop infusions over two hours, were compared under double-blind (double-dummy) conditions. All patients then received orally administered citalopram tablets for the remainder of the six-week treatment period.

Sixty moderately to severely depressed and hospitalized patients were included in this study (42 females, 18 males; average age 43 years). Total 17-item HAMD scores at baseline were 23.9 and 23.6 in the infusion (n=30) and tablet (n=30) groups, respectively. There was a trend toward a more rapid onset of action in the infusion group, as evidenced by a decrease of 6.3 points on the HAMD in the infusion group at day 7 compared with a 4.3 point improvement in the tablet group. This difference was not significant. At day 11 of double-blind treatment, 50% of the citalopram infusion patients were classified as responders on the CGI global improvement score (much or very much improved) as compared with 36.7% of the citalopram tablet patients. After six weeks of treatment, when all patients had received 32 days of citalopram tablets, the responder rate on the CGI was 73% in both treatment groups.

No clinically relevant group differences were seen with regard to adverse events, vital signs, laboratory data, and a series of ECG parameters.

It is concluded that the risk/benefit relationship of the slow drop infusion of citalopram is as favorable as that of oral citalopram. In spite of the limited sample size studied, the results suggest that, relative to oral citalopram treatment, the intravenous infusion of citalopram may produce a more rapid onset of efficacy in depressed inpatients.

### TARGET AUDIENCE:

Psychiatrists.

### REFERENCES:

1. Baumann P, Larsen F: The pharmacokinetics of citalopram. *Rev Contemp Pharmacother* 1995; 6:287–295.

2. Baumann P, Nil R, Souche A, et al: A double-blind, placebo-controlled study of citalopram with and without lithium in the treatment of therapy-resistant depressive patients: a clinical pharmacokinetic and pharmacogenetic investigation. *J Clin Psychopharmacol* 1996; 16:307–314.

**Poster 48** **Saturday, October 25 4:00 p.m.-5:30 p.m.**

## DEPRESSION IN CHRONIC PSYCHIATRIC PATIENTS

Faiq A. Hameedi, M.D., *Assistant Professor of Psychiatry, Yale School of Medicine, 34 Park Street, New Haven, CT 06519*; Lewis Greenley, M.D., *Medical Director, Bronx Mental Health Center, 3600 Jerome Avenue, Bronx, NY 10467*; Edward McGrew, Vijay Laxmi, M.D., Ellen Singer, Ph.D., Naveed Iqbal, M.D.

### SUMMARY:

The prevalence of depression is high in psychiatric patients. The presence of depressive symptomatology in these patients leads to significant morbidity and mortality. The role of pharmacotherapy in the treatment of these symptoms is limited by patients' noncompliance with medication, inadequate symptom relief, and potential for side effects, leading to continuation of these symptoms.

We administered the Zung Depression Rating Scale (ZDRS) to 146 chronic psychiatric patients carrying an Axis I diagnosis of either schizophrenia (n=62), schizoaffective disorder (n=19), bipolar disorder (n=13), depression (n=17), or other chronic psychiatric disorders (n=8) in a continuing day treatment (CDT) program. A preliminary analysis of the data from the 119 patients who completed the survey reveals that symptoms of depression were in the minimal range (mean SDS Index= 51) on the ZDRS; six patients (5%) had significant suicidal ideation, which is less than the prevalence of suicidal ideation in chronic schizophrenic and medical patients treated in an outpatient setting. While there were no statistically significant differences between patients in each of the diagnostic categories on their overall ZDRS scores, significant differences were found in suicidal ideation and feelings of tiredness between older (age 40–77, n=65) and younger (age 18–39, n=42) patients in all five diagnostic categories. There were also significant differences between these age and diagnostic groups in responses to questions related to insomnia and decision making.

### REFERENCES:

1. Zung WW: A self-rating depression scale. *Am J Psychiatry*. 1965; 12:63–65.
2. Rendon MI, Akbar MM, Hameedi FA: Depression in Medical Outpatients in a City Hospital. Presented at the American Psychiatric Association Annual Meeting, 1996.

**Poster 49** **Saturday, October 25 4:00 p.m.-5:30 p.m.**

## EFFICACY OF VENLAFAXINE IN BIPOLAR II DEPRESSION

Jay D. Amsterdam, M.D., *Professor of Psychiatry, University of Pennsylvania, 3600 Market Street, DRU, 8th Floor, Philadelphia, PA 19104*; Mary B. Hooper, B.S., *Senior Research Coordinator, Department of Psychiatry, University of Pennsylvania, 3600 Market Street, DRU, 8th Floor, Philadelphia, PA 19104*

### SUMMARY:

Guidelines for selecting antidepressant treatment for bipolar (BP) major depressive episode (MDE) have not been well established. In a double-blind, six-week, once (QD) vs. twice (BID) daily-dosing study, we examined efficacy and safety of venlafaxine in 17 BP type-II (41 ± 14 yrs) vs. 31 unipolar (UP) (45 ± 14 yrs) MDE patients with a pretreatment HAM-$D_{21}$ ≥20.

*Methods:* Venlafaxine was given QD (entire dose in a.m.; placebo in p.m.) or BID (half dose in a.m. and in p.m.) starting at 37.5mg/d and increased to 225mg/d.

*Results:* Using intent-to-treat analysis, we observed a similar reduction in mean weekly HAM-$D_{21}$ scores in BP and UP patients by week 6 (BP – 10 ± 8 vs. UP – 11 ± 7) (p=ns). BP patients had a slightly more rapid onset of efficacy by week 2 (p=0.07). Two BP vs. nine UP patients stopped treatment for adverse events or other reasons. None demonstrated a "manic switch" during treatment.

*Conclusion:* Venlafaxine may be an effective treatment for BP type-II MDE with a low "manic switch" rate.

### REFERENCES:

1. Kupfer D, et al: Possible role of antidepressants in precipitating mania and hypomania in recurrent depression. *Am J Psychiatry* 1988; 145:804–808.
2. Howland RT: Induction of mania with serotonin reuptake inhibitors. *J Clin Psychopharmacol.* 1996; 16:425– 427.

**Poster 50** **Sunday, October 26 10:00 a.m.-11:30 a.m.**

## SEXUAL AND RACIAL DISCRIMINATION IN THE ARMY

Mary B. Cruser, M.D., *Department of Psychiatry, Eisenhower Army Medical Center, Fort Gordon, GA 30905*; Elizabeth E. Correnti, M.D., Laura Davidson, Ph.D.

## SUMMARY:

*Objective:* This study of career soldiers stationed at two major Army bases assessed how service members who have served at least ten years on active duty perceive sexual and racial discrimination in the military.

*Method:* Questionnaires were distributed to 400 subjects who agreed to participate in a comprehensive survey of attitudes and military experiences. Equal numbers of men and women were enrolled and 248 returned the questionnaires. Subjects discussed personal experiences of sexual and racial discrimination and responded to questions regarding their perceptions of how much of a problem these are for the military. A subgroup of participants were interviewed by the researchers.

*Results:* Racial discrimination was reported by 20% of the sample; 35% of non-Caucasians reported it and 10% of white subjects felt they had experienced reverse discrimination. Sexual discrimination was reported by 33% of the women; 49% said they had been sexually harassed. Men, regardless of race, were evenly divided as to whether sexual or racial discrimination was the larger problem for the military. Nonwhite women reported that racial discrimination was a greater problem than sexual discrimination, but white women reported the opposite.

*Conclusion:* Career soldiers feel racial and sexual discrimination to be significant problems for the Army; race and gender influence their perceptions.

## REFERENCES:

1. Murdoch M, Nichol KL: Women veterans' experiences with domestic violence and with sexual harassment while in the military. *Archives of Family Medicine,* 1995; 4(5):411–8.
2. Shrier DK: Sexual harassment and discrimination: impact on physical and mental health. *New Jersey Medicine,* 1990; 87(2):105–107.

**Poster 51** **Sunday, October 26**
**10:00 a.m.-11:30 a.m.**

## VIOLENT THREATS BY COMMUNITY PSYCHIATRY PATIENTS

Gerard Gallucci, M.D., *Assistant Professor and Director of Creative Alternatives, Department of Psychiatry, Johns Hopkins Bayview Medical Center, 4940 Eastern Avenue, MFL Building, Baltimore, MD 21224-4304;* Sheila Seltzer, M.S.W., *Manager, Adult Outpatient Services, Johns Hopkins Bayview Medical Center, 4940 Eastern Avenue, MFL Building, Baltimore, MD 21224-4304*

## SUMMARY:

Violence in health care settings has been increasing at an alarming rate. Marge et al. noted that the highest rate of increase for violence in the workplace occurs in health care environments and that 86% of assaults are committed by patients.

The same authors note that risk factors for violence in the work setting include poor socioeconomic status, a reduction of available mental health services, and more severely ill patients living in the community. Public psychiatry clinics are most vulnerable to these problems given the demographic characteristics of the population served, the severity of symptoms experienced by patients, and the reduction of resources available for treatment.

The Johns Hopkins Bayview Community Psychiatry Program has reviewed the literature regarding violence in the workplace and has examined situations involving patient threat of violence in the community psychiatry clinic. The moral and legal issues associated with managing the violent patient will be discussed.

## REFERENCES:

1. Marge DK, Marge M: *Preventing Workplace Violence in Health Care Settings: Reference Manual* Safetynet International, Inc., March 1997.
2. Center for Healthcare Environmental Management. *Special Report: Developing a Violence Prevention program: a Guide for Healthcare Workers.* ECRI, 1997.

**Poster 52** **Sunday, October 26**
**10:00 a.m.-11:30 a.m.**

## SOLUTION-FOCUSED GROUPS IN A COMMUNITY MENTAL HEALTH CENTER SETTING

Daniel L. Buccino, M.S.W., *Clinical Social Worker, Department of Psychiatry, Johns Hopkins Bayview, 4940 Eastern Avenue, Baltimore, MD 21224-2780;* Karen L. Kaufman, M.S.W., *Clinical Social Worker, Department of Psychiatry, Johns Hopkins Bayview, 4940 Eastern Avenue, Baltimore, MD 21224-2780;* Gerard Gallucci, M.D.

## SUMMARY:

The Community Psychiatry Program at the Johns Hopkins Bayview Medical Center, a large, urban, teaching-hospital-based CMHC, has established a set of "Solutions" group therapy options for CMI patients at various stages on its continuum of care from partial hospital to regular outpatient. This descriptive study discusses the solution-focused treatment model and the successes in implementing these groups.

The Solutions groups are open, heterogeneous, ongoing, partially didactic, and seek to capitalize on patient strengths and goals. The groups have proven to be suc-

cessful in increasing group attendance (400% above clinic average), reducing utilization of inpatient and other treatment resources (only three readmits in 18 months), facilitating entry into other cost-effective group treatment settings, reducing payor cost, reducing staffing and no-show rates, expanding availability to high-risk/high-cost patients, and increasing positive outcome and planned discharge into work and/or more stable housing arrangements (800% above clinic average optimal outcome at discharge).

Solutions groups consolidate treatment options for maximal therapeutic sufficiency and time- and cost-effectiveness.

## TARGET AUDIENCE:

Clinicians, administrators.

## REFERENCES:

1. Miller SD, Hubble MA, Duncan BL (eds.): *Handbook of Solution-Focused Brief Therapy.* SF: Jossey-Bass, 1996.
2. Vaughn K, Hastings-Guerrero S, Kassner C: Solution-oriented inpatient group therapy. *J Systemic Therapies,* 1996.

**Poster 53** **Sunday, October 26**
**10:00 a.m.-11:30 a.m.**

## MEASURING CUSTOMER SATISFACTION AND GROUP LEADER SKILLS IN PSYCHOEDUCATIONAL GROUPS

Joseph D. Hamilton, M.D., *Chief, Psychiatry Service, Houston VA Medical Center, 2002 Holcombe Boulevard, Houston, TX 77030-3411*; Travis J. Courville, M.S.W., *Social Work Manager, Department of Social Work, VA Medical Center, 3810 West Valley, Missouri City, TX 77459*; Connie Swanson, R.N., Phillip Hanson, Ph.D., Joseph D. Hamilton, M.D., Chris C. Tokunaga, M.D., Sue Bailey, Ph.D., Joanne Clancy

## SUMMARY:

Measuring customers' satisfaction and therapists' skill level is part of the performance improvement of both process-oriented and educational group therapies at Houston VA Medical Center. Using methods analogous to the authors' previous study of process-oriented groups, an interdisciplinary team of educational and group experts constructed a seven-point Educational Group Rating Scale to directly observe selected educational group leaders twice. Leaders were rated on nine behavioral categories considered effective for educating participants in a group setting. After each observation, group members completed an Educational Group Satisfaction Survey and the leader completed a Leader Self-Report Survey, measuring the same items rated by the observers. These instruments permitted us to quantitatively assess and compare meaningful dimensions of mental health education from the vantage points of the group leader, the group members, and an outside observer. We also studied interrater reliability of the observer instrument. Our data show that (1) group leaders' performance improves during the second observation, after educational feedback from the observer immediately following the first observation, and (2) customer satisfaction has increased over several years. Our inexpensive methods can contribute to outcome measures for managed care organizations and to staff competency measures for meeting JCAHO standards.

## TARGET AUDIENCE:

Mental health staff overseeing or conducting psychoeducational groups.

## REFERENCES:

1. Hamilton JD, Courville TJ, Richman B, et al: Quality assessment and improvement in group psychotherapy. *Am J Psychiatry* 1993; 150:316–320.
2. Fuhriman A, Burlingame G: *Handbook of Group Psychotherapy: An Empirical and Clinical Synthesis.* New York, Wiley, 1994.

**Poster 54** **Sunday, October 26**
**10:00 a.m.-11:30 a.m.**

## DIFFERENCES BETWEEN RELATIVES' GROUPS ON ACUTE PSYCHIATRIC WARDS AND IN A DAY HOSPITAL

Johann Windhaber, M.D., *Psychiatrist in Training, Department of Psychiatry, University of Vienna, Waehringer Guertel 18-20, Vienna, Austria 1090*; Michaela Amering, M.D., *Assistant Professor of Psychiatry, University of Vienna, Waehringer Guertel 18-20, Vienna, Austria 1090*; Heinz Katschnig, M.D.

## SUMMARY:

*Purpose:* The purpose of this study is to show the differences between relatives' groups on acute psychiatric wards and in a day hospital.

*Methodology:* Over a two-year period relatives' groups were run on two acute psychiatric wards and in a day hospital. For each of the 242 group sessions several variables were recorded.

*Results:* A total of 566 attendences were recorded for 127 group sessions on the two acute wards (on an average 3.6 attenders/group), and 453 attendences for 86 group sessions in the day hospital (on an average 5.3 attenders/group). In the day hospital there was a clear preponderance of mothers (mothers 64.0%, partners 5.7% of all

attenders), on the acute wards the distribution among different types of family members was more even (mothers 32.7%, partners 28.3% of all attenders). Relatives on acute wards were much more interested in information about the illness; relatives in the day hospital were more interested in information about treatment in a broad sense.

*Discussion:* The importance of this study is that the motivation to attend and to cooperate in relatives' groups is less pronounced in the early stages of a psychiatric disorder than in the later ones.

## TARGET AUDIENCE:

Psychiatric nurses, psychiatrists, relatives, social workers.

## REFERENCES:

1. Kuipers L, Bebbington P: Relatives as a resource in the treatment of functional illness. *Br J Psychiatry* 1985; 141:465–470.
2. Miklowitz DJ, Goldstein MJ, Nuechterlein KH, et al: Family factors and the course of bipolar affective disorder. *Arch Gen Psychiatry* 1988; 45:225–231.

**Poster 55** **Sunday, October 26**
**10:00 a.m.-11:30 a.m.**

## PSYCHIATRIC WILLS OF PSYCHIATRIC PROFESSIONALS

Michaela Amering, M.D., *Assistant Professor of Psychiatry, University of Vienna, Waehringer Guertel 18-20, Vienna, Austria 1090*; Elisabeth Denk, M.D., *Assistant Professor of Psychiatry, University of Vienna, Waehringer Guertel 18-20, Vienna, Austria 1090*; Hemma Griengl, M.D., Ingrid Sibitz, M.D.

## SUMMARY:

*Objectives:* Psychiatric wills, as suggested by Thomas Szasz, are advanced directives for a possible future involuntary treatment in psychiatry. We attempted to find out about psychiatric professionals' knowledge about and attitude toward this legal possibility and their own formulation of advanced directives for themselves.

*Method:* 101 psychiatric nurses and psychiatrists at the department of psychiatry of the University of Vienna answered questions about knowledge about and attitude toward psychiatric wills and drafted anonymously psychiatric wills with advanced directives describing terms of rejections and requests concerning psychiatric treatment.

*Results:* 55% knew about the legal possibilities, and 70% considered it to be an important issue in terms of patients' rights and autonomy. Concerning their own psychiatric wills, findings include: 77% refused specific methods of therapy, e.g., 30% refused neuroleptic treatment for themselves, 46% refused ECT.

*Conclusions:* Although there is little experience so far with psychiatric wills of patients, there is an interest and a mostly positive attitude toward this legal possibility among psychiatric professionals. A considerable proportion of psychiatric professionals would consider some of the strategies for themselves, but would refuse some common treatments.

## REFERENCES:

1. Szasz TS: The psychiatric will: a new mechanism for protecting persons against "psychosis" and psychiatry. *American Psychologist,* 1982; 37:762–770.
2. Rosenson MK, Kasten AM: Another view of autonomy: arranging for consent in advance. *Schizophrenia Bulletin,* 1991; 17:1–7.

**Poster 56** **Sunday, October 26**
**10:00 a.m.-11:30 a.m.**

## TELEPSYCHIATRY IN THE DIAGNOSIS OF MENTAL ILLNESS

Paul E. Ruskin, M.D., *Assistant Chief of Psychiatry Services, Department of Psychiatry, Baltimore Veterans Affairs Medical Center, 10 North Greene Street, Baltimore, MD 21201*; Susan Reed, M.S.N., *Coordinator, Mood Disorders Clinic, Department of Psychiatry, Baltimore VA Medical Center, 10 North Greene Street, Baltimore, MD 21201*; Ramesh Kumar, M.D., Mitchel Kling, M.D., Eliot Siegel, M.D., Mitchell Rosen, M.D., Peter Hauser, M.D.

## SUMMARY:

Telemedicine is one means of providing expert medical care to patients at a distance from the source of care. In order to utilize this new technology in psychiatry, it must be demonstrated that psychiatric diagnosis and treatment conducted "remotely" via telecommunications is as reliable and effective as diagnosis and treatment conducted "live." The purpose of this pilot study is to demonstrate that psychiatric diagnosis can be reliably carried out "remotely" via telecommunications.

Two trained interviewers each interviewed 30 psychiatric inpatients using the Structured Clinical Interview for *DSM-III-R* (SCID-III-R). Subjects were assigned to have either two "live," in-person interviews ("live"-"live" condition: 15 subjects), or one "live" and one "remote" interview via telecommunications ("live"-"remote" condition: 15 subjects).

Inter-rater reliability was calculated for the four most common diagnoses: major depression, bipolar illness, panic disorder, and alcohol dependence. For each of the four diagnoses, inter-rater reliability (Kappa) was

identical or almost identical for the "live"-"remote" as the "live"-"live" condition:

| | *Live-Live (N = 15)* | *Live-Remote (N = 15)* |
|---|---|---|
| Major Depression | .73 | .70 |
| Alcohol Dependence | .86 | .86 |
| Bipolar | .76 | .81 |
| Panic Disorder | 1.0 | 1.0 |

Finally, based on a patient satisfaction scale we developed for this pilot study, patient satisfaction was as high for the "remote" as the "live" condition.

## TARGET AUDIENCE:

Psychiatrists and other mental health professionals.

## REFERENCES:

1. Bradham DD, Morgan S, Dailey ME: The information superhighway and telemedicine: applications, status and issues. *Wake Forest Law Review* 1995; 30:145–166.
2. Spitzer RL: Structured Clinical Interview for DSM-III-R-Patient Edition (With Psychotic Screen), Washington, DC, American Psychiatric Press Inc., 1990.

**Poster 57** **Sunday, October 26 10:00 a.m.-11:30 a.m.**

## USE OF OLANZAPINE BY INNER CITY MOBILE OUTREACH CLIENTS: REASONS FOR USE AND OUTCOMES

David M. Band, M.D., *Director, Mobile Community Outreach Treatment Team Program, 7101 Sycamore Avenue, Takoma Park, MD 20912-4634*; Marcella Maguire, M.A., *Mental Health Specialist, Mobile Community Outreach Treatment Team, 2700 Martin Luther King Avenue, S.W., Building 2E-13, Washington, DC 20032*; Maxine Faison, B.S.N., Rigaud Gordy, M.D., Lisa B. Dixon, M.D., M.P.H.

## SUMMARY:

*Introduction:* The novel antipsychotic agents have great promise in improving the lives of persons with severe mental illness. Little is known about the use of these agents in uncontrolled community settings. This study describes the use of olanzapine in a cohort of severely ill, unstable, inner-city clients receiving intensive outreach services.

*Methods:* We report clinical and demographic characteristics, reasons for olanzapine use, as well as compliance and clinical outcomes of 22 clients of the Mobile Community Outreach Treatment Team of Washington, D.C., who have received olanzapine (Total team clients=60).

*Results:* Clients were a mean of 38.7 years (SD 10.8). A total of 68% were men, and 86% were African American. A total of 77% had schizophrenia spectrum disorders, 23% had affective disorders, and 59% had a substance use disorder. The most important reasons for olanzapine use were: suboptimal response to conventional antipsychotics (32%), efficacy of olanzapine for affective symptoms (23%), ease of dosing (23%), and positive side-effect profile (18%). A total of 73% of patients were at least moderately improved on olanzapine. Using a 1-10 scale for medication compliance, patients improved from 4.18 (SD 2.50) to 7.18 (2.17), $p<.001$ while on olanzapine.

*Conclusions:* The new antipsychotic, olanzapine, can play an important role in improving compliance and outcome in inner-city clients who require mobile treatment services.

## TARGET AUDIENCE:

Mental health care providers.

## REFERENCES:

1. Dixon L, Weiden P, et al: Assertive community treatment and medication compliance in the homeless mentally ill, *American Journal of Psychiatry*, in press.
2. Beasley CM, Tollefson GD, Tran PV, Saltterless WG, et al: Olanzapine: Molecule to Drug Candidate, American Psychiatric Association 150th Annual Meeting, New Research, pp 135.

**Poster 58** **Sunday, October 26 10:00 a.m.-11:30 a.m.**

## UTILITY OF SCREENING THE HOMELESS MENTALLY ILL

Gurpreet S. Jawa, M.D., *Fellow in Community Psychiatry, Department of Psychiatry, University of North Carolina, 1708 Tryon Drive, Fayetteville, NC 28303*; John J. Haggerty, Jr., M.D., *Associate Professor of Psychiatry, University of North Carolina School of Medicine, 912 Kings Mill Road, Chapel Hill, NC 27514-4923*; Jay A. Yeomans, M.D., Bruce K. Noll, M.D.

## SUMMARY:

*Objective:* Up to 33% of homeless persons may have mental illness. In Charlotte, N.C., a substantial number of the homeless mentally ill are thought to be unidentified and, hence, untreated. We hypothesized that establishing a formal procedure for screening mental illness in a homeless shelter would increase access to services provided by Charlotte's public mental health system.

*Method:* Staff in Charlotte's men's homeless shelter administered a specially developed screening questionnaire to all clients admitted during a 12-week period in 1997. Individuals identified by the questionnaire with

serious mental illness were referred to Charlotte's outreach program for the homeless mentally ill, which attempted to contact them for further assessment and service planning. We then examined follow-up results on all referrals.

*Results:* Questionnaires were completed by 339 shelter residents (93% of total admissions). Excluding 24 (7%) individuals with symptoms that were solely due to substance use, 53 (16%) met screening criteria for primary serious mental illness. However, no new treatment linkages resulted from the screening, and the total number of shelter residents who accessed mental health treatment by all routes during the study period (11) did not differ from a similar period last year (12). Of those identified by the questionnaire, 15 refused follow-up, 28 could not be located by the time of follow-up, four were already being treated, and six were found to not need follow-up.

*Conclusions:* Routine screening of homeless shelter clients increases the identification of the seriously mentally ill, but is insufficient in itself to improve treatment access in the face of multiple barriers to establishing and maintaining contact.

## TARGET AUDIENCE:

All persons interested in community psychiatry.

## REFERENCES:

1. Fallon IRH, et al: Early detection and intervention for episodes of schizophrenia, *Journal of Clinical Psychiatry* 1995; 56(10):466–470.
2. Outcasts on Mainstreet: Report of the Federal Task Force on Homelessness and Severe Mental Illness, U.S. Dept of Health and Human Services, 1992.

**Poster 59** **Sunday, October 26**
**10:00 a.m.-11:30 a.m.**

## COMMUNITY PSYCHIATRY TRAINING: RESIDENTS' VIEWS

Sharon S. Levine, M.D., *Resident in Psychiatry, Department of Psychiatry, University of Ottawa, and Former APA/Mead Johnson Fellow, 1145 Carling Avenue, Lady Grey 3, Ottawa, ON, Canada KIZ 7K4*; Mary E. Johnston, M.D., *Department of Psychiatry, Ottawa General Hospital, 501 South Myth Road, Room 4330, Ottawa, ON, Canada K1H 8L6*; Alison D. Freeland, M.D., Keith Busby, Ph.D.

## SUMMARY:

Residency programs continue to struggle with how best to provide training in community psychiatry. Earlier surveys have focused on the views of practitioners and training directors. There is scant evidence in the literature though, that the views of psychiatry residents are being sought, either about their experiences during training or about the expertise they want to develop in community psychiatry. We surveyed 223 residents in the five psychiatry training programs in Ontario through a questionnaire. The response rate was 47.1%. Of these, 31.4% said their program had a required/core rotation, 71.4% said that didactic teaching was offered, and 91.4% said there were opportunities for electives in community psychiatry. Although 14.3% indicated that community psychiatry was a specific career choice, 90.5% of all respondents said that training in community psychiatry was necessary and 84.8% felt it provided clinical experiences not available elsewhere. Overall, we found that residents have been innovative in gaining community psychiatry experience. They have pragmatic views on how to improve experiences and training, without extensive change in existing curricula. Our research appears to be the first to reflect the views of residents, and thereby contributes a new perspective to the literature on community psychiatry and training.

## TARGET AUDIENCE:

Residents, training directors, community psychiatrists.

## REFERENCES:

1. Brown DB, et al: Training residents for community psychiatric practice: guidelines for curriculum development. *Community Mental Health Journal,* 1993; 29(3):p. 271–283.
2. Goldman CR, et al: Community psychiatry training for general psychiatry residents: results of a national survey. *Community Mental Health Journal,* 1993; 29(1):p. 67–76.

**Poster 60** **Sunday, October 26**
**10:00 a.m.-11:30 a.m.**

## AMPHETAMINE USE ON A COUNTY CRISIS SERVICE

Martin H. Leamon, M.D., *Assistant Professor, Department of Psychiatry, University of California at Davis Medical Center, 2315 Stockton Boulevard, Sacramento, CA 95817-1337*; Lloyd Benjamin, M.D., *Associate Clinical Professor, Department of Psychiatry, University of California at Davis Medical Center, 2150 Stockton Boulevard, Sacramento, CA 95817*

## SUMMARY:

The last several years have seen a dramatic increase in the use of methamphetamine in California and the West. In Sacramento, the major trauma center, UC Davis Medical Center, has seen a rise in trauma admissions associated with amphetamine use. Sacramento Mental Health Treatment Center is the main psychiatric emer-

gency service for the county and the sole provider for Medicaid recipients and the psychiatrically uninsured. Using the county database of the last ten years, as well as selected chart review, trends in the psychiatric impact of amphetamine use are analyzed. Rates of amphetamine-positive urine toxicology screens, utilization of 23-hour psychiatric crisis services, and subsequent admissions to the inpatient psychiatry service are described. To our knowledge, there have been no other recent descriptions on the impact of the rise in amphetamine use on psychiatric services in the United States.

## REFERENCES:

1. Increasing morbidity and mortality associated with abuse of methamphetamine—United States, 1991–1994. MMWR. *Morbidity and Mortality Weekly Report*, 1995; Dec 1, 44(47):882–6.
2. Rockwell DA, Ostwald P: Amphetamine use and abuse in psychiatric patients. *Arch Gen Psych* 1968; 18:612–616.

**Poster 61** **Sunday, October 26**
**10:00 a.m.-11:30 a.m.**

## GENDER DIFFERENCES IN ADOLESCENTS' COPING STRATEGIES

Fabien Durif, M.D., *Department of Psychiatry, Hospital Purpan, Place Du Docteur Baylac, Toulouse, France 31059*; Jean-Philippe Raynaud, M.D., Laurent Schmitt, M.D.

## SUMMARY:

*Objective:* To analyze gender coping strategy differences with the Coping Scale for Adolescents (CSA), which investigates three fields (behavior, cognition, emotion) and four strategies (social support, denial, withdrawal, control).

*Method:* 566 adolescents (285 girls, 281 boys) recruited from a high school and who were 12 to 20 years old completed the CSA.

*Results:* Boys use more total control strategies ($p<0.01$) than girls, but there are no differences for internal control referring to cognition and emotion. Use of control increases with age for both groups, particularly for boys ($p<0.05$). Boys use more denial ($p<0.001$) especially alexithymia (referring to emotional denial) ($p<0.0001$). During late adolescence, they tend to use less denial, whereas girls use more ($p<0.05$). For both groups, withdrawal increases during early adolescence and decreases later.

*Discussion:* Gender coping strategy differences appear during adolescence. Boys express both abilities to control (positive side), and denial of reality and refusal of emotion (negative side). In contrast, girls express both social support strategies (positive side) and social and behavioral withdrawal (negative side) due to emotional invasion (addiction) and alexythymia.

## REFERENCES:

1. Compas BE: Coping with stress during childhood and adolescence. *Psychological Bulletin* 1987; 101:393–403.
2. Lazarus RS, Folkman S: *Stress, Appraisal, and Coping*. New York, Springer, 1984.

**Poster 62** **Sunday, October 26**
**10:00 a.m.-11:30 a.m.**

## VALIDATION OF A NEW DEPRESSION SCALE FOR ADOLESCENTS

Fabien Durif, M.D., *Department of Psychiatry, Hospital Purpan, Place Du Docteur Baylac, Toulouse, France 31059*; Jean-Philippe Raynaud, M.D., Laurent Schmitt, M.D.

## SUMMARY:

*Objective:* The Durif Depressive Disorders Scale for Adolescents (DDDSA) is a self-rating scale for preliminary screening with these aims: easy use, few cognitive efforts, little time required (mean time three minutes) and competitive criterion validity.

*Method:* The DDDSA investigates 10 major depressive disorder symptoms: appetite, sleep, tiredness, sadness, self-image, suicidal thoughts, anxiety, pessimism, guilt, and concentration. Each item contains two propositions connected by an 11 centimeter side divided into 11 spaces going from 0 (no symptom) to 10 (maximal symptom). The subject checks the point corresponding to his mood. The score varies from 0 to 100, with three cut-off points defining four states going from no to high depression. A total of 409 schoolchildren (mean age 16.5 years) from 15 to 18 years old completed the DDDSA and the Beck Depression Inventory.

*Results:* Concurrent validity measured by the correlation between BDI and DDDSA scores is high ($r=.83$, $p<0.001$). Internal consistency measured by the Chronbach alpha-coefficient is elevated (.87, $p<0.001$). Internal hemogeneity is good: correlations among items vary from .16 to .66 ($p<0.01$), correlations between each item and total score vary from .57 to .80 ($p<0.001$). Factor analysis isolates two factors referring to emotional feelings and somatic complaints.

*Discussion:* The initial validation of the DDDSA is satisfactory. The simplicity and the little time required indicate it specifically for screening. Further studies are needed to study other points like test-retest and specificity.

## REFERENCES:

1. Angold A: Childhood and adolescent depression: II. research in clinical populations. *British Journal of Psychiatry* 1988; 53:476–492.
2. Compas BE, Ey S, Grant KE: Taxonomy, assessment and diagnosis of depression during adolescence. *Psychological Bulletin* 1993; 114:323–344.


**Poster 63** **Sunday, October 26**
**10:00 a.m.-11:30 a.m.**

## USE OF THE BECK DEPRESSION INVENTORY WITH FRENCH CHILDREN

Fabien Durif, M.D., *Department of Psychiatry, Hospital Purpan, Place Du Docteur Baylac, Toulouse, France 31059*; Veronique Gentil, M.D., Jean-Philippe Raynaud, M.D.


## SUMMARY:

*Objective:* To investigate by using the Beck Depression Inventory the incidence of depression in a French adolescent population and to compare results with previous studies of Canadian and American adolescents.

*Method:* 573 adolescents (282 girls, 291 boys) from a high school, aged from 12 to 19 years, completed the full version of the BDI.

*Results:* The mean score of the total sample is 10.7 (9.1 for boys, 12.3 for girls, $p<0.01$). 51.2% of the subjects (42.1% of boys, 63.6% of girls) scored above the adult cutoff point for "mild depression", 34.8% were "mildly depressed", 11% "moderately depressed", and 5.4% "severely depressed". Older children obtained higher mean scores (11.5 at 18 years against 9.9 at 12 years $p<0.01$).

*Discussion:* Girls and older children tended to have higher mean scores, which confirm Albert & Beck (1975). Whereas for Teri (1982) and Kaplan (1984), sex and age have no significant effects. Incidence of depression (51.2%) corresponds to previous studies, but for us a large majority express only depressed mood. However, the incidence of high depression (5.4%) corresponds to the adolescents' or adults' studies using the BDI or other scales. Although incidence of French adolescent depression (51.2%) is higher than Canadian (39%) (Albert & Beck) or American (49%) (Teri, 1982) incidences, further studies are needed to confirm and explain these differences.



## REFERENCES:

1. Albert N, Beck AT: The incidence of depression in early adolescence: a preliminary study. *Journal of Youth and Adolescence* 1975; 4:301–307.
2. Teri L: The use of Beck Depression Inventory with adolescents. *Journal of Abnormal Child Psychology* 1982; 10:277–284.


**Poster 64** **Sunday, October 26**
**10:00 a.m.-11:30 a.m.**

## MEDICATION COMPLIANCE IN ADOLESCENT PSYCHIATRIC INPATIENTS AFTER DISCHARGE

Anne L. Lloyd, M.A., *Department of Psychology, Four Winds Hospital, 800 Cross River Road, Katonah, NY 10536*; David L. Pogge, Ph.D., *Director, Department of Psychology, Four Winds Hospital, 800 Cross River Road, Katonah, NY 10536*; William P. Horan, M.A., Philip D. Harvey, Ph.D.


## SUMMARY:

The use of atypical neuroleptics and SSRI antidepressants is expected to substantially alter the short-term outcome of affective and psychotic disorders for two principal reasons: increased efficacy and reduced side effects compared with typical neuroleptics and TCA's. In adult patients, many failures in medication compliance are associated with the experience of side effects, but no similar data are available on adolescent patients. In this study, 97 adolescent psychiatric inpatients who were discharged from a private psychiatric hospital with a follow-up plan including neuroleptic or antidepressant medication were followed up 12 to 18 months post discharge and examined for medication compliance, compliance with other aspects of the discharge plan (e.g., psychotherapy, family therapy), and the experience of medication-related side effects. Overall medication compliance was only 35%, which exceeds the relatively low rate of medication side effects (24%). The rate of side effects in the noncompliant patients was only 38%. A stepwise regression analysis indicated that failure to comply with other aspects of the treatment plan, $R^2=.29$, $p<.001$, $t=5.3$, was a stronger predictor of medication noncompliance than the experience of side effects, $t=1.6$, $p=.13$, $R^2_{incremental}=0$. Furthermore, diagnosis, type of medication received, age, and gender did not relate to medication compliance. These data suggest that there are factors other than side effects and efficacy that predict compliance in adolescent patients, suggesting that improved medications may not improve outcome without consideration of other factors.


## TARGET AUDIENCE:

Psychiatrists and psychologists.


## REFERENCES:

1. Bastiaens L: Compliance with pharmacotherapy in adolescents: effects of patients and parents knowl-

edge and attitudes toward treatment. *Journal of Child and Adolescent Psychopharmacology*, 1995; 5:39–48.
2. Weiden PJ, Olfson M: Cost of relapse in schizophrenia. *Schizophrenia Bulletin*, 1995; 21:419–429.

**Poster 65** **Sunday, October 26 10:00 a.m.-11:30 a.m.**

## SOCIAL-STRESS DISORDERS IN REFUGEES FROM CHECHNYA

Vladimir N. Prokudin, M.D., *Associate Professor of Psychiatry, Russia State Medical University, Leningzadskow Shosse 31-91, Moscow, Russia 125212*

### SUMMARY:

The psychopathological analysis of 800 refugees from Chechnya with social-stress disorders (SSD) was carried out for the last three years. All volunteers were asked if they needed psychological, psychotherapeutic, or psychopharmacological help from psychiatrists from "The Council for Refugees and Forced Migrants," a United Nations sponsored public nongovernmental committee based in Moscow.

It was shown by means of phenomenological method that: 10% of these 800 refugees suffered from pre-disease conditions with emotional tension and insomnia; 20%-affective-shock reactions; 30%-psychoadaptive states with neurastenical, hysterical, anxiety, and phobic syndroms; 40%-pathological personal development, psychosomatic disorders, or reactions of social protest. Nosologically all above-mentioned groups of patients may be determined as SSD-term of Professor Y. Alexandrovsky (variant of post-traumatic stress disorder, when enormous groups of civil population are involved). In treatment of the patients with SSD, the combinations of different kinds of psychotherapy (rational, suggestive, and behavioral) with varied psychopharmacotherapy (anxiolytics, hypnotics, and mild neuroleptics were used.

### REFERENCES:

1. Charney DS et al.: Psychobiologic mechanisms of posttraumatic stress disorder. *Arch Gen Psychiatry* 1995; 152:529–535.
2. Alexandrovsky YA: The social-stress disorders. *Russian Med Journ* 1996; 11:689–694.

**Poster 66** **Sunday, October 26 10:00 a.m.-11:30 a.m.**

## A PSYCHIATRY CLUB AS AN EXTRACURRICULAR ACTIVITY FOR MEDICAL STUDENTS

Hinda F. Dubin, M.D., *Associate Director, Department of Psychiatry, University of Maryland, 701 West Pratt Street, Baltimore, MD 21201-1023*; Lisa Bailey, M.D., *Assistant Professor, Department of Psychiatry, University of Maryland, 701 West Pratt Street, Baltimore, MD 21201-1023*

### SUMMARY:

Many students enter medical school from liberal arts colleges or from other careers. While well immersed in the biological sciences of medical school, they often feel "unidimensional." The Psychiatry Club was formed to address this. It was begun as an extracurricular activity in January, 1995. Two psychiatry faculty serve as facilitators and work with the student officers to plan and organize events. Club events are held bimonthly and have included stress reduction, test-taking skills seminars, hypnosis workshops, and viewing and discussion of films. The club also sponsored an ad hoc crisis debriefing after a resident committed suicide on campus. This year the club also sponsored the first of an annual multimedia contest.

An educational grant is used to fund activities. Club events are open to all interested students.

The club's goal is to expose students to ideas outside of the classroom and to produce more well-rounded physicians. Moreover, it is felt that early positive interaction with faculty in psychiatry will help demystify the field.

We have received positive verbal feedback. Attendance at the program has grown over the past two years from five members to 80 members. The students have appreciated the activities that broaden their experience as physicians in training.

### TARGET AUDIENCE:

This workshop is intended for medical school faculty who work directly with students.

### REFERENCES:

1. Sondheimer A: The literature and medicine seminar for students: a potential recruitment tool. *Academic Psychiatry* 1995; 18:38–44.
2. Kaltreider NB, Lu FG, Thompson TL: Student education and recruitment into psychiatry: a synergistic proposal. *Academic Psychiatry* 1994; 18:154–161.

**Poster 67** **Sunday, October 26 10:00 a.m.-11:30 a.m.**

## INFORMED CONSENT: ASSESSMENT OF COMPREHENSION

Alexandra B. Strough, B.S., *Clinical Research Coordinator, Department of Psychiatry, West Los Angeles VA Medical Center, 11301 Wilshire Boulevard/B151H, Los Angeles, CA 90073;* Kathleen Johnston, M.S., *Director, Schizophrenia Clinic, Department of Psychiatry, West*

*Los Angeles VA Medical Center, 11301 Wilshire Boulevard/B151H, Los Angeles, CA 90073*; Danielle Goldstein, B.A., Donna A. Wirshing, M.D.

## SUMMARY:

*Objective:* To design and evaluate a stereotyped and rigorous informed consent procedure that maximizes the comprehension and learning of critical aspects of experimental treatment protocols involving subjects with schizophrenia.

*Methods:* 49 schizophrenia patients were screened for participation in several ongoing clinical research trials. The protocols' consent forms were read and explained. Subjects were then asked a series of standardized questions relating to critical aspects (i.e., procedures, risks, benefits, and alternatives to participation) of each protocol. Incorrect responses resulted in targeted re-education. This question, response, and education procedure was reiterated until the patient answered 100% of the questions correctly. Subjects were tested again seven days later.

*Results:* Patients' median scores on the first trial were 80% correct; 53% of patients required a second trial to be 100% correct and 37% of patients required three or more trials. Scores improved between the first trial and day 7 ($X^2$=9.8 p=0.02). A total of 96% of patients felt that they were adequately informed; 66% claimed they were participating for personal benefits or altruistic reasons, and 34% claimed they were participating in the study at the suggestion of others.

*Conclusions:* Schizophrenia research subjects appear to be able to understand and retain the critical components of informed consent.

## TARGET AUDIENCE:

Psychiatrists, registered nurses, and support staff.

## REFERENCES:

1. Kleinman I, Schacter D, Jeffries J, Goldhammer P: Effectiveness of two methods for informing schizophrenic patients about neuroleptic medication. *Hosp Comm Psychiatry* 1993; 44:1189–1191.
2. Schacter D, Kleinman I, Prendergast P, et al: The effect of psychopathology on the ability to give informed consent. *J Nervous and Mental Disease* 1994; 182(6):360–362.

**Poster 68** **Sunday, October 26 10:00 a.m.-11:30 a.m.**

## A BOARDING HOME PROGRAM FOR THE MENTALLY ILL

Samuel Packer, M.D., *Associate Professor, Department of Psychiatry, University of Toronto, St. Michael's Hospital, 30 Bond Street, Toronto, ON, Canada M5B 1W8*; Ronald J. Heslegrave, Ph.D., *Associate Professor, Department of Psychiatry, University of Toronto, Wellesley Hospital, 160 Wellesley, Toronto, ON, Canada M4Y 1J3*

## SUMMARY:

Individuals with severe and persistent mental illnesses continue to be discharged into sub-optimal housing in the community. In Toronto, Ontario, three government ministries have funded a program that subsidizes and monitors 36 houses that provide room and board for 705 residents with psychiatric disorders. Occupational therapy resources are made available through an interagency partnership. We studied 100 consecutive admissions to examine resident and housing characteristics. Seventy-two percent were males, 66% had a diagnosis of schizophrenia or schizoaffective disorder, and individuals had a mean of 5.4 previous hospitalizations. Residents experienced an overall moderate to slight degree of impairment in functioning as measured by the Maryland Functional Scale. Lowest ratings were in "social network" and "meaningful activity." Residents completing Lehman's Quality of Life Scales (Lehman, 1988) rated their general sense of well-being as "mixed" on a scale from "terrible" to "delighted." Lack of meaningful activity was correlated (p=0.003) with diminished quality of life. Residents were questioned about what makes a boarding home desirable, with quality of the food being most important and the gender of other residents least. Although study residents are in housing that meets specified standards, their quality of life remains diminished, which may be related to other psychosocial factors.

## REFERENCES:

1. Owen C, Rutherford V, et al: Housing accomodation preferences of people with psychiatric disabilities. *Psychiatric Services* 47:628–632, 1996.
2. Lehman AF, Slaughter JG, Myers CP: Quality of life in alternative residential settings. *Psychiatric Quarterly* 62:35–49, 1991.

**Poster 69** **Sunday, October 26 10:00 a.m.-11:30 a.m.**

## NEURODEVELOPMENT OF CHILDREN EXPOSED IN UTERO TO ANTIDEPRESSANT DRUGS

Donna E. Stewart, M.D., *Chair of Women's Health, The Toronto Hospital, 200 Elizabeth Street, EN-222, Toronto, ON, Canada M5G 2C4*

## SUMMARY:

*Background:* The purpose of this study was to determine if preschool children whose mothers took tricyclic

or SSRI antidepressants during pregnancy showed IQ, language, or behavioral changes compared with control children.

*Methods:* We studied 80 children of mothers who had received a tricyclic antidepressant, 55 children whose mothers had received fluoxetine, and 84 children whose mothers had received known nonteratogenic drugs during their pregnancies. All children were preschool age, and their global IQ and language development were assessed after at least 16 months of postnatal age by the Bayley and McCarthy tests (for IQ) and Reynell test (for language).

*Results:* The mean (± SD) global IQ scores were 118 ± 17 in the children of mothers who received a tricyclic antidepressant, 117 ± 17 in those whose mothers received fluoxetine, and 115 ± 14 in those whose mothers received a nonteratogenic drug. The language scores were similar in all three groups. The results were similar in those children exposed to a tricyclic or fluoxetine in the first trimester or throughout pregnancy. Similarly, children in the three groups did not differ in their scores on temperament, mood, arousal, activity, distractibility, or behavioral problems.

*Conclusion:* In utero exposure to tricyclic antidepressants or fluoxetine does not appear to affect global IQ, language, or behavioral development measured in preschool children.

## TARGET AUDIENCE:

Psychiatrists, family physicians, social workers, nurses, residents.

## REFERENCES:

1. Nulman I, Rovet J, Stewart DE, et al: Neurodevelopment of children exposed in utero to antidepressant drugs. *NEJM* Jan 22, 1997.
2. Stewart DE, Robinson GE: Psychotropic drugs and ECT during pregnancy and lactation. In: Stewart DE, Stotland NL (eds): *Psychological Aspects of Women's Health Care*, APPI, Washington, D.C., 1993, pp. 71–96.

**Poster 70** **Sunday, October 26 10:00 a.m.-11:30 a.m.**

## NUEVOS HORIZONTES: A LATINO DAY PROGRAM

Sara T. Adams, M.A., *Director, Outpatient Latino Services, Community Healthlink, 72 Jaques Avenue, Worcester, MA 01610*; Sarai Rivera, M.S.W., *Clinical Social Worker, Community Healthlink, 72 Jaques Avenue, Worcester, MA 01610*; Gustavo Rivera, M.D., Jeffrey G. Stovall, M.D.

## SUMMARY:

Latino consumers confront cultural and linguistic barriers in accessing mental health services in communities where they comprise a significant population. Few services are available, particularly for psychosocial rehabilitation for Latino individuals with severe mental illness. Community Healthlink, a large multiservice organization in central Massachusetts, developed a program that provides comprehensive clinical and social rehabilitation services, in Spanish, geared to the cultural needs of consumers. We will describe the main program features of Nuevos Horizontes, which are designed to ensure outreach, clinical, educational, and social rehabilitation services to adult, Spanish-speaking, Latino consumers who suffer from severe and persistent mental illness. Data will be presented that indicate that in its first year of operation the program has been successful in engaging Latino consumers who had not participated in mainstream rehabilitation programs available in the community. Our experience indicates that programs attempting to offer mental health services to Latino consumers must be designed and staffed to meet their linguistic needs within a clinically and culturally competent framework.

## TARGET AUDIENCE:

Providers of mental health services working with Latinos and designing programs for this growing population

## REFERENCES:

1. Abad V, Ramos J, Boyce E: A model for delivery of mental health services to Spanish-speaking minorities. *Am J Orthopsychiatry* 44:584–595, 1974.
2. Fischman G, Fraticelli B, Newman D, Sampson L: Day treatment programs for the Spanish-speaking: a response to underutilization. *International J Social Psychiatry* 29:215–229, 1983.

**Poster 71** **Sunday, October 26 10:00 a.m.-11:30 a.m.**

## EXECUTIVE DYSFUNCTION IN MENTALLY ILL INMATES

Pamela M. Diamond, Ph.D., *Director of Program Evaluation, Texas Tech University Health Sciences Center, 8602 Peach Street, Lubbock, TX 79404*; Eugene Wang, M.S., *Clinical Outcomes Studies Manager, Texas Tech University Health Sciences Center, 8602 Peach Street, Lubbock, TX 79404*; Stacy Kimberlin, B.A.

## SUMMARY:

The Executive Interview (EXIT) measures executive dysfunction and the Qualitative Evaluation of Dementia (QED) indicates whether the dysfunction is more "cortical" or "subcortical." The current study assesses the

validity of these instruments for use with hospitalized mentally ill offenders. Head injuries are common in this population as are the sequelae of substance abuse; therefore, an instrument that allows rapid screening of inmates for neuropsychological impairment is essential for treatment planning.

The EXIT and QED were given to 237 male inmates on admission. Almost 40% of the men scored above 15 on the EXIT, indicating the presence of impairment. Of those showing impairment, 65% were in the subcortical range on the QED and 28% were in the cortical range. A comparison of functioning between those with high EXITs, in either the cortical or subcortical range, and those with no elevation on the EXIT was made using the Multnomah Community Adjustment Scale (MCAS) and the Forensic Overt Aggression Scale (FOAS). Those with cortical impairment were functioning less well than either of the other groups on all subscales of the MCAS and on the total FOAS score. This provides some evidence of criterion validity for these instruments and suggests areas for program development.

## TARGET AUDIENCE:

Clinicians, program planners, researchers.

## REFERENCES:

1. Royall DR, Mahurin RK, Gray KF: Bedside assessment of executive cognitive impairment: The Executive Interview. *Journal of the American Geriatric Society.* 40:1221–1226, 1992.
2. Royall DR, Mahurin RK, Cornell J, Gray KF: Bedside assessment of dementia type using the Qualitative Evaluation of Dementia. *Neuropsychiatry, Neuropsychology and Behavioral Neurology.* 6(4):235–244, 1993.

**Poster 72** **Sunday, October 26**
**10:00 a.m.-11:30 a.m.**

## PATIENTS' EVALUATIONS OF THEIR PSYCHOEDUCATION

Haya Ascher-Svanum, Ph.D., *Assistant Professor of Clinical Psychiatry, Department of Psychiatry, Indiana University, Larue Carter/2601 Cold Spring, Indianapolis, IN 46222*

## SUMMARY:

Despite a preponderance of patient education programs, patients' expectations and appraisals of their experience have not been studied in an empirical fashion. This study assessed patients' expectations prior to participation in the educational program, and their evaluations upon its completion. Adult inpatients (n=117), who were referred to an educational group program about schizophrenia, have responded anonymously to a pre-group questionnaire assessing expectations about future satisfaction from the program, and post-group appraisals on an evaluation form. Since 47 patients opted to identify themselves on both assessment forms, they provided an added opportunity to study the link between patients' expectations and reported satisfaction.

Results point to a high level of initial expectations from the program, and a high level of satisfaction from it, with a self fulfilling prophecy effect in which those with higher expectations also report more satisfaction with the education process. Furthermore, patients' perceived helpfulness of the topics presented was significantly linked to their evaluation of the program, along with their identification of specific topics as being more helpful than others. Current findings empirically bolster previous impressions of patients' satisfaction with their educational experience, and point to specific preferences that may improve patients' motivation and level of participation.

## TARGET AUDIENCE:

Professionals involved in patient education.

## REFERENCES:

1. Ascher-Svanum H, Krause AA: *Psychoeducational groups for patients with schizophrenia: a guide for practitioners.* Maryland, Aspen, 1991.
2. Terrell D, Bisbee C: Patients' views on psychiatric patient education. *Orthomolecular Psychiatry* 11:182–184, 1982.

**Poster 73**

**WITHDRAWN**

**Poster 74** **Sunday, October 26**
**4:00 p.m.-5:30 p.m.**

## BILATERAL ECT AND AUTOBIOGRAPHICAL MEMORY OF SUBJECTIVE EXPERIENCES RELATED TO MELANCHOLIA: A PILOT STUDY

Charles Peretti, M.D., *Department of Psychiatry, Chru Strasbourg, 1 Place De L'Hopital, Strasbourg, France 67091*; Jean-Marie Danion, M.D., *Professor, Department of Psychiatry, Chru Strasbourg, 1 Place De L'Hopital, Strasbourg, France 67091*

## SUMMARY:

The aim of this pilot study was to systematically assess the influence of bilateral, sine wave ECT on autobiographical memory of past subjective experiences related

to melancholia. Twenty-one inpatients who met DSM-III-R criteria for a major depressive episode, melancholic type, were included in the study. Twelve patients were treated by ECT (12 treatments), antidepressants, and benzodiazepines; the comparison group of nine patients were treated by antidepressants and benzodiazepines. The Structured Interview Guide for the HDRS (SIGH-D) was used at admission and after the ECT treatment to standardize data collection about subjective experiences related to the depressive episode. Memory of subjective experiences related to melancholia was assessed with free-recall, cued-recall, and recognition tasks. In addition, a free recall of events of the day on which the patients came to the hospital for their treatment was administered. These tasks were administered one week after the last treatment in the ECT-treated group and four to six weeks after the beginning of the treatment in the comparison group.

Free-recall, cued-recall, and recognition performances were significantly lower in the ECT-treated group than in the comparison group. No significant correlation was found between memory of events related to hospital admission and memory of subjective experiences related to depression. In conclusion, bilateral, sine wave ECT impairs autobiographical memory of subjective experiences related to melancholia in subjects tested one week after completion of a course of ECT.

## TARGET AUDIENCE:

Psychiatrists and residents.

## REFERENCES:

1. Blaney PH: Affect and memory: a review. *Psychol Bull* 99:229–246, 1986.
2. Squire LR, Chace PM, Slater PC: Retrograde amnesia: temporal judgments about remote events following electroconvulsive therapy. *Nature* 260:775–777, 1976.

**Poster 75** **Sunday, October 26**
**4:00 p.m.-5:30 p.m.**

## AMANTADINE AND AMOXAPINE COCAINE TREATMENT

Murali R. Jonnalagadda, M.D., *Clinical Psychiatrist, Adult Services, Brynn Marr Hospital, 192 Village Drive, Jacksonville, NC 28546*; Carol A. King, R.N.

## SUMMARY:

It has always been difficult to treat cocaine-dependent individuals because of their unwillingness to participate in programs due to agitation, cravings, and sometimes frank paranoia. Amantadine, bromocriptine, desipramine, and other medications have been used to control some of the issues. There has never been an attempt to use a combination of a dopa stimulant and a dopa blocker, which also has non-epinephrine re-uptake blockade and HT-2 receptor activity. Empirically, about 40 patients were evaluated on a combination of amantadine and amoxapine at a fixed dose of amantadine 100 mg t.i.d. and amoxipine 50 mg t.i.d. The subjective experience and follow-up of these clients as well as the experiences of the staff members who work in this unit will be reported, noting decreased cocaine cravings and improved investment in rehabilitation. Primarily this is a favorable/useful combination. The authors would encourage guidance from the audience as to their clinical findings and guidance to further research the reports. The target audience includes clinical psychiatrists and researchers. In conclusion, the combination of amantadine and amoxapine has proven effective in reducing the cocaine cravings in a detoxing client.

## REFERENCES:

1. Elder IR: Daily cocaine craving in a 3-week inpatient treatment program. *Journal of Clinic Psychology* Mar; 49(2):292–7, 1993.
2. Practice Guideline for the Treatment of Patients with Substance Use Disorders: Alcohol, Cocaine, Opioids. *American Psychiatric Association*, 1995.

**Poster 76** **Sunday, October 26**
**4:00 p.m.-5:30 p.m.**

## PSYCHIATRIC EXAMINATION VERSUS SELF-REPORT RESEARCH SCREENING

Mary J. Fitz-Gerald, M.D., *Professor of Clinical Psychiatry, Louisiana State University, 1501 Kings Highway, Shreveport, LA 71130-3932*; Frederick A. Struve, Ph.D., *Professor of Psychiatry, Louisiana State University, 1501 Kings Highway, Shreveport, LA 71130-3932*

## SUMMARY:

Research investigations frequently rely on self-report data to detect exclusion variables. Without direct examination screening a significant number of subjects may have covert psychiatric exclusions not identified with self-report methods. Over 950 "normal" volunteers were screened to participate in a marijuana-EEG investigation for which one exclusion criterion was current or past Axis-I psychiatric diagnosis other than substance abuse. Of 855 normal THC users and non-user controls screened by initial telephone, 8.6% were rejected because of self-reported psychiatric exclusions. Of remaining subjects receiving an in-depth interview screening, 1.6% were also rejected because of a self-reported psychiatric exclusion. All remaining subjects then received a direct psychiatric examination including a SADS-L done by a board certified psychiatrist. Of these, fully 24.7% were found to have a current or prior Axis

1 psychiatric diagnosis other than substance abuse even though all prior screening failed to detect current or past psychiatric disorders. Thus, without direct psychiatric examination subjects with psychiatric exclusions would have been entered into the study in error if screening relied only on self-report measures obtained by nonpsychiatrists. The results emphasize the necessity for conducting direct psychiatric examinations to protect against methodological confounds resulting from entering research subjects with undetected, exclusion variables.

## TARGET AUDIENCE:

Clinical researchers.

## REFERENCES:

1. Swerdlow NR, Geyer MA, Perry W, et al: Drug screening in "normal" controls. *Biol Psychiatry*, 38:123–124, 1995.
2. Wiseman EJ, Heithoff KA: Comparison of DSM-III-R symptoms for alcohol dependence between patient self-report and clinician interview for DSM-III-R. *Journal of Addictive Disease*, 15:43–54, 1996.

**Poster 77** **Sunday, October 26**
**4:00 p.m.-5:30 p.m.**

## CHANGES IN DEPRESSIVE SYMPTOMS IN ABSTINENT ADOLESCENT ADDICTION PATIENTS

Geetha Subramaniam, M.D., *Resident in Child Psychiatry, Department of Child Psychiatry, Johns Hopkins Hospital, 600 North Wolfe Street, Baltimore, MD 21218*; Lindy Lewis, M.S.W., *Family Therapist, Mountain Manor Treatment Center, 3800 Frederick Avenue, Baltimore, MD 21229*; Marc Fishman, M.D.

## SUMMARY:

While several studies have demonstrated a high cross-sectional rate of depressive disorders among adolescent addiction inpatients, few have examined changes with length of abstinence. Previous work with adult male primary alcoholics presenting for inpatient addictions treatment showed high rates of depression initially, declining to low rates over two to four weeks of abstinence. One recent study in delinquent addicted adolescents at a residential treatment program showed persistence of depression at four weeks with abstinence. We assessed depressive symptoms by self-report in a mixed gender, poly substance abusing adolescent population at an inpatient addictions treatment center using the Beck Depression Inventory (BDI). This sample had an average 37 days of abstinence at time of first administration. Using a threshold of BDI score >11, we found significant depression among 41% of patients at week 1 of treatment, 38% of patients at week 3, and 17% of patients at week 6. We conclude that the rate of occurrence of depressive symptoms is high and tends to persist over several weeks of abstinence.

## REFERENCES:

1. Brown SA, Schuckit MA: Changes in depression among abstinent alcoholics. *Journal of Studies on Alcohol*, 49:412–417, 1988.
2. Riggs PD, Baker S, et al: Depression in substance-dependent delinquents. *J Am Acad Child Adolesc Psychiatry*, 34:764–771, 1995.

**Poster 78** **Sunday, October 26**
**4:00 p.m.-5:30 p.m.**

## PLASMA CORTISOL AND NEUROCOGNITIVE DECLINE IN HIV-1 INFECTION

Eric D. Jackson, B.S., *Social Research Assistant, Department of Psychiatry, University of North Carolina at Chapel Hill, CB#7160, Medical School Wing B, Chapel Hill, NC 27599*; Susan G. Silva, Ph.D.

## SUMMARY:

*Objective:* Recent studies indicate that glucocorticoid dysregulation is associated with immunosuppression and neurobehavioral dysfunction in HIV-1 infection. This study investigates whether early cortisol concentrations are associated with subsequent HIV-1 disease progression.

*Method:* The 59 HIV-seropositive gay male subjects were medically asymptomatic at baseline and were without histories of substance abuse, CNS/psychiatric disorder, learning disability, AZT use, and endocrinopathy. Analyses included baseline plasma cortisol measurements (high, medium, and low levels) and neurocognitive measures collected semi-annually over six years. Disease progression was defined as: (1) neurocognitive decline—timepoint when neurocognitive score dropped permanently below baseline score, (2) clinical decline—timepoint when subject became medically symptomatic, and (3) immunologic decline—timepoint when CD4+ count dropped below 200.

*Results:* A Cox Proportional Hazards model (controlling for age, education, baseline CD4+ count, baseline mood, tobacco use, and antiretroviral use) revealed that cortisol level was significantly related to declines in psychomotor speed (p=.06; risk=.49), manual dexterity (p=.05; risk=.53), and clinical symptoms (p=.03; risk=.52). For each increase in cortisol level the probability of progression decreases by approximately 50%. Interestingly, cortisol was not associated with immunologic decline (p=.88).

*Conclusions:* These findings suggest that lower plasma cortisol during early HIV-1 infection may predict faster disease progression.

## REFERENCES:

1. Sellmeyer DE, Grunfield C: Endocrine and metabolic disturbances in human immunodeficiency virus infection and the acquired immune deficiency syndrome. *Endocrine Reviews*, 17:518–532, 1996.
2. Christeff N, Gharakhanian SH, Thobie N, et al: Evidence for changes in adrenal and testicular steroids during HIV infection. *J Acquir Immune Deficiency Syndr*, 5:841–846, 1992.

**Poster 79** **Sunday, October 26**
**4:00 p.m.-5:30 p.m.**

## COMORBIDITY OF POLYDYPSIA AND ALCOHOLISM IN SCHIZOPHRENIA

Hedy E. Tasbas, M.D., *Staff Psychiatrist, Veterans Affairs Medical Center, 400 Fort Hill Avenue, Canandaigua, NY 14424*; James J. Kim, M.D., Jagannathan Srinivasaraghavan, M.D.

## SUMMARY:

*Objective:* The goal is to determine possible comorbidity between polydysia and alcoholism (alcohol abuse/dependence) among patients with schizophrenia.

*Subjects:* All 139 long-term psychiatric patients who were continuously hospitalized during the period between July 1, 1995, and December 31, 1995.

*Method:* Demographic data including age, sex, race, and length of hospitalization were collected. All patients were grouped using DSM-IV criteria for schizophrenia and alcohol abuse/dependence. All patients with past or present history of water intoxication were examined using criteria for polydypsia.

*Results:* Of 139 study subjects, 105 met the DSM-IV criteria for schizophrenia. There were 102 (97%) males; 99 (94%) were white. The mean age of the group was 62 years old (range 37–89), and the mean duration of hospitalization was 6.3 years. Of 105 veterans with schizophrenia, 51 had a history of alcohol dependence/abuse. Of these 51 subjects, 26 satisfied our criteria for polydypsia. However, of 54 subjects who had no history of alcoholism, only eight satisfied criteria for polydypsia. Chi-square for these proportions=14.059 df 1 p 0.0002.

*Conclusion:* Our data support that there is a difference in the proportion of polydypsia patients in alcoholic and nonalcoholic schizophrenic populations. Prevalence of polydypsia in this study is somewhat higher than previously reported (3% to 18%).

## REFERENCES:

1. Patel JK: Polydypsia, hyponatremia, and water intoxication among psychiatric patients. *Hospital and Community Psychiatry* 11:1073–1074, 1994.
2. Riply TL, Millson RC: Self-inducted water intoxication and alcohol abuse. *Am J Psychiatry* 146:102–103, 1989.

**Poster 80** **Sunday, October 26**
**4:00 p.m.-5:30 p.m.**

## PRACTICE PATTERN OF RISPERIDONE IN AN INNER CITY HOSPITAL

Olusanmi J. Babatola, M.D., *Resident Physician, Department of Psychiatry, Bronx-Lebanon Hospital Center, 1276 Fulton Avenue, 4 South, Bronx, NY 10456*; Ali Khadivi, Ph.D., *Associate Chief Psychologist, Department of Psychiatry, Bronx-Lebanon Hospital Center, 1276 Fulton Avenue, 6th Floor, Bronx, NY 10456*

## SUMMARY:

The objective of this descriptive study was to examine the pattern of use of risperidone in relation to other antipsychotics at a major inner-city hospital center. A retrospective chart review was conducted on all inpatients discharged on neuroleptic medications from January to March 1996. In addition, the inpatient attending psychiatrists from the study period were interviewed about their reasons for prescribing or not prescribing risperidone and the types of side effects that they observed.

A total sample of 244 inpatients were identified as having been treated and discharged with neuroleptic medications. Forty-three patients were discharged on risperidone; 53% were males and 47% were females. The mean age was 35 years. The sample was predominantly African American (49%) and Latino (47%). Risperidone was the third most commonly prescribed neuroleptic medication (17.6%). It was less frequently prescribed than haloperidol (51.6%) and Fluphenazine (18.9%). The dosage and the pattern of the side effects were consistent with the findings and recommendation of most studies. Despite having a low side-effect profile, the absence of an injectable form was seen by the attending psychiatrists as a limiting factor in prescribing risperidone.

## REFERENCES:

1. Land W, Salzman C: Risperidone: a novel antipsychotic medication. *Hospital and Community Psychiatry* 45:434–435, 1994.
2. Marder SR, Meibach RC: Risperidone in the treatment of schizophrenia. *Am J Psychiatry* 151:825–835, 1994.

**Poster 81** **Sunday, October 26 4:00 p.m.-5:30 p.m.**

## A COMPARISON OF THE LONGITUDINAL EFFICACY OF RISPERIDONE AND HALOPERIDOL DECANOATE

Dale A. D'Mello, M.D., *Associate Professor, Department of Psychiatry, Michigan State University, 1210 West Saginaw/St. Lawrence, Lansing, MI 48915*; Rafael Villicana, *Medical Student, Michigan State University, College of Human Medicine, East Lansing, MI 48824*

### SUMMARY:

Despite the widespread use and global efficacy of atypical antipsychotic agents, conventional depot antipsychotics such as fluphenazine and haloperidol decanoate continue to maintain a foothold in the pharmacotherapy of the involuntary and noncompliant psychotic patient.

*Objective:* The purpose of this study was to compare the efficacy of a conventional depot antipsychotic and an atypical antipsychotic.

*Method:* A naturalistic, retrospective, mirror-image study of all patients who were consecutively hospitalized with schizophrenic and schizoaffective disorders between June and December 1994 on the psychiatric unit of a university-affiliated general hospital in mid-Michigan identified patients discharged on haloperidol decanoate (n=28) and risperidone (n=52). Patients in both groups were similar in age and illness severity. The rate of hospitalization in the 24 months preceding the index admission was compared with that in the 24 months following.

*Results:* Patients discharged on haloperidol decanoate experienced a reduction of 15 (SD=15) days; those discharged on risperidone spent 12 (SD=35) fewer days in the hospital.

*Discussion:* Atypical antipsychotics appear to be just as effective as depot neuroleptics in the prevention of psychotic relapse.

### REFERENCES:

1. Marder SR: Clinical experience with risperidone. *J Clin Psychiatry* 57(S9):57–61, 1996.
2. Carpenter WT Jr: Maintenance therapy of persons with schizophrenia. *J Clin Psychiatry* 57(S9):10–18, 1996.

**Poster 82** **Sunday, October 26 4:00 p.m.-5:30 p.m.**

## GENDER AND ETHNIC VARIANCE IN METHOD OF SUICIDE

Dale A. D'Mello, M.D., *Associate Professor, Department of Psychiatry, Michigan State University, 1210 West Saginaw/St. Lawrence, Lansing, MI 48915*; Rafael Villicana, *Medical Student, Michigan State University, College of Human Medicine, East Lansing, MI 48824*

### SUMMARY:

*Introduction:* Several studies suggest that the availability of lethal methods for suicide may have an effect upon overall suicide rates. The purpose of this study was to examine ethnic and gender differences in the method of suicide.

*Method:* The Michigan Department of Public Health Office of Vital and Health Statistics provided data regarding the 8640 suicide deaths that occurred in the state during the years 1983–1990. The authors analyzed the data.

*Results:* Substantial gender and ethnic differences emerged in the methods and rates of suicide. European-American (EA) men completed suicide at the highest observed rate (20 deaths/100,000 population). They were followed by African-American (AA) men (14 deaths/100,000). As expected, suicide rates were substantially lower among women: five deaths/100,000 for EA women, and three deaths/100,000 population for AA women. Men tended to use firearms, women tended to use drug overdose. EA men and women used asphyxiation with auto emission more often than their AA counterparts.

*Discussion:* Limiting access to firearms in men and to potentially lethal prescription drugs in women may prevent suicide in vulnerable populations. Gender and ethnic-specific differences in suicide prevention will be presented.

### REFERENCES:

1. Simpson SG, Jamison KR: Suicide and mood disorders. *Primary Psychiatry* 4(5):59–66, 1997.
2. Lester D, Abe K: Car availability, exhaust toxicity, and suicide. *Ann Clin Psychiatry*, 1:247–250, 1989.

**Poster 83** **Sunday, October 26 4:00 p.m.-5:30 p.m.**

## TREATMENT RESPONSE OF A FEMALE PEDOPHILE TO SSRI

Eva W.C. Chow, M.D., *Psychiatrist, Department of Forensics, Clarke Institute, 250 College Street, Toronto, ON, Canada M5T 1R8*

### SUMMARY:

*Background:* Although there is a large body of literature on the clinical characteristics and treatment of male sex offenders, there have been few studies on female sex offenders. These are usually in the form of case reports or case series. In the few reports available, female sex offenders were found to have a high incidence of

psychiatric disorders such as psychosis, substance abuse, or subnormal intelligence. In most cases, the female offender was an accomplice to sexual acts perpetrated by a male partner. The use of a SSRI in the treatment of a female sex offender has also not been reported.

*Objective:* To examine the clinical characteristics and treatment response to a SSRI in a female pedophile.

*Method:* A 23-year-old female convicted of sexual assault and sexual interference on female children underwent a comprehensive psychiatric assessment and was treated with sertraline 50mg daily. The patient was assessed at baseline and monthly for six months post-treatment using the HAM-D, the HAM-A, the SCL-90-R, and the Impulsivity-30 scale. She was also asked to keep a diary of her pedophilic thoughts and her impulsive behaviors.

*Results:* A diagnosis of pedophilia, sexually attracted to females, was made. Unlike other female sex offenders reported in the literature, the patient has no psychiatric history and no other Axis I diagnosis. She has a history of impulsive behaviors (excessive spending, a quick temper, but not substance abuse), but did not have other features of a borderline personality disorder. She acted independently in her sexual offenses, which were motivated by sexual gratification. Her LH, FSH, prolactin, and free testosterone results were normal. After treatment with sertraline, her pedophilic interests attenuated. Sexual thoughts about children decreased in frequency, and when they occurred, they were more easily resisted by the patient. The patient also noted an improvement in her temper and more control over her spending. The SCL-90-R and the Impulsivity-30 scale scores also improved.

*Conclusion:* SSRI's can be helpful in the treatment of an impulsive female pedophile.

## REFERENCES:

1. Cooper AJ, Swaminath S, Baxter D, Poulin C: A female sex offender with multiple paraphilias: psychologic, physicologic and endocrine case study. *Can J Psychiatry* 35:334–337, 1990.
2. O'Connor AA: Female sex offenders. *Brit J Psychiatry* 150:615–620, 1987.

**Poster 84**

## WITHDRAWN

**Poster 85** **Sunday, October 26**
**4:00 p.m.-5:30 p.m.**

## OUTCOMES OF CLOZAPINE THERAPY IN OLDER ADULTS

Martha Sajatovic, M.D., *Associate Chief of Psychiatry, Department of Psychiatry, Cleveland VA Medical Center, 10000 Brecksville Road, Brecksville, OH 44141*; Luis F. Ramirez, M.D., David L. Garver, M.D.

## SUMMARY:

Although clozapine is useful for treatment refractory psychosis in younger populations, there are fewer data regarding clozapine in older adults. This study is an analysis of the U.S. national V.A. experience with clozapine therapy in older, treatment-refractory veterans with schizophrenia. Prior to beginning clozapine therapy, baseline demographic, clinical, and psychopathology data were collected. Psychopathology was rated with the Brief Psychiatric Rating Scale (BPRS), and involuntary movements were rated with the Abnormal Involuntary Movement Scale (AIMS). BPRS and AIMS were repeated on follow-up. For this study, patients were grouped into two categories: patients aged 55–64 and patients over age 65. There were 329 patients aged 55 or older. Mean age of the study population was 63.4, SD±6.5, range 55–86. Overall, patients were severely symptomatic and often had been chronically institutionalized. Mean duration of clozapine therapy was 51.5 weeks, ±51.3. Mean clozapine dosage was 301.2 mg/day, ±240.5. Overall, this group of older adults had improvement on clozapine therapy; however, there was wide variation in drug response. BPRS data were available for 97 older adults. The 55–64 age group (N=68) had a mean of 19.8% improvement in total BPRS, while the 65 and older group (N=29) had a mean improvement of 5.7% (p=.054). In addition, 42.6% of the 55–64 age group and 17.2% of the over age 65 group had at least a 20% improvement in BPRS. There was a mean of 16.6% improvement in AIMS score for this group. Clozapine is an important therapeutic agent in severely ill older adults with treatment-refractory psychosis.

## TARGET AUDIENCE:

Physicians, mental health clinicians.

## REFERENCES:

1. Jeste DV, Lacro JP, Gilbert, et al: Treatment of late-life schizophrenia with neuroleptics. *Schizophrenia Bulletin* 19:817–827, 1993.
2. Salzman C, Vaccaor B, Lieff J, et al: Clozapine in older patients with psychosis and behavioral disruption. *Am J Geriatric Psychiatry* 3(1):26–33, 1995.

**Poster 86** **Sunday, October 26**
**4:00 p.m.-5:40 p.m.**

## MEDICATION KNOWLEDGE IN PATIENTS WITH PSYCHOTIC DISORDERS

Avni Cirpili, M.S., *Nurse Manager, Department of Psychiatry, University of North Carolina Hospitals, 101*

*Manning Drive, Chapel Hill, NC 27514*; Diana O. Perkins, M.D., *Assistant Professor, Department of Psychiatry, University of North Carolina at Chapel Hill, CB#7600, Neurosciences Hospital, Chapel Hill, NC 27599-7160*; John Knoop, R.N., M.S., Rebecca McDiarmid, R.N., Kathryn Tesh, B.M.

## SUMMARY:

*Introduction:* Medication noncompliance following hospital discharge is a common problem in patients with schizophrenia. For outpatients who self-administer medication, knowing the prescribed medication regimen is a necessary (although not sufficient) requirement to correctly take their medication. However, as many as half of patients may not know key elements of their medication regimen on discharge. Here we describe an inpatient medication teaching program for patients with psychotic illnesses, and report the impact of the program on knowledge of their medication regimen.

*Methods:* The STEP Inpatient Unit at University of North Carolina Hospitals has developed and piloted a medication teaching program consisting of: (1) didactic classes on mental illness and pharmacotherapy, (2) individualized tutorials, and (3) monitored self-administration of medication.

*Results:* Subjects were 89 inpatients with a diagnosis of schizophrenia or schizoaffective disorder; 65 (73%) participated and 24 (27%) did not participate in the program. Compared with nonparticipants, participants knew a greater percent of their discharge psychotropic medication names (76% versus 91%, p=.03) and dosing frequency (63% vs. 81%, p=.04). There was a trend for participants to know the rationale for their medication (66% vs. 79%, p=.12). In addition, participants were better able to explain the medication dosing regimen from a sample medication bottle label (controlling on ability to explain label on admission, p=.002).

*Conclusions:* It is feasible to increase the pharmacotherapy knowledge level of hospitalized patients with schizophrenia and schizoaffective disorder. Further study is needed to determine the impact of increased knowledge on medication compliance following discharge.

## TARGET AUDIENCE:

Mental health professionals.

## REFERENCES:

1. Clary C, Dever A, Schweizer E: Psychiatric inpatient's knowledge of medication at hospital discharge. *Hospital and Community Psychiatry* 43:140–144, 1992.
2. Geller JL: State hospital patients and their medication—do they know what they take? *Am J Psychiatry* 139:611–615, 1982.

**Poster 87** **Sunday, October 26**
**4:00 p.m.-5:40 p.m.**

# DYSPHORIC EFFECTS: TYPICAL VERSUS ATYPICAL ANTIPSYCHOTICS

Diana O. Perkins, M.D., *Assistant Professor, Department of Psychiatry, University of North Carolina at Chapel Hill, CB#7600, Neurosciences Hospital, Chapel Hill, NC 27599-7160*; Kathryn Tesh, B.M., *Program Coordinator, Department of Psychiatry, University of North Carolina at Chapel Hill, CB#7600, Neurosciences Hospital, Chapel Hill, NC 27599-7160*; Avni Cirpili, M.S.

## SUMMARY:

*Introduction:* Dysphoric subjective response is a common side effect of conventional antipsychotics, occurring in as many as two-thirds of treated patients. Severity of dysphoric response is associated with increased chance of poor medication compliance. The new "atypical" antipsychotics have been shown to have a more favorable side effect profile, and to be better tolerated. In this study we compare the severity of subjective dysphoric response in patients treated with atypical compared with typical antipsychotics.

*Methods:* Subjective response to antipsychotic medication was measured at hospital discharge with the 10-item Drug Attitude Inventory (DAI), administered by unit nurses. Antipsychotic choice was clinically based, with 34 patients receiving typical, and 37 atypical antipsychotics.

*Results:* The 71 patients had a diagnosis of schizophrenia or schizoaffective disorder; 54% were male; 72% Caucasian; and mean age was 36 years. Average length of stay was 11 days. Patients treated with typical antipsychotics reported a greater degree of subjective dysphoric response (lower DAI score) compared with patients treated with atypical antipsychotics (mean score 7.3 vs 8.4, respectively; p=.004).

*Conclusions:* Patients with schizophrenia and schizoaffective disorder report less subjective dysphoria when treated with atypical compared with conventional antipsychotics. Further study is needed to confirm this finding, and to determine if chronic atypical antipsychotic treatment is associated with minimal dysphoric subjective response and better medication compliance.

## TARGET AUDIENCE:

Mental health professionals.

## REFERENCES:

1. Awad AG, Hogan TP, Voruganti LNP, Heslegrave RJ: Patients' subjective experience on antipsychotic medications: implications for outcome and quality of life. *Int Clin Psychopharm* 10:123–132, 1995.

2. Van Putten T, May PRA, Marder SR: Subjective response to antipsychotic drugs. *Arch Gen Psychiatry* 38:187–190, 1981.

**Poster 88** **Sunday, October 26 4:00 p.m.-5:30 p.m.**

## LACK OF TREATMENT COMPLIANCE: HIGH COSTS IN FIVE MANICS

Stephen D. Durrenberger, M.D., *Resident, Department of Psychiatry, University of Kentucky, Kentucky Clinic Wing B, Lexington, KY 40536-0284*; Thea Rogers, Pharm.D., José de León, M.D.

### SUMMARY:

Due to the increased focus on the cost of health care today, we did a retrospective case review of several patients whose primary reason for hospitalization was noncompliance with recommended treatment. These few patients use a disproportionately large percentage of resources.

During 1996, on the long-term ward at Eastern State Hospital (ESH) in Lexington, Kentucky, there were 35 patients. Of these, six had manic episodes. One of these six was hospitalized due to medical complications. The other five patients were hospitalized due to lack of compliance. The diagnoses were four DSM-IV bipolar and one schizoaffective disorder. During the last six years, these patients spent from 15%–95% of their time at ESH (mean, 41%). Using estimated costs for this time, ($210–$360 per day) and excluding physician fees, the cost for hospitalization ranged from $80,000– $550,000 per patient (mean, $240,000). The combined cost for the five patients was $1,440,000 for those six years.

When the cost of treatment is considered under a managed care system with a capitated budget, it is clear that these type of patients can quickly exhaust resources. Considering the concern over the cost of health care today and the need to carefully allocate resources, treatment compliance needs to be reconsidered as an important component in these decisions.

### TARGET AUDIENCE:

Psychiatrists.

### REFERENCES:

1. Keck Jr., et al: Compliance with maintenance treatment in bipolar disorder. *Psychopharmacology Bulletin* 33(1):87–91, 1997.
2. Goodwin FK, Jamison KR: *Manic Depressive Illness.* New York, Oxford University Press, 1990.

**Poster 89** **Sunday, October 26 4:00 p.m.-5:30 p.m.**

## DEPOT INJECTIONS: PROVIDERS AND CONSUMERS RESPOND

Lori L. Blahnik, R.N., M.A., *Clinical Specialist, Emergency Services Unit, Mental Health Center of Dane County, 625 West Washington Avenue, Madison, WI 53703*; Lori L. Kondora, Ph.D., R.N., *Clinical Specialist, Emergency Services Unit, Mental Health Center of Dane County, 625 West Washington Avenue, Madison, WI 53703*

### SUMMARY:

In an effort to develop a standardized protocol for administration of depot antipsychotics at the Mental Health Center of Dane County in Madison, WI, we conducted a survey of both providers and consumers regarding their experiences with injections. The results indicated very little consensus among providers about the techniques and injection sites that should be used. Practice tended to be based on "clinical wisdom" rather than research. Providers expressed disparate degrees of comfort administering injections and questioned their competence to ensure safety, efficacy, and comfort with existing procedures. Understandings of these techniques and rationales for their use varied widely and were idiosyncratic in nature. Consumers offered varying responses and were very interested in sharing their experience of receiving injections. This poster presentation will describe the findings of our surveys. It will also include an overview of nursing and medical research related to safe and efficacious injection techniques. Finally, we will share the protocol for the administration of depot antipsychotics currently in use at our outpatient community mental health center. Direction for future research will be recommended.

### TARGET AUDIENCE:

Nurses, physicians, pharmacists, consumers.

### REFERENCES:

1. Beyea SC, Nicoll LH: Administration of medications via the intramuscular route: an integrative review of the literature and research-based protocol for the procedure. *Applied Nursing Research* 8:23–33, 1995.
2. Weiden PJ: Using depot therapy for schizophrenia. *Journal of Practical Psychiatry and Behavioral Health* 11:247–250, 1995.

**Poster 90** **Sunday, October 26 4:00 p.m.-5:30 p.m.**

## ORAL SUBSTITUTION TREATMENT FOR OPIATE-DEPENDENT PREGNANT WOMEN USING METHADONE, MORPHINE AND BUPRENORPHINE

Gabriele Fischer, M.D., *Department of Psychiatry, University of Vienna, Wahringer Gurtez 18-20, Vienna, Austria 1090*; Petra Etzersdorfer, M.D., *Department of Psychiatry, University Hospital of Psychiatry, Vienna, Wahringer Gurtez 18-20, Vienna, Austria 1090*; Karin Diamant, M.D., Harald Eder

### SUMMARY:

In Austria, since 1987, oral substitution treatment for opiate-dependent patients has been permitted by law. In the beginning, methadone was the substance used for this purpose. After some time it was evident that methadone can produce side effects like depression, sleep disorders, and weight gain, which did not improve the therapy outcome. So it was necessary to choose alternative substances for maintenance therapy. In 1996, 2654 patients were enrolled in various maintenance programs in Austria. A total of 623 opiate-dependent patients have been treated at the drug addiction outpatient clinic at the University Clinic of Psychiatry in substitution programs: 219 were included in a methadone substitution program, 389 patients obtained slow-release morphine orally, and 15 patients were undergoing buprenorphine maintenance.

In 1993, a maintenance therapy study in pregnant opiate addicts started at the drug addiction outpatient clinic. Since then, 78 drug-dependent pregnant women have been enrolled in the study: 37 have been substituted with methadone (mean daily dosage: 48 mg), 30 with slow-release morphine (mean daily dosage: 350 mg), nine women have been substituted with buprenorphine (mean daily dosage: 8.1 mg). The mean age of the pregnant women was 26 years, the mean duration of pregnancy before starting maintenance treatment was 19 weeks. Seven percent were successfully detoxified and drug free at time of delivery. The newborns' mean weight at birth was 2850 g in the methadone group and 2880 g in the morphine group. Both substances showed safety and efficacy during pregnancy, but all the newborns showed a neonatal abstinence syndrome (NAS). No significant correlation between intensity of neonatal abstinence syndrome and mean daily dosage of methadone ($r=0.53$, $p=0.2$) and morphine ($r=0.39$, $p=0.14$) could be found.

In 1996, the drug addiction outpatient clinic started to maintain nine opiate addicts on sublingually applicable buprenorphine during pregnancy. The aim was to find a substance for maintenance therapy during pregnancy that shows safety and efficacy and does not produce any neonatal abstinence syndrome. Pregnant opiate addicts were switched from a mean daily dosage of 350 mg of slow-release morphine to a mean daily dosage of 8.1 mg of buprenorphine during pregnancy. In the buprenorphine group, three children have been born so far: our preliminary results demonstrate that those three did not show any abstinence syndrome.

### REFERENCES:

1. NIDA Monograph: *Medications Development for the Treatment of Pregnant Addicts and Their Infants.* Edited by Chiang CN, Finnegan LP, Monograph 149: 1995
2. Zuckermann B, Brown E: Maternal substance abuse and infant development. In: Tsang R, (ed.): *Handbook of Infant Mental Health*, New York: Guilford Press 143–158, 1993.

**Poster 91** **Sunday, October 26 4:00 p.m.-5:30 p.m.**

## CAFFEINE AND NICOTINE USE FOLLOWING ALCOHOL DETOXIFICATION

James J. Kim, M.D., *Department of Psychiatry, Veterans Affairs Medical Center, 400 Fort Hill Avenue, Canandaigua, NY 14424*; Hedy E. Tasbas, M.D., Jagannathan Srinivasaraghavan, M.D.

### SUMMARY:

*Objective:* The goal is to determine the relationship between the severity of alcohol dependence and the patterns of caffeine and nicotine use.

*Subjects:* All patients admitted to the Substance Abuse Rehabilitation Program at the Canandaigua V.A. Medical Center with a DSM-IV diagnosis of alcohol dependence and history of caffeine and/or nicotine use. During the study period (Oct. 1, 1995 to Mar. 31, 1996) there were 78 subjects.

*Methods:* We collected data on age, sex, use of caffeine and nicotine, and Severity of Alcohol Dependence Questionnaire (SADQ) scores.

*Results:* Based on SADQ, the patients were grouped as mild (SADQ<15), moderate (SADQ 16–34), or severe (SADQ>35). Nineteen mild group patients had mean nicotine and caffeine use of 27 cigarettes per day and 137.5 mg/day before detoxification and 22 cigarettes per day and 489.5 mg/day after detoxification, respectively. Forty-one moderate group patients had mean nicotine and caffeine use of 29 cigarettes per day and 259 mg/day before detoxification and 19 cigarettes per day and 594.5 mg/day after detoxification, respectively. Eighteen severe group patients had mean nicotine and caffeine

use of 30 cigarettes per day and 183 mg/day before detoxification and 21 cigarettes per day and 639 mg/day after detoxification.

*Conclusion:* A majority of patients with alcohol dependence ingest more caffeine and smoke fewer cigarettes during the period of alcohol rehabilitation treatment, regardless of the severity of alcohol dependence.

## REFERENCES:

1. Kozlowski LT, Henningfield JE, Keenan RM: Patterns of alcohol, cigarette, and caffeine and other drug use in two drug-abusing populations. *Journal of Substance Abuse Treatment* 10:171–179, 1993.
2. Istavan J, Matarazzo JD: Tobacco, alcohol, and caffeine use: a review of their interrelationships. *Psychological Bulletin* 2:301–326, 1984.

**Poster 92** **Monday, October 27 10:00 a.m.-11:30 a.m.**

## IMPACT OF OLANZAPINE ON VOCATIONAL REHABILITATION IN SCHIZOPHRENIA

Annette Zygmont, M.S., *Research Coordinator, Department of Psychiatry, St. Luke's Hospital/Roosevelt, 411 West 114th Street, Suite 3B, New York, NY 10025*; Marianne Emanuel, R.N., *Nursing Coordinator, Project Renewal, 448 West 48th Street, New York, NY 10036*; Peter Weiden, M.D., Kathy Nathans, Ph.D.

## SUMMARY:

Both the symptoms of schizophrenia and the side effects of antipsychotic treatment can impede the individual's capacity to work. Olanzapine is an atypical antipsychotic recently introduced in the treatment of schizophrenia. Compared with haloperidol, olanzapine has been shown to cause fewer extrapyramidal symptoms, and to have greater efficacy in the treatment of negative and depressive symptoms. Research is needed to assess whether newer antipsychotics, such as olanzapine, can help individuals with schizophrenia to achieve a more favorable work outcome.

This study followed a group of 40 individuals diagnosed with schizophrenia who were switched from their previous antipsychotics to olanzapine. All subjects were involved in a vocational rehabilitation program prior to entering the study. Changes in clinical status and vocational functioning were assessed over the course of six months following the medication switch.

Clinical outcome was defined as improvement in clinical status since the patient's baseline, as measured by the Clinical Global Impression-Improvement Scale (CGI). The CGI was administered independently to clinicians and to the vocational rehabilitation case managers. Vocational outcome was defined by number of hours worked, as well as personal attributes such as motivation, level of energy, social interaction, hygiene, and level of concentration.

These data are currently being collected and will be presented at the meeting. Data analysis procedures will be used to assess (1) the level of agreement regarding clinical response (CGI scores) between all three sources of information, and (2) the time course and magnitude of symptoms and vocational rehabilitation changes after the initiation of olanzapine.

## REFERENCES:

1. Lehman AF: Vocational rehabilitation in schizophrenia. *Schiz Bull* 21 (4) 645–656, 1995.
2. Weiden PU, Aquila R, Standard J: Atypical antipsychotic drugs and long-term outcome in schizophrenia. *J Clin Psychiatry* 57(1)53–60, 1996.

**Poster 93** **Monday, October 27 10:00 a.m.-11:30 a.m.**

## ATYPICAL ANTIPSYCHOTICS: WEIGHT GAIN AND RELATED RISKS

Marianne Emanuel, R.N., *Nursing Coordinator, Project Renewal, Inc., 448 West 48th Street, New York, NY 10036*; Janet Standard, M.S.N., *Nursing Coordinator, St. Luke's Hospital/Roosevelt, 411 West 114th Street, New York, NY 10025*; Ralph Aquila, M.D.

## SUMMARY:

In our large outpatient psychiatric clinic, we have been identifying medical pathology in a population that may not have had access to or has avoided medical care, as per their psychopathology. This population is currently part of a large study examining rehabilitation outcomes in adults with serious and persistent mental illness. In this setting, we are able to observe the psychological and physical responses of patients switched from standard neuroleptic therapy to atypical antipsychotics. The atypical drugs, such as olanzapine and risperidone are useful in the acute phase of psychoses, as well as preventing relapse. They also seem to cause fewer extrapyramidal symptoms and lessen the risk of developing tardive dyskinesia. In treating refractory schizophrenia, therefore, atypicals may appear to be the drug of choice. The side effects of these drugs include weight gain and possible obesity. While these effects may be viewed as less harmful than the proven benefits, for a population with risk factors such as smoking, inactivity, and poor nutrition, adding the side effects of weight gain and obesity may compromise the patient's medical health by increasing the risk of developing certain types of disease. We examined 70 patients randomized to olanzapine or usual care, tracking weight gain and blood

pressure levels. Evidence suggests that medications that increase appetite and cause weight gain may increase the risk for developing hypertension.

## REFERENCES:

1. Umbricht D, Kane J: Medical complications of new antipsychotic drugs. *Schizophrenia Bulletin* vol. 22, number 3, 1996.
2. Aquila R, Emanuel M: Atypical antipsychotics: weight gain and related risk of hyperglycemia. *H&CP* Conference Poster Session, Boston, 1995.

**Poster 94** **Monday, October 27**
**10:00 a.m.-11:30 a.m.**

## GENDER DIFFERENCES OF SUBSTANCE ABUSE AND MENTAL HEALTH PATIENTS SELF-REPORTED RISK FOR HIV INFECTION: DO PERCEPTIONS MIRROR REALITIES?

Thomas M. Brady, M.P.H., *Research Assistant, Department of Psychiatry, University of Illinois at Chicago, 912 South Wood Street, Chicago, IL 60612*; Joseph A. Flaherty, M.D., *Chairman and Professor of Psychiatry, University of Illinois at Chicago, 912 South Wood Street, Chicago, IL 60612*; Susan Adams, Ph.D., Sonja Nelson, M.S.

## SUMMARY:

The patterns of risk for HIV infection in the United States are changing rapidly. For example, the ratio of male to female HIV cases in Chicago has decreased from 12:1 to 5:1 within the last decade, and U.S. national statistics show a similar trend. As women, especially minority women and women substance users, become increasingly at risk for HIV infection, do they perceive themselves at equal risk of HIV infection compared with men? The study of risk perception is central to many diverse theories of protective health behavior and considered the first step in behavioral change.

In this study we surveyed 120 Chicago substance abuse patients' worry about HIV infection between March 1996 and February 1997 (Brady), and explored the relationship between vulnerability to HIV and a number of health risks, including sexual activities such as commercial sex and exchanging sex for drugs. Using HIV worry as the dependent variable, we found statistically significant differences between men and women, even after considering length of stay in treatment into an ANOVA model. In addition, in building a stepwise regression model, we entered demographic information, drug use, and finally high-risk sexual activities, and found gender an important correlate of self-reported worry of HIV infection. In our treatment program for substance abuse, although men practiced more sexual risk-taking behavior and had higher self-reported drug use, women perceived themselves at higher risk for HIV infection. Possible explanations are offered for this discrepancy (Kline) and suggestions are provided on how to incorporate these findings into HIV education programs based in substance abuse treatment programs.

## TARGET AUDIENCE:

Behavioral scientists, mental health providers, managers of women treatment centers.

## REFERENCES:

1. Brady TM, Flaherty JA, Miller NA: The progression of HIV knowledge, attitudes and behavior of drug and alcohol outpatients through treatment. New Research poster presented at the American Psychiatric Association Annual Meeting, San Diego, May 20, 1997.
2. Kline A, VanLandingham M: HIV-infected women and sexual risk reduction: the relevance of existing models of behavior change *AIDS Education and Prevention* 6(5), 390–402, 1994.

**Poster 95** **Monday, October 27**
**10:00 a.m.-11:30 a.m.**

## PATIENT SATISFACTION IN MENTAL HEALTH AND SUBSTANCE ABUSE TREATMENT

Thomas M. Brady, M.P.H., *Research Assistant, Department of Psychiatry, University of Illinois at Chicago, 912 South Wood Street, Chicago, IL 60612*; Joseph A. Flaherty, M.D., *Chairman and Professor of Psychiatry, University of Illinois at Chicago, 912 South Wood Street, Chicago, IL 60612*; Norman S. Miller, M.D.

## SUMMARY:

Patient satisfaction is an important measure of patient care, and this poster shares one drug and alcohol treatment program's experiences in the development, collection, and analysis of patient satisfaction data. The Division of Addiction Programs of the University of Illinois psychiatry department collected patient satisfaction data from Medicaid patients between March 1996 and June 1997, providing over 300 completed questionnaires for analysis. Two satisfaction measures were developed, a provider-specific scale and an overall global measure of program satisfaction. The outcome measure used was overall satisfaction with the addiction program, and other measures included ratings of group therapy, individual therapy, as well as comfort of meeting areas, art therapy, and HIV/AIDS education. The coefficient alpha or reliability for eight items that made up the counselor-specific scale was .96 and .92 for the six global items of

overall satisfaction. The most significant correlate of overall patient satisfaction was satisfaction with the patient's therapist. Threats to validity are important in interpreting patient satisfaction data, and we will highlight some obstacles identified from the literature on patient satisfaction as well as our own experiences (Cernovsky). Patient satisfaction data can be used to improve quality (Coker), and we emphasize in our "lessons learned" section the importance of using a standard questionnaire format such as HEDIS 3.0 Member Satisfaction Survey (1996), of the Health Plan Employer Data and Information Set.

## TARGET AUDIENCE:

Behavioral health program managers, administrators of substance abuse treatment programs, quality improvement managers.

## REFERENCES:

1. Cernovsky Z: Antisocial personality traits and patient satisfaction with treatment for addiction. *Psychological Reports* 80(1):275–82, 1997.
2. Coker M: Implementation of total quality management after reconfiguration of services on a general hospital unit. *Psychiatric Services* 48(2):231–6, 1997.

**Poster 96** **Monday, October 27**
**10:00 a.m.-11:30 a.m.**

# AN OPEN-LABEL STUDY OF NEFAZODONE HC1 IN ELDERLY DEPRESSED PATIENTS

Kenneth J. Weiss, M.D., *Clinical Professor of Psychiatry, Department of Psychiatry, Robert Wood Johnson Medical School, 133 Ivy Lane, King Of Prussia, PA 19406-2101*; Stephen M. Stahl, M.D., Ph.D., *Director of Clinical Neuroscience, and Adjunct Professor of Psychiatry, University of California at San Diego, 8899 University Center Lane, #130, San Diego, CA 92122-1009*; Jan A. Fawcett, M.D., John M. Zajecka, M.D., Frances E. Borian, R.N., John R. Ieni, Ph.D., Darlene N. Jody, M.D.

## SUMMARY:

*Objectives:* The purpose of this clinical trial was to evaluate the effectiveness, safety, and tolerability of nefazodone in depressed patients seen in the general psychiatric practice setting.

*Methods:* Of the 1151 patients enrolled in a 12-week, open-label study of nefazodone, 41 were considered elderly (65 to 75 years old). This subset of elderly patients is the basis for this report. Patients with depressive symptoms of sufficient severity to require antidepressant treatment were enrolled in the trial. Nefazodone, given bid, was to be titrated in the elderly patients at 100 mg/day (50 mg BID) for two weeks, then increased during the third week based on tolerability, to 200 mg/day (100 mg bid). Subsequent dose escalations were to be made based on clinical response and tolerance, at intervals no less than two weeks, to achieve an optimal therapeutic response within the dose range of 300–600 daily (150–300 mg bid). Efficacy assessments included the CGI, the Patient Global Assessment(PGA), and patient self evaluations of anxiety, sleep quality, and sexual function.

*Results:* A significant reduction from screening in the mean CGI Severity of Illness scale score ($p<0.002$) was noted beginning at the week 4 visit and continuing to the week 12 visit. Moreover, the change from screen in mean Severity of Illness scale scores continued to increase from the week 4 to the week 12 visit. In the observed-cases analysis at week 12, 15 of 19 patients (79%) of the Evaluable and the Intent-to-Treat patient samples were rated as much or very much improved (1 or 2) on the CGI Improvement Scale. In the Elderly Evaluable patient sample, significant improvements in anxiety and ability to sleep through the night were observed as early as the week 1 visit ($p<0.007$). These improvements were sustained throughout the 12-week treatment period. Improvements were observed in overall sexual function as well as male and female sexual function, however, not at a statistically significant level. Eleven elderly patients dropped out of the study due to adverse events. The rate of discontinuation due to adverse events may have been increased by lack of adherence to the proper titration; 35 of 40 patients were titrated too quickly and of those patients, 20 of 40 started nefazodone at 200 mg/day instead of 100 mg/day.

*Conclusions:* Approximately 79% of elderly patients who completed 12 weeks of nefazodone were thought to be responders by both physician and patient assessment. Many of the elderly patients treated with nefazodone experienced relief of anxiety and sleep difficulties. Nefazodone appears to be a safe antidepressant for elderly depressed patients. Nefazodone did not appear to compromise the sexual function of most elderly patients.

## TARGET AUDIENCE:

General and geriatric psychiatrists.

## REFERENCES:

1. Feiger A, et al: Nefazodone versus sertraline in outpatients with major depression: focus on efficacy, tolerability, and effects on sexual function and satisfaction. *J Clin Psychiatry*, 57(suppl 2):53–62, 1996.
2. Fontaine R, et al: A double-blind comparison of nefazodone, imipramine, and placebo in major depression. *J Clin Psychiatry*, 55(6):234–241, 1994.

**Poster 97** **Monday, October 27 10:00 a.m.-11:30 a.m.**

## QUETIAPINE FUMERATE TREATMENT OF PSYCHOSIS IN PARKINSON'S DISEASE

Mahmoud A. Parsa, M.D., *Director, Neuropsychiatry Unit, Department of Psychiatry, Case Western Reserve, 11100 Euclid Avenue, Cleveland, OH 44106*; Bijan Bastani, M.D.

### SUMMARY:

*Introduction:* Psychoses characterized by hallucinations and delusions are a relatively common clinical problem in patients with Parkinson's disease (PD). Treatment of psychosis with typical antipsychotic drugs and/or withdrawal of antiparkinsonian agents may improve the symptoms, but usually worsens the motor abnormalities. Quetiapine, a dibenzothiazepine derivative, is a novel antipsychotic medication with a high affinity for serotonin 5-HT2 receptors and low affinity for dopamine D2 receptors. It is virtually free of extrapyramidal side effects and has considerably low cholinergic muscarinic and alpha-1 adrenergic receptor antagonist activity.

*Objective:* This study was intended to evaluate the utility and safety of quetiapine in the treatment of psychosis in patients with PD.

*Method:* We enrolled two patients with idiopathic PD and psychosis in an ongoing 52-week open trial of quetiapine. Both patients were neuroleptic-naive and were stabilized on carbidopa/levedopa for motor symptoms prior to enrollment in this study. The dose of carbidopa/levodopa was held constant throughout the study. Severity of psychiatric symptoms was measured by BPRS and CGI-S; severity of motor symptoms was measured by Simpson Scale, Unified Parkinson's Disease Rating Scale (UPDRS), and AIMS. Quetiapine was started at 25 mg/day, and was increased as clinically indicated and/or tolerated.

*Results:* In both patients, psychotic symptoms improved markedly (80% or higher reduction in BPRS total score), without any worsening in parkinsonism.

*Conclusion:* Our data suggest that long-term treatment with quetiapine was well tolerated and effective in the treatment of psychosis in PD patients.

This study was supported by Zeneca Pharmaceuticals.

### REFERENCES:

1. Goetz CG, Stebbins GT: Risk factors for nursing home placement in advanced Parkinson's disease. *Neurology* 43:2227–2229, 1993.
2. Saller CF, Salama AI: Seroquel: biochemical profile of a potential atypical antipsychotic. *Psychopharmacology* (Berl) 112:285–292 ,1993.

**Poster 98** **Monday, October 27 10:00 a.m.-11:30 a.m.**

## OLANZAPINE IN TREATMENT-REFRACTORY SCHIZOPHRENIA

Joaquin Martin, M.D., *Department of Psychiatry, Hospital Valme, CTA Cadiz Bellavista, Room 5489, Sevilla, Spain 41014*; Enrique Garcia-Bernardo, M.D., *Chief, Inpatient Care Unit, Department of Psychiatry, Hospital 12 Octubre, Auda, Andalucia KM54, Madrid, Spain 28041*; Victor Peralta, M.D., Enrique Alvarez, M.D.

### SUMMARY:

Clozapine is currently the treatment of choice for neuroleptic-resistant schizophrenia (between 30% and 50% of these patients respond to clozapine). Olanzapine is a new antipsychotic drug that has shown efficacy against positive and negative symptoms of schizophrenia, with minimal extrapyramidal side effects. However, the effectiveness of olanzapine has not yet been reported among treatment-refractory schizophrenic patients.

A total of 25 schizophrenic patients (DSM-IV criteria) with documented lack of response to two conventional antipsychotic drugs entered this six-week prospective, open-label treatment trial with olanzapine 15 to 25 mg/day. An optional extension up to six months was allowed.

As a group, the olanzapine-treated patients showed statistically significant improvement ($p<0.05$) in both positive and negative symptoms by the end of six weeks therapy. Overall, 36% of the patients met criteria for treatment response (ℓ35% decrease in BPRS total score, plus post-treatment CGI-severity ℓ3 or BPRS total<18).

There was only one treatment discontinuation due to an adverse event (depression) during the entire study. There were no reports of parkinsonism, akathisia, or dystonia, and no patients required anticholinergic medication while taking olanzapine.

In conclusion, this uncontrolled study suggests that olanzapine may be effective for a significant number of neuroleptic-resistant schizophrenic patients. Further blinded, controlled trials are needed to confirm our results.

### REFERENCES:

1. Beasley CM Jr, Sanger T, Satterlee W, et al: Olanzapine versus placebo: results of a double-blind, fixed-dose olanzapine trial. *Psychopharmacology* 124:159–167, 1996.
2. Beasley CM Jr, Tollefson G, Tran P, et al: Olanzapine versus placebo and haloperidol: acute phase results of the North American double-blind olanzapine trial. *Neuropsychopharmacology*. 14:111–124, 1996.

**Poster 99** **Monday, October 27 10:00 a.m.-11:30 a.m.**

## QUALITY-OF-LIFE EXPERIENCE IN SCHIZOPHRENIA: ATYPICAL VERSUS TRADITIONAL MEDICATIONS

Sharon G. Dott, M.D., *Associate Professor, Department of Psychiatry, University of Texas Medical Branch, 301 University Boulevard, D28, Galveston, TX 77555-0428*; David P. Walling, Ph.D., *Vice President, Product Development, Psychiatric Management Resources, 301 University Boulevard, D28, Galveston, TX 77555-0428*; Daphne C. Brazile, M.D., Laura K. Slaughter, M.D.

### SUMMARY:

Schizophrenia can be a devastating disorder. Subjective quality of life experiences have increasingly become an important issue to all involved in the treatment of persons with schizophrenia. The development of novel psychopharmacotherapies and widespread deinstitutionalization have resulted in increased focus on life quality in schizophrenia. Life satisfaction, physical activities, leisure, and social enjoyment are all included within the concept of quality of life. Utilizing outcome measures of quality of life provides one method of gauging the efficacy of interventions and has been proposed as a requirement for the approval of new medications (Awad, 1992). This study was conducted to compare quality of life measurements in persons with chronic schizophrenia stabilized on traditional neuroleptics versus those using novel antipsychotics. The Quality of Life Enjoyment and Satisfaction Questionnaire (Q-LES-Q) measured the subjective interpretation of life quality by the individual patient. Severity of illness was assessed by the Clinician's Global Inventory (CGI) and Brief Psychiatric Rating Scale (BPRS). Novel antipsychotic medications were not assessed individually but grouped together and include clozapine, risperidone, quetiapine, and sertindole.

### TARGET AUDIENCE:

Psychopharmacologists, community mental health staff, clinical trials researchers.

### REFERENCES:

1. Awad G: Quality of life of schizophrenia patients on medications and implications for new drug trials. *Hospital and Community Psychiatry* 43:262–265, 1992.
2. Endicott J, Nee J, Harrison W, Blumenthal R: Quality of Life Enjoyment and Satisfaction Questionnaire: a new measure. *Psychopharmacology Bulletin* 321–326, 1993.

**Poster 100** **Monday, October 27 10:00 a.m.-11:30 a.m.**

## EFFECT OF COMBINED CONVENTIONAL/ ATYPICAL ANTIPSYCHOTICS

Michael C. Stevens, M.D., *Director Psychopharmacology Research, Valley Mental Health, 1141 East 3900 South A170, Salt Lake City, UT 84124*; Catherine Carter, Ph.D., Elizabeth Feick, B.S.

### SUMMARY:

*Background:* Clinical observations were made on our patients with schizophrenia that some individuals seem to achieve better symptom control when conventional and atypical antipsychotics were used in combination than single antipsychotics alone. As of yet, no data have been published on the effects of combining conventional and atypical antipsychotics.

*Method:* A retrospective review of service utilization during combined treatment was carried out (n=34), with a comparison to service utilization prior to combined treatment (most patients on conventionals).

*Results:* Substantial reductions in service utilization were observed during combination treatment compared with single antipsychotic treatment. Median cost of care per month prior to combination treatment was approximately $1,100; during combination treatment, median cost of care was $400. Savings were achieved via substantial reductions in hospitalizations and in other services. When medication costs were factored in, a net savings in cost of care was achieved.

*Conclusion:* Combining conventional and atypical antipsychotics in some patients with schizophrenia resulted in substantial reductions in service utilization that appears to reflect better clinical outcomes and cost effectiveness of this strategy. Several hypotheses will be offered that could explain these results and recommendations for future research will be given.

### REFERENCES:

1. Kapur S, Remington G: Serotonin-dopamine interaction and its relevance to schizophrenia. *American Journal of Psychiatry*, 153(4):466–76, 1996.
2. Lehman AF, Carpenter WT, Goldman HH, Steinwachs AM: Treatment outcomes in schizophrenia: implications for practice, policy, and research. *Schizophrenia Bulletin*, 21:669–675, 1995.

**Poster 101** **Monday, October 27 10:00 a.m.-11:30 a.m.**

## RISPERIDONE IN ELDERLY PATIENTS WITH PSYCHOTIC DISORDERS

Subramoniam Madhusoodanan, M.D., *Associate Chairman of Psychiatry, St. Johns Hospital, South Shore, Far*

*Rockaway, NY 11691*; Martin B. Brecher, M.D., Ronald Brenner, M.D., John W. Kasckow, M.D., Ph.D., Mark E. Kunik, M.D., Arnaldo E. Negrón, M.D., Nunzio Pomera, M.D.

## SUMMARY:

An open, multicenter, 12-week study was conducted to evaluate the tolerability and efficacy of risperidone in 103 elderly patients (mean age, 71 years) with a diagnosis of schizophrenia (75%) or schizoaffective disorder (25%). The starting dose of risperidone was 0.5 mg b.i.d., which could be increased to a maximum of 3 mg/day during the first week and then in increments of 0.5 mg b.i.d. per week to a maximum of 6 mg/day. Mean total and subscale Positive and Negative Syndrome Scale scores improved significantly from baseline to endpoint in all patients and in those receiving ≥3 and >3 mg/day of risperidone. The total and subscale Extrapyramidal Symptom Rating Scale scores significantly increased from baseline to worst score during treatment, but decreased significantly from baseline to endpoint. Antiparkinsonian medications were used by 33% of the patients. The most frequently reported adverse events were dizziness (22% of patients), insomnia (17%), agitation (15%), somnolence (15%), and injury (12%). No significant electrocardiographic changes were observed. It is concluded that risperidone was well tolerated and efficacious in elderly patients with schizophrenia or schizoaffective disorder.

## TARGET AUDIENCE:

Geriatric psychiatrists.

## REFERENCES:

1. Jeste DV, Eastham JH, Lacro JP, et al: Management of late-life psychosis. *J Clin Psychiatry* 57(Suppl 3):39–45, 1996.
2. Marder SR, Meibach RC: Risperidone in the treatment of schizophrenia. *Am J Psychiatry* 151:825–835, 1994.

**Poster 102** **Monday, October 27 10:00 a.m.-11:30 a.m.**

## SENSORY RESPONSES IN SCHIZOPHRENIA

Catana E. Brown, M.A., *Assistant Professor, Department of Occupational Therapy Education, University of Kansas Medical Center, 4415 Oxford, Prairie Village, KS 66208*

## SUMMARY:

Studies of sensory processing suggest that individuals with schizophrenia have a low threshold to sensory stimulation. Most studies focus on physiological response to sensory stimulation; however, an individual's sensory processing disposition is also reflected in his/her behavioral repertoire. Some behaviors clinically relevant to schizophrenia may be related to sensory processing. For example, social withdrawal and emotional blunting could be coping strategies adopted to manage sensory overload. This study used the *Adult Sensory Profile* to compare behavioral responses to sensory stimulation in individuals with and without schizophrenia. The *Adult Sensory Profile* was administered to 15 individuals with schizophrenia and 15 individuals without mental illness matched by age and gender. Individuals with schizophrenia had higher scores on the low threshold (t=2.24, p=.042) and high threshold (t=3.35, p=.005) subscales. These results suggest that individuals with schizophrenia may have a general neurological modulation problem resulting in regulatory instability. Thus, individuals with schizophrenia may miss or overrespond to sensory stimulation. Environments and situations that reduce unnecessary sensory stimuli but emphasize important sensory stimuli may be most supportive to individuals with schizophrenia.

## REFERENCES:

1. Kring AM, Kerr SL, Smith DA, Neale JM: Flat affect in schizophrenia does not reflect diminished subjective experience of emotion. *Journal of Abnormal Psychology* 102:507–517, 1993.
2. Moran MJ, Thaker GK, Smith D, et al: Shifts in covert visual attention in schizophrenia patients and normal controls. *Biological Psychiatry* 32:617–620, 1992.

**Poster 103** **Monday, October 27 10:00 a.m.-11:30 a.m.**

## CONCURRENT PHYSICAL ILLNESS AND SCHIZOPHRENIA: INFLUENCE UPON LENGTH OF STAY IN THE HOSPITAL

Isha Salva, M.D., *Resident, Department of Psychiatry, Michigan State University, B 109 West Fee Hall, East Lansing, MI 48824*; Dale A. D'Mello, M.D.

## SUMMARY:

Patients with schizophrenic disorders are known to suffer greater morbidity and mortality from cardiovascular, cerebrovascular, and infectious diseases. *Objective:* The purpose of the present study was to examine the influence of concurrent physical illness upon the outcome of treatment for schizophrenia. *Method:* A retrospective naturalistic study of 143 patients consecutively admitted to the adult psychiatric unit of a general hospital in mid-Michigan with the diagnosis of paranoid schizophrenia sought to establish the prevalence of concurrent

physical illness in the patient cohort, and examine the influence of physical illness upon the length of hospital stay (LOS) and the cost of treatment. *Results:* Forty-nine percent of the 143 patients included in the study had at least one physical disorder. The mean length of stay for all patients was 20 days. The presence of hypertensive disease was associated with a significantly longer length of stay (30 days; T=2.59, df=141, p<0.05). Concurrent diabetes mellitus was associated with a LOS of 35 days (T=2.14, df=141, p<0.05), chronic obstructive pulmonary disease with a mean LOS of 36 days (T= 3.34, df=141, p<0.005). *Conclusion:* Concurrent physical illness may have an adverse influence upon recovery from an episode of schizophrenic disorder. The clinical and therapeutic implications of the finding are discussed.

## TARGET AUDIENCE:

All.

## REFERENCES:

1. Jeste DV: Medical comorbidity in schizophrenia. *Schizophr. Bull* 22(3):413–425, 1996.
2. Lipper S: Schizophrenia and intercurrent physical illness: a critical review of the literature. *Comprehensive Psychiatry*, Vol. 18 NO I (Jan/Feb), 1977.

**Poster 104** **Saturday, October 25 10:00 a.m.-11:30 a.m.**

## NATURALLY OCCURRING RETIREMENT AND MENTAL HEALTH CARE

Mark R. Nathanson, M.D., *Associate Professor of Psychiatry, Geropsychiatry Fellowship, Columbia University for Geriatric and Gerontology Rehabilitation, 100 Haven Avenue, Tower 1, 29F, New York, NY 10032*; Harry Schwartz, Ph.D., *Professor of Urban Planning, Columbia University, 100 Haven Avenue, Tower 1, 29F, New York, NY 10032*

## SUMMARY:

The Naturally Occurring Retirement Community (NORC) is an urban planning model that conceptualizes densities of the aged in a population where over 50% of a community is over 65 years of age. The frail elderly are the fastest growing segment of the population and are in need of supportive community services to remain in their communities. The author has received a two-year foundation grant to develop mental health services to a middle-income cooperative in the Coney Island section of Brooklyn, New York. He reports on the model of service delivery, development of a network of mental health providers in the area, organizing a conference for local and state politicians to disseminate the model and inform legislators of its success and need for ongoing funding. The poster will inform the audience on the NORC model, serve as a stimulus for those interested in community-based services to the elderly, and offer suggestions to develop their own local programs through foundation start-up grants and local and state support of such programs.

## TARGET AUDIENCE:

All mental health providers interested in the aged.

## REFERENCES:

1. Newcomer RJ. Lawton MP, Byerts TO (Eds.) *Housing an Aging Society,* New York: Van Nostrand Reinhold, 1986.
2. Wykle ML: Geriatric mental health interventions in the home. *J Gerontol Nurs* 21(1):50, 1995.

**Poster 105** **Monday, October 27 10:00 a.m.-11:30 a.m.**

## THE ACTION OF SERTINDOLE ON NEGATIVE SYMPTOMS

Diana O. Perkins, M.D., *Assistant Professor, Department of Psychiatry, University of North Carolina at Chapel Hill*; Christopher J. Silber, M.D., *Department of Psychopharmacology, Abbott Laboratories*

## SUMMARY:

Sertindole, discovered and patented by H. Lundbeck (Copenhagen), is currently under clinical assessment by Abbott Laboratories in the United States, Latin America, and Canada for the treatment of schizophrenia. Sertindole is a novel antipsychotic with nanomolar affinities for dopamine $D_2$ serotonin 5-$HT_2$, and $\alpha_1$ adrenergic receptors. Importantly, the pharmacological profile of sertindole suggests little anti-cholinergic or anti-histaminergic effects, which may be particularly important in the treatment of elderly patients resulting in less memory loss and sedation. Clinically, sertindole is more effective than placebo for both positive and negative symptoms of schizophrenia and is indistinguishable from placebo in the production of motor side effects. It is expected that sertindole will demonstrate comparable efficacy results when administered to an elderly population although the doses necessary to attain efficacy in an elderly population need further exploration.

A path analysis was undertaken to correct the direct treatment effect on negative symptoms from the disturbance of other effects, namely, positive symptoms, depressed mood, extrapyramidal side effects, and baseline negative symptoms. The following table summarizes the results:

Differences Between Treatment Groups

| | HDL 4mg | HDL 8mg | HDL 16mg | HDL Pooled |
|---|---|---|---|---|
| SRT 12mg | n=140 | n=135 | n=253 | |
| | N/A | N/A | −1.3 | |
| SRT 20mg | n=244 | n=239 | n=357 | |
| | 0.1 | −0.5 | −1.1* | |
| SRT 24mg | n=246 | n=241 | n=359 | |
| | −1.0 | 0.3 | −1.2* | |
| SRT Pooled | | | | n=598 |
| | | | | −1.0* |

*p<0.05

The path analysis showed that the direct baseline effect on negative symptoms was significantly greater with sertindole than with haloperidol.

## REFERENCES:


1. Zimbroff D, Kane J, Tamminga C, et al: Controlled dose-response study of sertindole and haloperidol in the treatment of schizophrenia, *Am J Psychiatry* 1997; 154:782–791.
2. Sanchez C, Arnt J, Dragsted N, et al: Neurochemical and in vivo pharmacological profile of sertindole, a limbic-selective neuroleptic compound. *Drug Dev Res* 1991; 22:239–250.


**Poster 106** **Monday, October 27**
**10:00 a.m.-11:30 a.m.**

## THE LONG-TERM CARDIOVASCULAR SAFETY OF SERTINDOLE

Victor Vieweg, M.D., *Professor of Psychiatry and Medicine, Medical College of Virginia*; Rita Driscoll, M.D., Christopher J. Silber, M.D.

## SUMMARY:

Sertindole, discovered and patented by H. Lundbeck (Copenhagen) and under development in the United States, Canada, and Latin America by Abbott Laboratories, is a novel antipsychotic for the treatment of the manifestations of psychosis.

The QT interval, which represents ventricular repolarization on the ECG, has been found to be prolonged by a number of drugs with different pharmacologic effects. A number of psychotropics have also shown evidence of prolongation of the QT interval. Early in its clinical development, it was noted that sertindole was associated with slight prolongation at the QT interval on the electrocardiogram. Therefore, extensive electrocardiographic recordings (over 14,000 ECG's) were performed during major clinical trials so that the extent of this QT interval prolongation could be precisely assessed. The QT interval prolongation was small (+21 msec or 5.1% compared with baseline) and, importantly, there were no recorded instances of torsades de pointes among 2,194 sertindole-treated patients with 1,024 patient years of exposure. Furthermore, there were few serious cardiovascular adverse experiences and the overall mortality rate was low and consistent with other antipsychotics. An expert panel of cardiologists concluded that sertindole has a favorable cardiovascular risk profile.

## REFERENCES:


1. Skarsfeldt T, Perregaard J: Sertindole, a new neuroleptic with extreme selectivity on A10 versus A9 dopamine neurones in rat. *Eur J Pharmacol* 1990; 182:613–614.
2. Sanchez C, Arnt J, Dragsted N et al: Neurochemical and in vivo pharmacological profile of sertindole, a limbic-selective neuroleptic compound. *Drug Dev Res* 1991; 22:239-250.


**Poster 107** **Monday, October 27**
**10:00 a.m.-11:30 a.m.**

## THE LONG-TERM SAFETY, EFFICACY, AND QUALITY-OF-LIFE OF SERTINDOLE

David G. Daniel, M.D., *Senior Director, Clinical Studies, Ltd., Washington, DC*; Christopher J. Silber, M.D., P. Wozniak, Ph.D.

## SUMMARY:

Discovered and patented by H. Lundbeck (Copenhagen) and under development by Abbott Laboratories in the United States, Latin America, and Canada, sertindole is a novel antipsychotic with nanomolar affinities for dopamine $D_2$, serotonin 5-$HT_2$ and $\alpha_1$ adrenergic receptors. Demonstrating a 100-fold greater selectivity for dopamine neurons within the limbic area over the nigrostriatal area, sertindole has been hypothesized to effectively treat psychotic symptoms without causing unwanted extrapyramidal side effects.

The primary objective of this multicenter, double-blind, parallel design study (M93-132), was to assess the long-term (one year) efficacy and safety of sertindole (24 mg once daily) compared with haloperidol (10 mg once daily) in schizophrenic outpatients who had been stable on a neuroleptic agent (excluding clozapine) for at least three months. Secondary objectives included measurements of negative symptoms, quality-of-life, and resource utilization for each group.

Efficacy assessments included BPRS, PANSS, SANS, SDS, and CGL. Assessments of extrapyramidal symptoms (EPS) were made using movement rating scales, incidence of EPS-related adverse events, and use of anti-EPS medications. Adverse events, laboratory tests, and ECGs were utilized to assess safety; quality-of-life scale and a resource utilization questionnaire were used to assess secondary objectives.

Interim blinded data on 204 patients with up to six months of treatment showed the greatest mean improvement from baseline to total PANSS to take place at the second month. Improvement remained relatively stable through month six. One year unblinded data on sertindole and haloperidol for all efficacy, safety, quality-of-life, and resource utilization parameters will be presented.

## REFERENCES:

1. Skarsfeldt T, Perregaard J: Sertindole, a new neuroleptic with extreme selectivity on A10 versus A9 dopamine neurones in rat. *Eur J Pharmacol* 1990; 182:613–614.
2. Sanchez C, Arnt J, Dragsted N, et al: Neurochemical and in vivo pharmacological profile of sertindole, a limbic-selective neuroleptic compound. *Drug Dev Res* 1991; 22:239–250.

**Symposium 1** **Friday, October 24**
**8:30 a.m.-11:30 a.m.**

## INNOVATIONS IN DUAL DIAGNOSIS TREATMENT

Kenneth Minkoff, M.D., *Medical Director, Choate Health Systems, 23 Warren Avenue, Woburn, MA 01801-4979*

### EDUCATIONAL OBJECTIVES:

At the end of this session, the participant should be able to: describe the utility of the SSATs in assessment and outcome evaluation; list the elements of dual-diagnosis case management programs associated with positive outcome; identify the components of a managed care continuum for dual diagnosis, and the risks and benefits of shared risk payment for this population; enumerate three gender-specific differences in engagement and treatment of dual diagnosis.

### SUMMARY:

The overall goal of this symposium is to present the latest innovations in research and clinical practice in the treatment of comorbid psychiatric and substance disorders, with an emphasis on creative local program development in Baltimore and Washington, D.C. Dr. Drake will begin with a summary of recent research findings in treating people with SMI and substance disorder, focusing on assessment techniques, including the Stages of S.A. Treatment Scale (SSATS) and integrated case management program outcome studies. Dr. Minkoff will describe the development of an integrated psychiatric and addiction continuum of care in a public managed care environment and discuss the results of a "case rate" program for dual-diagnosis Medicaid recipients. Drs. Watkins and Harris will focus on the cutting-edge issue of gender and dual diagnosis. Dr. Watkins will present her findings regrading gender influences on access for homeless people with dual diagnoses, and Dr. Harris will report on the treatment of trauma issues in dual-diagnosis SMI women in Community Connections, a Washington, D.C. program. Finally, Dr. Osher and colleagues will discuss the implementation of innovative, integrated case management and homeless outreach for dual diagnosis in Baltimore, including outcome studies, housing issues, and the role of consumer case-management aides.

## No. 1A
## A REVIEW OF DUAL DIAGNOSIS TREATMENT RESEARCH

Robert E. Drake, Jr., M.D., Ph.D., *Professor, Department of Psychiatry, Dartmouth Medical School, 2 Whipple Place, Lebanon, NH 03766-1356*; Kim T. Mueser, Ph.D., Gregory J. McHugo, Ph.D.

### SUMMARY:

This paper reviews 34 studies of integrated dual-diagnosis treatment approaches. The authors surveyed the published literature and government reports on completed grants to identify studies of programs that combined mental health and substance abuse treatment interventions for persons with co-occurring servere mental illness and substance use disorder. There are few adequate studies of dual-diagnosis treatment in inpatient or day-treatment settings. The results of residential dual-diagnosis studies are discouraging, as are the results of adding dual-diagnosis groups to existing programs. On the other hand, results appear encouraging from several recent outpatient programs that combine assertive case management, outreach, stage-wise substance abuse treatment, and comprehensive mental health interventions.

## No. 1B
## DUAL DIAGNOSIS AND PUBLIC MANAGED CARE: A CASE RATE PROGRAM

Kenneth Minkoff, M.D., *Medical Director, Choate Health Systems, 23 Warren Avenue, Woburn, MA 01801-4979*

### SUMMARY:

This presentation describes the development of a horizontally (psychiatric and addiction) integrated acute service continuum and the successful evolution of a dual-diagnosis case-rate program for managed Medicaid patients in Massachusetts. The author describes both clinical and cost outcomes for the case-rate program, evaluates the advantages and disadvantages of this model for reimbursement, and identifies some principles for success in "shared-risk" programs for dual-diagnosis treatment for managed public-sector consumers.

## No. 1C
## TRAUMA IN THE LIVES OF DUALLY DIAGNOSED WOMEN

Maxine Harris, Ph.D., *Clinical Director, Community Connections, 1512 Pennsylvania Avenue, S.E., Washington, DC 20003*

### SUMMARY:

Women who are dually diagnosed, economically marginalized, and episodically homeless are also likely to be the survivors of past and/or current sexual and physical

abuse. Staff at Community Connections, an urban mental health and housing program, have designed an empowerment and recovery curriculum to address issues of trauma and abuse. This presentation will describe the Community Connections service continuum, with regard to the organization of comprehensive services for people with serious mental illness, many of whom are homeless and have comorbid substance disorders. Outcomes of some outreach housing programs for homeless dual-diagnosis patients will be briefly described. Discussion will then focus on data concerning gender issues in this population, and in particular the high prevalence of past and/or current trauma. The presenter will then describe the evolution of specific programming to address the specialized needs of these often "triple" diagnosis patients, and discuss initial outcomes and results.

## No. 1D
## GENDER DIFFERENCES IN ENGAGEMENT WITH TREATMENT

Katherine E. Watkins, M.D., *Psychiatry Resident, and Robert Wood Johnson Clinical Scholar, University of California at Los Angeles-Neuropsychiatric Institute, and Former APA/Mead Johnson Fellow, 139 N. Saltair Avenue, Los Angeles, CA 90049*; Andrew L. Shaner, M.D., Greer Sullivan, M.S.P.H.

### SUMMARY:

While individuals with comorbid mental illness and substance abuse are in general more likely to seek treatment, it is unknown whether this varies by gender. We report results from a qualitative study to look at whether gender impacts on treatment access and utilization. Eleven women and 10 men with both psychosis and substance abuse, from three settings and at various stages of engagement, were interviewed using a semistructured format to identify whether the process of engaging with treatment is different for men and women.

Our results indicate that while men and women identified similar reasons for seeking help, their paths to treatment and the obstacles they faced were quite different. In women, psychotic symptoms coupled with either real experiences or a perceived risk of being victimized led to a climate of fear that made it difficult for them to trust anyone, even outreach workers. Males, by contrast, spoke about a fear of their own violence, and this had the effect of bringing them into treatment. This has important implications for service delivery and suggests new strategies for engaging the dually diagnosed.

## No. 1E
## INTEGRATED ADDICTION SERVICES FOR PERSONS WITH SEVERE MENTAL ILLNESS

Fred C. Osher, M.D., *Director, Community Psychiatry, and Associate Professor of Psychiatry, University of Maryland at Baltimore, and Former APA/Mead Johnson Fellow, 655 W. Redwood Street, Baltimore, MD 21201*; Devang H. Gandhi, M.D.

### SUMMARY:

The presentation will review the principles associated with positive outcomes in serving persons with co-occurring addictive and mental disorders, emphasize the utility of assertive community treatment (ACT) teams as the core service setting for integrated treatment approaches, and evaluate the effectiveness of group interventions for persons with co-occurring disorders. The theoretical approach to providing integrated dual-diagnosis services within community settings will be outlined. The authors will describe the context of care for almost 300 persons with dual diagnoses served on ACT teams in urban Baltimore settings. Results of a study looking at the effectiveness of group therapy for these persons will be presented. The process and outcome measurement tools will be described, and data analysis will focus on the demographic, diagnostic, and outcome differences between dually diagnosed individuals who do and do not attend group therapy.

### REFERENCES:

1. Drake RE, Mueser K, Clark RE, Wallach MS: The course, treatment, and outcomes of substance use disorder in persons with severe mental illness. *American Journal of Orthopsychiatry*, 66: 42–51, 1996.
2. Minkoff K: Integration of Psychiatric and Addiction Services, in Minkoff K, Pollack D: (Eds.) *Managed Mental Health Care in the Public Sector: A Survival Manual*, Harwood Academic Press, 1997.
3. Harris M, Landis C: (Eds.) *Sexual Abuse in the Lives of Women Diagnosed with Serious Mental Illness*, Harwood Academic Publishers, Winter 1996.
4. Alexander MJ: Women with co-occurring addictive and mental disorders: an emerging profile of vulnerability. *American Journal of Orthopsychiatry* 66(1): 61–70, 1996.
5. Teague GB, Drake RE, Ackerson TH: Evaluating use of continuous treatment teams for persons with mental illness and substance abuse. *Psychiatric Services* 46: 689–695, 1995.

**Symposium 2** **Friday, October 24**
**8:30 a.m.-11:30 a.m.**

## CULTURAL COMPETENCE: LESSONS FOR MANAGED CARE

*American Association of Community Psychiatrists, Black Psychiatrists of America, American Society of Hispanic Psychiatrists, and Black Psychiatrists Association of Maryland*

Andres J. Pumariega, M.D., *Professor and Chair, Department of Psychiatry and Behavioral Sciences, James H. Quillen College of Medicine, East Tennessee State University, P.O. Box 70567, Johnson City, TN 37614-9567*; Annelle B. Primm, M.D., M.P.H., *Assistant Professor and Director, Public Psychiatry Programs, Johns Hopkins University School of Medicine, 600 N. Wolfe Street, Baltimore, MD 21287-7180*

### EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to recognize principles of cultural competence in mental health services, and identify how these principles can be applied in managed behavioral health services and systems.

### SUMMARY:

Public mental health services are increasingly coming under state managed care programs contracted to behavioral care organizations. Since managed-care approaches were initially developed to serve primarily mainstream, middle-class-majority populations, there is concern that the special needs of the mostly poor and ethnic minority clients traditionally served under public or Medicaid-funded services will be ignored under these programs. However, there are potential benefits for clients of color in the flexibility offered under this new paradigm, especially for the inclusion of culturally competent and community-based, nontraditional services. This symposium presents conceptual and practical models for incorporating principles of culturally competent services into public behavioral care plans. The guidelines for culturally competent behavioral health services developed by the National Latino Behavioral Health Work Group and similar guidelines developed for Asian Americans, both sponsored by CMHS, will be presented. An African-American operated behavioral health network serving inner-city populations will be presented as an example of implementation of cultural competence principles. Finally, Dr. Pedro Ruiz will lead the discussion of the implications of the integration of culturally competent approaches in these new models of care.

### No. 2A
### CULTURAL COMPETENCE: GUIDELINES FOR MANAGED CARE

Andres J. Pumariega, M.D., *Professor and Chair, Department of Psychiatry and Behavioral Sciences, James H. Quillen College of Medicine, East Tennessee State University, P.O. Box 70567, Johnson City, TN 37614-9567*; Josie Romero, M.S.W., Hank Balderrama, M.S.W., Javier Saenz, Ph.D., Pablo D. Hernandez, M.D., Joseph Torres, M.S.W., Marie Sanchez, M.A.

### SUMMARY:

This presentation will summarize guidelines for public mental health managed care services, developed by the National Latino Behavioral Health Work Group (NLBHWG), addressing the unique needs of Latino populations in the United States. The main principles within these guidelines are those of culturally competent services and community-based systems of care. Culturally competent services to Latinos incorporate traditional value orientations toward practical, family-centered, community-based care, and can result in higher quality, lower cost services. The presentation will briefly review the literature on community-based mental health services for Latinos. It will then outline the main components of the guidelines: 1) System Guidelines (including cultural competence planning, governance, benefit design, quality assurance and improvement, and management of information, 2) Clinical Guidelines (access, triage and assessment, care planning, treatment services, case management, and linguistic support), and 3) Provider Competencies for working with Latino populations. Proposed outcome indicators for each of these domains will also be presented. The presentation will discuss NLBHWG's role within the CMHS managed care initiative, the applicability of these guidelines to other populations of color, and strategies being developed for influencing policymakers at the state and federal level toward these guidelines.

### No. 2B
### SYSTEMS CULTURAL COMPETENCE FOR ASIAN-AMERICANS

Francis G. Lu, M.D., *Clinical Professor of Psychiatry, University of California at San Francisco, San Francisco General Hospital, 1001 Potrero Avenue, San Francisco, CA 94110-3518*; Harriet G. McCombs, Ph.D., Sue Stanley, Evelyn Lee, Ed.D.

### SUMMARY:

This presentation will focus on cultural competence guidelines for managed mental health services for Asian Americans. The results of two Center for Mental Health

Services (CMHS) sponsored initiatives will form the basis of the presentation. They are the proceedings of a CMHS conference entitled "Managed Care and Ethnic Minorities," held in Washington, D.C. June 12–13, 1996, and a CMHS sponsored document on cultural competence guidelines for managed mental health services for Asian Americans. First, the key evaluation areas for ethnic minorities in managed care will be briefly reviewed. They include access, information systems, economics and finance, system structure, human resources, clinical quality/standards of care, and the interface with the community and consumers. Second, specific recommendations from the guidelines document will be presented to illustrate how these evaluation areas apply to services with Asian Americans.

## No. 2C
## THE URBAN BEHAVIORAL HEALTH SYSTEM

Orlando R. Davis, M.D., *President and Chief Executive Officer, Urban Behavioral Health Associates, 2901 Druid Park Drive, Suite A-202, Baltimore, MD 21215*

### SUMMARY:

This presentation will describe Urban Behavioral Health System (UBHS), a model for community-based delivery of mental health care.

Encouraged by one of the leading urban hospital administrators in the country, a group of inner-city psychiatrists formed a psychiatric group and contracted to serve a community hospital, a community mental health center, and the only minority-operated HMO in the state of Maryland. The group is currently responsible for mental health and substance abuse services for 30,000 covered lives in inner-city Baltimore. The group is minority owned and operated and is a certified Minority Business Enterprise in the city of Baltimore and the state of Maryland. Challenges, opportunities, and strategies for serving inner-city populations by organizing multicultural community psychiatrists will be explored.

### REFERENCES:

1. Pumariega, AJ, Cross TL: Cultural competence in child psychiatry. *Basic Handbook of Child & Adolescent Psychiatry*. Volume IV. John Wiley Publishers, In press
2. Cross T, Bazeck B, Derns K̈, Isaacs M: *Culturally Competent Systems of Care for Children with SED* Wash. DC- Georgetown University, CASSP, 1989.
3. Cheng F, Saunders L: Community mental health and ethnic minority populations *Community Mental Health Journal*, 26(3): 277–291, 1990.
4. Center for Mental Health Services. Managed Care and Ethnic Minorities Conference Proceeding, Washington, D.C., June 12–13, 1996.
5. Center for Mental Health Services. *Cultural Competence Guidelines in Managed Care Mental Health Services for Asian Americans.* (In preparation, to be completed 1997).

**Symposium 3** **Friday, October 24**
**2:00 p.m.-5:00 p.m.**

## THE PSYCHIATRIST IN INTEGRATED DELIVERY SYSTEMS
**American Association of General Hospital Psychiatrists**

Paul Summergrad, M.D., *Chief, Inpatient Psychiatry, Massachusetts General Hospital, and Professor of Psychiatry, Harvard Medical School, 32 Fruit Street, Warren 1220, Boston, MA 02114*

### EDUCATIONAL OBJECTIVES:

To describe problems faced and progress made by three large psychiatric groups in integrating with the general medical delivery system, including administrative and clinical integration, affiliation proposals, and contractual demonstration projects.

### SUMMARY:

As managed care, capitation, and health care reform continue to develop across the United States, psychiatrists are increasingly becoming involved in various models of integrated delivery systems. In some cases these may be integrated health care systems that include all general medical and psychiatric services. In other cases psychiatrists, either as providers or in groups with institutional affiliations, may create separate behavioral health care corporations that then provide both specialty psychiatric services and services to the primary care sector. With growth in the development of integrated delivery systems and capitation and the importance of primary care, the ability of psychiatrists in integrated delivery systems to work closely with primary care physicians and to be available across the full continuum of psychiatric services is becoming increasingly important.

Our keynote address and panel will focus on three models that have been developed in New England for the management and provision of psychiatric services in general medical environments: the Lifespan model, the Caregroup model, and the Partners model. We will then have an extensive panel and audience discussion of these models of psychiatric integration in delivery systems and alternatives that are developing elsewhere in the United States.

## No. 3A
## THE PSYCHIATRIST'S ROLE IN INTEGRATED SYSTEMS OF CARE

Steven M. Mirin, M.D., *Medical Director, American Psychiatric Association, 1400 K Street, N.W., Washington, DC 20005*

### SUMMARY:

Growing pressure to contain the costs and manage the delivery of mental health care is reshaping the role of psychiatrists practicing in both community-based and institutional settings. At the same time, the national trend toward the development of integrated health care delivery systems poses new challenges and opportunities for psychiatrists and mental health care professionals.

This paper will focus on the role of psychiatrists within integrated systems as both managers and providers of care. Issues related to the interface with primary care physicians, the criteria for decision making with respect to the placement of clinical services, the development of standards of care and practice guidelines, and the role of treatment outcome measures in demostrating the value of mental health care in these systems will be discussed.

## No. 3B
## THE LIFE SPAN MODEL

Richard J. Goldberg, M.D., *Psychiatrist-in-Chief, Rhode Island Hospital, Department of Psychiatry, 593 Eddy Street, Providence, RI 02903-4923*

### SUMMARY:

This presentation will discuss the progress and problems faced by one large psychiatric group in its efforts to integrate with the general medical delivery system. Integration was seen as a priority for several reasons including: more control over referrals to mental health by primary care gatekeepers, RFPs for integrated medical-psychiatric management by the state, and a belief in the value of integration. Attempts at integration took place at a number of levels including: administrative structure within the medical center, leadership structure within the emerging medical IPA/PSOs, clinical integration with medical group practices and foundations, affiliation proposals with other groups, and contractual demonstration projects for insurers. Overall, progress toward integration involves multiple levels of intervention and must address the incentives already present within the medical system.

## No. 3C
## THE CAREGROUP MODEL

Andrew W. Brotman, M.D., *Chief of Psychiatry, Beth Israel Deaconess Hospital, Harvard Medical School, Department of Psychiatry, One Deaconess Road, Boston, MA 02115*

### SUMMARY:

CareGroup is a six-hospital, 1800-physician, integrated delivery system of which psychiatry is a relatively small part. Within CareGroup, there are just over 100 mental health or substance abuse beds, three day hospital programs, over 60,000 outpatient visits, and a special emphasis on integration with primary care. Members of CareGroup have developed their own "product line," but in addition have formed a behavioral health company with other nonprofit and for-profit entities to serve a wide geographic area.

CareGroup has a 20% ownership of a company called Behavioral Health of New England in combination with other large providers. This entity is suited for both "carve out and carve in" business and has operated one statewide risk contract for the last two years. The rationale, structure, and function of this partnership will be discussed, particularly in light of the changing marketplace. Integrating nonprofit and for-profit general hospital programs, and free-standing psychiatric and free-standing substance abuse programs is a significant challenge that will be reviewed.

## No. 3D
## THE PARTNERS MODEL

Paul Summergrad, M.D., *Chief, Inpatient Psychiatry, Massachusetts General Hospital, and Professor of Psychiatry, Harvard Medical School, 32 Fruit Street, Warren 1220, Boston, MA 02114*

### SUMMARY:

This presentation will review the strategic development of the Partners mental health services, and in particular will pay attention to clinical care for patients within both the primary care and specialty mental health sectors.

### REFERENCES:

1. Summergrad P, Herman JB, Weilburg JB, Jellinek MS: Wagons ho: forward on the managed care trail. *General Hospital Psychiatry* 17:251–59, 1995.
2. Mirin SM, Sederer LI: Mental healthcare: current realities, future directions, *Psych Quarterly* V. 65, 1994.
3. Sederer LI, Mirin: The impact of managed care on clinical practice. *Psych Quarterly*. V. 65, 1994
4. Goldberg RJ: *Integrating Behavioral Health Services with General Medical Care*. Strategic Planning for Health Care Execs . . . , Manisses Communications Group, Inc., 1996.

5. National Advisory Mental Health Council: Health care reform for Americans with severe mental illness. *Am J Psychiatry* 150:1447–1465, 1993.

**Symposium 4** **Friday, October 24**
**2:00 p.m.-5:00 p.m.**

## CULTURE AND MENTAL HEALTH IN PRIMARY CARE

Ann Marie T. Sullivan, M.D., *Director, Department of Psychiatry, Elmhurst Hospital Center, 79-01 Broadway #A6-5, Elmhurst, NY 11373*; Juan E. Mezzich, M.D., Ph.D., *Professor of Psychiatry, Mt. Sinai School of Medicine, One Gustave Levy Place, New York, NY 10029*; Arnold Eiser, M.D.

### EDUCATIONAL OBJECTIVES:

Participants should be able to identify (1) cultural influences on the presentation and identification of mental health problems in primary care, (2) useful tools to assess and measure such influences, (3) techniques of interfacing effectively with ethnic healers, and (4) training approaches for the primary care provider.

### SUMMARY:

This symposium will focus on the increasing need to understand the impact of cultural influences on mental health problems presenting to primary care physicians. Key issues to be explored will include the difficulty of recognizing mental illness in a culturally diverse population resulting in barriers to access of services, the influence of culture on recommended treatments and compliance with traditional Western medicine, the interfacing of ethnic healers and remedies with traditional Western medicine, and the problems of integrating bilingual, bicultural services into the new world of managed care. Innovative approaches in dealing with these issues from a variety of clinical settings will be presented. Some areas of presentation will include cultural screening tools for primary care physicians, a "how to" discussion of working with traditional ethnic healers, and training approaches for primary care clinicians to increase cultural sensitivity and awareness of cultural factors in mental illness. Active audience participation and exchange of related experiences are encouraged.

## No. 4A
## CULTURE AND MENTAL HEALTH ASSESSMENT IN PRIMARY CARE

Neal L. Cohen, M.D., *Commissioner, New York City Department of Mental Health, Mt. Sinai Hospital, Department of Psychiatry, One Gustave L Levy Place, Box 1230, New York, NY 10029*; Juan E. Mezzich, M.D., Ph.D., Ann Marie T. Sullivan, M.D.

### SUMMARY:

An expanding literature is documenting the high frequency of somatization and psychological distress among patients seen in the primary care setting. Furthermore, untreated adults with depression are significantly more likely to visit their primary care physician than are those who are not depressed. While mental health services for middle-class white patients are commonly obtained from family practitioners, the pathway for access to these services among ethnic minorities is unclear.

This presentation examines the influence of culture on somatic symptoms and the consequence of beliefs about mind/body relationships with utilization of health and mental health services in multicultural communities. It is postulated that cultural, social, and individual factors will interact with acculturation in influencing access to and utilization of primary medical care and mental health care services.

The rapidly growing managed health care environment places greater demand for training primary care physicians to recognize and refer minority patients for whom both cultural and institutional barriers would inhibit access to mental health services.

## No. 4B
## ANTHROPOLOGICAL RESEARCH ON PRIMARY CARE PSYCHIATRY

Laurence J. Kirmayer, M.D., *Department of Psychiatry, Institute on Community and Family Psychiatry, 4333 Cote Street Catherine, Montreal, PQ, Canada H3T 1E4*; Juan E. Mezzich, M.D., Ph.D.

### SUMMARY:

Anthropological studies of primary care psychiatry have examined: (1) cultural determinants of patients' symptom experience, illness behavior, and help-seeking; (2) the cultural shaping of doctor-patient interaction; and (3) the embedding of clinical practice in professional, institutional, and larger social ideologies and practices. This presentation will review major findings from recent culturally informed epidemiological and ethnographic research on the diagnosis and treatment of psychiatric disorders in primary care. Results from the following two studies by our research group will be presented: (1) a study of doctor-patient communication in the context of primary care patients presenting with nonspecific somatic complaints (musculoskeletal or abdominal pain, fatigue) will illustrate cultural constraints on the negotiation of illness meaning in the clinical encounter; (2) a study of primary care providers working in a multicultural community clinic will provide a typology of clini-

cians' strategies for working with cultural difference. Implications for psychiatric research, training, and consultation in primary care will be discussed.

## No. 4C
## LATINO PERSPECTIVES ON MENTAL HEALTH IN PRIMARY CARE

Roberto Lewis-Fernandez, M.D., *Department of Social Medicine, Harvard Medical School, Calle Marti #809, Miramar, San Juan, PR 00907*; Gloria Canino, Ph.D., Rafael Ramirez, Ph.D., Vivian Febo, Ph.D., Milagros Bravo, Ph.D.

### SUMMARY:

U.S. research reveals that a high proportion of primary care patients suffers from psychiatric disorders. Concerns have been raised as to how able primary care clinicians are to detect and treat these disorders. Concern is heightened when cultural factors complicate illness phenomenology and help-seeking patterns, such as among ethnic minorities.

This talk will present community-based research from Puerto Rico revealing that both mental health and primary care services exhibit significant mismatch between research diagnoses and psychotropic treatment obtained via prescription. Multivariate analysis reveals no correlation between diagnoses and medications; instead, only gender and utilization of psychiatric services in the last 12 months were significant predictors of medication type. Apparently, ethnic matching of patients and clinicians by itself does not prevent inappropriate prescribing. Structural factors (e.g., medication availability and clinician training) and cultural issues (e.g., gender-linked treatments and diagnostic ambiguity caused by folk syndromes) appear more important. Cultural factors possibly contributing to diagnosis-psychotropic mismatch in Puerto Rico will be discussed based on a consecutive sample of 95 rural outpatients presenting to primary care who were referred to psychiatrists. Common phenomenologies complicating psychiatric assessment, such as the folk categories *nervios* and *ataques* and widespread auditory and visual perceptual alterations, will be described.

## No. 4D
## ASIAN-AMERICAN PERSPECTIVES ON MENTAL HEALTH IN PRIMARY CARE

Keh-Ming Lin, M.D., *Associate Professor of Psychiatry, and Director, Research Center on the Psychobiology of Ethnicity, Harbor-UCLA Educational Institute, 1124 West Carson Street, Torrance, CA 90502*

### SUMMARY:

Asian Americans have been consistently found to be less likely to utilize mental health services than other ethnic groups. At the same time, Asian-American patients in the mental health system are characterized by significantly longer delays between the onset of the disorder and the initial clinical contract, as well as by more severe symptomatology, suggesting that this is an iceberg phenomenon, with a large proportion of patients in the community deprived of the benefit of modern mental health care. One of the most important factors contributing to this phenomenon may be the often-reported tendency of Asian Americans to "somatize," which is partially rooted in Asian cultural traditions that de-emphasize the distinction between the body and the mind. Thus, the primary care sector represents a particularly important setting for mental health care for Asian Americans. This notwithstanding, research in this regard is just in the beginning stage of its development. In this presentation, in addition to reviewing issues relevant to the phenomenon of "somatization" in Asians and Asian Americans, some initial results from a project studying mental health problems in an Asian primary care clinic will be presented.

## No. 4E
## AFRICAN-AMERICAN PERSPECTIVES ON MENTAL HEALTH ISSUES IN PRIMARY CARE

Michelle O. Clark, M.D., *Associate Clinical Professor of Psychiatry, University of California at San Francisco School of Medicine, Department of Psychiatry, Room 7E-21, 1001 Potrero Avenue, San Francisco, CA 94110*

### SUMMARY:

Current trends in health care service delivery focus increasingly on primary care, with goals of prevention and early intervention. There is less emphasis on specialty services. These trends extend to training of health care providers. The shift in the distribution of specialists available and the structure of health care delivery challenges those concerned with appropriate intervention into mental health problems. Our challenge is to foster the interest of primary care providers in prevention and early intervention with psychiatric illness. It may be our role to develop and advance training in these areas in the medical school curriculum and residency training.

The broadening diversity of our nation's population adds to the challenge of health care service delivery. We must adapt the traditional medical model from the generic to include attention to cultural issues. Everything from assessment to outcome is impacted by a patient's cultural context. The challenge is greatest with the popu-

lation of African descent in this country because of their unique and controversial history.

The presentation will outline the experiences in training at the University of California, San Francisco. Discussion will include specific issues commonly raised in work with African-American populations.

## No. 4F
## CULTURE AND MENTAL HEALTH ASSESSMENT IN PRIMARY CARE

Juan E. Mezzich, M.D., Ph.D., *Professor of Psychiatry, Mt. Sinai School of Medicine, Department of Psychiatry, One Gustave Levy Place, New York, NY 10029*; Ann Marie T. Sullivan, M.D., Neal L. Cohen, M.D.

### SUMMARY:

Mental health assessment, particularly in primary care settings, must be culturally informed. The frequency with which emotional problems are presented in somatic terms by individuals identified with traditional societies highlights this point.

Given that culture permits the experience, reporting, and interpretation of health problems, it should be attended to through the various aspects and phases of the evaluation process. This will be illustrated with the presentation of culturally informed instruments for the description of cultural identity for the detection of mental problems and for the appraisal of quality of life.

Cultural identity, particularly among immigrants, seems to be best described by separately appraising identification with the original culture and with the host culture. Comparable 20-item bicultural scales for Latinos, Asian-Americans, African-Americans, and Native-Americans, and through a generic form for other immigrant groups, will be summarily presented.

Next, the Personal Health Scales, a 10-item screening instrument for identifying mental problems in primary care will be briefly described.

Finally, a simple index of quality of life that allows the subject to rate each of 10 dimensions according to his/her own cultural norms will be outlined.

### REFERENCES:

1. Rogler LH, Cortes DE: Help-seeking pathways; a unifying concept in mental health care. *American Journal of Psychiatry,* 150(4):554–561, 1993.
2. Kirmayer LJ, Young A, Robbins JM: Symptom attribution in cultural perspective. *Canadian Journal of Psychiatry*, 39(10):584–595, 1994.
3. Guarnaccia PJ, Good BJ, Kleinman A: A critical review of epidemiological studies of Puerto Rican mental health. *American Journal of Psychiatry*, 147:1449–1456, 1990.
4. Lin KM: Asian-American Perspectives. In Mezzich J, Kleinman A, Fabrega H Jr., and Parron D (Eds). *Culture and Psychiatric Diagnosis.* American Psychiatric Press, Washington, D.C. 1996.
5. Lum CK, Korenman SG: Cultural sensitivity training in U.S. medical schools. *Academic Medicine* 69:239–241, 1994.
6. Mezzich JE, Caldera J, Berganza CE: Psychiatric Diagnosis in Primary Care and the Personal Health Scale. In: Beigel A. Lopez-Ibor JJ, Costa E. Silva JA (eds) *Past, Present, and Future of Psychiatry.* World Scientific Publishing, Singapore, 1994.

**Symposium 5** **Saturday, October 25**
**8:30 a.m.-11:30 a.m.**

## COUNTY GOVERNANCE IN MANAGED BEHAVIORAL CARE

Gordon R. Hodas, M.D., *Statewide Child Psychiatrist, Pennsylvania Office of Mental Health and Substance Abuse Services, 214 East Gravers Lane, Philadelphia, PA 19118-2803*

### EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to recognize the prerequisite steps for a statewide initiative in decentralized, managed behavioral care, utilizing county governance and drawing from the unique expertise of both the public system and the for-profit system, within the single new care structure.

### SUMMARY:

This symposium describes the commonwealth of Pennsylvania's use of county governance as the preferred organizational structure for statewide capitation for mandatory behavioral health care. This work-in-progress was implemented on a limited, trial basis in 1997. The symposium describes a strategic process that integrates the previously separate services of adult and child mental health and substance abuse treatment for public sector populations. The process brings together the technical expertise of the private sector and the experience of the overseeing public county system. Topics include: development of a statewide RFP that incorporates a value-based system into managed care, the range of county responses, state assistance for county initiatives, and ongoing monitoring. The Pennsylvania experience is of generic relevance because it confronts the limitations of solely privatized managed care through decentralized care systems that build upon a well-established, pre-existing organizational and political structure—the county system of governance.

Faculty: Three statewide program directors discuss challenges of program development. A parent representative highlights the importance of family and consumer

participation. The commonwealth's statewide child psychiatrist discusses training and best practice.

## No. 5A
## THE CARVE-OUT FRAMEWORK

Jerry Kopelman, M.S.W., *Director, Bureau of Program Policy Development, Pennsylvania Office of Mental Health and Substance Abuse Services, Health and Welfare Building, Harrisburg, PA 17120*

### SUMMARY:

The decision by the commonwealth of Pennsylvania to carve out mandatory behavioral health care from physical health, and to offer the right of first opportunity for systems management to the counties on a nonprofit basis, was based on a strong consensus that included consumers and advocates, provider agencies, and county government. Underutilization of mental health services by voluntary, for-profit managed care organizations operational within Pennsylvania served as an additional impetus. Mr. Jerry Kopelman, director of adult services for Pennsylvania's Office of Mental Health, describes the process that led to Pennsylvania's trial of a carved out, capitated behavioral health care system, with county governance as the preferred organizational structure and with county oversight over private sector participation. The creation of state level teams required the identification of those system representatives with an ability to function beyond their field of expertise, partnering with others in pursuit of common goals and structures for the new system of care. The commonwealth's incorporation into the RFP and the review process of a shared value system for adult services—known as Community Support Principles (CSP)—has important implications for consumer participation and empowerment.

## No. 5B
## STATE AND COUNTY READINESS AND PARTNERSHIP

Lenora Stern, R.N., M.Sc., *Chief, Division of Research and Program Development, Bureau of Program Policy Development, Pennsylvania Office of Mental Health and Substance Abuse Services, Health and Welfare Building, Room 625, Harrisburg, PA 17120*

### SUMMARY:

Following internal commonwealth review and approval of county RFP responses, a series of steps were undertaken to prepare the counties for the task of managing the behavioral health needs of public sector children and adolescents, adults, and families. Ms. Lenora Stern, assistant director of the Children's Bureau for Pennsylvania's Office of Mental Health, describes the intensive readiness training of state reviewers, preparatory to a week of site visits to designated counties. The interaction between the county and its private sector partner with state reviewers, including family/consumer representatives, served to empower all parties. The incorporation of a shared value system—known as Child and Adolescent Service System Program (CASSP) Principles—into the RFP represents a key element in support of continuity of best practice for children and adolescents within a managed care system.

## No. 5C
## THE CHALLENGE OF SUBSTANCE ABUSE AND MENTAL HEALTH

Sherry Snyder, B.A., *Chief, Care Management Section, Drug and Alcohol Programs, Pennsylvania Department of Health, Drug & Alcohol Programs, Health and Welfare Building, Room 933, Harrisburg, PA 17120*

### SUMMARY:

Incorporation of drug and alcohol treatment into the new integrated behavioral health (mental health/substance abuse) carve-out system posed special challenges. Drug and alcohol services, unlike adult and child mental health, operate out of a separate state department (Department of Health rather than Public Welfare), and only limited partnering had previously taken place. Although the service populations overlap at times, provider systems are often quite distinct. In addition, rules of confidentiality differ markedly from those of mental health. Ms. Sherry Snyder, chief of Care Management Section of Drug and Alcohol Programs, describes how relevant administrative and clinical issues were addressed, and how mutual learning paved the way for more effective services integration.

## No. 5D
## FAMILY AND CONSUMER PARTICIPATION

Wendy Luckenbill, *Statewide Family Representative, Children's Bureau, Pennsylvania Office of Mental Health, 240 South 5th Street, Womelsdorf, PA 19567*

### SUMMARY:

In order for managed behavioral health treatment programs to be effective, families and consumers must be full partners in the development, implementation, and monitoring of the new systems of care. Such participation needs to occur on an individual child-specific basis and at the systems level. Quality care requires informed parents and children, so that appropriate choices are

available within a capitated system concerned with cost-effectiveness. Quality care also requires the development of new competencies by providers and by managed care contractors working with public sector children and adolescents, particularly those with serious emotional and behavioral disturbance. Ms. Wendy Luckenbill, a Parent Involved Network (PIN) representative serving the commonwealth, discusses the above principles and her own participation at all levels of Pennsylvania's recent initiative in managed behavioral care.

## No. 5E
## BEST PRACTICE, QUALITY, AND THE FUTURE

Gordon R. Hodas, M.D., *Statewide Child Psychiatrist, Pennsylvania Office of Mental Health and Substance Abuse Services, 214 East Gravers Lane, Philadelphia, PA 19118-2803*

### SUMMARY:

An effective system of care requires education of consumers and of those providing services at all levels. Dr. Gordon Hodas, statewide child psychiatrist for Pennsylvania's Children's Bureau, highlights the commonwealth's emphasis on best practice and training within the new system of care and throughout other regions of the state. The need for comprehensive quality improvement and for ongoing monitoring is also discussed. Future challenges are identified.

### REFERENCES:

1. Feldman J, Fitzpatrick R: *Managed Mental Health Care: Administrative and Clinical Issues.* Washington: American Psychiatric Association Press, Inc., 1992.
2. Shore M: Clinical practice and service delivery: getting back on track. *Am J Orthopsychiatry* 63(2):164–165, 1993.
3. Friedman R, Kutash K: Challenges for child and adolescent mental health. *Health Affairs.* Fall: 124–136, 1992.
4. Knitzer J, Yelton S: Collaboration between child welfare and mental health. *Public Welfare,* Spring: 24–46, 1990.
5. Osher F: A vision of the future: toward a service system responsive to those with co-occurring addictive and mental disorders. *Am J Orthopsychiatry,* 66(1):71–76, 1996.
6. Fine G: Developing a partnership with families: parent-professional collaboration. In Snyder W, Ooms T. (eds). *Empowering Families, Helping Adolescents: Family-Centered Treatment of Adolescents with Alcohol, Drug Abuse, and Mental Health Problems* (Technical Assistance Publication Series #6). Rockville: U.S. Department of Health and Human Services, 1992.
7. Cole R, Poe S: *Partnerships of Care: Systems of Care for Children and Adolescents with Serious Emotional Disturbances and Their Families.* Washington: Washington Business Group on Health, Mental Health Services Program for Youth, 1993.
8. Hodas G: *What Makes Wraparound Special: Understanding and Creating a Unique Experience for Children and Their Families.* Harrisburg: Pennsylvania CASSP Training and Technical Assistance Institute, 1996.
9. Hodas G: In support of genuine parent-professional collaboration. *Sharing: A Newsletter from Parent Involved Network,* 12(3): 1–2, 1996.

**Symposium 6** **Saturday, October 25**
**8:30 a.m.-11:30 a.m.**

## THE SCOPE OF CLINICAL PSYCHIATRY

Richard Balon, M.D., *Department of Psychiatry and Behavioral Sciences, University Psychiatric Center, Wayne State University, 2751 E. Jefferson Street, Suite 200, Detroit, MI 48207*

### EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should understand strategies to use individual initiatives in helping the poor, establish the similarities between single-payer and full-risk capitation, and discover the world of alternative medicine, its demographics, economics, and synergies with conventional medicine.

### SUMMARY:

Given the health care coverage situation in the United States and other countries, this session will focus on the current health coverage for poor patients and explore alternative medicine techniques. It will focus on strategies to use individual initiatives to help the poor gain access to medical care. The similarities between single-payer and full-risk capitation will be examined. The world of alternative medicine, its demographics, economics, and synergies with conventional medicine will be addressed, along with the various alternative practices and how some of them are being mainstreamed into hospital settings. The role of psychiatry in this movement will also be explored.

## No. 6A
## WHO IS TAKING CARE OF POOR PATIENTS?

Rodrigo A. Munoz, M.D., *President-Elect, American Psychiatric Association, 3130 5th Avenue, San Diego, CA*

**SUMMARY:**

This portion of this symposium will analyze the current health coverage for poor patients and explore strategies to use individual initiatives to help the poor gain access to medical care.

## No. 6B
## ALTERNATIVE MEDICINE: CAN WE LEARN FROM IT?

Arnold L. Lieber, M.D., *Clinical Associate Professor of Psychiatry, University of Miami School of Medicine, 250 West 63rd Street, Miami Beach, FL 33141-5801*; Wayne Jonas, M.D.

**SUMMARY:**

This session will provide an overview of the world of alternative medicine, its demographics, economics, and synergies with conventional medicine. Attendees will be able to identify and understand the various alternative practices and how some of them are being mainstreamed into hospital settings. The role of psychiatry in this movement will also be examined.

**REFERENCES:**

1. Colt GH: The healing revolution, *Life Magazine*, pp. 35–50, September 1996.
2. Benson H: The power of biology and belief, *The New Yorker*, pp. 43–56, 1996.
3. Simon GE, et al: Health care costs associated with the poor and indigent. *Amer J Psychiatry* 152:352–357, 1995.
4. Preston J, Brown FW, Hartley B: Using a variety of resources to improve health care in distant areas. *Hospital and Community Psychiatry* 43:25–32, 1992.

**Symposium 7** **Saturday, October 25**
**2:00 p.m.-5:00 p.m.**

## WHAT'S REALLY GOING ON IN PSYCHIATRY? A PRACTICE RESEARCH NETWORK UPDATE

*Office of Research, American Psychiatric Association*

John S. McIntyre, M.D., *Chair, APA Steering Committee on Practice Guidelines, Chair, Department of Psychiatry, St. Mary's Hospital, and Past President, American Psychiatric Association, 919 Westfall Road, Suite 210, Rochester, NY 14618-2670*

**EDUCATIONAL OBJECTIVES:**

At the conclusion of this symposium, the participant should understand the research aims of the *APA's Practice Research Network* and understand major trends related to psychiatry and psychiatric clinical practice patterns, and be aware of recent clinical and services findings from PRN studies, including findings related to child and adolescent psychopharmacology.

**SUMMARY:**

The APA Practice Research Network (PRN) conducts clinical and services research. With funds from the MacArthur Foundation and CMHS, the PRN is expanding into a nationally representative network of 1,000 psychiatrists. This symposium provides an update on the PRN and recent findings. Findings from the National Survey of Psychiatric Practice, a large national probability sample survey of APA members, will highlight critical clinical, financial, and other psychiatric issues. This study collects nationally representative data on psychiatrists' professional activities, work settings, and patient caseloads. The Study of Psychiatric Patients and Treatments provides data systematically characterizing PRN members, their practices, patient caseloads, and clinical treatment patterns. It provides detailed clinical and diagnostic data on PRN patients and the specific types and combinations of treatments provided. Findings from the Child and Adolescent Pilot Treatment Study of Attention-Deficit Hyperactivity Disorder will be presented highlighting patterns of medication use for children with ADHD and factors that are associated with variations in psychopharmacologic treatment patterns; plans for a larger study investigating these issues will also be discussed. Key findings from other PRN studies will also be presented along with data on psychiatric practice from other national databases.

## No. 7A
## NATIONAL SURVEY OF PSYCHIATRIC PRACTICE

Deborah A. Zarin, M.D., *Deputy Medical Director, and Associate Director, Office of Research, American Psychiatric Association, 1400 K Street, N.W., Washington, DC 20005*; Harold Alan Pincus, M.D., John S. McIntyre, M.D.

**SUMMARY:**

In 1996, the APA Office of Research, supported by a grant from the John D. and Catherine T. MacArthur Foundation, implemented the first annual National Survey of Psychiatric Practice to study critical clinical, financial, and other issues of importance in the field of psychiatry. The principal objective of this study, which gathered data on a large, randomly selected sample of APA members, was to collect nationally representative data on psychiatrists' professional activities, work settings, and patient caseloads to create a scientific baseline

for research in the rapidly changing field of psychiatry. Of the 1,500 APA members who were randomly selected for study participation in 1996, 70.6 percent responded to the survey. Key findings and trends related to psychiatrists' professional activities, practice settings, patient caseloads, and referrals will be presented along with data on psychiatrists' participation in managed care plans and the financing and economics of psychiatric practice. The Office of Research plans to conduct this large national survey on an annual basis to track important changes and trends in psychiatric practice over time. Preliminary findings from the 1997 survey will also be presented.

## No. 7B
## STUDY OF PSYCHIATRIC PATIENTS AND TREATMENTS

Harold Alan Pincus, M.D., *Deputy Medical Director, and Director, Office of Research, American Psychiatric Association, 1400 K Street, N.W., Washington, DC 20005*; Deborah A. Zarin, M.D., Joyce C. West, M.P.P.

### SUMMARY:

Findings from the PRN's core survey, which is conducted on an annual basis to systematically characterize Network members, their practices, patient caseloads, and clinical treatment patterns, will be presented. This includes detailed patient-level clinical and treatment data that have been collected on a randomly selected sample of psychiatric patients. These data provide a valuable database from which to study trends in psychiatry and psychiatric clinical practice patterns. Because the core data provide detailed, linkable data on psychiatrists, patients, and treatments, the relationship of various psychiatrist, patient, and financing/services delivery factors to clinical treatment patterns can be assessed.

Data will be presented on the sociodemographic and diagnostic characteristics of a large sample of psychiatric patients, including data on mental and general medical comorbidities, personality disorders, and level of functioning. Detailed data will be presented on the types and combinations of treatments provided to psychiatric patients, including data on psychiatric treatment settings, specific treatments, psychopharmacologic agents, and combinations of treatments provided to patients, including patients with specific types of disorders. Variations in the types of psychiatric patients and treatments utilized across different types of health plans and managed care organizations will also be presented.

## No. 7C
## CHILD AND ADOLESCENT PILOT TREATMENT STUDY OF ADHD

Deborah A. Zarin, M.D., *Deputy Medical Director, and Associate Director, Office of Research, American Psychiatric Association, 1400 K Street, N.W., Washington, DC 20005*; Ana Suarez, M.P.H., Terri Tanielian, M.A.

### SUMMARY:

Parents and prescribing professionals have raised concern about the use of psychotropic medications in children and adolescents. Even though new scientific information on child and adolescent psychopharmacology has emerged, the knowledge base is still relatively thin across most childhood mental disorders. To address these concerns as well as to assess psychiatric practice patterns for ADHD, the PRN conducted a pilot treatment study. Findings from this pilot study will be used to augment the current knowledge base and to plan for a large multidisciplinary study to examine treatments for ADHD in children and adolescents.

Despite the expanding research base in child psychopharmacology, the growing awareness of attention deficit hyperactivity disorder (ADHD), and the concern about increasing prevalence rates have highlighted the need for better information regarding the diagnosis and treatment of ADHD. The PRN pilot study sought to 1) determine if there are differences in the patterns of prescribing for children and adolescents among child psychiatrists and other psychiatrists for the treatment of ADHD and what factors might account for those differences; 2) compare the patients and treatments found in use in the community with patients and treatments being studies in other clinical trials, thus assessing the generalizability of these studies; 3) compare the treatments in use in the community with available clinical practice guidelines, textbooks, and other reference materials; 4) collect data in preparation for a longitudinal outcomes study; and 5) compare ADHD patients treated by psychiatrists with ADHD patients treated by pediatricians and family practitioners. Findings from this pilot study and plans for the larger study will be described.

### REFERENCES:

1. Zarin D, West J, Pincus H, McIntyre J: The APA Practice Research Network. In: Sederer L and Dickey B. *Outcomes Assessment in Clinical Practice.* Baltimore: Williams & Wilkins, 1996, 146–153.
2. Olfson M, Pincus HA, Dial TH: Professional practice patterns of U.S. psychiatrists. *Am J Psychiatry* 151:89–95, 1994.
3. West JC, Zarin DA, Pincus HA, McIntyre JS: Datapoints: treatments provided to psychiatric patients. *Psychiatric Services* 47:693, 1996.
4. Richters JE, Arnold LE, Jensen PS, et al: NIMH collaborative multisite, multimodal treatment study of children with ADHD: I. background and rationale. *J Am Acad Child Adolesc Psychiatry* 34:987–1000, 1995.
5. Jensen PS, Vitiello B, Leonard H, Laughren TP: Child and adolescent psychopharmacology: expanding the

research base. *Psychopharmacology Bulletin* 4:17–20, 1984.

**Symposium 8** **Saturday, October 25**
**2:00 p.m.-5:00 p.m.**

## NATIONS FOR MENTAL HEALTH: SERVING THE UNDERSERVED

*Joint Session with the World Health Organization and the World Association of Social Psychiatry*

Eliot Sorel, M.D., *President, World Association for Social Psychiatry, Department of Psychiatry, George Washington University, 2021 K Street, N.W. Suite 206, Washington, DC 20006*; Itzhak Levav, M.D.

### EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to recognize mental health needs of underserved populations and become informed about new global initiatives to meet such needs with collaborative potential.

### SUMMARY:

Mental health represents one of the last frontiers in the improvement of the human condition. In the face of widespread stigma and inattention, mental health must now be placed on the international agenda. The symposium presents the pioneering initiative of Harvard University's social medicine department in developing the World Mental Health Report and its implementation through the United Nations, World Health Organization Division of Mental Health. Epidemiological data on mental health, illness, substance abuse, and violence are presented along with implications for services, training, research, and policy. A progress report on the implementation phase of the World Health Organization Model on Nations for Mental Health identifying opportunity for public/private collaboration, and the role of NGO's is addressed.

## No. 8A
## NATIONS FOR MENTAL HEALTH

Jorge A. Costa e Silva, M.D., *Director, Division of Mental Health, World Health Organization, 20 Avenue Appia, CH-1122 Geneva 27, Switzerland*

### SUMMARY:

WHO estimates that at any given point in time, approximately 500 million people suffer from different forms of mental disorders including neuroses, affective disorders, alcohol and drug abuse, epilepsy, dementias, mental retardation and schizophrenia. Figures published in the World Bank Report for 1993 indicate that 8% of the burden of disability and morbidity in the world is due to mental and neurological problems. Nevertheless, beyond these figures, which are exclusively related to the mental disorders, we recognize that far too many people, particularly women and children, are vulnerable to stress and deprivation. Furthermore, there are estimated to be 50 million refugees and internally displaced persons worldwide.

Solutions to mental health problems entail a joint mobilization of social, economic, and political forces as well as substantial changes in governmental policies related to education, health, and economic development in each country. Therefore, the objectives of the program are the following: to enhance the attention of the people and governments of the world to the effects of mental health problems and substance abuse on the social well-being and physical health of the world's underserved populations, and to identify and promote collaborative strategies that can be implemented by the organization of the United Nations system, in cooperation with other international governmental and nongovernmental organizations, for improving the mental and psychosocial health of the world's underserved populations through country-level technical cooperation projects in the field of mental health promotion and mental disorders prevention and control, and focus financial and human resources, both public and private, on program implementation.

## No. 8B
## WORLD MENTAL HEALTH REPORT

Arthur M. Kleinman, M.D., *Chair, Department of Social Medicine, Harvard University Medical School, 641 Huntington Avenue, Boston, MA 02115*

### SUMMARY:

There must be an international movement that prioritizes mental health. It is essential to draw international attention to mental health concerns in international agencies such as the United Nations and the World Health Organization.

It is also essential to raise the international level of awareness that will affect the priority that policymakers and program developers worldwide assign to mental health.

A global campaign for mental health should involve the media, businesses, educational institutions, and networks of health and social policy makers. The problems of global mental health can be addressed in three ways: through health services and appropriate medical technologies, through a new generation of public health interventions, and through relevant national and international policy innovations.

The author presents the findings and recommendations of the World Mental Health Report and the implementation model developed in collaboration with the WHO Division of Mental Health with partnership opportunities for public/private institutions including nongovernmental organizations.

## REFERENCES:


1. Desjarlais R, et al: *World Mental Health Report* Oxford, Oxford University Press, 1995.
2. Kleinman A: *Rethinking Psychiatry: From Culture Category to Personal Experience*, New York: The Free Press, 1988.
3. Gleick P H: The implications of global changes for international security. Climatic Change 15:309–325, 1989.
4. Glickman T, et al: *Acts of God and Acts of Man: Recent Trends in Natural Disasters and Major Industrial Accidents*, Washington, D.C.: Center for Risk Management, 1992.


**Symposium 9** **Saturday, October 25**
**2:00 p.m.-5:00 p.m.**

# THE IMPACT OF MANAGED CARE ON PUBLIC MENTAL HEALTH

*American Association of Community Psychiatrists*

Kenneth Minkoff, M.D., *Medical Director, Choate Health Systems, 23 Warren Avenue, Woburn, MA 01801-4979*

## EDUCATIONAL OBJECTIVES:

To understand the general principles of managed care and how they are theoretically applied to public mental health service systems.

## SUMMARY:

Public sector managed care is currently one of the most dramatic forces affecting the delivery, organization, and financing of community mental health services. Many systems are being pressured to demonstrate more efficient methods of service delivery while simultaneously having to demonstrate a commitment to quality service. The mandate for publicly funded organizations to prove that service is of sufficient quality may compromise their efforts to contain costs. Some providers consider that the principles of managed care are contrary to public mental health principles.

The purpose of this presentation is to identify some of the major issues related to public sector managed care and to discuss their impacts on existing service systems at the state, program, and clinical levels.

The first three presentations will cover the history and theoretical basis of the principles of managed mental health care, the ideological basis for its implementation in community and other public-sector programs, and the content and importance of effective outcomes monitoring.

The final set of presenters will describe two different public systems and their current models of managed mental health care. They will discuss the impact of implementation on service delivery and will provide current information on system design, evaluation, and outcomes. These presentations will pair representatives from managed behavioral health care organizations and the corresponding public agency with which they are contracting.

## No. 9A
## PUBLIC SECTOR MANAGED CARE: WHAT IS IT?

Michael A. Hoge, Ph.D., *Associate Professor of Psychology, and Director, Managed Behavioral Health Services Development, Yale University School of Medicine, Department of Psychiatry, 25 Park Street, Room 622, New Haven, CT 06519*

## SUMMARY:

This presentation will provide a functional analysis and definition of public sector managed care and will begin by identifying the problems in "unmanaged" public sector systems. It will then review the form and function of the various strategies that have been employed to address these problems. From this analysis, a definition of public-sector managed care will be distilled that provides a useful conceptual framework for planning and evaluating managed care initiatives for the severe and persistently mentally ill individuals typically served in the public sector.

## No. 9B
## PUBLIC SECTOR MANAGED CARE AND COMMUNITY MENTAL HEALTH IDEOLOGY

Kenneth Minkoff, M.D., *Medical Director, Choate Health Systems, 23 Warren Avenue, Woburn, MA 01801-4979*

## SUMMARY:

The parallels between public sector managed care and community mental health principles will be highlighted, comparing areas of perceived incompatibility, the roots and evolution of community mental health ideologies, and proposing acceptable principles of public-sector managed care ideology.

## No. 9C
## OUTCOMES MEASURES: WHY, WHAT AND HOW?

Howard H. Goldman, M.D., *Department of Psychiatry, Center for Mental Service Research, 685 W. Baltimore Street, Baltimore, MD 21201*

### SUMMARY:

The proof of the success of managed care initiatives is often considered in relation to the question of whether the program or system is cost-effective. This presentation will emphasize the evaluation of the effectiveness component of the cost-effectiveness equation.

One challenge in evaluating effectiveness in a public sector managed care (PSMC) environment is that there are multiple stakeholders. Any measure of effectiveness demands a consensus from all stakeholders. This presentation will focus on the measurement of outcomes, particularly relevant to PSMC systems, how to promote and monitor effectiveness measures, and methods for evaluating (and influencing) the performance of providers. Public sector concerns about outcomes differ from concerns of the private sector: (1) The public sector has the critical responsibility to protect the public trust. Although this *may* be a concern of a private managed mental health care provider or payer, it *must* be the concern of a public mental health authority. (2) The public sector has responsibility for the entire population, especially individuals who are indigent and those who are most vulnerable and impaired. The special problem of outcome evaluation in the public sector is to address the broadest of societal concerns for the entire population with the same specificity and rigor practiced in the private sector.

## No. 9D
## CASE STUDY: PHILADELPHIA

Altha J. Stewart, M.D., *Behavioral Health Consultant, Community Behavioral Health, The Fidelity Building, 123 S. Broad Street, 22nd Floor, Philadelphia, PA 10109-1029*; Denis J. Milke, M.D.

### SUMMARY:

These two presentations will include one representative each from the managed behavioral health care organizations that contracted with or consulted with the public entity responsible for the provision of services in that jurisdiction and a provider or public administrator directly involved in the project. They will describe the development of the initiatives and how they have progressed, with emphasis on lessons to be shared with others and how their projects seem to be working.

## No. 9E
## CASE STUDY: TENNESSEE

Ann N. Boughtin, M.P.A., *Executive Director and Vice President, Merit Behavioral Care of Tennessee, 209 Tenth Avenue, South, #547, Nashville, TN 37203*; Ben Dishman

### REFERENCES:

1. Goldman W, Feldman S (Eds): *Managed Mental Health Care, New Directions for Mental Health Service;* no. 59. San Francisco, Jossey-Bass, 1993.
2. Minkoff K, Pollack D (Eds): *Managed Mental Health Care in the Public Sector: A Survival Manual.* Newark, NJ, Gordon & Breach, 1996.
3. Minkoff K: Community mental health in the nineties: PSMC. *Community Mental Health Journal*, 30:317–321, 1994.
4. Dorwart RA: Managed mental health care: myths and realities in the 1990s. *Hospital and Community Psychiatry*, 41:1087–1091, 1990.
5. Hoge MA, Davidson L., Griffith EEH, et al: Defining managed care in public-sector psychiatry. *Hospital and Community Psychiatry*, 45:1085–1089, 1994.
6. Essock SM, Goldman HH: Health reform and changing state mental health systems: Why States are embracing managed care. *Health Affairs.* 34–44, 1995.

**Symposium 10** **Saturday, October 25**
**2:00 p.m.-5:00 p.m.**

## THE CO-EVOLUTION OF PSYCHIATRY AND THE CLUBHOUSE

Dennis J. McCrory, M.D., *Council on Education, Research and Training, Fountain House, 6 Ridge Avenue, Newton Centre, MA 02159*

### EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should understand the clubhouse model, appreciate the synergistic effects of coordinated treatment and rehabilitation, relate to his/her local clubhouse or help to start a new one, and envision coordinated services under managed care.

### SUMMARY:

Recently, psychiatrists have been able to offer more accurate diagnosis and effective treatment to patients with serious mental illness. Yet, our interest goes beyond this: we care about them as people and wish to support their hopes for happy and productive lives.

In another tradition, the clubhouse model, which originated in 1948, helps members to find meaning by offering opportunities to make friends, work, go to school, and have a decent home. There are now 240 programs

worldwide. It is clear that psychiatrists, clubhouses, and policymakers need to recognize the value of working together to support consumers' recovery, quality of life, and community (re) integration.

This symposium will present the clubhouse and how it and psychiatry are "co-evolving." Members, staff, and psychiatrists who relate to the four presenting programs will share experiences, focusing in particular on ways of working together. We will also focus on systems/issues and the impact of managed care. Anyone interested in helping with mental illness will find support, information, and energy at this session. Tours of the Green Door can be arranged for those who wish to visit.

## No. 10A
## PSYCHIATRY AND THE CLUBHOUSE

Thomas J. Malamud, C.S.W., *Associate Director, Fountain House, Inc., 425 West 47th Street, New York, NY 10036*; Mark Glickman, M.A.

### SUMMARY:

Nearly 50 years ago, the clubhouse model of rehabilitation was founded on the principle of self-help through mutual help. An intentional community was created wherein every voice is important. Over the ensuing years there has emerged the conviction that given opportunity, support, and time, individuals with severe mental illnesses will achieve their life objectives of being good workers, neighbors, and friends. In the last five to 10 years, the belief has evolved that to accomplish these objectives, members and staff must work together in developing collegial alliances with psychiatrists.

This presentation will describe: 1) basic characteristics of the clubhouse; 2) various successful examples that have been constructed in which clubhouse participants and psychiatrists are working together; and 3) how outcomes have affected both clubhouse members and staff workers in terms of quality-of-life issues.

Specifically, the presentation will focus on ways in which clubhouse members and staff view this emerging alliance, and how their lives have been affected by it. In particular, attention will be paid to differences in outcomes over time, as related to the growth that has occurred in the process. Lastly, expectations for the future of the alliance will be discussed.

## No. 10B
## THE PSYCHIATRIST'S ROLE IN THE RECOVERY PROCESS

Paul J. Barreira, M.D., *Deputy Commissioner for Clinical and Professional Services, Massachusetts Department of Mental Health, 25 Staniford Street, Boston, MA 02114*

### SUMMARY:

Traditionally psychiatrists have been trained in settings that reinforce their identity as physicians controlling the care of patients. The typical rotation in the first year of residency includes the emergency room and inpatient units, settings in which the psychiatrist is likely to have more to say about the treatment than the patient. At the same time, recovery as part of the growing development of the rehabilitation model emphasizes the process by which people with psychiatric disability rebuild and develop personal, social, environmental, and spiritual connections, and confront the destructive effects of stigma through personal empowerment. Few settings exist that allow psychiatrists to understand experientially the meaning of recovery and to influence the way psychiatry is practiced.

This presentation will describe the development of a unique role for a psychiatrist in a clubhouse. For the past five years, Genesis Club has offered a "med-ed" group for interested members and staff, led by a faculty member of the psychiatry department of the University of Massachusetts Medical School. The psychiatrist as a resource about diagnosis and use of medication will be explained with an emphasis on the way relationships develop differently in the clubhouse from the office/clinic setting and what can be learned about recovery. The unique advantages to using a clubhouse as a training site for psychiatric residents will also be discussed.

## No. 10C
## THE REHABILITATION ALLIANCE

Ralph Aquila, M.D., *Director, Residential Community Services, Department of Psychiatry, St. Luke's-Roosevelt Hospital Center, 63 Washington Avenue, Cliffside Park, NJ 07010*

### SUMMARY:

The physician-patient relationship is rightly seen as a key to successful treatment. However, the therapeutic alliance, as it is known, has often been hard to build in meeting the needs of people with serious and persistent mental illness, with resulting noncompliance with treatment. The patient's perception of lack of choice in treatment decisions and goals that do not appear to have personal meaning contribute to this.

In the rehabilitation alliance the patient role shifts from passive recipient of services to an active participant, a co-team leader where the life goals of the individual are thoughtfully linked to the goals of treatment. The idea of treating symptoms *qua* symptoms disappears, and

the focus shifts to treating the symptoms to achieve a life goal, such as improved function on the job.

In the past five years, such an alliance has developed at Fountain House among members, staff, and a team of psychiatrists, which has led to the growth of all as we have co-evolved. This presentation will focus on the process and present the current design and learnings of this collaboration between Fountain House and Roosevelt/St. Luke's Hospital department of psychiatry.

## No. 10D
## A VISION FOR WORKING TOGETHER WITH MANAGED CARE

Judith Johnson, *Executive Director, Green Door, 1623 16th Street, N.W., Washington, DC 20009*

### SUMMARY:

Managed behavioral health care is feared by many people. But it also has the potential to significantly improve the quality of care for people with a major mental illness. MBHC's goals are to provide services in the least restrictive, least expensive settings, and to improve outcomes and consumer satisfaction. Given flexibility to meet these goals, an alliance of clubhouses and psychiatrists has the potential to significantly improve services to consumers while lowering costs.

Clubhouses focus on wellness and outcomes. Teamwork between the consumer, their clubhouse day program, case manager, and doctor is the key to improving their lives. MBHC forces teamwork to improve outcomes.

Clubhouses are cost-effective. They use peer support, consumer work, and generalist staff to reduce the costs. Clubhouses use consumer work as a therapeutic method of recovery. They are certified and use an MIS evaluation software program to measure their outcomes. The treatment alliance of clubhouses, case managers, and psychiatrists is attractive to MBHC companies.

### REFERENCES:

1. Bachrach LL: Psychosocial rehabilitation and psychiatry in the care of long-term patients. American Journal of Psychiatry 149(11):1455–1463, 1992.
2. Glickman M, Flannery M: *Fountain House: Lives Reclaimed from Mental Illness*, Minneapolis, Hazelton Press, 1996.
3. Leete E: How I perceive and manage illness. *Schizophrenic Bulletin* 15(2):197–200, 1989.
4. McQuillen B: My life with schizophrenia. In: Spaniol L, Kockler M: *The Experience of Recovery*, Boston, The Center for Psychiatric Rehabilitation, 1993.
5. Links PS, Kirkpatrick H, Whetson C: Psychosocial rehabilitation and the role of the psychiatrist, *Psychosocial Rehabilitation Journal* 8(1), 1994.
6. McCrory DJ: The rehabilitation alliance. *Journal Vocational Rehabilitation* 1(3):58–66, 1994

**Symposium 11** **Sunday, October 26**
**8:30 a.m.-11:30 a.m.**

## CORRELATES OF SUBSTANCE USE IN SCHIZOPHRENIA

Jean Gearon, Ph.D., *Post Doctoral Fellow, Department of Psychiatry, University of Maryland School of Medicine, 685 W. Baltimore Street, HSRF, Suite 618, Baltimore, MD 21201*; Robert Coursey, Ph.D.

### EDUCATIONAL OBJECTIVES:

At the end of the symposium, the participant will be able to identify possible factors relating to the etiology, maintenance, and subsequent management of substance use in a cohort of outpatients with schizophrenia.

### SUMMARY:

This symposium will identify possible factors relating to the etiology, maintenance, and subsequent management of substance abuse in people with schizophrenia. All data presented are a part of a larger study of dually diagnosed outpatients with schizophrenia who are receiving a battery of clinical, social competency, substance abuse, and neuropsychological measures. First, the possible role of families will be discussed. Family members' substance use (current vs. past), recovery, and direct efforts in assisting patients achieve sobriety will be presented. Second, various reasons for use will be presented. Participants' responses to questions about how frequently they use drugs or alcohol to cope with the positive and negative symptoms of schizophrenia, side effects of their psychotropic medication, and the negative consequences of having a serious mental illness will be discussed. Next, gender differences in how this cohort of outpatients accesses drugs and alcohol and how they maintain or finance their habits will be reviewed. Finally, the validity of the stages-of-change model for people with schizophrenia who abuse substances will be discussed. Measures of readiness to change and the pros and cons of continued substance use will be compared with several measures of the patterns and severity of substance use.

## No. 11A
## FAMILIES AND DUAL DIAGNOSIS PATIENTS

Lisa B. Dixon, M.D., M.P.H., *Associate Professor of Psychiatry, Center for Mental Health Services Research, University of Maryland, 685 W. Baltimore Street, MSTF/*

*Room 300, Baltimore, MD 21201*; Jill A. RachBeisel, M.D., Alan S. Bellack, Ph.D.

**SUMMARY:**

Little is known about the role of families in the understanding of the etiology and management of substance abuse disorders in persons with severe mental illness (SMI). We have previously found an increased rate of substance use in the families of substance-abusing schizophrenic inpatients. We reported in another study that dual diagnosis SMI inpatients reported lower family satisfaction and a greater desire for family treatment than non-dually diagnosed patients. In our more recent outpatient study, patients reported that 91% of their families had substance use, while the family informant reported a family substance use rate of only 40%. According to patients, the majority of parental use was alcohol, while siblings more frequently used nonalcohol drugs. Ongoing studies to be presented will assess the timing of family substance use (current vs. past), the recovery of family members, and the direct efforts of family members to assist patients to achieve sobriety on a cohort of dually diagnosed patients receiving extensive clinical and neuropsychological assessments.

## No. 11B
## SUBSTANCE ABUSE IN THE SERIOUSLY MENTALLY ILL

Jill A. RachBeisel, M.D., *Assistant Professor, Department of Psychiatry, University of Maryland School of Medicine, 4713 Ribble Court, Ellicott City, MD 21043-6519*; Jean Gearon, Ph.D., Lisa B. Dixon, M.D., M.P.H.

**SUMMARY:**

The prevalence of substance use disorders (SUD) in the seriously mentally ill (SMI) is a growing concern among health care providers. Studies have shown that the incidence of SUD in the SMI exceeds that in the general population, and there has been some attempt to explain this by the self-medication hypothesis. Findings have been nonspecific, including an earlier study done by our group where we were unable to clearly identify the etiology for this phenomenon. In this current study, a cohort of 50 persons with schizophrenia and SUD in the outpatient setting are assessed for reasons for use of drugs or alcohol. Categories pertinent to SMI include: 1) use to counter the side effects of psychotropic medication, 2) use to cope with the negative symptoms of schizophrenia, 3) use to cope with the positive symptoms of schizophrenia, and 4) use to cope with the negative consequences of having a SMI. The impact of such an understanding on program development and treatment approaches for this population could be potentially far reaching.

## No. 11C
## ACCESS TO DRUGS AND ALCOHOL IN SCHIZOPHRENIA

Jean Gearon, Ph.D., *Post Doctoral Fellow, Department of Psychiatry, University of Maryland School of Medicine, 685 W. Baltimore Street, HSRF/Suite 618, Baltimore, MD 21201*; Lisa B. Dixon, M.D., M.P.H., Alan S. Bellack, Ph.D.

**SUMMARY:**

To develop effective preventative interventions for substance abuse in people with schizophrenia, we need to better understand how drugs and alcohol are first accessed and how habits are maintained. Research has found that women in the general community who abuse substances first access and typically currently use substances with sexual partners. Men, however, first and currently use most frequently with peers. While women are more likely to finance their habits by trading sex for drugs, men are more likely to engage in illegal activities such as stealing or panhandling. Little is known, however, about how people with schizophrenia first access substances or continue to maintain their habits. Data from a large ongoing study of outpatients with schizophrenia comparing gender differences in how substances are first accessed, current use partners, and how habits are maintained or financed, will be presented. Gender differences in the consequences of use, such as violent victimization, will also be presented. The applicability of this information to the development of effective interventions for this population will be discussed.

## No. 11D
## READINESS TO CEASE SUBSTANCE ABUSE IN SCHIZOPHRENIA

Jack E. Scott, Sc.D., *Assistant Professor of Research, Department of Psychiatry, University of Maryland, 685 W. Baltimore Street, MSTF/Room 300, Baltimore, MD 21201*; Alan S. Bellack, Ph.D., Jean Gearon, Ph.D.

**SUMMARY:**

Substance abuse is a severe, costly, and disruptive problem among patients with schizophrenia. While interventions for treating substance abuse among these patients are being developed and evaluated, research on the processes underlying abstinence and recovery is at an earlier stage of development. For patients with primary substance abuse, the readiness-to-change behavioral model of Prochaska and DiClemente has been widely adopted as a useful framework for understanding how, when, and why patients stop using alcohol or other drugs. There have been few efforts to examine the validity of

this model for patients with schizophrenia. This study examines the applicability and validity of the readiness to change framework in a sample of 50 outpatients with DSM-IV schizophrenia and schizoaffective disorders. Measures of the readiness to change and the pros and cons of continued substance use are compared with several measures of the patterns and severity of substance use within this sample, and the direction and magnitude of these relationships are compared with those found for primary substance abusing patients. The implications of these findings for the development of a clinical model of the addiction recovery process among patients with schizophrenia are discussed.

## REFERENCES:

1. Dixon L, McNary S, Lehman A: Substance abuse and family relationships of persons with severe mental illness. *American Journal of Psychiatry* 152:456–458, 1995.
2. Lehman LF, Myers PC, Dixon LB, Johnson JL: Defining subgroups of dual diagnosis patients for service planning. *Hospital and Community Psychiatry*, 45(6):556–561, 1994.
3. Prochaska JO, DiClemente CC, Norcross JC: In search of how people change: applications to addictive behaviors. *American Psychologist*, 47(9):1102–1114, 1992.

**Symposium 12** **Sunday, October 26**
**8:30 a.m.-11:30 a.m.**

# CLINICAL EXPLORATION OF THE PATIENT'S WORLD VIEW

Irving S. Wiesner, M.D., *Clinical Assistant Professor of Psychiatry, Hahnemann Medical College of Pennsylvania, Allegheny University of the Health Sciences, 119 Pennock Place, Media, PA 19063-3828*

## EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participants should be able to benefit both in their diagnostic and therapeutic skills from an increased understanding of world view issues especially as they relate to guilt, forgiveness, sexuality, suffering, death in Hindu, Jewish, Catholic and African-American Protestant faith traditions.

## SUMMARY:

In 1990, APA issued a set of guidelines for psychiatrists, which in part stated that "it is useful for clinicians to obtain information on the religious or ideological orientation and beliefs of their patients so that they may properly attend to them in the course of treatment."

There has been increasing attention directed at this significant facet of patients' lives over the past several years both at the APA annual meetings and at various medical centers across the country. Courses are being designed for residency training programs and there is also a need for practicing psychiatrists to become better informed.

This symposium is designed to increase cultural/religious sensitivity and to provide a valid scientific knowledge base upon which we can improve diagnostic and therapeutic interventions.

A female Hindu Indian psychiatrist, a male Protestant African-American psychiatrist, a male Catholic Caucasian psychiatrist, and a male Jewish psychiatrist will respond to an initial presentation of a generic clinical approach to eliciting a patient's world view. Within this context, attitudes toward concepts of guilt, forgiveness, sexuality, death, and suffering will be addressed.

Since we interpret the world around us through various filters or lenses, the variety of responses of the panelists will lend themselves to a rich discussion among the panelists as well as the audience.

**No. 12A**

# A GENERIC EXPLORATION OF THE PATIENT'S WORLD VIEW

Irving S. Wiesner, M.D., *Clinical Assistant Professor of Psychiatry, Hahnemann Medical College of Pennsylvania, Allegheny University of the Health Sciences, 119 Pennock Place, Media, PA 19063-3828*

## SUMMARY:

All would agree that bad things can and do happen to us and that we at times have done bad things. Also generally agreed is that as we grow we are required to accomplish developmental tasks, which we sometimes resist. Finally, there are transcendent questions we must answer concerning who we are in relation to the universe and who we are in relation to eternity. This is the substance of the common ground upon which there is general agreement.

It is useful to clearly establish this common ground before venturing into a discussion of the uncommon ground of the various world view perspectives and faith traditions of our patients. As clinicians, we can obtain valuable information by investigating how patients frame their world and see themselves in it. Issues of guilt and forgiveness and steps in their resolution will be discussed. Approaches to questioning patients concerning their concept of God, the nature and use of prayer and ritual, and their involvement in a faith community will be introduced.

A generic format will be presented differentiating healthy from unhealthy and mature from immature faith or belief, regression in faith under stress, incompletely

developed world views, and contradictions between stated world views and behavior.

## No. 12B
## WORLD VIEW OF THE HINDU PATIENT

Nalini V. Juthani, M.D., *Associate Professor, Department of Psychiatry, Albert Einstein College of Medicine, 17 Pheasant Run, Scarsdale, NY 10583-3100*

### SUMMARY:

The clinical approach to eliciting a patient's world view must take into consideration the patient's cultural and religious beliefs and practices. A Hindu patient believes in one creator who lays the ground for one's divinity. This divinity is "Self." Therefore, God, or "Atman," are synonymous. God or Self is pure consciousness and complete. This completeness resides within us; however, we feel incomplete due to our unfulfilled desires and overwhelming ego. Hindus accept desires that are controlled and encourage sublimation. Anger, jealousy, attachments, sex, greed are examples of desires that need to be sublimated.

Hindu religion does not have any established temple and a Hindu is free to grow in one's spiritual life at one's own pace. Hinduism allows one to formulate one's own sacred life as long as it is not transgressive of others. Therefore, you can choose your own form of God and belong to that sect. A Hindu pattern of religious and spiritual life will be more like a mosaic than a melting pot.

In this presentation, the concepts of guilt, forgiveness, and death will be discussed using the Hindu way of thinking. The role of rituals involving fasting, prayers, charity, etc. will also help participants understand a Hindu patient's world view.

## No. 12C
## WORLD VIEW OF THE JEWISH PATIENT

Jacob H. Jacoby, M.D., Ph.D., *Clinical Associate Professor, Department of Psychiatry, University of Maryland at New Jersey, 654 Avenue C, Bayonne, NJ 07002*

### SUMMARY:

Contemporary Jewish practice shows a wide range of observance and belief, ranging from strict adherence to the laws and subsequent Rabbinic interpretation of those laws given to Moses on Sinai (the Torah) to minimal or no observance or to a questioning of the divine origins of these laws. Those individuals that most closely adhere to the precepts of traditional Judaism would fall into the category commonly called "Orthodox," with intensity of the level of observance and commitment to these precepts diminishing along a spectrum ranging from Orthodoxy to Conservative to Reconstructionist and Reform Judaism.

Jewish religious literature from the Torah, the Talmud, and later commentaries over the centuries is replete with issues of life challenges, conflicts, failings, and resolutions. These are presented as a formal system of laws, as inexact discussions, and in treatises meant to inspire greater levels of awareness and observance. The extent to which normative Jewish values or expectations influence or impinge on any single patient's response to major life challenges including issues of death, suffering, sexuality, forgiveness, and feelings of guilt, will in turn reflect the extent to which Jewish values have been internalized and have played an already significant role in that patient's world view.

## No. 12D
## WORLD VIEW OF THE CATHOLIC PATIENT

Alfred W. Murphy, M.D., *Department of Psychiatry, New York Medical College, 22 Salem Place, White Plains, NY 10605-3719*

### SUMMARY:

A Catholic patient finds himself or herself part of the many centuries of the Judeo-Christian tradition. The Catholic Church acknowledges its ancient roots in Jewish history and belief. This is embedded deeply within the patient's memory structures and may on occasion be less than fully integrated. The specifically Catholic tradition reaches back 2,000 years. Events recalled from the intervening period are not easily reconciled with the social and cultural values of the present day. The merciful and charitable image of Jesus, the founder of the patient's faith, frequently clashes with the narcissism and aggressiveness that pervade the social and work environment. The teachings of Jesus of divine love and his redemptive death for all men and women create a special problem for the patient who has been raised and instructed in the skills or adaptations necessary to survive and prosper in confrontation with a secular world of contrary attitudes and expectations.

The basic structures of the theological and philosophical reflections upon the patient's faith are treasured in writings and sermons extending over the centuries and treasured within universities and schools, churches and libraries, as well as the memory of the faith community. The patient may have been exposed to only a modicum of this knowledge and teaching or on the other hand have the very highest instruction and education in his

faith. The patient's strengths in this regard may or may not be effective in resolving related spiritual conflicts.

## No. 12E
## WORLD VIEW OF THE AFRICAN-AMERICAN PROTESTANT PATIENT

James H. Carter, M.D., *Professor of Psychiatry, Duke University Medical Center, Department of Psychiatry, Durham, NC 27710-0001*

### SUMMARY:

There is an astonishing diversity of religious beliefs and practices in the history of African Americans. The majority of African Americans, however, are evangelical Christians with religious experiences originating in the regions of ancient Africa (Cush, Punt, and to a great extent Egypt), as well as black adaptation of Hebraic, Jewish, Christian, and Islamic beliefs and rituals. Seldom spoken of is the role of traditional African religious rituals and numerous religious derivatives found in the black diaspora impacting Candomble (Brazil), Graifuna (Honduras), Shango (Trinidad), and Vodun (Haiti). The impact of slavery, colonialism, and racism in the oppression of African-American people also helped to crystalize the African-American evangelical Christian experience.

Clinicians attempting to reach African Americans in therapy would be helped by understanding that African-American religious experiences typically consider the supernatural as a mere extension of the natural order. It is an experience that seeks harmony, not dominance, over nature. It reveres ancestors and rejoices in rhythm. African-American evangelical Christians take both spirituality and the after-life seriously. Death and suffering are perceived as a result of Adam's original sin. Guilt and forgiveness do not coexist, and there is a tremendous fear that blasphemy is unforgivable, resulting in "soul lost."

### REFERENCES:

1. Lovinger RJ: *Working with Religious Issues in Therapy*. Jason Aronson, Inc. NY. 1984.
2. Sharma A: *Our Religions*. Harper Collins Publisher, San Francisco 1993.
3. *The Babylonian Talmud*
4. Meissner WW: *Psychoanalysis and Religious Experience*. Yale University Press, New Haven, 1984.
5. *Catechism of the Catholic Church*. Paulist Press, Mahwah, NJ, 1994.
6. Adebimpe VR: Overview: white norms and psychiatric diagnosis of black patients. *American Journal of Psychiatry* 138(3):279–285, 1981.

**Symposium 13** **Sunday, October 26**
**8:30 a.m.-11:30 a.m.**

## ACUTE OR CRISIS TREATMENT OF THE DUAL-DIAGNOSIS PATIENT

Peter L. Forster, M.D., *Chair, Department of Psychiatry, Alameda City Medical Center, JGPP, Room 201, 2060 Fairmont, San Leandro, CA 94578-1835*

### EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to work effectively with dual-diagnosis patients and address specific needs of this population.

### SUMMARY:

Changes in service availability, the impact of managed care, and changes in eligibility criteria for benefits and services are all having a significant impact on the provision of crisis or emergency care for patient's with dual substance abuse and mental health problems. In this symposium the literature on the relationship between mental health problems and substance abuse is reviewed, particularly as it relates to the use of acute or crisis services. Then the forces that are affecting service delivery are discussed and their impact on acute or crisis services is described. Finally, three models of care for this population are described: (1) a short-term case management model, (2) an outpatient crisis group or day treatment model, and (3) a brief inpatient model that uses clinical pathways to ensure high quality care despite a very brief stay.

## No. 13A
## THE UNPREDICTABLE PRESENTATION OF THE DUAL DIAGNOSIS PATIENT IN A PSYCHIATRIC EMERGENCY SERVICE

Saundra K. Gilfillan, D.O., *Assistant Professor of Psychiatry, University of Texas Southwestern Medical Center, and Medical Director, Psychiatric Emergency Services, Parkland Memorial Hospital, Department of Psychiatry, 5323 Harry Hines Boulevard, Dallas, TX 75235-8898*

### SUMMARY:

What presents to a large metropolitan hospital psychiatric emergency service when you consider the drugs currently available on the streets? Not exactly an easy question to answer, given the drug combinations that are concocted in the area "kitchens" that are producing illegal drugs for use in the addicted population. Mix this with underlying mental illness, and the task of diagnosing the primary cause of the destabilization of this patient becomes even more difficult in this emergency setting. We are not as likely to see a young "pure alcoholic"

anymore; the overwhelming numbers of drug and alcohol using children, adolescents, and adults are evident in the admission statistics in the emergency service department. Intoxication of the new street drugs makes assessment and treatment very difficult to accomplish initially, as the signs and symptoms may mimic PCP, cocaine, LSD, or other psychoactive drugs. The real problem becomes evident when rapid tranquilization is attempted due to behavioral dyscontrol, and the patient's vital signs deteriorate, possibly due to one of the street drugs such as flunitrazepam, "legal" ephedrine, or "whack," a combination of marijuana soaked in formalin, dried, and ultimately smoked, with the presentation very similar to that of hallucinogen use. Because of the many faces of drug presentation and coexisting mental illness, documentation of the urine toxicology test results is necessary, given the unreliable correlation between suspicion of drug use and ultimate urine results. The final diagnosis can easily be "provisional" based on the time spent in the emergency service, crisis intervention accomplished, collateral history, and plans for disposition.

## No. 13B
## THE SOLANO COUNTY DUAL DIAGNOSIS TREATMENT PROGRAM

J. Rodney Kennedy, M.D., *Program Manager, Crisis and Acute Treatment, Solano County Division of Mental Health and Substance Abuse, 2101 Coral Drive, Fairfield, CA 94533*; Larry Stentzel, M.A., Mina Smith, M.S.N.

### SUMMARY:

In response to the increasing numbers of persons presenting both mental illness and substance abuse problems, Solano County's Mental Health and Substance Abuse Divisions have collaborated on an innovative approach to unify substance abuse and mental health treatment for those people meeting mental health's target population. This is an outpatient treatment approach with a multidisciplinary team addressing social, physical, and psychiatric health issues. The service is provided out of the county's brief therapy and crisis unit, but incorporates staff from all mental health programs as well as a representative from the county's substance abuse division. It serves as an alternative and/or diversion to inpatient treatment or other increasingly stressed community resources.

Solano County Mental Health began with an aggressive training program for all staff in the identification, understanding, and treatment of dually diagnosed consumers. The dual diagnosis program includes two outpatient treatment tracks, psychiatric medications, and case management services. The open treatment track consists of drop-in support and education groups open to the general dual diagnoses community. The open track is designed to enable staff to evaluate people for inclusion in the structured track or refer the clients out for a more appropriate community referral if they do not meet mental health's target population criteria. The structured track includes the open groups as well as at least one closed "core" group in which the client focuses on relapse prevention and/or establishing and maintaining abstinence. Other specialized groups are included in each individual's written treatment contract as appropriate. Examples of such specialized groups are anger management, depression, wellness, panic disorder, and exercise groups. Clients' treatment contracts set out their individualized schedule, which can include community 12-step groups, and require client agreement to drug and alcohol screening and all recommended treatment modalities, which can include psychotropic medications. Short-term individual sessions are available if needed, but the primary focus is on group work. Psychiatrists, where appropriate, medicate clients even before abstinence has been established and can tie access to medications to attendance at treatment groups where a nursing evaluation, urine screen, and psychiatric evaluation are available as needed.

## No. 13C
## SHORT-STAY INPATIENT STABILIZATION AND CLINICAL PATHWAYS

Aline Wommack, R.N., M.S., *Director, Psychiatric Emergency Services, Department of Psychiatry, San Francisco General Hospital, 1001 Potrero Avenue, San Francisco, CA 94110*

### SUMMARY:

The complexity and acuity of the dual diagnosis patient with coexisting medical complications may require extended assessment and stabilization beyond the PES length of stay. This presentation will discuss the addition of a 72-hour detoxification unit to the psychiatric emergency services, which allows for further assessment and engagement. The care rendered is guided by clinical pathways defining the inpatient process and introduction of case management services, which continue after discharge.

## No. 13D
## THE MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES INTERFACE

Peter L. Forster, M.D., *Chair, Department of Psychiatry, Alameda City Medical Center, JGPP, Room 201, 2060 Fairmont, San Leandro, CA 94578-1835*

## SUMMARY:

Substance abuse services and mental health services have had very different approaches to the evaluation and treatment of affected individuals throughout the modern era—approaches that reflect a different philosophy about the nature of individual responsibility for problems, the appropriate role for psychoactive medications, the understanding of treatment failure, and the role of professional staff in treatment. These differences intersect every time an emergency or crisis service is asked to evaluate a patient with both substance abuse and mental health problems. This paper reviews the history of those differences. It summarizes the relevant epidemiologic data on dual diagnosis and evidence that dually diagnosed patients are particularly likely to access crisis and acute services. Finally, it reviews recent studies on the course and response to treatment of dual diagnosis patients that suggest that the primary versus secondary substance abuse distinction first described by Winokur in 1971 can be helpful in the development of services for these patients.

## No. 13E
## CRISIS CASE MANAGEMENT OF MULTI-DIAGNOSIS PATIENTS

Grad Green, M.S.N., R.N., *Clinical Nurse Specialist, Psychiatric Emergency Service, San Francisco General Hospital, 1001 Potrero Avenue, San Francisco, CA 94110*

## SUMMARY:

Crisis stabilization and linkage of dual and triple diagnosis patients who do not fit well into existing mental health or substance abuse services is not only a challenge to the clinician and case manager but also to the health care system. The emergency services are the point of entry of care for these clients who do not follow through with community-based maintenance care and usually present with a multitude of problems. The focus of this presentation will be on the crisis case manager's engagement of the patient into the process of recovery through harm reduction and connection with existing resources through education and reframing of the patient's symptoms. The case manager becomes the agent for the patient, who is the "star of this show," but who may also be a bit "eccentric". Identification of the patient's strengths, supports, providing basic needs, and assisting the patient in identifying replacement behaviors for the more destructive ones will be demonstrated through case presentations.

## REFERENCES:

1. Regler D, Farmer M, Rae D, et al: Comorbidity of mental disorders with alcohol and other drug abuse, *JAMA* 264:2511–2518, 1990.
2. Rics R: Clinical treatment matching models for dually diagnosed patients: recent advances in addiction disorders, *Psychiatric Clinics of California* N.A. Vol 16, #1–1993.
3. Jansen A, et al: Harbinger Team, Assertive Community Treatment for People with Dual Diagnosis of Mental Illness & Substance Abuse.
4. Winokur G, Rimmer J, Reich T: Alcoholism; IV: is there more than one type of alcoholism? *Br J Psychiatry* 118:525–531, 1971.
5. Schuckit M, Anthenelli RM, Buckholz KK, et al: The time course of development of alcohol related problems in men and women. *J Stud Alcohol.* 56:218–225, 1995.
6. The impact of crisis resolution teams on the use of acute care services. VALAN, 1991.

**Symposium 14** **Sunday, October 26**
**2:00 p.m.-5:00 p.m.**

## NEIGHBORHOOD INTEGRATED DELIVERY SYSTEMS

Kenneth S. Thompson, M.D., *Director, Institute for Public Health and Psychiatry, Western Psychiatric Institute and Clinic, and Former APA/Mead Johnson Fellow, 3811 O'Hara Street, Pittsburgh, PA 15213*; Stephen D. Mullins, M.D., M.P.H.

## EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to describe the public health approach to community-oriented mental health services and the development of a neighborhood integrated service delivery system.

## SUMMARY:

Among the features that managed care brings to behavioral health care services is the concept of the integrated service delivery system, organized to provide seamless comprehensive psychiatric care to a population. For the most part, such service systems are built around the needs of particular subpopulations identified by their need for psychiatric services, e.g. persons with severe and persistent mental illness or emotionally disturbed children. It is relatively rare for a system to construct itself in response to the mental health needs of a community, despite the fact that this is what the community mental health movement originally called for.

This symposium will present the efforts of several clinicians involved in the Institute for Public Health and Psychiatry at the University of Pittsburgh to create a more comprehensive approach to the mental health needs of an inner-city African-American neighborhood in Pittsburgh. The efforts address individuals and families across the life span and are bound together by the aware-

ness clinicians have of the community, its structure, strengths, and weaknesses. This knowledge has been gained in an informal process of "community dialogue," which will be described. The impact of the values of the community on clinical services will be explored.

## No. 14A
## CHILDREN FROM LOW-INCOME FAMILIES FACING MULTIPLE STRESSORS

Claire M. Cohen, M.D., *Department of Psychiatry, Western Psychiatric Institute and Clinic, 1029 Farragut Street, Pittsburgh, PA 15206-1743*

### SUMMARY:

Children from low-income families facing multiple stressors, such as parental mental illness, parental substance abuse, etc., may show psychiatric disturbance and developmental delays. When referred for outpatient therapy, such children and their families tend to have low compliance with treatment. At the Matilda Theiss Child Development Center, a team treats such children and their families in a partial hospital program integrated into a regular daycare setting, within a community center located in the middle of a housing project. Children who meet criteria for a psychiatric diagnosis receive a treatment plan, therapy, child-centered parent counseling, pharmacotherapy, speech therapy, physical therapy, and milieu behavioral management. Parent workers do home visits when indicated. The center has a pediatrics clinic and a family medicine clinic. Theiss works closely with two substance abuse treatment programs for women to coordinate the treatment needs of parent and child(ren). This paper will provide some hypotheses on why such a program may be the best treatment for children from low-income, highly distressed families.

## No. 14B
## COMMUNITY MENTAL HEALTH AND FAMILY SUPPORT SERVICES: PARTNERING TO STRENGTHEN LOW-INCOME FAMILIES

Cathy D. Moore, Ph.D., *Allegheny University of the Health Sciences, 4 Allegheny Center, 8th Floor, Pittsburgh, PA 15212*

### SUMMARY:

Despite the association between poverty and mental health problems, the mental health needs of low-income people are often not considered in the design and implementation of mental health services. This paper briefly reviews the results of a mental health service needs assessment administered to a sample of 47 low-income African-American mothers who belong to a family support agency. The paper also discusses how information gained from the survey was used to begin a collaboration and partnership with a local community mental health center to develop culturally congruent and appropriate mental health services for the families involved in family support. Suggestions for future research, as well as suggestions for needed additional collaborative efforts are also discussed.

## No. 14C
## THE PARTNERS PROJECT: A CONTINUUM OF CARE FOR INNER-CITY WOMEN IN RECOVERY AND THEIR CHILDREN

Vaughn Stagg, Ph.D., *Director, Thesis Center, Department of Psychiatry, Western Psychiatric Institute and Clinic, 3811 O'Hara Street, Pittsburgh, PA 15213*

### SUMMARY:

The Partners Project is a collaborative of agencies that was designed to wrap recovery services around substance abusing inner-city women and their children. Funded by a local philanthropy and Health Start, Inc., the Partners include the following public and private agencies: Matilda H. Theiss Center, located in the largest public housing development in Pittsburgh, provides primary care and child development; Hill District Community Collaborative provides case management and referral services; Dolores Howze Day Treatment Center provides drug and alcohol treatment from an Afro-centric perspective; Housing Authority of Pittsburgh is working to provide specialized safe housing; Womens Space East, Inc., provides safe emergency housing; and the Public Housing Residents Council provides us with community guidance. Our goals are to coordinate services for women and children affected by substance abuse, continue to refine a gender- and culture-specific drug and alcohol treatment program for African-American women, provide an intervention program to enhance childhood development, and provide safe drug-free housing for mothers in recovery. We will present data regarding child outcomes, referral data, and lessons that we have learned in mounting this collaborative effort.

## No. 14D
## RETHINKING COMMUNITY PSYCHIATRY IN THE INNER CITY

Kenneth S. Thompson, M.D., *Director, Institute for Public Health and Psychiatry, Western Psychiatric Institute*

*and Clinic, and Former APA/Mead Johnson Fellow, 3811 O'Hara Street, Pittsburgh, PA 15213*

## SUMMARY:

Urban poor persons find themselves in a socioeconomic disaster. Entwined with this catastrophe is a public health crisis, which can be observed in the high morbidity and mortality rates affecting this population. It can particularly be seen in high infant mortality rates and in the epidemics of crack use, AIDS, TB, violence, and trauma. It is likely that there has also been an increase in the prevalence of social psychological problems such as loneliness and grief and of psychiatric disorders such as depression, post-traumatic stress disorder, and psychosis. Community mental health organizations would seem to have a part to play in addressing the public health problems occurring in this population, especially since "behavior" makes a critical contribution to their prevalence. What role do mental health organizations have in society's response to the urban public health crisis? This presentation will examine the crisis in depth and attempt to begin answering this question. The work of the recently created Institute for Public Health and Psychiatry at Western Psychiatric Institute and Clinic will be described.

## No. 14E
## COMMUNITY CARE FOR RESIDENTS OF A SENIOR HIGH-RISE HOUSING PROJECT

Andrea Fox, M.D., *Medical Director, Benedum Geriatric Center, University of Pittsburgh Medical Center, 3520 Fifth Avenue, Keystone 300, Pittsburgh, PA 15213*

## SUMMARY:

This symposium reports on a joint effort of the University of Pittsburgh's Graduate School of Public Health's Center for Minority Health, the University of Pittsburgh Medical Center's (UPMC) Alzheimer Disease Research Center's Community Satellite Program, the Alzheimer's Outreach Center, and the Benedum Geriatric Center to pilot test a model of community care. The overall goal of the model was to increase the access of older African Americans, particularly those who are medically underserved or may lack health care. Initiated in June 1995 at the Lou Mason High Rise (167-household facility, 90% of which are African American), the goal was carried out by means of four objectives: establishing initial trust and credibility with residents and on-site staff; identifying the needs of the residents regarding health care, access to health care, and health care information; identifying barriers to accessing health care and health care information; and establishing a mechanism at the site that will increase access to health care and health care information. UPMC has adopted the Lou Mason High Rise and has begun to offer on-site physician coverage for residents identified and desiring in-home medical care. The process of how this model was implemented, the issues involved in carrying out this type of programming, and the current status and findings of the evaluation of the project are presented.

## REFERENCES:

1. Muir EE, Thorlaksdottir E: Psychotherapeutic intervention with mothers and children in day care. *Amer J Orthopsychiatry* 64(1):60–67, 1994.
2. Townsend J: Racial, ethnic and mental illness stereotypes: cognitive process and behavioral effects. In Willie C, Ricker P, Kramer B, & Brown B (eds): *Mental Health, Racism and Sexism*, University of Pittsburgh Press, Pittsburgh: PA, 119–147, 1995.
3. Bailey D, McNally Koney K: Interorganizational community-based collaboratives: a strategic response to shape the social work agenda. *Social Work* 41(6):602–611, 1996.
4. Mosher L, Burti L: *Community Mental Health: Principles and Practice*, WW Norton and Co, New York, NY, 1989.
5. Community Care Network Resource Center: *Background and Resources for a Community Health Status Focus*. Chicago, IL, 1996.

**Symposium 15** **Sunday, October 26**
**2:00 p.m.-5:00 p.m.**

## MANAGED CARE AND THE PUBLIC MENTAL HEALTH SYSTEM
**National Alliance for the Mentally Ill**

Laurie M. Flynn, M.A., *Executive Director, National Alliance for the Mentally Ill, 200 N. Glebe Road, Suite 1015, Arlington, VA 22203*

## EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to: understand the motivation of the contractor and identify corporate values; specify performance indicators, standards, and outcome measures; require demonstration of regional knowledge by the contractor; identify the entity responsible for oversight; and recognize potential benefits/optimize potential advantages.

## SUMMARY:

Managed care is rolling through the public mental health system, increasingly affecting care to people with severe and chronic mental disabilities. In some states, private sector managed care organizations are assuming roles traditionally held by the state, in terms of manage-

ment of care, treatment decision making, and information collection. Providers, advocates, families, and consumers are increasingly worried by this wholesale revolution of the public mental health system. Problems are becoming apparent, as dollars for services are decreased, long-term care is neglected, and hospital care is all but abolished. This symposium will discuss several perspectives on the impact of managed care on caring for people with severe mental illness in the public mental health system. Providers, evaluators, academics, and advocates will give voice to their concerns as increasing evidence indicates that public sector managed care is likely to be as big a debacle as deinstitutionalization was.

## No. 15A
## MANAGED CARE AND THE PUBLIC MENTAL HEALTH SYSTEM

Laura Lee Hall, Ph.D., *Deputy Director, Department of Research and Policy, National Alliance for the Mentally Ill, 200 N. Glebe Road, Suite 1015, Arlington, VA 22203*

### SUMMARY:

NAMI has performed a year-long study of managed care's impact on people with severe mental illness in the public mental health system. This session will present the findings of the study, including results from the first nationwide survey of patients and family members about managed care; a survey of managed care organizations in the public mental health system; and an examination of state policies that have permitted managed care to move forward. The study shows that patients and families have a lot of questions about managed care and even more concerns. The MCO survey identifies significant gaps in their approach to managing care for people with severe mental illnesses. Finally, significant questions about how states have implemented managed care will be raised.

## No. 15B
## A PSYCHIATRIST CRIES OUT: PUBLIC SECTOR MANAGED CARE CAN HURT

Jeffrey L. Geller, M.D., M.P.H., *Professor of Psychiatry, University of Massachusetts Medical Center, 55 Lake Avenue North, Worcester, MA 01655*

### SUMMARY:

For well over half a century, sweeping reform and/or novel interventions have been instituted, putatively to benefit those with chronic mental illness, but without the data to support beneficial outcomes. In the name of progress we have advocated the wholesale use of prefrontal lobotomies in the 1940's, chlorpromazine in the 1950's, electroconvulsive therapy in the 1960's, the dangerousness standard for civil commitment in the 1970's, "deinstitutionalism" in the 1980's, and managed care in the 1990's. In the care and treatment of those with chronic mental illnesses, it is time we recognize that one size does not fit all.

Is there evidence that managed care applied to the long-term needs of those with chronic mental illness is an appropriate match of needs and interventions?

Is there evidence that we can target specific interventions to specific needs? Is there evidence we have even tried?

Is there evidence that we can, at this time, differentiate between ill-conceived and poorly executed public sector managed care endeavors?

Is there evidence that second and third generation public sector managed care endeavors are learning from earlier efforts?

Basically, the answers to these inquiries is "no." What's to be done?

## No. 15C
## THE MASSACHUSETTS MEDICAID EXPERIENCE

Richard H. Beinecke, D.P.A., *Assistant Professor, Department of Public Administration, Suffolk University, 8 Ashburton Place, Boston, MA 02108*

### SUMMARY:

The Massachusetts Medicaid Mental Health/Substance Abuse Program (MH/SAP) is in its sixth year and is now being managed by the Massachusetts Behavioral Health Partnership. This presentation will update a case study of the MH/SAP written for the National Alliance for the Mentally Ill, with a particular emphasis on how consumers can become involved in managed care programs.

The presentation will:

- Review the first four years of the program under MHMA;
- Update the first year of the partnership's management;
- Summarize internal and external evaluations of the program; and
- Describe methods whereby consumers and providers can become more effective participants in setting managed care policies and programs.

## No. 15D
## MEDICAID MANAGED MENTAL HEALTH CARE: IMPACT ON THE PUBLIC

Barbara M. Rohland, M.D., *Assistant Professor of Psychiatry, University of Iowa College of Medicine, Depart-*

*ment of Psychiatry, Psychiatry Research 1-400 MEB, Iowa City, IA 52242-1000*

## SUMMARY:

Contractors can, and should, be held accountable for the delivery of comprehensive mental health care services that meet acceptable standards of care quality. In Iowa, initial problems encountered by the rapid implementation of Medicaid managed mental health care may have been avoided if performance indicators and standards were specified in the original contract. This presentation, based on experiences described in the Medicaid Managed Mental Health Care: Iowa Case Study, summarizes issues that should be considered by stakeholders in other states who are implementing Medicaid managed care programs.

## REFERENCES:

1. A national report card: the impact of managed care on people with severe mental illness-NAMI February 1997.
2. Robinson G, et al: Substance abuse mental health services administration's managed care tracking system; Third report. Substance Abuse and Mental Health Services Administration, Public Health Service, U.S. Department of Health and Human Services 10/31/96.
3. National Association of State Mental Health Program Directors: mental health services under eight state managed care contracts. U.S. Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, Public Health Service, U.S. Department of Health and Human Services, May 1996.
4. Callahan JT Jr., Sitepard DS, Beineeke RH: Larsen, MS Cavanaquset D: Mental health/substance abuse treatment in managed care: the Massachusetts medical experience. *Health Affairs* 14(3), 173–184, 1995.
5. Egnew RC: Administrative and management issues in public and private collaboration. *Behavioral Healthcare Tomorrow* 4, 25, 29, 1995.

**Symposium 16** **Sunday, October 26**
**2:00 p.m.-5:00 p.m.**

# WHAT AMERICANS CAN LEARN FROM THE FRENCH SYSTEM

John A. Talbott, M.D., *Liaison, APA Institute Scientific Program Committee, and Professor and Chair, Department of Psychiatry, University of Maryland School of Medicine, 645 W. Redwood Street/P1G08, Baltimore, MD 21201-1542*; Gerald J. Sarwer-Foner, M.D.

## EDUCATIONAL OBJECTIVES:

To understand the history, current status, and looming threats to the French system of mental health care, including factors such as "secteur" (catchment) psychiatry, funding, organizational complexity, and patient outcomes.

## SUMMARY:

This presentation will review the history, current status, and looming threats to the French system of mental health care including "secteur" (catchment) psychiatry, funding, organizational complexity, and patient outcomes. John A. Talbott will provide an overview and introduction on the problems of comparing mental health systems in different countries. Simon-Daniel Kipman will provide an overview of the history of the system of care, including the inauguration of "secteur" psychiatry, e.g., by catchment areas, in the 1960's, the inter-relationship between "public" and "private" services, and the role of long-term treatment in France. Jean-Charles Pascal will then review the complexities of organizing the system of care, its various funding streams, and coverage of services such as rehabilitation, emergency services, and long-term care. Jean-Yves Cozic will cover what experts studying the system of care have learned about outcomes from mental health services research. Finally, Gerald Sarwer-Foner will discuss the ramifications of the French system, what we can learn from it, and how we can apply these lessons to our system-reform efforts.

## No. 16A
## AN OVERVIEW OF THE HISTORY OF THE FRENCH SYSTEM

Simon-Daniel Kipman, M.D., *Association Francaise De Psychiatrie, 7 Rue du Montparnasse, 75006 Paris, France 00110*

## SUMMARY:

This presentation will provide an overview of the history of the system of care, including the inauguration of "secteur" psychiatry, e.g., by catchment areas, in the 1960's; the inter-relationship between "public" and "private" services; and the role of long-term treatment in France.

## No. 16B
## THE COMPLEXITIES OF ORGANIZING THE FRENCH SYSTEM

Jean-Charles Pascal, M.D., *Department of Psychiatry, Centre Jean Wier, Psychiatry, 30 Rue Anatole France, Puteaux, France 92800*

## SUMMARY:

This presentation will review the complexities of organizing the system of care, its various funding streams, and coverage of services such as rehabilitation, emergency services, and long-term care.

## No. 16C
## WHAT HAVE EXPERTS LEARNED FROM STUDYING THE FRENCH SYSTEM?

Jean-Yves Cozic, M.D., *Chairman, Department of Psychiatry, Centre Hospital, Hospital De Bohars, University of De Brest, Bohars, France 29820*

## SUMMARY:

This presentation will cover what experts studying the system of care have learned about patient outcomes from mental health services research.

## REFERENCES:

1. Freeman H, Henderson J: *Evaluation of Comprehensive Care of the Mentally Ill.* Gaskell (Royal College of Psychiatrists), London, 1991.
2. Bennett D, Freeman HL: *Community Psychiatry: The Principles.* Churchill Livingstone, New York, (1991).
3. Masse G: *La Psychiatrie Ouverte: Une Dynamique Nouvelle en Sante Mentale.* Ecole Nationale de la Sante Publique, Rennes Cedex, France, 1992.
4. Vidon G, Halmos P, Goutal M: *Situations Europeennes: de L'Hebergement Therapeutique.* Eres Toulouse, France, 1992.

**Symposium 17** **Monday, October 27**
**8:30 a.m.-11:30 a.m.**

## PSYCHIATRIC CONSULTATION AND MENTALLY RETARDED PERSONS

Lawrence K. Richards, M.D., *Psychiatric, Administrative and Business Consultant, Department of Mental Health and Developmental Disabilities, 714 South Lynn Street, Champaign, IL 61820-5817*

## EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should demonstrate improvements in understanding and performing quality consultation-liaison services for persons with mental retardation.

## SUMMARY:

The symposium will quickly, but in more than summary fashion, update attendees on approaches to performing quality psychiatric consultations for the benefit of people burdened with mental retardation, their families, and other caregivers. The need for such consultations increases as deinstitutionalization of persons with mental retardation increases.

Several series of observations, principles, conclusions, and guidelines are presented. This begins with a frontline report from a case coordinator who brings management and organizational observations indicating what is necessary to achieve a useful quality consultation. It is of great value for attendees to hear from and ask questions of a representative of the care system at the community (placement) level. This is followed by material on assessing the data, working toward a diagnosis, and developing thinking on planning and recommendations.

After a general review of the state of the art in these matters, major areas of concern and applicability are detailed. Disturbing, maladaptive, and symptomatic behaviors are usually the reason someone puts a person having some mental retardation in contact with a psychiatrist; this may occur via the emergency room of a hospital, or if caregivers were also able to comprehend the need expeditiously it will be as an office visit or (preferably) at the site of placement.

Principles in observing, recording, analyzing, and deducing from the data are discussed at varying lengths so as to give a balanced summarized overview with enough details to be useful to the psychiatrist and those assisting in making the diagnoses and beginning the therapeutic interventions.

## TARGET AUDIENCE:

Very useful to all persons assisting mentally retarded people.

## No. 17A
## INCREASING EFFECTIVENESS IN CONSULTATIONS WITH MENTALLY RETARDED PERSONS

Shelly K. Lawler, B.S., *Individual Services Coordinator, Southern Illinois Case Coordinating Services, Inc., P.O. Box 588, Centralia, IL 62801*; Lawrence K. Richards, M.D.

## SUMMARY:

Mentally retarded persons (MRP) also develop mental illnessess, and the need for psychiatric intervention arises. This presentation describes approaches for achieving high-quality consultations of value to MRP, family, and other caregivers.

Information that is necessary before direct evaluation is described and discussed, including: Why is the consult being sought? What are the past and current DSM Axis I, II, and III diagnoses? Where is and what are the characteristics of the person's living setting? Who are

key family and staff persons? What is the current support system? Have there been any significant changes in the latter? What are the general medical and medication histories, (including allergies and medication sensitivities)? What are the current behavior problems? What therapeutic approaches have and have not worked in the past?

Reasons it may be advisable to confer with the referral source before an/or during the direct exam process are described, particularly if the source is the case manager or is someone performing in that capacity. The importance of the degree of language capacity is discussed, emphasizing the importance of remembering that many MRP understand what is being said far better than their verbal expressivity would indicate. This is a constant source of frustration for MRP and of common errors by caregivers. The consult should include the opportunity to question direct care staff. An excellent consultation may require three or four exam visits over three or four weeks.

While the prescription of psychotropic medication is often needed and of great value to many MRP, whether it is to treat a mental illness or to aid them in controlling their behavior, or both, too often medication is changed before it is known if the person has improved on the medication or behavior program. (Examples are given.)

Some staff think medication is needed for any type of behavior, and staff attitudes toward medications, MRP, and over-use of medications are of major importance. This attitude is transferrable to the MRP, causing psychological dependence, and/or resulting in failures of personal growth within the MRP.

## No. 17B
## THE BIOPSYCHOSOCIAL ROOTS OF DIAGNOSIS IN MENTALLY RETARDED PERSONS

Lawrence K. Richards, M.D., *Psychiatric, Administrative and Business Consultant, Department of Mental Health and Developmental Disabilities, 714 South Lynn Street, Champaign, IL 61820-5817*; Richard H. Hunter, Ph.D.

### SUMMARY:

As deinstitutionalization of the mentally retarded occurs as it has for the mentally ill, an increasing number of different habilitative and placement settings will be requesting psychiatric consultation for behavioral problems, adjustment disorders, and evaluation for the existence of major CNS illnesses. For psychiatrists the central diagnostic activity is that of making a correct DSM-IV diagnosis, which in turn drives various interventions and services, including medications. However, a reliance only on medications risks outcomes being designed only for symptom suppression. A Group for the Advancement of Psychiatry 1992 report concluded medications may be necessary but that any approach to treatment that "ignores the psychosocial components" risked adversely affecting an individual's longitudinal treatment.

A person's symptoms in most instances reflect a relationship between preceding circumstances and the person's attempts to adapt to changes in more current biopsychosocial contexts. Diagnostic hypotheses and procedures can be selected to identify these relationships and design interventions to replace symptomatic adaptations with more normalizing ones. These diagnostic hypotheses drive interventions and lead to specific assessment procedures that allow for confirmation or disconfirmation of the diagnostic hypothesis.

These diagnostic hypotheses are particularly helpful in monitoring the outcomes of treatment approaches used with MRP, whose various forms of receptive and expressive language deficits interfere with the usual doctor-patient interview and examination format. This presentation will expand on these concepts and set matters up for subsequent presentations.

## No. 17C
## SIGNS AND SYMPTOMS OF MENTAL ILLNESS: IS THERE A DIFFERENCE WITH DEVELOPMENTAL DISABILITY

Alison Reeve, M.D., *Department of Psychiatry Research, University of New Mexico Health Sciences Center, 943 Stanford Drive, N.E., Albuquerque, NM 87131-5326*

### SUMMARY:

The rates of mental illness in persons with developmental disability are higher in those with mild and moderate mental retardation than in those with severe and profound mental retardation. Past history of physical and sexual trauma is found more often in this population than in the general psychiatric population. The clinician's dependence upon verbal self-reporting by the patient cannot be the primary clinical tool of assessment. Yet, meanings and intents of action as reported by (untrained) staff are also frequently unintentionally biased or incomplete. Nonverbal and biological markers of psychiatric disturbance must be measured and gleaned from direct contact with the patient. *DSM-IV* diagnoses can be used appropriately, if the clinical criteria are carefully reviewed. As with comprehensive neurological examination, the astute psychiatric formulation requires that the history of the patient be accurate. Behavior always has meaning. Behaviors indicative of pathological disorders must be differentiated from habits and acute stress responses. Aggression, for example, has many causes—not all of them mental illnesses! Clinical examples will

be given to illustrate different diagnostic conceptualizations of behavior.

## No. 17D
## ASSISTING DIAGNOSIS WITH SPECIFIC PSYCHOLOGICAL TESTING

Nolan K. Nakamura, M.A., *Psychologist, Choate Mental Health and Developmental Center, 1000 North Main Street, Anna, IL 62906*

### SUMMARY:

Requests for technical assistance (TA) in the treatment and habilitation of mentally retarded persons (MRP) often occur due to increasingly inappropriate behaviors by a MRP. The Motivational Assessment Scale (MAS) and the Diagnostic Assessment for the Severely Handicapped (DASH) are particularly useful in identifying factors related to socially inappropriate behaviors.

For example, if Mr. A seeks interaction and smiles when praised, these are strengths or assets useful for (re)habilitation. Enjoying writing in a paper-pad, looking at a photo album, and wearing a cap are both potential therapy levers (assets) and trigger areas. These areas expand if Mr. A finds certain objects interesting, tries to collect them, or finds certain activities interesting, but becomes distressed when unable to gain access to these favored activities or objects.

The MAS of Mr. A showed his assaultive, destructive, self-injurious, and tantrum behaviors were related to frustrated attempts to gain such access, and often occurred after access was denied. The DASH of Mr. A indicated the presence of psychiatric symptoms related to three types of disorders: impulse control, mood disturbance, and pervasive developmental disorders. (Handouts and slides detail these.) Of seven symptoms referrable to impulse control, five related to aggressive/destructive outbursts, either unprovoked or provoked by minor precipitants, with denial of access the most common provocation. The mood disturbance symptoms indicated times when irritability or arousal occurred; his reaction to access blockage was more intense when mood disturbance symptoms were observed concurrently. Such reactions and strong limited interests also link with autism. The details of data collection, analysis, diagnosis, recommendations, treatment planning, and its evaluation are presented in coordinated fashion.

## No. 17E
## EFFECTIVE CASE FORMULATION: MOVING BEYOND *DSM-IV*

Richard H. Hunter, Ph.D., *Clinical and Consulting Psychologist, Illinois Department of Mental Health and Developmental Disabilities, 10202 Briggs Road, Mario, IL 62959*

### SUMMARY:

*DSM-IV* diagnoses drive treatment decisions that for many lead to effective response. However, many people with psychiatric disorders do not adequately respond to standard interventions (e.g., medication regimens, behavior therapy, social skills programming, etc.). People experiencing the dual diagnoses of mental retardation and mental illness often face additional challenges that complicate their ability to benefit from treatment (e.g., neurological impairments, communication deficits, cognitive deficits, comorbid medical conditions, adverse life circumstances, etc.). Effective biopsychosocial case formulation utilizing a model designed for treatment-resistant people allows one to move to a level of understanding of symptoms and behaviors that are individual and context specific. The Multimodal Functional Model (Gardner, Graeber, & Cole, 1996; Gardner & Cole, 1993; Gardner & Hunter, in press) provides a structure for understanding clinical symptoms and behaviors that are individual and situation-specific and have the potential to substantially improve the specificity of interventions and allow for precise measurement of progress. The model is efficient in that it measures the impact of each intervention, allows for timely change in interventions, and provides guidelines for terminating procedures not producing desired effects. The Multimodal Functional Model will be introduced as a tool for improving the effectiveness of consultants working with treatment-resistant clients.

### REFERENCES:

1. Gardner WI, Sovner R: *Self Injurious Behavior: Diagnosis and Treatment*, Vida Publishing, Willow Street, PA 1994.
2. Menolascino F, Fleisher M: Training psychiatric residents in the diagnosis and treatment of mental illness in mentally retarded persons. *Hospital and Community Psychiatry*, May, 43: 500–503, 1992.
3. Bishop A: Emperical approach to psychopharmacology for institutionalized individuals with severe or profound mental retardation. *Mental Retardation*, 30: 283–288, 1992.
4. Myers B, Pueschel S: Differentiating schizophrenia from other mental and behavioral disorders in persons with developmental disabilities. *The Habilitative Mental Healthcare Newsletter*, vol 12:93–97, 1993.
5. Matson JL, Gardner WI, Coe DA, Sovner R: Diagnostic Assessment for the Severely Handicapped Scale (DASH); *British J Psychiatry*, 159, 401–409, 1991.

6. Durand VM: Motivational Assessment Scale In: Hersen and Bellock (eds): *Dictionary of Behavioral Assessment Techniques*, Pergamon Press, NY 1988.
7. Lowry MA: Functional analysis of problem behavior; *Habilitative Mental Healthcare Newsletter,* 12: 17–22, 1993.
8. Rardner WI, Graeber JL, Cole CL: Behavior therapies: a multimodal diagnostic and intervention model. In: Jacobson JW, Mulick JA (eds.): *Manual of Diagnosis and Professional Practice in Mental Retardation.* Washington, DC, Am Psychological Assn, 1996.
9. Gardner WI, Cole CL: Aggression and related conduct disorders: definition, assessment, and treatment. In: Matson JS, Barrett RP (eds): *Psychopathology in the Mentally Retarded* (2nd Ed) Boston, Allyn and Bacon, 1993.
10. Gardner, WI, Hunter, RH: *The Multimodal Functional Model Enhances Treatment. . .* (in press).

**Symposium 18** **Monday, October 27**
**8:30 a.m.-11:30 a.m.**

## SCHIZOPHRENIA: PUTTING RESEARCH INTO PRACTICE

Anthony F. Lehman, M.D., M.S.P.H., *Professor of Psychiatry, Center for Mental Health Services Research, University of Maryland School of Medicine, 645 W. Redwood Street, Baltimore, MD 21201*; William T. Carpenter, Jr., M.D.

### EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to discuss research findings on the efficacy of pharmacotherapies, family interventions, and assertive community treatment for schizophrenia, as well as barriers to best practices.

### SUMMARY:

Considerable research efforts over the past few decades on the nature and treatment of schizophrenia have yielded important advances to improve the outcomes for this disorder. As research advances, it is critical to ensure that patients in everyday practice receive the most effective treatments being developed. This symposium presents the results of a major five-year study, the Schizophrenia Patient Outcomes Research Team (PORT), funded by the Agency for Health Care Policy and Research and the National Institute of Mental Health. Anthony Lehman, M.D., will provide an overview of the PORT and highlight major findings and treatment recommendations. A series of three papers will present PORT treatment recommendations, supporting evidence, and findings on patterns of care in the areas of pharmacotherapy (Robert Buchanan, M.D.), family interventions (Lisa Dixon, M.D.), and assertive community treatment (Jack Scott, Sc.D.). A fifth paper by Howard Goldman, M.D., Ph.D., will summarize the results of efforts to disseminate these treatment recommendations in two states. Implications of the PORT findings for clinical practice, research, and policy will be discussed by William T. Carpenter Jr., M.D.

### TARGET AUDIENCE:

Practitioners, consumers, family members, administrators.

## No. 18A
## THE SCHIZOPHRENIA PATIENT OUTCOMES RESEARCH TEAM: AN OVERVIEW

Anthony F. Lehman, M.D., M.S.P.H., *Professor of Psychiatry, Center for Mental Health Services Research, University of Maryland School of Medicine, 645 W. Redwood Street, Baltimore, MD 21201*

### SUMMARY:

Research over the past few decades on the treatment of schizophrenia have yielded important advances to improve the outcomes of this disorder. The current federal research agenda promises major new advances over the next several years. Therefore, it is critical to ensure that patients in everyday practice receive the most effective treatments being developed. The Schizophrenia Patient Outcomes Research Team (PORT) is a five-year project that is developing treatment recommendations based upon a comprehensive review of the scientific literature and examination of current patterns of care in usual practice and their relationship to patient well-being and outcomes. The PORT has developed more than 40 specific recommendations about "best practices" covering a broad range of interventions including pharmacotherapies, psychosocial interventions, and service-system models. This presentation will provide an overview of the methods used to developed these recommendations as well as provide specific examples of the recommendations and their implications.

## No. 18B
## PATIENT OUTCOMES RESEARCH TEAM PHARMACOLOGICAL TREATMENT RECOMMENDATIONS

Robert W. Buchanan, M.D., *Associate Professor of Research, Department of Psychiatry, Maryland Psychiatric Research Center, 300 Concert Way, Baltimore, MD 21228-5567*; Julie M. Zito, Ph.D., Alan Lyles, Sc.D., Anthony F. Lehman, M.D., M.S.P.H.

SUMMARY:

The modern era of the pharmacological treatment of schizophrenia began in 1952 with the discovery that chlorpromazine possessed antipsychotic properties. There followed the development of hundreds of pharmacological agents for the treatment of schizophrenia. The Patient Outcomes Research Team (PORT) for schizophrenia project has conducted an extensive review of the studies investigating the use of these agents. Specific areas reviewed include: (1) the efficacy of conventional antipsychotics in the treatment of acute episodes and maintenance treatment; (2) the efficacy of atypical antipsychotics, including clozapine and risperidone; and (3) the efficacy of adjunctive pharmacotherapies, i.e., benzodiazepines, antiepileptics, antidepressants, and lithium. Outcome measures of efficacy include positive and negative symptoms, social and occupational functioning, and quality-of-life measures. These reviews form the basis of the PORT recommendations for the pharmacological treatment of schizophrenia.

In this presentation, we will present the PORT recommendations for the use of conventional and atypical antipsychotics and adjunctive agents for the treatment of schizophrenia. In addition, we will present data on: (1) the relationship of PORT treatment recommendations to actual clinical practice, and (2) patient and provider characteristics predictive of compliance with the recommendations.

## No. 18C
## FAMILY INTERVENTIONS IN SCHIZOPHRENIA

Lisa B. Dixon, M.D., M.P.H., *Associate Professor of Psychiatry, Center for Mental Health Services Research, University of Maryland, 685 W. Baltimore Street, MSTF/Room 300, Baltimore, MD 21201*; Alan Lyles, Sc.D., Jack E. Scott, Sc.D.

SUMMARY:

A literature review of controlled research provides the basis for the following schizophrenia treatment recommendation on family interventions: Patients who have ongoing contact with their families should be offered a family psychosocial intervention that provides a combination of education about the illness, family support, crisis intervention, and problem-solving skills training. Analysis of primary and secondary data reveals probable poor compliance with this recommendation in clinical practice. *Less than one percent* of persons with schizophrenia who are on Medicare received a schizophrenia service billed as family therapy. Younger persons were more likely to receive this service. Of persons with schizophrenia in Georgia who have Medicaid (N= 9,934), 7.4% received a schizophrenia service billed as family therapy. Younger, Caucasian, and male patients were more likely to receive a family service. A sample of directly interviewed treated schizophrenia patients in Georgia and Ohio (N=719) revealed that only 30% of their families had received information about mental illness. Patients who were younger, had more education, and lived in the community rather than the hospital were more likely to report receiving family education. Dissemination efforts suggested that the most important obstacles to implementation perceived by a group of Ohio providers was uncertainty about agency and intervention funding.

## No. 18D
## QUALITY-OF-LIFE AND SERVICE USE IN SCHIZOPHRENIA

Jack E. Scott, Sc.D., *Assistant Professor of Research, Department of Psychiatry, University of Maryland, at Baltimore, 685 W. Baltimore Street, MSTF/Room 300, Baltimore, MD 21201*; Anthony F. Lehman, M.D., M.S.P.H., Donald Steinwachs, Ph.D.

SUMMARY:

The primary data collection component of the Schizophrenia PORT was designed to evaluate the impact of practice variations on important treatment outcomes that could not be assessed from the literature review or the secondary data analyses. One of the key questions the primary data component is addressing is the degree to which adherence to the "best practices" described in the PORT Treatment Recommendations predicts better client outcomes. This presentation examines the impacts of providers' adherence to recommendations concerning medication dosage levels and ongoing involvement in community-based treatment on quality of life and other outcomes. Using data from a sample of 650 respondents in Georgia and Ohio, we examine the respondents' objective living standards, describe subjective well-being across several life domains, and estimate a multivariate model that tests the effects of higher and lower than recommended daily dosages (in chlorpromazine equivalent units) and continuity of community-based care on quality of life, social functioning, and other outcomes.

## No. 18E
## DISSEMINATING TREATMENT RECOMMENDATIONS

Howard H. Goldman, M.D., *Department of Psychiatry, Center for Mental Health Services Research, 685 W. Baltimore Street, Baltimore, MD 21201*; Elizabeth A. McGlynn, Ph.D.

## SUMMARY:

This presentation will focus on the dissemination of the treatment recommendations. The five communities involved in the Schizophrenia PORT data collection were also selected to participate in the plan to disseminate the recommendations, permitting the PORT to track the impact of the effort. In March and April 1996, providers, patients, and their families in each of the communities were exposed to a one-day continuing education program on a selection of treatment recommendations focusing on psychopharmacology, family interventions, assertive community treatment, and inpatient care. In addition, pairs of the communities were involved in supplementary dissemination strategies: for example, "academic detailing" was used to amplify the dissemination of the psychopharmacologic recommendations during the autumn of 1996 and training in specific techniques of family supportive interventions were begun in June 1996. The feasibility of these strategies will be assessed and their impact will be evaluated, examining patterns of practice abstracted from clinical records.

## REFERENCES:

1. Lehman AF, Carpenter WT, Goldman HH, Steinwachs DM: Treatment outcomes. *Schizophrenia Bulletin*, 21:669–675, 1995.
2. Kane KM: Schizophrenia. *New England Journal of Medicine* 334(1):34–41, 1996.
3. Dixon L, Lehman A: Family interventions in schizophrenia. *Schizophrenia Bulletin* 21(4):631–643, 1995.
4. Scott JE, Dixon LB: Assertive community treatment and case management for schizophrenia. *Schizophrenia Bulletin*, 21(4): 657–668, 1995.
5. Soumeral S, Avorn J: Principles of educational outreach ("Academic Detailing") to improve clinical decision making. *JAMA*, 263(4): 549–556, 1990.

**Symposium 19** **Monday, October 27**
**2:00 p.m.-5:00 p.m.**

# POLY-DIAGNOSIS IN DRUG-INVOLVED ADOLESCENTS

Marc Fishman, M.D., *Assistant Professor, Department of Psychiatry, Johns Hopkins School of Medicine, 600 N. Wolfe Street/Meyer 4-119, Baltimore, MD 21287-7419*

## EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to recognize the multiple comorbid medical and psychiatric conditions that accompany addiction in adolescents; and, outline an approach to treatment of poly-diagnosis in drug-involved in adolescents.

## SUMMARY:

Rates of substance abuse among adolescents are high and rising. Drug abuse in adolescents is associated with a wide variety of problems causing severe impairment in many domains of function. Increasingly, drug-involved adolescents present with other concurrent (or comorbid) medical and psychiatric diagnoses. In any given patient some of these conditions may be pre-existing to, and some may be sequelae of, drug use. However, in the majority of cases these distinctions are difficult, even impossible to make. Single or even dual diagnoses are rarely sufficient to encompass multiple intertwined problems. Assessment of the drug-involved adolescent should always include medical and psychiatric evaluation with the expectation of poly-diagnosis. Treatment should always involve a multidisciplinary team targeting the broad array of identified conditions.

## No. 19A
# RESIDENTIAL TREATMENT FOR MULTI-PROBLEM ADOLESCENTS

Jacob R. Fishman, M.D., *Department of Psychiatry, Riverside Hospital, 4460 MacArthur Boulevard, N.W., Washington, DC 20007*; Andrew Kapit, M.B.A., Marc Fishman, M.D.

## SUMMARY:

There is a large group of severely psychiatrically impaired adolescents who have been historically underserved by traditional psychiatric services. Adolescents who are identified through social agencies, schools, or court involvement for a variety of maladaptive, disruptive, aggressive, or antisocial behaviors have very high rates of psychiatric disorders, which are often underdiagnosed and undertreated. These teens are characterized by extremely high rates of drug involvement, including abuse, dependence, trafficking, toxicity, and addicted family members. We describe the development of an inner-city psychiatric hospital for the evaluation and treatment of these patients. We report high rates of poverty, severely disrupted families, familial violence including sexual assault, criminal behaviors, educational failure, and unstable living situations. We also report high rates of affective disorders, ADHD, cognitive impairment, and drug-induced (especially PCP) neuropsychiatric disorders. We describe an approach to the evaluation and treatment of these multi-problem patients that attempts to bridge diagnostic clarity and focused psychiatric treatment on the one hand with psychosocial rehabilitation that emphasizes moral values, cultural identity, and "the craft of living" on the other hand. This must take place with sometimes competing agendas from patients, parents/guardians, social agencies, courts, payors,

regulatory agencies, etc. These constraints provide an obstacle to longitudinal continuity of care.

## No. 19B
## ADOLESCENT ADDICTIONS IN RESIDENTIAL TREATMENT

Lindy Lewis, M.S.W., *Family Therapist, Mountain Manor Treatment Center, 3800 Frederick Avenue, Baltimore, MD 21229*; Ken Weinberg, M.Ed., Marc Fishman, M.D.

### SUMMARY:

Mountain Manor Treatment Center is a medically monitored residential treatment facility for adolescent substance abuse patients in an inner-city setting in Baltimore. The program cares primarily for indigent patients with Medicaid reimbursement. Retrospective chart review of 197 patients reveals very high severity of drug use and functional impairment. Patients reported rates of regular drug use that included marijuana, 92%; ETOH, 83%; PCP, 36%; LSD, 31%; nasal heroin, 29%; inhalants, 27%; crack cocaine, 25%; and nasal cocaine, 22%. A total of 44% of subjects reported daily use of at least two substances. Ten percent reported intravenous heroin use, and 7% reported intravenous cocaine use. The majority of patients had a parental history of substance abuse: 65% in at least one parent, 24% in both parents. A total of 28% of patients had a history of sexual abuse, 25% physical abuse; 35% of patients had dropped out of school. High rates of criminal sequelae of addiction included 55% prior incarceration, 34% history of drug trafficking, 52% current probation. Ongoing follow-up interviews reveal high rates of relapse of varying degrees. AMA discharge status correlates with very poor outcome. Post-treatment participation in outpatient aftercare correlates with improvement. Mortality four years post-treatment may be as high as 5%.

## No. 19C
## MEDICAL CARE FOR DRUG-INVOLVED ADOLESCENTS

Hoover Adger, M.D., *Department of Pediatrics, Johns Hopkins University School of Medicine, 600 N. Wolfe Street, Park 307, Baltimore, MD 21287*; Ann Brunner, M.D., Marc Fishman, M.D.

### SUMMARY:

Medical problems are a major source of comorbidity among drug-involved adolescents. Unfortunately, there is usually little linkage or coordination between treatments of drug use disorders and medical disorders. Adolescent substance abuse is common and under-recognized in the primary care setting. Screening of 180 patients at the Hopkins adolescent clinic revealed 30% had significant problems with drugs or alcohol. Of these, 25% identified themselves as wanting help, but had not found access to treatment opportunities. Conversely, many adolescents entering drug abuse treatment report significant medical problems, and are unable to identify a current source of medical care. At Mountain Manor, a residential addiction treatment center for adolescents, we identified high rates of medical morbidity, including viral hepatitis, STD's, iron deficiency, folate deficiency, reactive airways disease, injury, and others. Medical assessment is an essential component of addictions treatment, and drug use screening is an essential component of primary care. We propose a model for linked medical, substance abuse, and psychiatric services for the multiproblem, drug-involved adolescent.

## No. 19D
## PSYCHIATRIC DISORDERS IN ADOLESCENT ADDICTIONS

Marc Fishman, M.D., *Assistant Professor, Department of Psychiatry, Johns Hopkins School of Medicine, 600 N. Wolfe Street, Meyer 4-119, Baltimore, MD 21287-7419*; Lindy Lewis, M.S.W., Geetha Subramaniam, M.D., Michelle K. Leff, M.D.

### SUMMARY:

Several studies have attempted to ascertain severity of comorbid psychiatric symptoms and diagnoses in adolescent addiction patients. With varying methodologies, previous cross-sectional assessments of addiction patients in residential treatment have shown rates of comorbid psychiatric disorders as high as 50%. The definitions and implications of "independent" disorders remain problematic. In our patients, cross-sectional assessment revealed a 91% rate of comorbid conduct disorder. Retrospective chart review of referred, treatment refractory patients with sustained abstinence by confinement, revealed a rate of 46% of patients with a comorbid Axis I disorder requiring medication treatment. Symptoms of psychological distress as estimated prospectively by SCL-90 scores decreased with abstinence and addictions treatment by 55% over four weeks. Rates of depression as estimated by BDI scores were 26% in the first week of treatment, decreasing to 10% by week 4. The majority of the patients with high BDI scores had previously been identified as having comorbid affective disorders. Distinguishing symptoms of psychological distress that can be expected to resolve spontaneously with addiction-focused treatments from those that require additional treatments for comorbid disorders remains a major problem in the assessment of the multi-problem, drug-involved adolescent.

## REFERENCES:

1. Dusenbury L, et al: Adolescent substance abuse: a sociodevelopmental perspective In: Lowinson, et al, (eds): *Substance Abuse*, 1992.
2. Kandel D, et al: High school students who use crack and other drugs. *Arch Gen Psych* 53:71–80, 1996.
3. Wartenberg A: Medical syndromes associated with specific drugs. In: *Principles of Addiction Medicine. ASAM* 1994.
4. Kaminer Y: Issues in the pharmacological treatment of adolescent substance abuse. *Journal of Child and Adolescent Psychopharmacology*. Vol. 5, No. 2, Pp. 93–106, 1995.


**Symposium 20** **Monday, October 27**
**2:00 p.m.-5:00 p.m.**

## THE HIV/AIDS MENTAL HEALTH SERVICES DEMONSTRATION

Jennifer F. Havens, M.D., *Director, Special Needs Clinic, Department of Child Psychiatry, Babies Hospital, 110 West 86th Street, Apartment 17B, New York, NY 10024-4061*

## EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to describe the goals and objectives as well as the design of the federally funded HIV/AIDS Mental Health Service Demonstration Program and be familiar with four of the model service site programs.

## SUMMARY:

In 1994, the Center for Mental Health Services (CMHS) of the Substance Abuse and Mental Health Services Administration, in collaboration with two other federal agencies, the National Institutes of Health and the Health Resources and Services Administration, funded the first national cooperative demonstration program designed to develop and evaluate mental health services for people living with or affected by HIV. In this symposium, CMHS staff will present an overview of the goals and objectives of the demonstration program, including the development of a variety of service models and a plan for the evaluation of these models. Four of the 11 funded national sites, the Emory Center for AIDS Mental Health Services in Atlanta, the AMHAP program in Alexandria, the CHHAPS program in Chicago, and the Special Needs Clinic in New York City, will present detailed descriptions of their service models and client populations. Research Triangle Institute (RTI), the coordinating center, will describe the logic of the multi-site evaluation plan for the demonstration. In addition, RTI will present data on the sociodemographic characteristics and service needs of clients served by the 11 projects as well as the types and amounts of services they received.

## No. 20A
## THE FEDERAL GOVERNMENT SPONSORS THE FIRST MENTAL HEALTH SERVICES EVALUATION

Elaine Corrigan, M.S.P., *Psychiatric Health Services, United States Department of Health and Human Services, 5600 Fishers Lane, Rockville, MD 20857*; Melvyn R. Haas, M.D.

## SUMMARY:

In 1994, the Substance Abuse and Mental Health Services Administration's Center for Mental Health Services (CMHS), in collaboration with two other federal agencies, the National Institutes of Health and the Health Resources and Services Administration, funded the first national cooperative demonstration program designed to develop and evaluate mental health services for people living with or affected by HIV. In this symposium, CMHS staff will present an overview of the goals and objectives of the demonstration program, including the development of a variety of service models and a plan for the evaluation of those models. The demonstration funds 11 unique mental health projects across the country, which represent a range of service models. CMHS staff will present a brief overview of the service models implemented at the 11 sites, with emphasis on the differences and commonalities among the models. The government expects to learn the impact of high-quality mental health services on the lives of people affected by and living with HIV/AIDS—for example, the approaches that the projects found productive, the influence of the federal and private collaboration on the delivery of mental health services, and the identification of questions for further study.

## No. 20B
## A COMMUNITY PSYCHIATRY RESPONSE TO HIV/AIDS

J. Stephen McDaniel, M.D., *Grady Infectious Disease Program, Department of Psychiatry and Behavioral Sciences, Emory University School of Medicine, 1365 Clifton Road, N.E., Atlanta, GA 30322*; Eugene W. Farber, Ph.D., Peter E. Campos, Ph.D., J. Emshoff, G. Uhl, Ph.D.

## SUMMARY:

To date, no organized national project has evaluated fully the spectrum of mental health needs or effectiveness of interventions among persons affected by HIV/

AIDS. The purpose of this presentation is to describe a model of community-based HIV/AIDS mental health care implemented at the Emory Center for AIDS Mental Health Services, one of 11 national sites of the HIV/AIDS Mental Health Services Demonstration Program funded through the collaborative efforts of CMHS, NIMH, and HRSA. Specifically, we will describe the development and implementation of a consortium of academic, community, and state agencies in metropolitan Atlanta organized to provide a diverse spectrum of compassionate care to individuals with HIV infection. A variety of data was collected from more than 300 patients receiving mental health services utilizing qualitative, quantitative, interview-based self-report, consumer and staff focus group, and evaluation measures on an ongoing basis. We will describe the development of our community consortium and present data describing demographic characteristics of the sample, psychological morbidity, quality of life, and risk behavior. Evaluation data describing the effectiveness of our consortium also will be presented. This model of HIV-related psychiatric care is proposed as a sensitive, community-minded, consumer-oriented approach to providing HIV/AIDS mental health services.

## No. 20C
## COMMUNITY MENTAL HEALTH HIV SERVICES

Andrea Ronhovde, M.S.W., *Director, HIV Services, Alexandria Mental Health Center, 720 North St. Asaph Street, Alexandria, VA 22314*

### SUMMARY:

This presentation will describe the Alexandria Mental Health HIV/AIDS Project (AMHAP), a community mental health center's attempt to deliver comprehensive mental health services to persons with HIV. Serving primarily those who are seriously mentally ill, dually diagnosed, incarcerated, homeless or otherwise hard to reach, the AMHAP model delivers targeted street outreach to the African-American and Hispanic communities through a subcontract with a minority-run community organization. With a team approach emphasizing intensive case management, coordinated multidisciplinary, multicultural treatment planning, AMHAP attempts to enhance the quality of life of the target population through close collaboration with other medical and social service providers. Diagnostic, service utilization, and quality of life data will be presented.

## No. 20D
## THE CHICAGO HIV HEALTH AND PSYCHOLOGICAL SUPPORT MODEL: AN INTEGRATION OF COMMUNITY-BASED MENTAL HEALTH AND PRIMARY CARE SERVICES

Tomas A. Soto, Ph.D., *Associate Director, HIV Mental Health Services, Department of HIV Primary Care, Cook County Hospital, 1900 West Polk Street, Room 1256, Chicago, IL 60612*; An-Lee Kuo, B.A.

### SUMMARY:

The medical complexity of HIV/AIDS and its psychosocial sequelae necessitates an integrated approach to the mental health and primary health care of patients living with HIV/AIDS. The Chicago HIV Health and Psychological Support (CHHAPS) project, a project of the Cook County HIV Primary Care Center, is one of 11 federally funded demonstration projects. Working in collaboration with the city of Chicago bureau of mental health, the project aims to provide quality mental health services to patients accessing HIV outpatient medical care at community health centers and to bridge the gap in providing mental health services within these outpatient clinics. The purpose of this presentation is to provide an overview of the development and implementation of the CHHAPS model and address its ongoing evolution. Specifically, we will present our experiences in the development and implementation of integrated services within multiple health care delivery systems, discuss recruitment and engagement strategies for our diverse patient population, report patient demographic and diagnostic characteristics, and discuss the varied clinical treatment approaches for the patients served in this demonstration project. Finally, evaluative issues in measuring treatment effectiveness will be highlighted.

## No. 20E
## FAMILY-BASED HIV MENTAL HEALTH SERVICES

Jennifer F. Havens, M.D., *Director, Special Needs Clinic, Department of Child Psychiatry, Babies Hospital, 110 West 86th Street, Apt. 17B, New York, NY 10024-4061*

### SUMMARY:

The Special Needs Clinic (SNC), which provides comprehensive mental health services to children and families affected by the linked epidemics of HIV and substance abuse, was funded in 1994 by CMHS to expand family-based services to the adult AIDS service at Presbyterian Hospital. The service model is based on *multidisciplinary* mental health clinicians providing

comprehensive *family-based* services to *adults and children in one site*. Formalized liaison teams working with HIV/AIDS medical services increase patient identification and engagement. Aspects of the service model will be presented, including staffing patterns and explication of the family-based approach to mental health treatment in this complex population. Risk factor and demographic data will be presented on 400 children and adolescents, including HIV serostatus, prenatal drug exposure, and exposures to abuse, neglect, and trauma. Diagnostic data will be presented on the 400 children and 215 adults evaluated to date. Service data will illustrate the intensive treatment needs of these families and children. Finally, a model for the mental health assessment and treatment of children and families dually affected by HIV and substance use over the course of HIV illness progression and after parental death will be presented.

## No. 20F
## HIV/AIDS MENTAL HEALTH SERVICES PROGRAM EVALUATION

William E. Schlenger, Ph.D., *Program Director, Research Triangle Institute, P.O. Box 12194, Research Triangle Park, NC 27709*; Juesta M. Caddell, Ph.D.

### SUMMARY:

In this presentation we will describe findings from the second year of the multisite evaluation of the Center for Mental Health Services' HIV/AIDS Mental Health Services Demonstration. Findings will be presented based on the demonstration's "core data set," a set of information about characteristics of clients and the services they receive that is being collected by all 11 demonstration projects using a common protocol. Information about client characteristics is collected via structured interviews conducted with clients at the time they enter the demonstration programs, and information about services received is recorded by program clinicians on a routine basis as they provide services. Findings concerning the sociodemographic characteristics (e.g., age, sex, race, SES) and the prevalence of specific psychiatric disorders (e.g., major depression, dysthymic disorder, GAD) at baseline among clients served by the 11 projects, and the types and amounts of services they received (e.g., assessment, psychotherapy, case management) during the second year of the demonstration will be presented and discussed.

### REFERENCES:

1. Lyketsos C: Changes in depressive symptoms as AIDS developments, *American Journal of Psychiatry,* Vol. 153, No. 11:1430, 1996.
2. McDaniel JS, Fowlie E, Summerville MB, et al: An assessment of rates of psychiatric morbidity and functioning in HIV disease. *General Hospital Psychiatry,* 17:346–352, 1995.
3. McDaniel JS, Purcell DW, Farber EW: Severe mental illness and HIV/AIDS: medical and neuropsychiatric sequelae. *Clinical Psychology Review.* (in press).
4. Knox M, Boaz T, Friedrich M, Dow G: HIV risk factors for persons with serious mental illness. *Community Mental Health Journal,* 30: 551–563, 1994.
5. Cohen MA: Biopsychosocial approach to the human immunodeficiency virus epidemic. *General Hospital Psychiatry, 12,* 98–123, 1990.
6. Engel GL: The clinical application of the biopsychosocial model. *The American Journal of Psychiatry, 137*(5), 535–544, 1980.
7. Havens J, Mellins CA, Pilowski D: (1996) Mental health issues in HIV-affected women and children. *International Review of Psychiatry,* 8:217–225, 1996.
8. Schlenger W, Roland J, Magruder K, Ray B: Evaluating services demonstration programs: a multistage approach. *Evaluation and Program Planning,* 17(4):381–390, 1994.

**Symposium 21** **Monday, October 27**
**2:00 p.m.-5:00 p.m.**

## NWHOME PROJECT: HOMELESSNESS IS NOT JUST A HOUSING PROBLEM

Katherine E. Edstrom, Ph.D., *Instructor of Clinical Psychiatry, Northwestern University School of Medicine, 30 North Michigan, Suite 717, Chicago, IL 60602*; Howard Telson, M.D.

### EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, participants should be able to: understand the wide range of biopsychosocial problems of homeless mentally ill individuals, recognize the need for sophisticated and comprehensive services to homeless mentally ill patients in an outpatient setting, understand problems in assessing dual diagnosis and how these affect engagement, understand how gender differences and environmental factors affect homelessness and outcome, and understand the unique challenges and opportunities for trainees from a variety of disciplines in learning to work with the homeless mentally ill.

### SUMMARY:

This symposium will examine a variety of perspectives on homelessness and mental illness that have been developed in working with this population in the NWHOME Project, a Supportive Services Program for the homeless mentally ill in Chicago. Funded by the Department of Housing and Urban Development, the project was created in light of the recognition that homelessness is a multifaceted problem that needs to be under-

stood in all its complexity. Presenters will share what they have learned about the operation of the project, treatment, and outcome, and will offer insights into the multitude of biopsychosocial factors associated with homelessness. Characteristics of the population served, including factors contributing to homelessness will be discussed. Case examples and research data will serve to acquaint the participant with the world of the homeless mentally ill. Issues of dual diagnosis are highlighted. Individual presentations will examine the problem of homelessness from the perspective of a continuum from environmental antecedents to homelessness engagement, treatment process, and outcome. Unique opportunities and challenges to training in a university setting will be examined. Presenters will conclude their discussion by highlighting factors maximizing treatment effectiveness and key questions to be addressed in planning service delivery to this population.

## TARGET AUDIENCE:

All disciplines (psychiatry, psychology, social work, nursing, occupational therapy, case management).

## No. 21A
## THE NWHOME PROJECT: OUTCOME AT SIX MONTHS

Kenneth A. Cohen, M.D., *Instructor of Clinical Psychiatry, Stone Institute of Psychiatry, Northwestern Memorial Hospital, 259 East Erie Street, Room 251, Chicago, IL 60611-2814*; Katherine E. Edstrom, Ph.D., Lisa Rouff, B.A.

## SUMMARY:

Characteristics of 100 consecutively admitted individuals to the NWHOME Project will be examined at intake and at six-months follow-up. For participants who remained in the project for six months, data will be presented indicating that they can be engaged in treatment, improve their psychological functioning and quality of life, obtain entitlements, and reduce their symptomatology. Presenters will also discuss results of a retrospective analysis of characteristics of patients who participated in the project for at least six months as compared to those who left the project. Discriminant function analysis will be employed to distinguish the two groups. Presenters will compare these findings with those of their previous study of an outpatient population with severe mental illness (Cohen, Edstrom, Smith-Papke, 1995) and will discuss implications for successful strategies for engaging and treating this vulnerable population.

## No. 21B
## DUAL DIAGNOSIS AND HOMELESSNESS: ISSUES IN TREATMENT

Wendy E. Charness, B.A., *Clinical Psychology Graduate Student, Northwestern University School of Medicine, 3110 N. Sheridan Road, #1410, Chicago, IL 60657*

## SUMMARY:

It is recognized that the homeless mentally ill are a difficult population to assess and engage in ongoing treatment. The high rate of substance abuse disorders in this population further complicates these processes. The psychoactive properties of many substances combined with patients' frequent denial or underreporting of use makes determination of a clear diagnosis and treatment plan difficult. Standardized measures of substance use are not sensitive to the lives of the homeless and may not portray an accurate picture of their behavior or consequences of use. Additionally, the literature reports that psychiatric patients with comorbid substance abuse drop out of treatment more frequently than patients with only a psychiatric disorder.

This presentation will address the difficulties the NWHOME Project has faced in assessing substance abuse within a sample of 100 homeless mentally ill individuals. Variables related to substance abuse comorbidity (e.g., race, diagnosis, psychiatric severity) will be examined in their relationship to engagement within the critical period of the first three months of treatment. The discussion will focus on how substance abuse issues can be addressed in the context of research and clinical work in ways that facilitate engagement with this population.

## No. 21C
## ABUSE AS A PRECURSOR TO HOMELESSNESS: PATTERNS OF HOUSING STABILITY, SOCIABILITY AND HELP-SEEKING IN HOMELESS MEN AND WOMEN

Nancy Burke, Ph.D., *Staff Psychologist and Assistant Clinical Professor, Stone Institute of Psychiatry, Northwestern Memorial Hospital, 259 East Erie Street, 2nd Floor, Chicago, IL 60611*

## SUMMARY:

This presentation will attempt to explore the correlation between previous experiences of physical and sexual abuse, and current relationship/housing instability. It is predicted, first, that housing instability is strongly correlated with an instability in personal relationships; second, that both sorts of instability are strongly correlated with a history of physical or sexual abuse about which the individual was unable to confide in others at the

time; and third, that the capacity to confide in others, mitigates to some extent the instability in housing and relationships that occurs later on. Further, it is hypothesized that while a history of abuse will have similarly devastating effects upon the future stability of both men and women, confiding in others will be more strongly mitigating for women than for men. Lastly, it is hypothesized that while relational instability is highly correlated with the development of a negative attitude toward receiving help, having confided in others early on will be suggestive of a greater capacity to use the help of mental health professionals later on.

## No. 21D
## GENDER DIFFERENCES IN HOMELESSNESS AND MENTAL ILLNESS

Jacqueline S. Grober, Ph.D., *Assistant Professor of Psychology, Department of Psychiatry, Stone Institute of Psychiatry, Northwestern Memorial Hospital, 259 East Erie Street, 2nd Floor, Chicago, IL 60611*

### SUMMARY:

"The homeless mentally ill" are often conceived of and treated as a single homogeneous group in need of psychiatric and social services. However, research suggests that they are quite diverse in terms of the factors that contribute to homelessness, the nature of the homeless experience, and response to psychiatric treatment (Roth & Toomey, 1992). This paper will explore gender differences as one such distinction among homeless mentally ill that may moderate the development and course of psychosocial dysfunction in this population. Although scant research has examined gender differences, existing evidence suggests that men and women differ in length of time they have been homeless, family structure, substance use, criminal activity, victimization, and prior institutionalization (Buckner, Bassuk, & Zima, 1993).

This presentation will further explore the differences between homeless mentally ill men and women by examining the above variables in a sample of 100 homeless mentally ill individuals who participated in the NWHOME Project. In addition, gender differences in potentially protective factors, which have been found in other populations to moderate the effects of social and economic adversity, will be examined (e.g., coping style, social support).

## No. 21E
## TRAINING ISSUES IN HOMELESSNESS AND MENTAL ILLNESS

Elizabeth L. Brumfield, M.D., *Clinical Instructor in Psychiatry, Stone Institute of Psychiatry, Northwestern Memorial Hospital, 303 E. Superior Street, Chicago, IL 60611*

### SUMMARY:

The NWHOME Project offers a broad range of educational opportunities to trainees from various disciplines including medical students, psychiatric residents, psychology trainees, social work students, nursing students, and occupational therapy students. The educational experience includes all aspects of assessment and treatment of the homeless mentally ill. Included are rather unique opportunities for participating in the early engagement process through outreach, milieu interactions, individual contacts, and collaboration with other agencies providing services to homeless persons. The NWHOME Project integrates a developmental and dynamic model of understanding with a biopsychosocial assessment. Trainees learn about the complex issues that impact upon homeless persons with severe mental illness (e.g., medical, psychiatric, social, and political). They also learn how more systemic issues, such as institutional and societal barriers, impact on the provision of services. Trainees learn first-hand how to address the challenges of assessing and engaging homeless persons with severe mental illness in treatment. Patients are helped to progress along a continuum from homelessness to early engagement, attachment, treatment collaboration, and, ultimately, increased self-determination and independent living. In addition to direct clinical service, educational and research opportunities are an integral part of the NWHOME Project.

### REFERENCES:

1. Cohen CI, Thompson KS: *Homeless* mentally ill or mentally ill *homeless*? *Am J Psychiatry* 149:816–823, 1992.
2. Cohen KA, Edstrom K, Smith-Papke L: Identifying early dropouts from a rehabilitation program for psychiatric outpatients. *Psychiatric Services* 46:1076–1078.
3. Drake RE, Osher FC, Wallach MA: Homelessness and dual diagnosis, special issues: homelessness. *American Psychologist*, 46(11), 1149–1158, 1991.
4. Koegel, et al: Childhood risk factors for homelessness. *Am Journal of Public Health* 85.
5. Wagner & Perrine: Women at risk for homelessness. *Psychological Reports* 75(3 pt 2), 1994.
6. Buckner JC, Bassuk EL, Zima BT: Mental health issues affecting homeless women: implications for intervention. *American Journal of Orthopsychiatry* 63:385–399, 1993.
7. Diamond RJ, Stein LI, Susser E: Essential and nonessential roles for psychiatrists in community mental health centers. *Hospital & Community Psychiatry* 42:187–189, 1991.

8. Susser E, Goldfinger SM, White A: Some clinical approaches to the homeless mentally ill. *Community Mental Health Journal* 26:463–480, 1990.

**Symposium 22** **Tuesday, October 28**
**8:30 a.m.-11:30 a.m.**

## TRAVESTY IN JUSTICE: THE SEVERELY MENTALLY ILL INCARCERATED

*American Association of Community Psychiatrists*

Fred C. Osher, M.D., *Director, Community Psychiatry, and Associate Professor of Psychiatry, University of Maryland at Baltimore, and Former APA/Mead Johnson Fellow, 655 W. Redwood Street, Baltimore, MD 21201*; Robert T.M. Phillips, M.D., Ph.D.

### EDUCATIONAL OBJECTIVES:

At the conclusion of the symposium the participant should be able to identify the pathways into the criminal justice system for adolescents and adults with serious mental illnesses. Participants will also be able to incorporate critical principles for treatment within, and diversion from, jails and prisons into community programs.

### SUMMARY:

Estimates of the prevalence of behavioral disorders in our country's corrections and criminal justice system range from 20% to 72%. Many jails acknowledge holding persons with severe mental illnesses without any criminal charges, not having mental health services, and not knowing whether persons released receive outpatient mental health services. With current changes in mental health and criminal justice policy, the number of jail and prison inmates needing mental health services continues to grow. In California alone, the annual cost of handling persons with serious mental illness in the criminal justice system is almost $2 billion. This symposium will provide information on the etiology, effect, and creative solutions to the needs of individuals who come into contact with the criminal justice system. Presentations will focus on juvenile offenders, persons with dual diagnoses, and innovative jail and prison service programs. Additional emphasis will be placed on identifying effective prevention and diversion interventions.

## No. 22A
## WHO GETS REFERRED FOR TREATMENT IN JUVENILE HALL?

Kenneth M. Rogers, M.D., *Instructor, Department of Psychiatry, University of South Carolina, 1800 Colonial Drive, P.O. Box 202, Columbia, SC 29202*; Elaine Powell, Ph.D.

### SUMMARY:

*Objective*: The purpose of this study was to examine factors that are associated with detained youth being referred for mental health evaluation and treatment. *Method:* Focus groups were conducted with four groups of employees (nurses, administrators, and direct service staff) at a juvenile detention facility to determine how youth were identified for mental health referral. Additionally, regression analyses, applied to a sample of 120 detained youth referred for mental health evaluation and 120 nonreferred youth who were matched on the basis of gender, length of time detained, and age to assess the association of demographic, service use, and criminal history on internalizing behavior and assigned primary diagnosis. *Results*: There was no consistent method in determining which youth were referred for mental health evaluation. Females were more likely to be referred than males. Latino youth were less likely to be referred. Both African-American and Latino youth were more likely to receive a diagnosis of conduct disorder than were Caucasian youth. *Conclusion:* The decision to refer a youth for mental health services is often made in a random and haphazard manner. Because of the lack of objective screening measures, many youth, especially ethnic minorities may underutilize clinical services in a juvenile detention setting.

## No. 22B
## HOW TO SERVE PERSONS WITHIN LOS ANGELES COUNTY JAILS

Kathleen A. Daly, M.D., M.P.H., *Medical Director, Westside Mental Health Center, 11080 Olympic Boulevard, Los Angeles, CA 90064*

### SUMMARY:

Los Angeles County contains the largest jail system in the country, with 18,000 men and 2,000 women in five facilities. Most male inmates with mental illness are transferred to Central Jail, which houses 6,000 inmates and processes 300 admissions per night, of whom 25 to 30 require a mental health intake. An estimated 6% of the men have serious mental illnesses and are assigned to one of three different modules—176 of the most severely ill to single cells with closer observation, while 280 share cells with four to six inmates. Mental health workers staff the modules, and a suicide watch area is directly in front of the deputy on duty. Central Jail has eight psychiatrists, operates a 35-bed forensic inpatient unit, and a 24-hour crisis response team. The women's jail has 130 admissions per night, requiring 10 or 11 intakes, but 15% will need mental health services while in jail. One psychiatrist is responsible for all treatment at the women's facility. Inmates who meet criteria for involuntary treatment can be transferred to

a state hospital, where there are 100 beds, but access is limited based on the severity of the crime committed.

Most inmates are in for minor crimes committed after discontinuing antipsychotic medication. Stabilization of acute psychosis is usually accomplished, leaving jail case workers to arrange for placement and attempt to establish ongoing care with community-based clinics.

## No. 22C
## CRIMINAL JUSTICE CONCERNS AMONG RURAL POPULATIONS

Constance Corson, M.D., *Director, Public Psychiatry, Tulane University School of Medicine, and Former APA/ Mead Johnson Fellow, 1430 Tulane Avenue, MED-SL-23, New Orleans, LA 70112*

### SUMMARY:

While there have been many important issues identified in this symposium on the incarcerated SMI, it is important to remember that rural areas often have very different problems and solutions to this burgeoning problem. Working with homeless outreach teams in rural and semirural Louisiana has underscored the fact that the lack of specially trained psychiatric personnel leaves the mentally ill very misunderstood and often even more subject to stigma. This problem leads to the law officers, judges, and occasional small outreach programs trying to stop an almost unstoppable force: mentally ill criminals. Despite the low potential for serious crime in most of our seriously mentally ill individuals, they are conspicuous and then handled by the only available agencies due to fear and other complex factors. Two examples of extraordinary circumstances of SMIs, one with and one without a criminal diversion program in place, will be discussed in this part of the symposium, illustrating the problems and often disastrous consequences of the underserved rural SMIs.

## No. 22D
## ALABAMA MODELS: MOVING BEYOND CHAIN GANGS

Jacqueline M. Feldman, M.D., *Director, Division of Public Psychiatry, University of Alabama at Birmingham, 4CCB 908 20th Street South, Birmingham, AL 35294*

### SUMMARY:

Multiple programs extant in Alabama prevent the arrest and incarceration of those with serious mental illness. If incarceration appropriately occurs, innovative efforts are made to assist consumers with their recovery. Passage of state law encouraging the development and funding of community support officer programs has created opportunities to place skilled mental health professionals who work as law enforcement personnel in communities across the state; these officers are often the first to respond to mental health emergency calls. Alabama AMI, consumers, and the UAB Mental Health Center developed and provide lectures, videos, and other educational materials to local and statewide law enforcement academies to ensure a level of competency in dealing with those with serious mental illness.

If persons are incarcerated at the local level, psychiatric care is often provided by local mental health centers. A new federally funded grant (called "Break the Cycle") will drug screen all those arrested and provide rigorous treatment options aimed at diversion from the correctional system. If convicted and sentenced to serve in the state system, each inmate is psychiatrically assessed; if diagnosed with a serious mental illness, appropriate care is provided. There are several newly established specific treatment programs, including highly effective therapeutic communities, which have significantly reduced recidivism to the department of corrections.

## No. 22E
## TRAVESTY IN JUSTICE: THE SEVERELY MENTALLY ILL INCARCERATED

Henry J. Steadman, Ph.D., *President, Policy Research Associates, 262 Delaware Avenue, Delmar, NY 12054*

### SUMMARY:

At all stages of the criminal justice system, high proportions of persons with mental disorders have co-occurring substance abuse disorders. In addressing their needs, whether it is for diversion at the "front door," for treatment while detained pretrial or serving a sentence in jail, for reintegration under conditions of probation or parole, or for longer sentences in state prisons, little long-term benefit to the client, the community, or the treatment and detention systems usually accrue without developing integrated service approaches.

This presentation will suggest some strategies that communities throughout the U.S. have used to begin to develop such integrated responses and how to overcome some of the major barriers often faced.

### REFERENCES:

1. Fabrega H, Ulrich R, Mezzich JE. Do black youth differ at intake? *American Journal of Child and Adolescent Psychiatry*, 32:407–413, 1993.
2. Torrey EF, et al: Criminalizing the Seriously Mentally Ill—The Abuse of Jails as Mental Hospital. Public Citizens Health Research Group and the National Alliance for the Mentally Ill, 1992.

3. Lamb HR: Will we save the homeless mentally ill? *American Journal of Psychiatry*, 147:649–651, 1990.
4. Lamb HR, et al: Outcome for psychiatric emergency patients seen by an outreach police-mental health team. *Psychiatric Services* 46:1267–1271, 1995.
5. Lamb HR, et al: Court intervention to address the mental health needs of mentally ill offenders. *Psychiatric Services* 47:275–281, 1996.
6. *Double Jeopardy: Persons with Mental Illnesses in the Criminal Justice System* In: A Report to Congress from the Center for Mental Health Services SAMHSA, 1995.

**Symposium 23** **Tuesday, October 28**
**8:30 a.m.-11:30 a.m.**

## OVERCOMING SOCIAL CHALLENGES FOR THE YEAR 2000

*American Association for Social Psychiatry*

Leah J. Dickstein, M.D., *Professor and Associate Chair for Academic Affairs, Director, Division of Attitudinal and Behavioral Medicine, Department of Psychiatry and Behavioral Sciences, and Associate Dean for Faculty and Student Advocacy, University of Louisville, 550 S. Jackson Street, ACB, Louisville, KY 40202*

### EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should know specific issues and be able to select specific options related to care for inner city distressed children, minority adolescents and chronic schizophrenic patients' rehabilitation. Furthermore, they will have increased knowledge of current dilemmas of the ethics of managed systems of care which are clearly interrelated.

### SUMMARY:

Sponsored by the American Association of Social Psychiatry, this symposium, "Overcoming Social Challenges for the Year 2000," will include discussion by national leaders. Focus topics will include: the rehabilitation of chronic schizophrenic patients; appropriate interventions with inner city distressed children; the dilemmas of adolescence; the dilemmas of the ethics of managed systems of care; and major issues in access to care for minority patients.

## No. 23A
## REHABILITATION OF CHRONIC SCHIZOPHRENIC PATIENTS

Gerald J. Sarwer-Foner, M.D., *Professor of Psychiatry and Behavioral Neurosciences, Wayne State University School of Medicine, 3220 Bloomfield Shores Drive, West Bloomfield, MI 48323*

### SUMMARY:

The greatest problem in the treatment of chronic schizophrenic patients is the issue of their rehabilitation. The issues posed by the newer neurophysiology data on schizophrenia, in relationship to the actions of the "novel" newer neuroleptics is discussed in particular reference to the rehabilitation of these patients.

## No. 23B
## ETHICS AND THE CONTEMPORARY PRACTICE OF PSYCHIATRY

Donna E. Frick, M.D., *Adjunct Professor, Department of Psychiatry, University of North Carolina, 109 Corner Drive, Building III, #203, Chapel Hill, NC 27514-7039*

### SUMMARY:

Challenges to the current ethical practice of medicine include appropriate management of conflicts of interest, attention and adherence to principles of honesty and confidentiality, and continued dedication to our fiduciary responsibility to patients. Each of these will be examined in light of practical considerations in contemporary practice.

## No. 23C
## THE DILEMMAS OF TOMORROW'S CHILDREN

Jeanne Spurlock, M.D., *American Psychiatric Association Deputy Medical Director (Retired), 1628-B Beckman Place, N.W., Washington, DC 20009*

### SUMMARY:

Major issues for female and male children, whether in inner city or suburbia, will be discussed and include trauma as victim or observer, lack of effective parent role models and parenting and the development of healthy self-esteem as well as effective educational opportunities.

## No. 23D
## PROBLEM BEHAVIORS IN URBAN ADOLESCENTS

Mary E. Schwab-Stone, M.D., *Harris Associate Professor of Child Psychiatry, Yale Child Study Center, 230 South Frontage Road, New Haven, CT 06520-7900*

### SUMMARY:

Dr. Mary Schwab-Stone will report on an ongoing longitudinal study of problem behaviors in urban adolescents. Consideration will be given to the role of risk

factors, particularly violence exposure, in relation to aspects of behavioral and psychological development.


## REFERENCES:

1. Bush PI, D'Eliema et al., Surveying and tracking urban directory, school children's use of abusable substances, *NIDA Research Monograph*, 130:280–17, 1993.
2. Webb E., Meeting the needs of minority ethnic communities, *Archives of Disease in Childhood*, 74(3):267–7, March 1996.
3. Christensen KT, Ethically important distinctions among managed care organizations, *J. of Law, Medicare & Ethics* 23(3):223–9, 1995.
4. Liberman RB Ed., Psychiatric rehabilitation of chronic mental patients, Washington, DC, *APA Press* 1988.
5. Sarwer-Foner, GJ "Aspects of rehabilitation of long-term schizophrenia, patients." *Past, Present and Future of Psychiatry*, Eds. Bargel, A; Lopez Ibor, J.P.; Costa e Silva, J., New Jersey, *World Scientific Publ. Co.*, Vol. I, p. 525–530, 1994.
6. Fabrega H., Toward a more comprehensive medical anthropology, *Medical Anthropology Quarterly* 9(4):431–61, December 1995.


**Symposium 24** **Tuesday, October 28**
**8:30 a.m.-11:30 a.m.**

## ETHICAL DILEMMAS IN PUBLIC PSYCHIATRY

Julia Eilenberg, M.D., *Medical Director, Ulster County Mental Health Department, and Former APA/Mead Johnson Fellow, 239 Golden Hill Lane, Kingston, NY 12401*; Jeremy A. Lazarus, M.D.

## EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to demonstrate an understanding of various ethical dilemmas that confront community psychiatry and appreciate recommendations for approaching such dilemmas in public-sector mental health.

## SUMMARY:

Psychiatry has adopted a set of guidelines that define professional ethics according to general ethical precepts for the practice of medicine. Many of these ethical principles assume that the psychiatrist is delivering care in a dyadic setting with a competent patient. For psychiatrists and other providers who practice in public mental health settings, treating the most ill with the fewest resources, these assumptions often do not hold. As a consequence, an ethics vacuum exists where guidelines are most needed.

In this symposium, the authors will discuss aspects of public mental health service delivery that pose particular ethical problems. These include, for example, problems in maintaining confidentiality, autonomy versus paternalism, and rationing of care. Psychiatrists, administrators, and case managers in community settings confront ethical dilemmas almost daily and often must make their decisions in the heat of the moment. The authors contend that the ethical vacuum surrounding these individually made decisions constitutes a major reason for burn-out and stigmatization of public-sector careers. They will provide examples of ethical dilemmas confronting the public mental health system and discuss approaches to developing cohesive ethical guidelines that address the often conflicting interests of consumers, their families, the public, managed care, and others.

## No. 24A
## CONFIDENTIALITY IN THE COMMUNITY

Ronald J. Diamond, M.D., *Professor of Psychiatry, University of Wisconsin, 6001 Research Park Boulevard, Madison, WI 53718*

## SUMMARY:

Traditional psychiatric practice operates within the clear boundaries of office walls. Community-based mental health treatment often occurs while helping a client negotiate a lease with a new landlord or visiting a client at his work site or grocery shopping with the client. How should staff handle the query from the store clerk, "You're from the mental health center, aren't you?" Does it matter if the client's history of odd behavior is already well known? When a helpful landlord happens to meet community-based staff while they are visiting the client's apartment, how should they respond to the query, "How is John doing? He doesn't look good recently." Does it matter if staff knows that John has been damaging the apartment or that this landlord has been particularly helpful to a number of other clients?

Questions of confidentiality in the community do not come in neat packages with clear releases of information, but out of the informal complexity of interacting with people in the community. Some of the common dilemmas of confidentiality will be discussed, along with general guidelines that can help one develop a solution to these complicated problems.

## No. 24B
## DECIDING WHO GETS WHAT

Julia Eilenberg, M.D., *Medical Director, Ulster County Mental Health Department, and Former APA/Mead Johnson Fellow, 239 Golden Hill Lane, Kingston, NY 12401*

## SUMMARY:

The ethical dilemmas posed by lack of available resources prove to be among the thorniest confronting modern medicine. This is much evident in psychiatry, where the biopsychosocial model has afforded a plethora of treatment modalities, many with proven efficacy, but often costing more than shrinking mental health care budgets will cover.

As resources for treatment grow ever more scarce in community-based treatment settings, decisions face us regarding our priorities: Who should we treat and which technologies should be used? Public sector administrators face conflicting obligations to consumers, families, taxpayers, legislators, and the judiciary in their resource allocation decisions.

The presenter, who is a medical director of a county mental health clinic, will provide examples of the ethical dilemmas posed by shrinking resources. Should efforts be made to treat any and all in distress, albeit superficially, or should resources be directed to those most ill and/or dangerous? And who should be making these sorts of decisions? Governing bodies, clinical administrators, or staff or consumers? A model proposing consensus-building and collaborative approaches will be discussed.

## No. 24C
## ETHICAL DILEMMAS POSED BY MEDICAID MANAGED CARE

Arthur T. Meyerson, M.D., *Professor and Vice Chair, Department of Psychiatry, University of Maryland at New Jersey, 215 South Orange Avenue, University Heights, Newark, NJ 07103*

## SUMMARY:

As states have taken advantage of the federal relaxation of control over the provision of Medicaid services, many have begun to implement or plan for implementation of managed care of mental health coverage under Medicaid. Ethical dilemmas that arise in this context are manifold and include the following:

1) How do we advocate for program funding within the public arena when control shifts from the legislature to managed care companies? Further complications arise from the threat of being compelled to sign agreements disallowing public disclosure.

2) Despite clinical indications, a needed program may not be covered by the patient's managed care plan. Should referrals be made nonetheless, thus jeopardizing the fiscal viability of public programs, or should clinicians settle for lesser levels of care?

3) When capitation allowances fall below levels that allow adequate care for the severely mentally ill, what ethical stance should the public-sector administrator or clinicians assume? Public psychiatry is no stranger to the challenges of resource allocation, but the new managed care public psychiatry presents unique problems. This presentation will discuss possible solutions and areas where ethical psychiatrists must draw the line.

## No. 24D
## RESPONDING TO ETHICAL CONFLICTS IN COMMUNITY SETTINGS

David L. Cutler, M.D., *Director, Public Psychiatry Training Program, Oregon Health Sciences University, 3181 Sam Jackson Road, Portland, OR 97201-3011*

## SUMMARY:

The author describes how a large community mental health service organized an effort to increase staff awareness of ethical concerns, with particular emphasis on boundary issues. A variety of interventions were implemented, including the creation of an ethics committee to identify problems, develop policy and training recommendations, and monitor dilemmas as they arose. Recommendations for the successful incorporation of ethical decision making in community mental health settings include the development of such committees, provision of baseline training to all staff, and distribution of ethics guidelines as part of an orientation packet for new staff. Such activities are critical for community mental health settings because they orient staff toward the existence of the unique ethical problems. They also serve to promote the notion that it is perfectly acceptable to ask for help in resolving ethical dilemmas. In case discussions or "ethics rounds" conducted by the ethics committee, a number of difficult dilemmas were identified and discussed in an open and supportive atmosphere. Several such case examples will be presented, with an emphasis on showing how the staff identified and responded to ethical conflicts.

## REFERENCES:

1. Reiser SJ (ed.): *Divided Staffs, Divided Selves: A Case Approach to Mental Health Ethics.* Cambridge University Press, 1986.

**Workshop 1** **Friday, October 24**
**8:00 a.m.-9:30 a.m.**

## A TRAINING PROGRAM'S ADAPTATION TO MARKET FORCES

*1996-1998 APA/Mead Johnson Fellows Workshop*

Richard T. Kotomori, Jr., M.D., *1996-1998 APA/Mead Johnson Fellow, and Psychiatry Resident, University of California at Los Angeles, Department of Psychiatry, 1000 West Carson Street, Torrance, CA 90509*; Milton H. Miller, M.D., John R. Elpers, M.D.

### EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, participants should be able to: 1) explain how the present cost-cutting context of Los Angeles County portends a tenuous future for community psychiatry residencies; 2) recognize proactive options for community psychiatry residency programs seeking to ensure their survival; 3) understand the need for well-thought-out implementation plans before pursuing a course of action; and 4) describe possible effects that managed care can have on resident training.

### SUMMARY:

The discussion will focus on Harbor UCLA's adoption of a Firm System to become more competitive in the managed care market. The topic is a timely one and appeals to anyone interested in residency training in the managed care setting.

In Los Angeles County prior threats of hospital closures have become realities. The loss of community clinics, and the reorganization or discontinuation of entire departments is an ominous harbinger. Harbor UCLA Department of Psychiatry was forced to position itself at the crest of the managed care wave or wash out like other programs unable to adapt. With our Firm approach, multidisciplinary teams form three distinct teams that are responsible for the inpatient, outpatient, and day treatment care of randomly assigned patient populations. Successful outcomes are increased outpatient follow-up and fixed points of responsibility. Most importantly, we can now bid for the managed care dollar competitively. Unfortunate side effects have been a drop in morale, doubled resident and attending responsibilities, and the occasional sacrifice of didactic and structured supervision.

We will encourage participation by presenting our discussion topic as the evolving dynamic that it is. We invite the audience to grapple with this issue and learn from our experience.

### REFERENCES:

1. Nerenz DR, Zajac BM: Inpatient firms in a teaching hospital. *Medical Care* 29:JS26–JS20, 1991.
2. Ebert TH: Initiating the firm system at a community teaching hospital. *Med Care* 29:JS65–JS70, 1991.

**Workshop 2** **Friday, October 24**
**10:00 a.m.-11:30 a.m.**

## EDUCATIONAL INTERVENTIONS IN SERIOUS MENTAL ILLNESS

*Therapeutic Education Association*

Charles R. Goldman, M.D., *Director, Public Psychiatry Training and Professor of Psychiatry, University of South Carolina School of Medicine, 3555 Harden Street Extension, Columbia, SC 29203*; Cynthia C. Bisbee, Ph.D.

### EDUCATIONAL OBJECTIVES:

At the conclusion of this session, participants will be able to: 1) define psychoeducation and other educational interventions, 2) describe content and process models for educational intervention, and 3) discuss issues involved in providing educational interventions.

### SUMMARY:

Educational interventions provide benefit as an integral part of treatment of persons with serious mental illnesses. This presentation will address current models and issues in psychiatric patient/client/consumer education, providing definitions of terms, discussion of models pertaining both to content of educational interventions and to the educational process, and exploration of issues to be considered in providing educational interventions. Included will be definitions of psychoeducation and other types of educational interventions, presentation of working hypotheses to guide the educational approach, and discussion of how educational interventions are provided. The session will propose a unique three-part model showing the interrelationships among treatment, rehabilitation, and education. Suggested guidelines for the educational approach will be given, relative to issues such as to whom, by whom, with what timing, and at what levels of intervention education can be provided. Also discussed will be the relationship of educational interventions to concepts of empowerment. Targeted toward any professional, consumer, or family member interested in educational interventions, the presentation will be interactive, with considerable audience participation in the discussion of definitions, models, and issues surrounding educational interventions.

### TARGET AUDIENCE:

Any professional, consumer or family member interested in educational interventions.

**REFERENCES:**

1. Goldman CR: Toward a definition of psychoeducation. *Hospital and Community Psychiatry* 39(6):666–668, 1988.
2. Bisbee CC: *Educating Patients and Families about Mental Illness.* Birmingham, AL: Partnership for Recovery, 1991.

**Workshop 3** **Friday, October 24**
**10:00 a.m.-11:30 a.m.**

## FUNCTIONAL EVALUATION OF ALZHEIMER'S DISEASE

*American Occupational Therapy Association*

Marian K. Scheinholtz, M.S., O.T., *Mental Health Program Manager, American Occupational Therapy Association, 4720 Montgomery Lane, Box 31220, Bethesda, MD 20824-1220*; Frances Oakley, M.S., O.T., Trey Sunderland, M.D.

### EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to gain knowledge of two standardized assessments used to measure ADL functioning in people with Alzheimer's disease; gain insight into the effect of Alzheimer's disease on ADL functioning; and gain insight into the use of functional assessments to measure response to pharmacologic intervention.

### SUMMARY:

While Alzheimer's disease is primarily characterized as a memory disorder, abnormalities in performing activities of daily living (ADL) are also common manifestations of the illness. There are few standardized assessments measuring ADL in people with Alzheimer's disease that are well designed, culturally relevant, and sensitive to change over time. This workshop, presented by an occupational therapist and a geriatric psychiatrist, will begin with a description of two standardized assessments used to measure ADL functioning: the Daily Activities Questionnaire and the Assessment of Motor and Process Skills. These assessments use familiar, meaningful, and culturally relevant tasks and have been administered to a large number of people in the context of ongoing studies in Alzheimer's disease at NIH and elsewhere.

Results of our research on baseline ADL functioning and on the relationship of ADL functioning to cognitive tests, biologic markers, and measures of illness severity will be described. A typical profile of the ability of mild-to-moderate Alzheimer's subjects to perform ADL and those skills that support or constrain performance will also be elaborated. Finally, the implications for clinical practice and the value of the functional assessments in pharmacologic research will be discussed. The session will include lecture and audience participation.

**REFERENCES:**

1. Fisher AG: *The Assessement of Motor and Process Skills.* Fort Collins, CO: Three Star Press, 1995.
2. Oakley F, Sunderland T, Hill J, et al: The daily activities questionnaire: a functional assessment for people with Alzheimer's disease. *Physical and Occupational Therapy in Geratrics,* 10:67–81, 1991.

**Workshop 4** **Friday, October 24**
**10:00 a.m.-11:30 a.m.**

## PUBLIC PSYCHIATRY AND PUBLIC HEALTH: BUILDING BRIDGES

*1996-1998 APA/Mead Johnson Fellows Workshop*

Donna T. Chen, M.D., M.P.H., *Psychiatry Resident, Columbia University, Department of Psychiatry, 722 West 168th Street, Box 92, New York, NY 10032*; Sharon S. Levine, M.D., M.P.H., Robert R. Franklin, M.D., Kenneth S. Thompson, M.D., William R. Breakey, M.B.

### EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to recognize the theoretical commonalities between public psychiatry and public health; to identify several examples of programs in each field with similar structures and approaches; and to design and implement a joint program in the field of public psychiatry and public health.

### SUMMARY:

Public psychiatry has long focused on finding ways to provide mental health services to underserved populations. Public health works on finding ways to improve the health of underserved communities. It is appropriate that these fields increasingly share their extensive knowledge bases.

This workshop will bring together examples from both fields to facilitate discussion of theoretical commonalities, practical experiences, and potential future directions. We will discuss the educational and organizational underpinnings that currently support and must shape future endeavors in bridging public psychiatry and public health. Specific examples will include psychiatric consultation/liaison activities in the community, educational pathways combining psychiatry and public health, and respective groups doing this work on national and international levels.

The purpose of this workshop is to elucidate similarities in goals and strategies of groups working in both fields. The audience is encouraged to share their experi-

ences and ideas about the future of bridging public psychiatry and public health.

## REFERENCES:

1. Susser M, Susser E: Choosing a future for epidemiology: I. eras and paradigms. *Am J Public Health.* 86:668–673, 1996.
2. Susser M, Susser E: Choosing a future for epidemiology: II. from black box to Chinese boxes and eco-epidemiology. *Am J Public Health.* 86:674–677, 1996.

**Workshop 5** **Friday, October 24**
**1:30 p.m.-3:00 p.m.**

## A COMMUNITY-BASED COMMITMENT THAT WORKS

Rebecca R. Neal, M.D., *Department of Psychiatry, New Hampshire Hospital, 105 Pleasant Street, Concord, NH 03301-3861*; Barbara M. Maloney, Esq., Chester P. Swett, Jr., M.D., Robert M. Vidaver, M.D.

## EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, participants should be able to: 1) describe a time-limited commitment, which is initiated during hospitalization, but allows the patient to move between inpatient and outpatient treatment as clinically indicated; 2) know something about its evolution and implementation; 3) recognize its uses and limitations; and 4) review outcome data.

## SUMMARY:

During the past 10 years New Hampshire has been using an involuntary civil commitment that covers both inpatient and outpatient treatment for the time period specified in the judge's ruling. When the hospital's petition for commitment is granted, the law allows the treatment team to discharge the patient when clinically appropriate. The commitment becomes defined by the terms of the discharge, which include a negotiated list of specific conditions of treatment for the outpatient phase. If the patient fails to comply with these terms, the discharge is revoked, and the patient is returned to the hospital. If the patient meets the specific expectations set forth in the contract, he or she will complete the remainder of the commitment in outpatient treatment.

This presentation will cover experience with the conditional discharge from a variety of perspectives, including the process that preceded the legislation; the checks and balances that protect patient rights; and administrative, clinical, and ethical aspects of its use. Outcome data will be included to assist participants in evaluating the utility of this unique form of commitment. Ample time will be allowed for discussion.

## REFERENCES:

1. Torrey EF, Kaplan RJ: A national survey of the use of outpatient commitment. *Psychiatric Services* 46:778–784, 1995.
2. Munetz MR, Grande T, et al: The effectiveness of outpatient civil commitment. *Psychiatric Services* 47:1251–1253, 1996.

**Workshop 6** **Friday, October 24**
**1:30 p.m.-3:00 p.m.**

## THE AFRICAN DIASPORA: HEALING ACROSS THE WATERS

Patricia A. Newton, M.D., M.P.H., *Psychiatrist in Private Practice, Newton & Associates, 4100 N. Charles Street, Suite 507, Baltimore, MD 21218*; Toi L. Blakley Harris, M.D., Dawn M. Porter, M.D., Tanya A. Royster, M.D.

## EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to enhance recognition and encourage understanding of the administration and utilization of mental health services among peoples of African ancestry.

## SUMMARY:

Joined by ancestry, there remain remnants of West-African heritage within the African-American culture (Canino and Spurlock). Visiting Senegal for a transcultural conference, the authors were afforded an opportunity to observe similarities and disparities among the two countries. Boykin and Jagers formerly described features transmitted from Africa across generations to Black America. The commonalities of spirituality, communalism, and affect were illustrated in conversations and interpersonal interactions (Jagers and Mock). Moreover, these factors have greatly influenced the manner in which persons of African descent function individually and within society.

As a result of an extended support system composed of relatives, neighbors, and religious entities, these cultures have survived despite adversity and hardship. Combining traditional and modern medicine, Senegalese mental health professionals and trainees utilize a holistic approach. In contrast, psychiatric services rendered to African-Americans have neither effectively nor consistently addressed nuances germaine to their culture. Returning to the "roots" of a people, a better understanding and sharing alternative concepts and strategies can facilitate more effective, culturally based diagnosis and treatment. Thus, the intent of this workshop is to encourage dialogue that will result in development of more culturally sensitive strategies.

## TARGET AUDIENCE:

Mental health professionals.

## REFERENCES:

1. Canino I, Spurlock J: *Culturally Diverse Children and Adolescents Assessment, Diagnosis and Treatment.* The Guilford Press, 1994.
2. Jagers RJ, Mock LO: Culture and social outcomes among inner-city African children: an Afrographic analysis. *Journal of Black Psychology.* 19:391–405, 1993.

**Workshop 7** **Friday, October 24**
**1:30 p.m.-3:00 p.m.**

## TALKING ABOUT DEPRESSION: MODELS AND METAPHORS

*1996-1998 APA/Mead Johnson Fellows Workshop*

James B. Potash, M.D., *1996-1998 APA/Mead Johnson Fellow, and Department of Psychiatry, Johns Hopkins University Hospital, 600 N. Wolfe Street, Meyer 4-109, Baltimore, MD 21287*; Jonathan W. Bolton, M.D., Francis J. McMahon, M.D.

## EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participants should be able to discuss the variety of ways that people understand and explain depression. They should also gain a sense of what influences why people use the particular models and metaphors that they do.

## SUMMARY:

Psychiatrists see depressed patients all the time. We know what depression is clinically. But what underlies this syndrome? What is its cause? Explaining to patients why they are depressed is often an uncertain process, in part because we don't know the etiology of depression and in part because we need to address the patient's preconceptions, which are themselves quite varied.

In this workshop we will first discuss some of the ways that psychiatrists and other health professionals explain depression, using medical models (e.g., a broken part in the brain), psychological models (e.g., anger turned inward), and metaphors (e.g., mood is stuck in low gear). Next we will present a study that looks at the explanations that patients and their families have for depression, with an emphasis on understanding the demographic and cultural variables that may be associated with particular explanations.

There will be ample time to discuss how to use the various modes of thinking about depression in a way that best informs our patients about the nature of their illness. Models and metaphors that members of the audience have found to be common and/or useful will be solicited.

## TARGET AUDIENCE:

Mental health professionals and lay people.

## REFERENCES:

1. Kendler KS, Kessler RC, Neale MC, et al: The prediction of major depression in women: toward an integrated etiologic model. *Am J Psychiatry* 150:1139–1148, 1993.
2. Kleinman A, Good B (eds): *Culture and Depression.* Berkeley, CA, University of California Press, 1985.

**Workshop 8** **Friday, October 24**
**3:30 p.m.-5:00 p.m.**

## PROBATE COMMITMENT: ASSET OR LIABILITY TO CONSUMERS?

Dorothy M. Maloney, D.Min., *New Hampshire Hospital Liaison and Intake Clinician for Level II, The Mental Health Center of Greater Manchester, Department of Psychiatry, 1555 Elm Street, Manchester, NH 03104*; Daniel P. Potenza, M.D., Christopher D. O'Keefe, M.A.

## EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to determine when an involuntary commitment is necessary for the safety and welfare of the severely mentally ill and others with whom they come in contact.

## SUMMARY:

Recent literature indicates that forms of outpatient commitment are associated with positive treatment outcomes. This form of treatment is, however, frequently involuntary and coercive. Such coercion is justified as protecting the community and preventing the patients from either directly or indirectly harming themselves. Many question whether the ends justify the means.

The state of New Hampshire allows persons to be conditionally discharged for a period of up to five years. Such conditions often include medication and compliance, adhering to treatment schedules of individual and group sessions, and refraining from behaviors that may be harmful to self or the community.

This panel consisting of a psychiatrist, a hospital liaison, an intensive treatment team coordinator, a patient, and a family member, will discuss their experiences with such conditional discharges and what they view as the costs and benefits. Treatment providers will focus on the considerations in deciding to file for a conditional discharge and the inherent dilemma regarding the patient's rights. The patient and family member will focus

on how the conditional discharge has impacted their lives.

This presentation is targeted toward professionals faced with this important dilemma. Time will be allotted for the audience to ask questions of the panel members.

## REFERENCES:

1. Torrey EF, Robert J, Kaplan RJD: A National Survey of the Use of Outpatient Commitment, *Psychiatric Services* 46 #8, August 1995.
2. Slobogin, C., J.D, LL. M. Involuntary community treatment of people who are violent and mentally ill: a legal analysis *Hospital & Community Psychiatry* V45 #7 July 1994.

**Workshop 9** **Friday, October 24**
**3:30 p.m.-5:00 p.m.**

## PRACTICE GUIDELINES FOR OCCUPATIONAL THERAPY

*American Occupational Therapy Association*

Marian K. Scheinholtz, M.S., O.T., *Mental Health Program Manager, American Occupational Therapy Association, 4720 Montgomery Lane, Box 31220, Bethesda, MD 20824-1220*; Deborah Lieberman, M.H.S.A., O.T.R., Jane D. Acquaviva, O.T.R.

## EDUCATIONAL OBJECTIVES:

At the conclusion of this presentations, participants should be able to understand the need for practice guidelines; learn how to use these guidelines with students, peers, and external audiences such as third-party payers; demonstrate an understanding of the terminology, approach, and conceptual framework used with AOTA's practice guidelines; and learn how AOTA's practice guidelines fit into today's evolving health care environment.

## SUMMARY:

The concept of practice guidelines is not new or unique to a particular health care profession. Practice guidelines have become the focus of increased interest with the advent of health care reform. Optimally, they should reduce unwarranted variation in the provision of health care services, improve quality, enhance consumer satisfaction, promote appropriate utilization, and reduce costs, all of which are compatible with the goals of health care reform. Many health professions have developed practice guidelines to assist practitioners in clinical decision making and patient management and to serve as a resource for third-party payors, regulators, and consumers.

The development of occupational therapy guidelines was a targeted response to health care reform and the changing economic environment.

This workshop will be taught using lecture, discussion, and audiovisual aids.

## TARGET AUDIENCE:

Occupational therapy practitioners and other interested health care providers.

## REFERENCES:

1. Agency for Health Care Policy and Research: *Practice Guidelines*. Rockville, MD: 1995.
2. Radomski MV: *Occupational Therapy Practice Guidelines for Adults with Traumatic Brain Injury*. Bethesda, MD: American Occupational Therapy Association, 1996.

**Workshop 10** **Friday, October 24**
**3:30 p.m.-5:00 p.m.**

## MULTIDISCIPLINARY MENTAL HEALTH CARE IN SPECIAL SETTINGS

*1996-1998 APA/Mead Johnson Fellows Workshop*

John J. Spollen III, M.D., *1996-1998 APA/Mead Johnson Fellow, and Psychiatry Resident, Department of Psychiatry, Medical University of South Carolina, 171 Ashley Avenue, Charleston, SC 29425*; Tamar Meidav, M.D.

## EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to understand the advantages of using multidisciplinary teams in special settings (i.e., rural areas) and special populations (i.e., trauma victims).

## SUMMARY:

This workshop will review two model programs that use multidisciplinary teams to bring quality mental health care to patients in special settings and populations. The presenters are both residents in psychiatry and APA/Mead Johnson Fellows and will discuss their roles in the respective programs. The ROADS (Rural Outreach, Assessment, and Direct Services) program brings mental health services to an area of South Carolina that had none. Using a flexible and creative approach and staff, it has improved mental health and quality of life for its patients/clients. The Cambridge Hospital's Community Crisis Response Team is a group of social workers, psychologists, teachers, counselors, police officers, street workers, and psychiatrists that does focused traumatic stress debriefings for communities that have experienced an incidence of violence. The intervention is both

psychoeducational and supportive, with an intention that is both therapeutic and prophylactic.

## REFERENCES:

1. Santos AB, Deci PA, et al: Providing assertive community treatment for severely mentally ill patients in a rural area. *Hospital and Community Psychiatry.* 44:34–39, 1993.
2. Herman JL: *Trauma and Recovery.* New York: Basic Books, 1992.

**Workshop 11** **Saturday, October 25**
**8:00 a.m.-9:30 a.m.**

## ASSESSMENT OF OUTCOMES IN MENTAL DISORDERS

Harold Alan Pincus, M.D., *Deputy Medical Director, and Director, Office of Research, American Psychiatric Association, 1400 K Street, N.W., Washington, DC 20005*; G. Richard Smith, Jr., M.D., Deborah A. Zarin, M.D., Deborah L. Blacker, M.D., Sc.D.

## EDUCATIONAL OBJECTIVES:

At the session's conclusion, participants will have knowledge of the issues in outcomes assessment for mental disorders and will know how to choose, use, and interpret measures for use in the assessment of outcomes. The role of the Handbook of Psychiatric Measures & Outcomes will also be addressed.

## SUMMARY:

The workshop will focus on a presentation and discussion of the many issues involved in the assessment of outcomes for mental disorders and current outcomes research. The participants will learn what to consider in choosing, using, and interpreting psychiatric measures for clinical practice. The role of the Handbook of Psychiatric Measures and Outcomes and its relevance to the assessment of outcomes will be presented.

## REFERENCES:

1. Pincus HA, Zarin DZ, West JC: Peering into the black box: measuring outcomes of managed care. *Archives of General Psychiatry* 1996; accepted for publication.
2. Zarin D, West J, Pincus H, McIntyre J: The American Psychiatric Association Practice Research Network, In *Outcomes Assessment in Clinical Practice.* Edited by Sederer L, Dickey B. Baltimore, Williams & Wilkins, 1995.
3. Smith GR, Rost KM, Fischer EP, et al: Assessing the effectiveness of mental health care in routine clinical practice: characteristics, development, and uses of outcomes modules. *Evaluation and the Health Professions* 1996; In press: 1996.

**Workshop 12** **Saturday, October 25**
**8:00 a.m.-9:30 a.m.**

## CLINICAL AND COMMUNITY APPLICATIONS OF FUNCTIONAL NEUROIMAGING: SCHIZOPHRENIA AND VIOLENCE

*1996-1998 APA/Mead Johnson Fellows Workshop*

Diana M. Martinez, M.D., *1996-1998 APA Mead Johnson Fellow, and Psychiatry Resident, Bellevue Hospital, First Avenue and 27th Street, New York, NY 10023*; Pauline F. McHugh, M.D.

## EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to recognize basic neuroimaging research techniques and speculate on their possible future clinical applications.

## SUMMARY:

Much of neuroimaging research has attempted to find anatomical correlates to distinct psychiatric syndromes, such as schizophrenia. Recently, some neuroimaging studies have attempted to correlate specific psychiatric symptomatology with structural and metabolic brain abnormalities. Still in their nascent stages, these studies have not yet found uses in the clinical setting. However, as these studies develop, they should suggest a variety of clinical applications, including diagnosis, treatment, early detection, and prevention strategies.

Violent behavior, while multifactorial in nature, often co-occurs with certain psychiatric syndromes. Many studies have correlated a patient's high incidence of violence with neuropsychiatric dysfunction, as measured by neurological exam, psychology testing, and EEG. Some investigators are now attempting to correlate structural and metabolic brain abnormalities with high levels of violence in psychiatric patients. This presentation will focus on violence as a specific psychiatric symptom that may be detected by neuroimaging techniques. This will serve as an illustration for the possible role of neuroimaging in confirming or suggesting etiologies for psychiatric symptoms, as well as possibilities for treatments. Implications of these will also be discussed.

## REFERENCES:

1. Blake PY, et al: Neurologic abnormalities in murderers. *Neurology* 45(9):1641–7, 1995.
2. Convit A, et al: Frontotemporal abnormalities and violent behavior; Chapter 9, *Aggression and Violence*, Stoff & Cairns (eds), Lea-Martis Graphics, 169–194, 1995.

**Workshop 13** **Saturday, October 25**
**10:00 a.m.-11:30 a.m.**

## DOMESTIC VIOLENCE SHELTERS: DO PSYCHIATRISTS HELP?

Paula G. Panzer, M.D., *Staff Psychiatrist, Domestic Violence Shelter and AIDS Day Treatment Program, Jewish Board of Family and Children's Services, and Former APA/Mead Johnson Fellow, Department of Psychiatry, Suite GR-J, 500 West End Avenue, New York, NY 10024*; Julia Eilenberg, M.D., Emily B. Newman, M.D.

### EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to recognize the complex relationship between domestic violence shelters and the mental health profession, particularly psychiatry. The participant will identify two methods of interaction between shelters, psychiatrists, and traumatized families that allow for clinically sound crisis-intervention work.

### SUMMARY:

Recent recognition of intrafamilial violence as a major public health problem has focused on four components of prevention: law enforcement, shelters, legislation, and health care. Clinical services have expanded to meet the psychological needs of victims and their families. However, many problems remain. These include minimization of the complex social problem; emphasis on diagnosis and treatment (the medical model), which reduces the problem to incomplete categories; and segmentation of services, which perpetuates isolation.

This workshop will address the shelter-system aspect of prevention. Shelters began outside the professional environment, when communities (predominantly women) offered safe havens to otherwise neglected, battered women. Now some shelters offer clinical services, including psychiatric and medical care. How has this change occurred? Does it meet the needs of victims of violence? Can a psychiatrist address the sequelae of battering without retraumatizing the woman? The workshop will focus on these questions. A brief historical overview will be followed by a description of one integrated domestic violence shelter team (combining social service, legal, family, health, and psychiatric services). The third presentation will offer alternative approaches to service delivery. Case vignettes will be available to stimulate discussion among participants after the presentations.

### TARGET AUDIENCE:

All professionals who work with intrafamilial violence.

### REFERENCES:

1. Warshaw C: Domestic violence: changing theory, changing practice. *JAMWA* 51:87–91, 1996.
2. Campbell J, Kub JE, Rose L: Depression in battered women. *JAMWA* 51:106–110, 1996.

**Workshop 14** **Saturday, October 25**
**10:00 a.m.-11:30 a.m.**

## MEASURING COMMUNITY MENTAL HEALTH IN NEW YORK CITY

Neal L. Cohen, M.D., *Commissioner, New York City Department of Mental Health, Mt. Sinai Hospital, Department of Psychiatry, One Gustave L Levy Place, Box 1230, New York, NY 10029*; Jane D. Zimmerman, Ph.D., William Lichtenstein

### EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to understand the factors that influence the mental well-being of urban communities and the development of indices that provide measures of progress toward public mental health goals.

### SUMMARY:

This workshop describes the development of two community mental health indices. The first is a measure of the "well-being" of persons with mental illness, and the second is a more general measure of the "social and mental well-being" of the people of New York City. Two premises underlie the Mental Health Index: that the quality of the socioeconomic environment can alter the risk of developing mental illness, the likelihood that it becomes chronic, and its consequences and outcome; and that mental health services can improve outcomes. A single premise underlies the Social and Mental Well Being Index: that the quality of the socioeconomic and community support systems can alter the well-being of the community at large. Both indices include measures of outcomes, social and economic conditions, and of the availability and utilization of support systems.

In the field of social health or social conditions, the effort to develop indicators has been extensive and focused. In contrast, while there is a sizable literature on indicators for mental health, it is more diffuse, and few efforts have directly concentrated on measuring the mental health of an urban area. The "report card" aspect of the indices should allow ongoing measures of progress and suggest pathways to reach a community's public mental health goals.

### TARGET AUDIENCE:

Mental health professionals, policy makers, and planners.

## REFERENCES:

1. Goodman AB, Haugland G: Mental health service needs assessment. Administration and policy in mental health, 21:173–197, 1994; Miringoff ML: Toward a national standard of social health: The need for progress in social indicators. *American Journal of Orthopsychiatry,* 65:462–467, 1995.

**Workshop 15** **Saturday, October 25**
**10:00 a.m.-11:30 a.m.**

## THE VIRTUAL LIBRARY: PRESENT DEVELOPMENTS, FUTURE CHALLENGES AND OPPORTUNITIES

*Association of Mental Health Librarians*

Ester Saghafi, M.Ed., M.L.S., *Library Manager, Western Psychiatric Institute and Clinic, Library Manager's Office, 3811 O'Hara Street, Pittsburgh, PA 15213*

## EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to recognize cutting-edge technologies affecting library services; to demonstrate an understanding of the impact of information technologies on library services by giving specific examples of pioneer work done in the field; to discuss the impact of the changes affected by information technologies on the future of library services.

## SUMMARY:

Electronic information technologies are having an immense impact on library and information services and products. In the face of rapid technological change, libraries have traditionally taken a proactive stance by adapting and taking the lead in the utilization of available technology for the enhancement of services and products they offer their patrons. This workshop will look at information technologies available to library and information services, their impact on specific information, services and products, and how these technological developments affect the economic, social, and legal framework within which libraries operate. It will explore some examples of libraries that are taking advantage of cutting-edge information technologies to enhance their traditional services and products, and how these libraries utilize these technologies in running more effective and efficient operations. By examining innovative trends and programs initiated by pioneering libraries, the group discussion will focus on the challenges and opportunities that the concept and reality of "the virtual library" pose for provision of information services in mental health.

## TARGET AUDIENCE:

Mental health professionals interested in the provision of information services/products.

## REFERENCES:

1. Broering NC: Changing focus: tomorrow's virtual library. The *Serials Librarian* 26:73–94, 1995.
2. Lowry CB, Richards BG: Courting discovery: managing transition to the virtual library. *Library Hi Tech* 12:7–13, 1994.

**Workshop 16** **Saturday, October 25**
**1:30 p.m.-3:00 p.m.**

## MANAGED CARE MODELS IN PUBLIC PSYCHIATRIC HOSPITALS

*American Association of General Hospital Psychiatrists*

Douglas H. Hughes, M.D., *Harvard Medical School, Boston Veterans Affairs Medical Center, Department of Psychiatry, 150 South Huntington Avenue, #116A, Boston, MA 02130;* Donna M. Moores, M.D., Jayne F. Trachman, M.D.

## EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to identify models of health care delivery that can both be applied to public psychiatry and that can promote excellent clinical care while meeting the guidelines being put forth by managed care concerns.

## SUMMARY:

Managed care has significantly altered the way psychiatry is practiced in the private sector. Increasingly, it is also affecting the way psychiatry is practiced at the city, county, state, and federal levels. This workshop will focus on practical models of how private managed care criteria were safely implemented in both a large urban state hospital and in a large urban VA hospital. These are models of health care delivery that do not compromise clinical care and meet the guidelines being put forth by managed care. The federal system of VA hospitals in the northeast region of United States is being changed by the implementation of InterQual, a managed care corporation. Managed care penetration into state-level psychiatry varies according to the state. In Massachusetts, inpatient mental health benefits have been managed through control of Medicaid by private corporations for several years. Currently, public psychiatry in Massachusetts is managed by a Tennessee-based corporation called Behavioral Health. This discussion will review the advantages and disadvantages of managed care in these two distinct health care delivery systems. Also, practical implementation techniques, general policies

and procedures, and contracting guidelines will be reviewed.

## REFERENCES:

1. Hughes D: Trends and treatments in emergency psychiatry. *Hospital Community Psychiatry* 44:927–928, 1993.
2. Rashin R, Novaceh J, Bahlinger D, Firth L: A model for evaluating intensive outpatient behavioral health care programs. *Hospital Community Psych*, 47:1227–1232, 1996.

**Workshop 17** **Saturday, October 25**
**1:30 p.m.-3:00 p.m.**

## PHYSICIAN-PATIENT RELATIONSHIPS: WHAT'S CRUCIAL?

Fred Gottlieb, M.D., *Treasurer, American Psychiatric Association, and Clinical Professor of Psychiatry, University of California at Los Angeles, 3586 South Bentley Avenue, Los Angeles, CA 90034-6505*; Roger Peele, M.D.

## EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant will be able to describe the crucial aspects of the physician-patient relationship.

## SUMMARY:

With the changes in the delivery of health care in this country, it is frequently stated that it is essential that the physician-patient relationship not be destroyed. Having stated that there is a need to preserve that relationship, what aspects of the relationship are crucial?

For the initial 10 minutes, Drs. Gottlieb and Peele will outline aspects of the relationship that might be regarded as crucial in the care of patients, e.g., choice, confidentiality, competence, communication, compassion, continuity, and no conflict of interest.

Next, each characteristic will be explored by the audience, followed by a concluding summary of the literature by Dr. Gottlieb or Peele, before moving on to discuss the next key crucial element.

Since the audience will be composed of clinicians who have all undoubtedly had an extensive experience with the physician-patient relationship, about two-thirds of the time alloted for this workshop will be for audience participation.

## TARGET AUDIENCE:

All clinicians having to deal with the physician-patient relationship.

## REFERENCES:

1. Glass RM: The physician-patient relationship. *JAMA* 75:147–148, 1996.
2. Laine D, Dvidoff F: Patient-centered medicine: a professional evolution. *JAMA* 275:152–156, 1996.

**Workshop 18** **Saturday, October 25**
**1:30 p.m.-3:00 p.m.**

## ETHICAL ISSUES IN MANAGED MENTAL HEALTH CARE

*American Association of Psychiatric Administrators*

Paul Rodenhauser, M.D., *Professor of Psychiatry, Department of Psychiatry and Neurology, Tulane University Medical Center, 1430 Tulane Avenue - SL23, New Orleans, LA 70112-2699*; Richard C. Christensen, M.D., Jeremy A. Lazarus, M.D., L. Mark Russakoff, M.D., Steven S. Sharfstein, M.D.

## EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to recognize, articulate, and address (through interactive ethical analysis of case examples) the most common ethical issues confronted by mental health care providers practicing within a managed care setting.

## SUMMARY:

Because the competing interests of the financial and service aspects of mental health care are at best difficult to negotiate, because managed care intensifies the conflicts at this interface, and because the provider is intricately and instrumentally involved in the interaction between payors and patients, the confluence of interests encountered frequently not only impinge on therapeutic efforts, but also challenge professional ethical standards. Premature hospital discharge is a prime example. Physicians have frequently been obligated to tailor their therapeutic approaches and even recommendations on a contractual basis. Many contracts tie physician income or bonuses to denial of services. Managed care has been described by some as "legalized malpractice." On a daily basis, clinicians struggle with ethical issues in their attempts to treat patients according to professional guidelines. Anchored by presentations by four experts in the fields of managed care and ethics, this workshop will explore ethical conflicts that arise at the interface of managed mental health care and psychiatric practice. Topics include double agentry, informed consent, conflict of interest, and ethical gatekeeping. The workshop will encourage dialogue among the panelists and full participation among attendees, including contribution of case examples.

## REFERENCES:

1. Kassirer JP: Managed care and the morality of the marketplace. *New England Journal of Medicine*, 333(1):50–52, 1995.
2. Backler P: Managed health care: conflicts of interest in the provider/client relationship *Community Mental Health Journal*, 32(2):101–106, 1996.


**Workshop 19** **Saturday, October 25 3:30 p.m.-5:00 p.m.**

## RESIDENT RESEARCH SEMINAR: PROGRAM DESCRIPTION

Anita L.H. Clayton, M.D., *Associate Professor of Psychiatry, Department of Psychiatry, University of Virginia, Northridge Building, Suite 210, 2955 Ivy Road, Charlottesville, VA 22903*; Adrienne E.R. Sheldon-Keller, Ph.D.


## SUMMARY:

*Objective:* To describe and evaluate a residents' research seminar.

*Method:* All general psychiatry residents and combined internal medicine-psychiatry residents participate in a weekly research seminar during their assignment to outpatient psychiatric services. The goals of the seminar are to develop abilities to critically evaluate clinical and research data, participate in the design and conduct of a specific clinical research project, stimulate creative research ideas, develop skills in accurate data collection and presentation of results, and provide the experience of "ownership" of a research project. The seminars are led by two experienced faculty: a clinical researcher and an epidemiologist.

*Results:* During the past two years, the process of the course has been refined and standardized and is now well described in a time-dependent flow chart. The outcomes of the course include the design, approval, and funding of a number of clinical drug trials by the participating residents.

*Conclusion:* The incorporation of research training into a clinical training program is essential and can be accomplished interactively with a group of residents through a combination of didactic presentations, learner-centered learning seminars, and hands-on experience. This successful model has been well-received by the residents, well-documented, and is amenable to replication in a variety of settings.


## TARGET AUDIENCE:

Faculty and residents in psychiatric training programs.


## REFERENCES:

1. Internal Medicine Clinical Research Consortium Faculty: housestaff team research in the ambulatory setting: it can be done. *JGIM 10*: 219–222, 1995.
2. deGroot JM, Kennedy SH: Integrating clinical and research psychiatry *J Psychiatr Neurosci 20*:150–154, 1995.


**Workshop 20** **Saturday, October 25 3:30 p.m.-5:00 p.m.**

## WHEN THE HORSE GETS THIRSTY: HOMELESS OUTREACH IN WASHINGTON

Kenneth Freeman, M.P.H., *Mental Health Specialist, EPRD-WIU, 1905 E Street, S.E., Building 25, Washington, DC 20003*; Sara F. Carroll, M.S.N., Lien A. Hung, M.D., Robert W. Keisling, M.D.

## EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop the participants will learn and recognize the complexities of working with the unsheltered severely mentally ill homeless population. They will gain insight in how to approach and work with this population and to understand the need for flexible and creative housing.


## SUMMARY:

This workshop will present methods of working with the unsheltered homeless mentally ill by the Homeless Outreach Program of the Emergency Psychiatric Bureau of the Commission on Mental Health in Washington, D.C.

The purpose of this workshop is to present strategies used in engaging homeless, severely chronic, mentally ill based on data from a five-year study of the clients on the streets of Washington, D.C. A sample of 100 clients who went into housing will be used, including those who went into housing and remained and those clients who left housing, and their reasons for doing so. Clinical vignettes will be used to illustrate methods used to engage the client, identify problems encountered and various treatment strategies, what type of housing the client went to, and why the client stayed or left, and where the client is today.

Ideas will be shared about clinical approaches, creativity, and collaboration with other agencies. The housing needs to be flexible and the client's choice of housing should be honored.

The four participants will each present for 15 minutes and the audience will have one-half hour for discussion.



## REFERENCES:

1. Baum A: *A Nation in Denial: The Truth About Homelessness,* 1993.
2. Grob GN: *The Mad Among Us,* 1994. Harvard University Press, 1994.

**Workshop 21** **Saturday, October 25**
**3:30 p.m.-5:00 p.m.**

## PSYCHODYNAMIC CONTRIBUTIONS TO COGNITIVE-BEHAVIORAL THERAPY

Ronald C. Albucher, M.D., *Assistant Residency Training Director, University of Michigan Medical Center, 2215 Fuller Road - 116A, Ann Arbor, MI 48105*; Claire Tuthill, M.D., Allan Tasman, M.D.

### EDUCATIONAL OBJECTIVES:

At the end of this workshop, the participant will understand factors affecting outcome in psychotherapy and have an appreciation of psychodynamic factors that play a role in short-term cognitive-behavioral therapy.

### SUMMARY:

Cognitive-behavioral therapy (CBT) achieves long-lasting improvement in patients with a variety of psychiatric disorders in a time-limited fashion. However, especially in complicated cases, psychodynamic factors that are not easily addressable in the CBT paradigm may significantly influence the outcome of treatment. Can the exploration of the transference neurosis, resistance, countertransference, and termination issues further the work in a CBT treatment? We will review the literature regarding the overlap between psychodynamic psychotherapy and CBT, as well as general factors affecting outcome in psychotherapy treatments. We will then present a case illustrating the overlapping areas and offer suggestions for improving technique in CBT treatment. Participants should bring examples of problematic CBT cases to be discussed, as we explore whether addressing the psychodynamic aspects of CBT can lead to improved outcomes.

### REFERENCES:

1. Beck AT, Freeman A: *Cognitive Therapy of Personality Disorders.* New York, The Guilford Press, 1990.
2. Wachtel PL: *Psychoanalysis and Behavior Therapy.* New York, Basic Books, Inc, 1977.

**Workshop 22** **Saturday, October 25**
**3:30 p.m.-5:00 p.m.**

## LOCUS AND PRINCIPLES FOR LEVEL OF CARE DETERMINATION

Wesley E. Sowers, M.D., *Medical Director, Center for Chemical Dependency Treatment, St. Francis Medical Center, and Former APA Mead Johnson Fellow, 400 45th Street, Pittsburgh, PA 15201*; Kenneth S. Thompson, M.D.

### EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to identify principles useful in the development of resource utilization systems to understand implications of rational and objective level of care determinations for the evaluation of behavioral health care systems; and to recognize barriers to implementation of these systems.

### SUMMARY:

Recent changes in health care financing have created the impetus for risk-bearing entities to develop guidelines for patient placement determinations designed to reduce the utilization of costly services. At the same time, community service providers have aggressively reorganized their treatment systems to meet changing expectations. Providers have sought standardization of patient placement criteria to protect quality of care and good treatment outcomes. Emerging concepts guiding level of care determinations in psychiatry must address both of these concerns.

This workshop will examine principles to be employed in the development of systems to ensure that patients are placed in the most appropriate level of care to suit their needs and to maintain appropriate utilization of resources. The Level of Care Utilization System for Psychiatric and Addiction Services (LOCUS) developed by the American Association of Community Psychiatrists will be used as an example of such a system, and early experiences with its use will be presented. Participants will be encouraged to critique this system and to discuss alternative systems for objectively organizing the utilization of psychiatric and addiction services.

### REFERENCES:

1. Barker S, et al: A community ability scale for chronically mentally ill consumers: Part I: reliability and validity. *Community Mental Health Journal*, Vol. 30, No. 4, 1994.
2. Glazer WM, Gray GF: Psychometric properties of a decision-support tool for the era of managed care. *J Mental Health Administration,* 23:2, Spring 1996.

**Workshop 23** **Sunday, October 26**
**8:00 a.m.-9:30 a.m.**

## REVIEW OF APA PRACTICE GUIDELINES

John S. McIntyre, M.D., *Chair, Steering Committee on Practice Guidelines, Chair, Department of Psychiatry, and Past President, American Psychiatric Association, St. Mary's Hospital, 919 Westfall Road, Suite 210, Rochester, NY 14618-2670*; Deborah A. Zarin, M.D., Paula

T. Trzepacz, M.D., Dilip V. Jeste, M.D., Deborah L. Blacker, M.D., Sc.D.

## EDUCATIONAL OBJECTIVES:

Participants should be able to understand the broad array of issues relating to practice guidelines including guideline content, overall development procedures, dissemination and evaluation strategies, and implications for the field. Presentations will focus on practice guidelines on geriatric care (slated for publication first quarter 1998), Alzheimer's disease (published in May 1997), delirium (slated for publication in first quarter 1998), and panic and related anxiety disorders (slated for publication third quarter 1997).

## SUMMARY:

The APA practice guidelines project has moved forward according to a previously approved process designed to result in documents that are both scientifically sound and clinically useful to practicing psychiatrists. On the basis of nationally recognized standards for the development of practice guidelines (sometimes termed "practice parameters"), APA guidelines reflect: 1) comprehensive literature reviews; 2) classifications of supporting evidence and the nature of recommendations; and 3) a series of revisions based on input from the Steering Committee, Work Group, Assembly, Board of Trustees, Joint Reference Committee, related APA components, and from psychiatric consultants, nonpsychiatrist experts, and representatives from related organizations. The final draft is approved by the Assembly and Board of Trustees.

This session will explore the treatment recommendations contained in practice guidelines on panic disorder and related anxiety disorders, and the geriatric series: geriatric care and delirium. Persons attending the session are invited to comment on the broad array of issues relating to practice guidelines including guideline content, overall development procedures, dissemination and evaluation strategies, future guideline topics, and implications for the field.

## REFERENCES:

1. Zarin DA, Pincus, HA, McIntyre JS: Editorial on practice guidelines. *Am J Psychiatry* 150:2, 1993.
2. American Psychiatric Association: Practice Guideline for Treatment of Patients with Nicotine Dependence. *Am J Psychiatry* 153:10(suppl) 1996.

**Workshop 24** **Sunday, October 26**
**8:00 a.m.-9:30 a.m.**

## CASE MANAGEMENT AND PSYCHIATRY

Jaak Rakfeldt, Ph.D., *Associate Professor, School of Professional Studies, Southern Connecticut State University, Lang Social Work Center, 101 Farnham Avenue, New Haven, CT 06515*; Kenneth S. Thompson, M.D., Mary Kay Macik, M.Ed.

## EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, participants should be able to recognize the relationship between psychiatric practice and case management and should be better able to integrate these concepts into their clinical practice.

## SUMMARY:

The workshop will explore the interface between psychiatry and case management from an ecological, open-systems, perspective, emphasizing life-space analysis, rehabilitation, recovery, as well as the growth and development tasks areas of psychiatry. Relevant literature will be reviewed, and a functional analysis of current practices will be provided. The workshop will feature a dialogue between a psychiatrist and a case manager who will discuss their efforts to develop a collaborative working model of practice. The lessons case management can teach psychiatry and vice versa will be emphasized. Workshop participants will be encouraged to join in this discussion, thus sharing their clinical experiences with case management in psychiatric practice.

## TARGET AUDIENCE:

Mental health professionals, consumers, family members.

## REFERENCES:

1. Rakfeldt J, Sledge WH, Bailey MA, Anderson C: A two-tiered approach to case management. *Continuum: Developments in Ambulatory Mental Health Care, 3* (1):45–57, 1996.
2. Sledge WH, Astrachan B, Thompson K, et al: Case management in psychiatry: an analysis of tasks. *Am J Psychiatry, 152* (9):1259–1265, 1995.

**Workshop 25** **Sunday, October 26**
**8:00 a.m.-9:30 a.m.**

## CONSUMER VOICES ROUNDTABLE
**National Depressive and Manic-Depressive Association**

Martha M. Manning, Ph.D., *Psychologist, National Depressive and Manic-Depressive Association, 730 North Franklin, Suite 501, Chicago, IL 60610*; Jim McNulty, Sandra P. Turner, M.S.W., L.I.S.W.

## EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to recognize the issues that are most

important to mental health consumers and be able to demonstrate a better understanding of the viewpoints and concerns of the consumers.

## SUMMARY:

The National Depressive and Manic-Depressive Association (National DMDA) workshop will present findings from its Consumer Voices Roundtable held in June 1997 in Pittsburgh. The Consumer Voices Roundtable is composed of patients and family members who have come together to discuss issues of importance to patients. Roundtable topics discussed at the June meeting include legal issues pertaining to individuals and families such as stigma and access to health care; legal issues pertaining to the workplace such as discrimination and the Americans with Disabilities Act; and managed care topics, including setting standards for managed care, on-site coping skills training for patients, and insurance coverage. Finalized data will be distributed nationally later in the year.

## TARGET AUDIENCE:

Physicians, psychiatrists, mental health educators and advocates and consumers.

## REFERENCES:

1. *Consumer Voices Roundtable Report.*
2. *National DMDA Consensus Statement on The Undertreatment of Depression.*

**Workshop 26** **Sunday, October 26**
**10:00 a.m.-11:30 a.m.**

# PRACTICE GUIDELINE IMPLEMENTATION EVALUATION

John S. McIntyre, M.D., *Chair, APA Steering Committee on Practice Guidelines, Chair, Department of Psychiatry, and Past President, American Psychiatric Association, St. Mary's Hospital, 919 Westfall Road, Suite 210, Rochester, NY 14618-2670*; Deborah A. Zarin, M.D., Joel Yager, M.D., Brian Mittman, Ph.D., Mark Olfson, M.D., M.P.H., Terri Tanielian, M.A., Leslie Seigle

## EDUCATIONAL OBJECTIVES:

The New York State Psychiatric Association, APA, and RAND conducted a study to evaluate the effectiveness of two practice guideline implementation strategies designed to bring about improvements in patient treatment and outcomes. This presentation will describe the study methods, details of intervention, and preliminary findings.

## SUMMARY:

Although APA's evidence-based practice guideline for the treatment of major depressive disorder offers considerable promise in improving the quality and outcomes of care, research has demonstrated that specific implementation efforts are needed to assure guidelines are effectively put into practice. The New York State Psychiatric Association, APA, and RAND conducted a study to evaluate the effectiveness of two practice guideline implementation strategies. This study will describe guideline dissemination efforts in psychiatry in order to bring about improvements in patient treatment and outcomes.

## REFERENCES:

1. American Psychiatric Association: Practice Guideline for Major Depressive Disorder in Adults. *Am J Psychiatry,* 150:4 (suppl) 1996.
2. Mittman BS, Siu A: Changing provider behavior: applying research on outcomes and effectiveness in health care. Shortell S and Reinhardt U (eds): *Improving Health Policy and Management: Nine Critical Research Issues for the 1990's.* Ann Arbor: Health Administration Press, 1992.

**Workshop 27** **Sunday, October 26**
**10:00 a.m.-11:30 a.m.**

# TREATMENT PLANS: INTEGRATING THE SPIRITUAL

Barbara Sheehan, S.P., *Director, Urban Clinical Pastoral Education, Association of Chicago Theological Schools, 1178 E. 58th Street, Chicago, IL 60637*; Andrea H. Schmook

## EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to assess spirituality, recognize the dynamic elements affecting it, and identify treatment forms that move people toward integration.

## SUMMARY:

Clinical practice and individual experience demonstrate clearly a strong imperative for the spiritual to be integrated within a treatment plan for persons challenged with a mental illness. The focus of this workshop is the integration of the spiritual component into the overall treatment plan or care map. Spiritual assessments and diagnostic tools will be presented along with methods for addressing issues of loss, belief systems, and other value systems in the healing process.

Clinical examples will demonstrate the spiritual depths encountered by those challenged with a mental illness and the subsequent "rising out of the depths" experienced in moving through grief, re-imaging, and use of guided imagery, and other forms of spiritual methodologies. Examples of cure and long-term healing will be incorporated within the workshop.

Spiritually is often the neglected aspect of treatment. This workshop will offer the participants some insights into the importance of the spiritual component. The participants will engage briefly in the identification of the meaning of spirituality (not religion) and be invited to present their own clinical vignettes for discussion.

This workshop in its spiritual specificity will be a springboard for more effective and integrated treatment of those challenged with a mental illness.

## REFERENCES:

1. Farran CJ, et al: Development of a model for spiritual assessment and intervention, *Journal of Religion and Health* 28:185–194, Fall 1989
2. Gaiser FJ, (ed): *Ministry and Mental Health, Word and World* 9:109–173, Spring 1989.

**Workshop 28** **Sunday, October 26**
**1:30 p.m.-3:00 p.m.**

## CULTURAL ISSUES AND MENTALLY ILL AFRICAN-AMERICANS

Bronwen L. Millet, Ph.D., *Research Specialist, Department of Psychology, Community Connections, 1512 Pennsylvania Avenue, S.E., Washington, DC 20003*; Annelle B. Primm, M.D., M.P.H.

## EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, participants will be able to recognize ways to increase cultural sensitivity in their work with African Americans. Clinicians will have specific tools that can enhance their ability in both the assessment and treatment setting.

## SUMMARY:

The issue of cultural awareness is becoming more widely addressed by human service delivery systems and professionals. While culture is often defined as one's identity with a specific race, a more useful definition includes a shared set of common behaviors, beliefs, and attitudes. This definition allows for a more comprehensive understanding of culture and directs attention to specific areas where knowledge and sensitivity are needed. A comprehensive approach is necessary in order to work effectively with mental health service users from varying cultures. This workshop examines two different ways to incorporate cultural sensitivity into work with mentally ill African Americans. The first presentation will briefly address the need to include issues of cultural sensitivity in the assessment process and specific ways to enhance clinicians' awareness of these issues. The audience will be engaged in discussion about how various assessments and assessment techniques were used to enhance clinicians' awareness of cultural sensitivity. The second brief presentation will use theoretical frameworks and case studies to emphasize the importance of cultural issues in treatment. Again, clinical examples and specific techniques will be used to facilitate discussion about the need for clinicians to develop an inclusive understanding of consumers and their cultural context.

## REFERENCES:

1. Mason JL, Benjamin MP, Lewis BS: *The Cultural Competent Model: Implications for Child and Family* Services. California: Sage Newberry Park, In press.
2. Orlandi MA: *The Challenge of Evaluating Community-Based Prevention Program: A Cross-Cultural Perspective.* Maryland: U.S. Dept. of Health and Human Services, 1992.

**Workshop 29** **Sunday, October 26**
**1:30 p.m.-3:00 p.m.**

## PATERNALISM VERSUS AUTONOMY IN COMMUNITY OUTREACH

Howard Telson, M.D., *Assistant Clinical Professor of Psychiatry, New York University School of Medicine, 215 E. 24th Street, #321, New York, NY 10010-3804*; David C. Lindy, M.D., Neil Pessin, Ph.D.

## EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop the participant should be able to understand the legal and ethical basis for outreach to and court-mandated treatment of the seriously and persistently mentally ill living in the community.

## SUMMARY:

The theory of paternalism asserts that the state has the right to restrict an individual's liberty when it is acting for the person's own good. This theory served as the traditional basis for the commitment of nondangerous mentally ill individuals to hospital care. Community care was offered on a voluntary basis, and was therefore available only to those who identified a need for treatment.

Beginning in the 1960's deinstitutionalization became the dominant social policy, and commitment laws were amended to allow for the forced treatment only of individuals who were deemed dangerous to self or others. As a result, many seriously and persistently mentally ill individuals who had limited insight into their need for treatment or who resisted or refused treatment entered the community. Many of these individuals became homeless, deteriorated while living in the community, and/or required repeated rehospitalizations.

Over the past 30 years a range of clinical services, including mobile crisis, intensive case management, and assertive community treatment, have been developed to meet the needs of the seriously mentally ill living in

the community. While many respond to the outreach orientation of these services, some object to what they perceive to be an intrusion into their privacy and a meddling in their affairs.

This workshop will examine the legal and ethical justification for outreach work with seriously mentally ill individuals living in the community. It will also explore the role of paternalism theory in outpatient commitment, which allows the courts to mandate community treatment based exclusively on an individual's history of mental illness. Participants will be encouraged to share their views and experiences of outreach work and involuntary treatment in the community.

## TARGET AUDIENCE:

Mental health professionals working with seriously mentally ill individuals.

## REFERENCES:

1. Stone AA: Psychiatry as morality, in: *Law, Psychiatry and Morality,* Washington, D.C., American Psychiatric Press, Inc., pp. 237–250, 1984.
2. Tavolaro KB: Preventive outpatient civil commitment and the right to refuse treatment: can pragmatic realities and constitutional requirements be reconciled? *Medicine and Law.* 11:249–267, 1992.

**Workshop 30** **Sunday, October 26**
**1:30 p.m.-3:00 p.m.**

# VIOLENCE AGAINST WOMEN AND CHILDREN

*World Psychiatric Association's Section on Conflict Resolution*

Eliot Sorel, M.D., *President, World Association for Social Psychiatry, George Washington University, Department of Psychiatry, 2021 K Street, N.W., Suite 206, Washington, DC 20006*; Marianne C. Kastrup, M.D., Amelia E. Musacchio de Zan, M.D., Aida Seifel Dawla, M.D.

## EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to recognize the etiology and know some of the epidemiology of violence against women and children in different parts of the world as well as identify effective treatment intervention.

## SUMMARY:

Global violence against women and children has reached epidemic proportions. The epidemic of violence against women and children has been fueled by an explosion of ethnic conflict, economic dislocation, substance abuse, political upheavals, and a tide of intolerance. The workshop addresses the etiology and epidemiology of global violence with a focus on culturally specific primary, secondary, and tertiary interventions for women and children. Following the chairman's 10-minute opening remarks, there will be three 20-minute presentations by the faculty. There will be ample opportunity for substantial audience participation though questions and answers as well as discussion.

## REFERENCES:

1. Sorel E: Urban violence in the United States. *Soc Psych* 1:8–11, 1994.
2. Heise L: Int'l Dimensions of Violence Against Women, *Response* 12 (1):3–11, 1989.

**Workshop 31** **Sunday, October 26**
**1:30 p.m.-3:00 p.m.**

# THE PROCESS OF LEARNING IN SHORT-TERM DYNAMIC PSYCHOTHERAPY TRAINING

Manuel Trujillo, M.D., *Professor of Psychiatry, New York University Medical Center, Department of Psychiatry, 550 First Avenue, Suite 22 North, New York, NY 10016*; Waguih W. Ishak, M.D., Harold Lifshutz, Ph.D.

## EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participants will acquire knowledge about the process of learning short-term dynamic psychotherapy, including the difficulties encountered by trainees, and planned systematic ways to address these difficulties in supervision.

## SUMMARY:

Short-term dynamic psychotherapy, a time-limited therapy, is gaining more attention as an effective and efficient treatment modality for a variety of psychiatric disorders. Training in this particular modality requires the trainee to have an adequate knowledge base of psychodynamic theory, and to acquire new therapeutic skills throughout the process. The highlights of these skills include assuming an active role, helping the patient to develop specific psychodynamic focus or foci, and challenging defensive styles. The ultimate goal is to help the patients gain more insight into the way they react to both their outer and inner worlds. For trainees, learning these new skills can be initially difficult. The trainees have to change their stance from the traditional active listener role to active participants who confront defenses, invoke and tolerate intense emotions, and help develop insights. The supervisor's role is to help the trainees develop a psychodynamic understanding of the patient's problems and identify the patient's responses in the therapeutic interaction, including verbal and nonverbal com-

munication, in order to guide the trainee in making the most appropriate interventions. The use of video-taped sessions for supervision has proven to be extremely helpful in assisting the trainees in overcoming their initial difficulties. In this workshop, the experiences of a trainee, a middle-career therapist, and a senior supervisor will be reviewed in detail. The participants will have the opportunity to participate in an active discussion about the psychotherapy learning-teaching process.

## TARGET AUDIENCE:

Educators, psychotherapy supervisors, residents.

## REFERENCES:

1. Rodenhauser P, et al: Attributes conducive to learning in psychotherapy supervision. *Am J Psychotherapy*, 43(3):368–377, 1989.
2. Trujillo M: Short-term dynamic psychotherapy, In: Kutash L, Wolf I (eds): *Psychotherapists Casebook: Casebook, Theory and Techniques,* San Francisco/ London, Jossey Bass Publishers, 1986.

**Workshop 32** **Sunday, October 26 3:30 p.m.-5:00 p.m.**

# INTEGRATING WORK INTO TREATMENT

Jonathan E. Morris, M.D., M.P.H., *Director, Division of Consultation-Liaison Psychiatry, Maine Medical Center, Department of Psychiatry, 22 Bramhall Street, Portland, ME 04102*; Richard M. Balser, M.A., Stephen Waterhouse

## EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, participants should be able to discuss the changing practice of mental health professionals resulting from the emerging role of business, as people with mental illnesses are supported in work settings.

## SUMMARY:

Work provides an opportunity for people with mental illnesses to engage in activities that have been demonstrated to have significant therapeutic import. The role of mental health professionals vis-a-vis rehabilitation professionals has also been determined to be critical. The business and employer community, however, has not been seen as a *necessary partner* in the development of employment choices for persons with psychiatric illnesses, and has, therefore, not been an active participant in this highly effective, therapeutic venue, i.e., work.

Maine Medical Center has pursued an intense and yet broad initiative to engage businesses and nonprofit employers as full partners in its vocational agenda. In this regard, businesses are not only approached as possible places of employment, but are also tapped as resources and consultants in determining how to best make work a viable part of recovery for people with mental illnesses.

Through this training, mental health practitioners will gain new insight into the importance of workplace dynamics within the total treatment of people with mental illnesses. Effective partnership strategies between mental health professionals and business will be demonstrated and explored. How the practice of psychiatric rehabilitation can become profoundly altered within this change of professional perspective will be demonstrated.

## REFERENCES:

1. Test MA: *Vocational Outcome in PACT after Seven Years.* Paper presented at 1994 Annual Meeting, American Psychiatric Association, Philadelphia, PA.
2. McFarlane WR, Stanstny P, Deakins SM: Family-aided assertive community treatment: a comprehensive rehabilitation and intensive care management approach for persons with schizophrenic disorders. *New Directions for Mental Health Services,* 53: 43–54.

**Workshop 33** **Sunday, October 26 3:30 p.m.-5:00 p.m.**

# CAPACITY PRESERVATION FOR MENTALLY ILL VETERANS

*APA Organized Systems Consortium, APA Council on Psychiatric Services and the Veterans Health Administration*

Thomas B. Horvath, M.D., *Chief Consultant for Mental Health, Department of Veterans Affairs, Veterans Health Administration, 810 Vermont Avenue, N.W., Washington, DC 20420*; Billy E. Jones, M.D., William W. Van Stone, M.D., Richard S. Suchinsky, M.D., Laurent S. Lehmann, M.D.

## EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, participants should be able to describe new legislative and organizational changes affecting veterans' access to health care and methods to identify, monitor, preserve, and enhance access to services for patients with PTSD, substance disorders, schizophrenia, and other serious mental illnesses.

## SUMMARY:

This workshop will describe the significant legislative and organizational changes that are currently affecting how the Department of Veterans Affairs (VA) health care system delivers services to veterans suffering from mental disorders. Legislative changes include "eligibility reform" authorizing access to comprehensive services for veterans and preserving VA's capacity to serve

certain populations of veterans, including those with mental disorders. Organizational changes include emphasis on primary care and the formation of "service lines" to coordinate and consolidate care. Dr. Horvath, VA's chief consultant for mental health, will describe these general trends and steps taken by headquarters and field coordinators to monitor and direct these changes so an efficient and effective system of care for these patients can be preserved and perhaps enhanced. Drs. Van Stone, Suchinsky, and Lehmann, respectively, the headquarters coordinators for programs caring for seriously mentally ill; substance abuse disorder, and posttraumatic stress disorder patients, will each describe particular challenges and solutions they have encountered. Dr. Jones will discuss these issues and their applicability to non-VA settings. Audience participants can ask questions after each presentation and after the discussant's comments.

## REFERENCES:

1. Rosenheck R, Neale M, et al.: Multisite experimental cost study of intensive psychiatric community care. *Schizophrenia Bulletin*, 21:129–140, 1995.
2. Fortney JC, Booth BM, et al.: The effects of travel barriers and age on the utilization of alcoholism treatment aftercare. *Am J Drug Alcohol Abuse,* 3:391–406, 1995.

**Workshop 34** **Sunday, October 26**
**3:30 p.m.-5:00 p.m.**

## SURVIVAL OF THE INPATIENT TEACHING UNIT

John G. Csernansky, M.D., *Medical Director, Metropolitan St. Louis Psychiatric Center, 4949 Childrens Place, St. Louis, MO 63110*; Gregory L. Dale, M.B.A., M.S.W., Joy A. Haven, Ph.D., Devna Rastogi-Cruz, M.D.

## EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participants will recognize challenges that currently face inpatient teaching units in public and private psychiatric hospitals. Using this information, the participants should be able to better organize and manage similar teaching units in their own institution.

## SUMMARY:

The inpatient teaching unit has been one of the cornerstones of the psychiatric residency program for many decades. Interactions of psychiatric residents on these units with senior and junior members of other mental health disciplines often become the model upon which later interdisciplinary treatment team work is based. In addition, many residents have their first exposure to clinical research on such units. In the past, inpatient teaching units have combined the needs of clinical care, teaching, and research, with few restrictions on available resources. However, in the era of dwindling resources and managed care, cost considerations can conflict with clinical care decisions and the needs of teaching and research programs. While residents must be trained to meet the challenges of the modern era, the best aspects of the traditional inpatient teaching program must be preserved. This workshop will discuss ways of maintaining the traditions of the inpatient teaching program, while increasing the efficiency of clinical care delivery. Examples of innovative solutions will include 1) overlaps between research protocols and clinical pathways, which serve the needs of managed care; and 2) combining selected training activities among disciplines with utilization review.

## REFERENCES:

1. Tucker W: Public-academic liaison in psychiatric residency training in New York State. *Psychiatric Services* 46:1289–1291, 1995.
2. Summergrad P, et al: Wagons ho: forward on the managed care trail. *General Hospital Psychiatry* 17:251–259, 1995.

**Workshop 35** **Monday, October 27**
**8:00 a.m.-9:30 a.m.**

## CLINICAL MANAGEMENT OF VIOLENT PATIENTS IN THE EMERGENCY ROOM

*American Association for Emergency Psychiatry*

Janet S. Richmond, M.S.W., *Director of Psychiatry Emergency Service, Boston Veterans Affairs Medical Center, 150 South Huntington Avenue, 116A, Boston, MA 02130*; Rachel L. Glick, M.D., Douglas H. Hughes, M.D.

## EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to treat a variety of violent and threatening patients safely within an acute setting, and obtain practical clinical strategies and theory pertaining to these patients.

## SUMMARY:

Violence can be an unpredictable event in an acute-care setting and puts patients and staff at risk for physical and emotional trauma. This workshop is intended for the clinician who works in acute-care settings.

We will offer practical clinical strategies for early detection and acute clinical management of the violent patient.

Since aggression may occur in a variety of psychiatric conditions ranging from the psychoses to nonpsychotic

disorders, attention will be paid to general behavioral methods that can lead to successful de-escalation for a variety of violent patients.

A theoretical review will be provided as well as psychopharmacologic interventions, including the use of new generation antipsychotics in the management of acute violence.

The audience will be encouraged to present their own clinical vignettes to demonstrate successful methods and learn about alternate methods of management of violence.

## REFERENCES:

1. Marder SR, Meibach RC: Risperidone in the treatment of schizophrenia. *Am J Psychiatry*, 151:825–834, 1994.
2. Richmond JR, Ruparel MK: Management of violent patients in a psychiatry walk-in clinic. *J. Clin Psychiatry*, 41:370–373, 1980.

**Workshop 36** **Monday, October 27**
**8:00 a.m.-9:30 a.m.**

## GROUP PSYCHOTHERAPY AND THE CONTINUUM OF CARE

Lawrence L. Kennedy, M.D., *Director, Partial Hospitalization Services, The Menninger Clinic, P.O. Box 829, Topeka, KS 66601*; E. Garcia Bernardo, M.D.

## EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able 1) to recognize the basic tasks and techniques for group psychotherapy in a short-term, acute hospital setting; 2) to demonstrate the role of "transitional group psychotherapy" in the partial hospital setting following inpatient treatment; 3) to understand the value of a group psychotherapy experience, which begins in the hospital and continues in a transitional setting; and 4) to understand techniques of "transitional group psychotherapy."

## SUMMARY:

This workshop will focus on the uses of group psychotherapy in treatment systems that utilize short-term hospital treatment followed by a transitional partial hospital program. The tasks of the group psychotherapy in these two settings is different but interrelated and can be viewed as parts of a continuum of care. Patients in inpatient settings acquire experience and knowledge in the use of group psychotherapy that can continue to be helpful to them as they move to transitional settings. "Transitional group psychotherapy" will be defined by its special characteristics and techniques and these will be presented in the workshop. In such groups, patients deal with important life tasks related to beginnings, separations, and terminations. The fact that the two presenters are from different cultures and countries will help to emphasize the universality of these concepts.

## REFERENCES:

1. Yalom I: *Inpatient Group Psychotherapy*, Basic Books, NY, 1983.
2. Kiser L, Lefkovitz P, Kennedy L, Knight M: The continuum of ambulatory mental health services. *Continuum: Developments in Ambulatory Mental Health Care*, 1:7–13, 1994.

**Workshop 37** **Monday, October 27**
**8:00 a.m.-9:30 a.m.**

## THE MENTALLY ILL HOMELESS: ROLES OF THE PSYCHIATRIST

*APA New York County District Branch's Task Force on the Homeless Mentally Ill*

Hunter L. McQuistion, M.D., *Medical Director, Project Renewal, Inc., and Former APA/Mead Johnson Fellow, 200 Varick Street, New York, NY 10014*; Ezra S. Susser, M.D., D.P.H., Howard Telson, M.D., Katherine Falk, M.D.

## EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop the participant will be familiar with the clinical, administrative, academic, advocacy, and policy-making roles that psychiatrists have in working with the mentally ill homeless.

## SUMMARY:

The manifold issues presented by mentally ill homeless people have been increasingly explored within psychiatry over the past decade. Effective treatment of this population requires not only competent clinical assessment and treatment (including psychopharmacology and psychosocial rehabilitation) but also outreach and engagement, housing, laws that can allow for treatment over objection, and social policies that recognize all of these needs.

As health care costs continue to rise and the system is being restructured, there is risk that psychiatrists will be utilized only for medication management. As clinicians, administrators, academics, advocates, and policy makers, psychiatrists are actually very involved in many phases of the care and study of mentall illness among homeless people.

The New York County District Branch Task Force on the Homeless Mentally Ill brings together psychiatrists who perform multiple functions within the system. This workshop will explore the rewards, challenges, and conflicts posed by these roles in working with mentally

ill homeless people. Participants will be encouraged to share their experiences and views about these roles.

## REFERENCES:

1. Cohen CI, Thompson KS: Homeless mentally ill or mentally ill homeless? *Am J Psychiatry* 149:816–23, 1992.
2. Valencia E, Susser E, McQuistion HL: Critical Time Points in the Clinical Care of Homeless Mentally Ill Individuals, in Vaccaro, J, Clark, G (eds) *Practicing Psychiatry in the Community: A Manual*, American Psychiatric Press, Washington, DC, 1996.

**Workshop 38** **Monday, October 27**
**8:00 a.m.-9:30 a.m.**

## TEACHING TRAINEES IN TURBULENT THERAPEUTIC SETTINGS

Helen G. Muhlbauer, M.D., *Director, Comprehensive Psychiatric Emergency Program, Bronx-Lebanon Hospital Center, Inpatient Psychiatry, 1276 Fulton Avenue, Bronx, NY 10456*; Nalini V. Juthani, M.D., Salman Siddiqui, M.D., Ali Khadivi, Ph.D.

## EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to teach mental health trainees effectively and safely in clinical settings caring for acutely ill psychiatric patients.

## SUMMARY:

Mental health professionals typically start their professional training in the most turbulent settings—inpatient and emergency services. This workshop will explore issues related to helping the novice learn how to adapt more easily to acute settings and to work more effectively with severely ill psychiatric patients. Several perspectives will be considered: that of the novice trainee, training director, service director, and mentor/support faculty, all working in an inner-city hospital.

As a background to the discussion, we will discuss issues pertaining to staff and trainee safety in acute settings, with description of training program responses. A psychiatric resident will give the trainee's perspective on dealing with volatile and hostile patients, describing adaptive ways to deal with the stress of being a novice in a complex setting. Various support models for trainees will be described. Issues of safety, working with difficult patients, and acculturation on an acute unit will be addressed.

The workshop will be highly interactive. The audience will be encouraged to comment on issues raised in the presentations, contribute experiences and information, and seek the discussant's opinions on clinical, educational, and systems problems involved in helping the next generation of professionals to work with severely mentally ill patients.

## TARGET AUDIENCE:

Service chiefs and providers on teaching units, chief residents, directors of training for any mental health student program.

## REFERENCES:

1. Thienhaus OJ: *Manual of Clinical Hospital Psychiatry*, Chapter 14, "Teaching Unit" Washington DC, American Psychiatric Press Inc., 1995.
2. Crowner M, Peric G, Stepcic F, Ventura F: Psychiatric patients' explanations for assaults. *Psychiatric Services* 46:614–5, 1995.

**Workshop 39** **Monday, October 27**
**10:00 a.m.-11:30 a.m.**

## NEW THERAPIES FOR DUAL DIAGNOSIS PATIENTS

*American Academy of Addiction Psychiatry*

Richard N. Rosenthal, M.D., *Associate Chair, Department of Psychiatry, Beth Israel Medical Center, First Avenue at 16th Street, New York, NY 10003*; Douglas M. Ziedonis, M.D.

## EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, participants should be able to recognize the contribution of syndrome type, motivational state, and degree of integation of mental health and addiction services to clinical outcome.

## SUMMARY:

The high prevalence of comorbid substance use disorders and schizophrenia has been documented through epidemiologic methods (Regier, 1990). However, only recently has there been increasing attention to the problems associated with the clinical treatment of this group. Care of these patients has often been an amalgam of treatments taken from the schizophrenia and substance abuse fields, without real specificity for these patients. Our evolving clinical practice demands more specific treatments for specific disorders. This allied group session of the American Academy of Addiction Psychiatry will present findings by several groups of investigators who are examining the specific contributions of comorbidity to the clinical picture in substance-using schizophrenia patients, and using these data to inform novel approaches to inpatient and outpatient treatment. Major areas that will be addressed are: a) effects of integrating mental health and addiction services; b) the role of motivation in capacity for treatment; c) the contribution of schizophrenia syndromes to capacity for treatment en-

gagement and to outcome; and d) the role of targeted assertive community outreach in stabilizing high-risk patients. Presenters will describe clinical advances and potential new treatments derived from these areas of investigation.

## REFERENCES:

1. Hellerstein DJ, Rosenthal RN, Miner CR: A prospective study of integrated outpatient treatment for substance abusing schizophrenic patients. *Am J Addict*, 4:33–42, 1995.
2. Miner CR, Rosenthal RN, Hellerstein DJ: Prediction of non-compliance with outpatient treatment referral in substance-abusing schizophrenics *Arch Gen Psychiatry*, in press.

**Workshop 40** **Monday, October 27**
**10:00 a.m.-11:30 a.m.**

## HISPANIC MENTAL HEALTH: CLINICAL AND CULTURAL ISSUES

Leslie M. Snider, M.D., *Professor and Vice Chairperson for Clinical Affairs, University of Texas Health Sciences Center, 1430 Tulane Avenue, SL23, New Orleans, LA 70112-2699*; Andres J. Pumariega, M.D., Jose M. Pena, M.D., Ricardo Galbis, M.D., Pedro Ruiz, M.D.

## EDUCATIONAL OBJECTIVES:

At the end of this workshop, the participants should be able to recognize the unique clinical and cultural characteristics of Hispanic patients. This knowledge can be utilized to appropriately diagnose Hispanics and to better design treatment plans, including resolution of barriers to access to care.

## SUMMARY:

Hispanics are the fastest growing minority group in this country. As with other migrant groups to the U.S., Hispanics have brought with them not only aspirations for an improvement in their socioeconomic conditions, but also their cultural characteristics and heritage. These cultural characteristics greatly impact on symptom manifestations, their understanding of the etiology of mental illness, and effective utilization of the treatment prescribed. For instance, Hispanics do not experience anxiety based on psychological symptomatology but more as a manifestation of somatic symptomatology. Furthermore, the explanation of mental illness based on supernatural phenomena might lead to cultural barriers in their access to care. These characteristics must be taken into account when mental health professionals attempt to diagnose psychiatric conditions in this population. In this presentation, the panelists will define the most common culture-bound syndromes observed in the Hispanic population, will address barriers to their access to care, and will discuss the clinical characteristics that are commonly seen among Hispanics suffering from mental illness. This workshop is intended to help ensure the provision of cost-effective mental health services, with more positive outcomes, to the Hispanic population rendered by non-Hispanic mental health professionals. The target audience is psychiatrists, psychologists, social workers, and mental health professionals who treat Hispanic patients.

## REFERENCES:

1. Ruiz P: Access to health care for uninsured Hispanics: policy recommendations *Hospital and Community Psychiatry*, 44:10:958–962, 1993.
2. Dworkin R, Adams G: Retention of Hispanics in public sector mental health services *Community Mental Health Journal*, 23:204–216, 1987.

**Workshop 41** **Monday, October 27**
**10:00 a.m.-11:30 a.m.**

## WHY TREAT THE HOMELESS? NEW YORK STORIES

*APA New York County District Branch's Study Group on the Homeless Mentally Ill*

Katherine Falk, M.D., *President and Founder, Project for Psychiatric Outreach to the Homeless, Inc., 141 East 88th Street, New York, NY 10128-2248*; Howard Telson, M.D., Alan D. Felix, M.D., Diane L. Stone, M.D., Gail Albert, Ph.D.

## EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to 1) understand some of the clinical, ethical, political, and legal challenges and dilemmas involved in treating the homeless mentally ill both within and outside of New York City's mental health delivery system; and 2) appreciate the satisfaction involved in treating the homeless mentally ill.

## SUMMARY:

Tens of thousands of seriously and persistently mentally ill individuals are homeless in New York City. Some of them seek psychiatric treatment, which may be available through an array of public and private hospitals, clinics, and shelters, while others seek only housing or resist involvement with society altogether. The enormous diversity of clinical presentations and the complexity of the service system raise multiple questions for clinicians such as: When is it appropriate to intervene with individuals who do not want help and are not dangerous? When is denying access to services ethical? Can psychiatrists advocate politically without compromising their organizations' sources of funding?

The New York County District Branch Study Group on the Homeless Mentally Ill brings together practitioners who are employed in a variety of settings with those who volunteer their time with housing and outreach programs, and offers them an opportunity to freely discuss many difficult and sensitive issues. This workshop will provide an opportunity for study group members to present clinical and systems case studies that have had successful outcomes or have led to positive changes. Audience members will be encouraged to use their own experiences and viewpoints as a basis for assessing and discussing the cases.

## TARGET AUDIENCE:

Psychiatrists, social workers, psychologists, case managers who are working with or interested in working with homeless mentally ill persons.

## REFERENCES:

1. Martell DA, Rosner R, Harmon RB: Base-rate estimates of criminal behavior by homeless mentally ill persons in New York City. *Psychiatric Services* 46:596–601, 1995.
2. Lucksted AL, Coursey, RD: Consumer perceptions of pressure and force in psychiatric treatments *Psychiatric Services* 46:146–152, 1995.

**Workshop 42** **Monday, October 27**
**10:00 a.m.-11:30 a.m.**

# CONSULTATION-LIAISON PSYCHIATRY AND BEHAVIORAL HEALTH CARVE OUTS: INSURING INCLUSION

Carol L. Alter, M.D., *Assistant Professor, Department of Psychiatry, Temple University, 3322 N. Broad Street, Philadelphia, PA 19140*; Barbara A. Schindler, M.D., Kevin C. Hails, M.D., Charles Fishman, M.D.

## EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to develop an increased understanding of how changes in public and private sector financing impact on C-L services, what avenues are available for insuring funding sources, and assuring that appropriate levels and quality of C-L service are provided.

## SUMMARY:

Provision of psychiatric services to the medically ill has been significantly impacted by changes in mental health financing. Public sector financing is increasingly dependent on legislated managed care plans, which stipulate specific "covered services" for reimbursement. In most states psychiatric consultations have not been included in these plans. Private sector payment for consultation-liaison (CL) services is somewhat better, but diligence is required on the part of providers to ensure that psychiatric consultations remain a covered service whether they be integrated in the medical plan or included in part of a behavioral health carve out. Pennsylvania has recently received approval to initiate a mandatory Medicaid Managed Care program, with a behavioral health (BH) carve out. The C-L Association of Philadelphia (CLAP) has worked closely with Community Behavioral Health (CBH), the Philadelphia county-run agency, that will administer the new Medicaid BH plan, to develop mechanisms for including psychiatric services for the medically ill in its covered services. The workshop will provide an interactive opportunity for attendees to learn how systems for referral, reimbursement, and integration of medical and behavioral care programs were developed from CL psychiatrists and the medical director of CBH. In addition, the multiple issues related to credentialing, training, and quality of care, which are specific to CL psychiatry in managed care agreements, will be discussed.

## REFERENCES:

1. Alter CL, Schindler BA, Hails K, et al: Funding for consultation-liaison services in public sector managed care plans: the experience of the Consultation-Liaison Association of Philadelphia. *Psychosomatics*. In press.
2. Goldberg RJ, Stoudemire A: The future of consultation-liaison psychiatry and medical-psychiatric units in the era of managed care. *General Hospital Psychiatry*, 17:268–277, 1995.

**Workshop 43** **Monday, October 27**
**10:00 a.m.-11:30 a.m.**

# ECT IN THE UNITED STATES: CLINICAL PRACTICE, LEGAL ISSUES AND USAGE

Jagannathan Srinivasaraghavan, M.D., *Clinical Associate Professor of Psychiatry, University of Rochester, and Chief, Psychiatry Service, Veteran's Affairs Medical Center, 400 Fort Hill Avenue, Canandaigua, NY 14424*; Richard D. Weiner, M.D., Ph.D., James W. Thompson, M.D., Ph.D.

## EDUCATIONAL OBJECTIVES:

At the conclusion of this session, participants should be able to describe new task force guidelines, regulation of ECT in different jurisdictions, and current usage of ECT in the United States.

## SUMMARY:

Modern electroconvulsive therapy utilizing general anesthesia, muscle relaxation, oxygenation during the procedure, routine seizure and cardiac monitoring, and

devices using brief pulse stimulus has been a safe and effective treatment for many mental disorders. In 1990, the American Psychiatric Association published comprehensive recommendations on practice, training, and clinical privileging in ECT. At present, these recommendations are undergoing revision. There will be a discussion of these revisions and their implications for the field. Utah was the first state to pass laws regulating ECT in 1967. Currently, most states have some regulation of ECT. Legal issues pertaining to ECT will include informed consent, substitute consent by a guardian or court based on substitute judgment or best interest of the patient, and malpractice. There will be discussion addressing pertinent regulations covering different jurisdictions. The use of ECT in the U.S. experienced a decline until the 1980's, when a resurgence of interest in this treatment modality was associated with the leveling out of this decrease, particularly among the elderly. Recent ECT utilization data will be presented including a discussion of pertinent factors that affect its use such as hospital type, diagnosis, and demographic factors.

## REFERENCES:


1. *The Practice of Electroconvulsive Therapy: Recommendations for Treatment, Training, and Privileging. A Task Force Report of the American Psychiatric Association.* American Psychiatric Association, Washington D.C., 1990.
2. Leong GB, Eth S: Legal and ethical issues in electroconvulsive therapy, *Psychiatric Clinics of North America.* December 1991.
3. Thompson JW, Weiner RD, Myers CP: The Use of ECT in the United States in 1975, 1980, and 1986. *Am J Psychiatry* 151:1657–61, 1994.


**Workshop 44** **Monday, October 27**
**1:30 p.m.-3:00 p.m.**

## CLINICIAN, PATIENT AND FAMILY COLLABORATION: PART I

*American Association of Community Psychiatrists*


Donald B. Brown, M.D., *Associate Clinical Professor of Psychiatry, Columbia University College of Physicians and Surgeons, 156 West 86th Street, Suite 1A, New York, NY 10024*; Kenneth Minkoff, M.D.


## EDUCATIONAL OBJECTIVES:

At the conclusion of these two workshops, the participant should be able to utilize a collaborative approach through understanding the subjective experience and differing agendas of clinicians, family members, and patients as they interact with one another in dealing with the patient's mental illness.

## SUMMARY:


Persons with mental illness, their family members, and mental health service providers must learn to trust one another and work together if they are to have the best chance of successfully ameliorating the impact of psychotic illness and succeeding in rehabilitation efforts. This workshop will demonstrate a model for collaboration among patients, their family members, and the clinicians who serve them. An actual patient, a family member with a mentally ill relative, a psychiatrist, and a case manager will offer their personal reactions to each of three scenarios of a fictional, but typical, clinical case that will be presented to them. The case example will focus on familiar issues faced by community-based clinicians and patients and their families when they work together. These include engagement in treatment, concerns about safety, the appropriate use of psychotropic medications, substance use, the impact of the illness on each of the persons involved, fragmented and/or inadequate treatment systems, and rehabilitation. A role play of the participants attempting to deal with each of the situations will be conducted with the help of a consultant. The workshop will offer an opportunity to learn about the differing perspectives of each player in the clinical situations enacted. Specific principles of collaboration among the players will be demonstrated and taught.

Attendance at Part II of this workshop, which immediately follows Part I, is required to obtain the educational objectives intended.


## TARGET AUDIENCE:

Clinicians of all disciplines working in community settings, patients, and family members.

## REFERENCES:


1. Corrigan PW, Liberman RP, Engel JD: From noncompliance to collaboration in the treatment of schizophrenia. *Hospital & Community Psychiatry* 41:1203–1211, 1990
2. Grunebaum H, Friedman H: Building collaborative relationships with families of the mentally ill. *Hospital & Community Psychiatry* 39:1183–1187, 1988


**Workshop 45** **Monday, October 27**
**1:30 p.m.-3:00 p.m.**

## PSYCHOHOMOPHOBIA: ANTI-HOMOSEXUAL BIAS IN PSYCHIATRY


Kenneth B. Ashley, M.D., *Clinical Instructor, Department of Psychiatry, New York University Medical School, 85 East 10th Street, #1F, New York, NY 10003-5407*; Mary E. Barber, M.D., Laura J. Bernay, M.D., Robert J. Mitchell, M.D.

## EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to recognize the presence of homophobia in diverse psychiatric settings, understand the impact these negative attitudes have on all in these environments, and learn strategies of addressing these issues when they arise.

## SUMMARY:

Despite APA's removal of homosexuality as a diagnosis from the *DSM*, and despite a variety of strategies aimed at educating the public and mental health care practitioners about lesbian, gay, and bisexual people, anti-homosexual bias continues as a significant and pervasive social phenomenon. These negative attitudes have an adverse effect on our society, and those in the mental health culture, both providers and patients, are not exempt. When issues related to anti-homosexual bias arise in a psychiatric setting, it is important for all members of the community that they are addressed.

The workshop will address anti-homosexual bias as it is manifested in a variety of psychiatric settings, including the inpatient psychiatric unit, outpatient psychiatric settings, and the consultation/liaison psychiatry environment. The impact of homophobia on both patients and health care workers will be discussed, as well as strategies for addressing these issues as they arise. Audience members will be encouraged to discuss individual experiences, present clinical vignettes, and comment on the material presented.

## TARGET AUDIENCE:

Health care workers.

## REFERENCES:

1. Cabaj RP, Stein TS (eds): *Textbook of Homosexuality and Mental Health*, Washington, DC: American Psychiatric Press, Inc., 1996.
2. Murphy BC: Educating mental health professionals about gay and lesbian issues. *Journal of Homosexuality* 22:229–246, 1992.

**Workshop 46** **Monday, October 27**
**1:30 p.m.-3:00 p.m.**

# PSYCHIATRIC CONFIDENTIALITY IN A COMPUTER AGE

*American Psychiatric Association Auxiliary*

Catherine Kirschner, *President, American Psychiatric Association Auxiliary, 3421 Garrison Street, N.W., Washington, DC 20008*; Richard S. Epstein, M.D., Denise M. Nagel, M.D.

## EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to recognize the importance of confidentiality for successful psychiatric treatment. Participants will also have a better understanding of the far-reaching threats that exist to confidentiality as a result of the trend toward increasing computerization of medical information.

## SUMMARY:

Many state and federal government leaders in this country view extensive, interconnected, computerization of medical and psychiatric records as a way of reducing health care costs. There are serious dangers inherent in this trend, because it threatens the confidentiality upon which effective treatment is founded. Once entered into large computer databases, it is almost impossible to secure private information from misuse. The panelists will review some of the problems connected with computerized threats to patient confidentiality and list some of the strategies that the mental health community can use in alerting the public to the dangers involved.

## TARGET AUDIENCE:

The target audience is mental health clinicians and the general public.

## REFERENCES:

1. *The Principle of Medical Ethics With Annotations Especially Applicable to Psychiatry.* Washington D.C., American Psychiatric Press, 1995.
2. Epstein RS: *Keeping Boundaries: Maintaining Safety and Integrity in the Psychotherapeutic Process.* Washington D.C., American Psychiatric Press, 1994.

**Workshop 47** **Monday, October 27**
**1:30 p.m.-3:00 p.m.**

# PARADIGM SHIFT IN PSYCHIATRIC TRAINING IN THE NEW DEPARTMENT OF VETERANS AFFAIRS

Jagannathan Srinivasaraghavan, M.D., *Clinical Associate Professor of Psychiatry, University of Rochester, and Chief, Psychiatry Service, Veterans Affairs Medical Center, 400 Fort Hill Avenue, Canandaigua, NY 14424*; Murray A. Morphy, M.D., Surinder S. Nand, M.D., Renato D. Alarcon, M.D., M.P.H., Gloria J. Holland, Ph.D.

## EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participants should be able to identify major changes happening in health care delivery in the VA and the impact of such

changes on psychiatric training of residents and medical students.

## SUMMARY:

A major re-engineering of the Veterans Health Administration has placed emphasis on primary, managed, and ambulatory care. Cost-effective health care of high technical quality, producing high customer satisfaction, is the goal. There has been closure of a large number of inpatient beds, reduced length of inpatient stay, and increased accessibility to outpatient care. Many hospitals have merged and functions of some hospitals integrated. The Veterans Health Administration is divided into 22 Veterans Integrated Service Networks (VISN). Each VISN is comprised of up to 11 medical centers. A significant number of the 156 VA medical centers in operation have academic affiliations for student and residency training. The new proposal calls for VISN affiliation with all academic institutions in the service area instead of one hospital with one particular academic institution. Emphasis on primary care and primary mental health care teams has resulted in a dramatic shift in training of psychiatric residents and medical students. Further, there is a proposal by the Residency Realignment Review Committee to reduce the total number of residency positions (currently 8,900), reduce the total number of psychiatric residency positions (currently 890), and increase the primary care residency positions. One of the panelists is from the Office of Academic Affiliations in V.A. national headquarters and the rest are psychiatric academicians in leadership positions in the VA; they will discuss how they are coping with the changes and imparting knowledge to the trainees. The audience will be able to share its experience.

## REFERENCES:

1. Kizer K: *Prescription for Change*. Department of Veterans Affairs, March 1996.
2. VHA to Reduce, Revamp Residencies. *U.S. Medicine* Vol. 32, Nos 11 & 12, June 1996.
3. VHA to Restructure Links to Academia. *U.S. Medicine* Vol. 32, Nos 21 & 22, November 1996.

**Workshop 48** **Monday, October 27**
**3:30 p.m.-5:00 p.m.**

## CLINICIAN, PATIENT AND FAMILY COLLABORATION: PART II

*American Association of Community Psychiatrists*

Donald B. Brown, M.D., *Associate Clinical Professor of Psychiatry, Columbia University College of Physicians and Surgeons, 156 West 86th Street, Suite 1A, New York, NY 10024*; Kenneth Minkoff, M.D.

## EDUCATIONAL OBJECTIVES:

At the conclusion of these two workshops, the participant should be able to utilize a collaborative approach through understanding the subjective experience and differing agendas of clinicians, family members, and patients as they interact with one another in dealing with the patient's mental illness.

## SUMMARY:

Persons with mental illness, their family members, and mental health service providers must learn to trust one another and work together if they are to have the best chance of successfully ameliorating the impact of psychotic illness and succeeding in rehabilitation efforts. This workshop will demonstrate a model for collaboration among patients, their family members, and the clinicians who serve them. An actual patient, a family member with a mentally ill relative, a psychiatrist, and a case manager will offer their personal reactions to each of three scenarios of a fictional, but typical, clinical case that will be presented to them. The case example will focus on familiar issues faced by community-based clinicians and patients and their families when they work together. These include engagement in treatment, concerns about safety, the appropriate use of psychotropic medications, substance use, the impact of the illness on each of the persons involved, fragmented and/or inadequate treatment systems, and rehabilitation. A role play of the participants attempting to deal with each of the situations will be conducted with the help of a consultant. The workshop will offer an opportunity to learn about the differing perspectives of each player in the clinical situations enacted. Specific principles of collaboration among the players will be demonstrated and taught.

Attendance at Part I of this workshop is required in order to understand or benefit from Part II.

## TARGET AUDIENCE:

Clinicians of all disciplines working in community settings, patients, and family members.

## REFERENCES:

1. Weiden P, Havens L: Psychotherapeutic management techniques in the treatment of outpatients with schizophrenia. *Hospital & Community Psychiatry* 45:549–555, 1994.
2. Lefley H: *Family Caregiving in Mental Illness*. Thousand Oaks, Calif, Sage, 1996.

**Workshop 49** **Monday, October 27**
**3:30 p.m.-5:00 p.m.**

## UNDERSTANDING PUBLIC SECTOR MANAGED CARE

Michael A. Hoge, Ph.D., *Associate Professor of Psychology, and Director, Managed Behavioral Health Services*

*Development, Yale University School of Medicine, 25 Park Street, Room 622, New Haven, CT 06519*; Selby C. Jacobs, M.D., Neil Thakur, M.A.

## EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to identify the specific functions of managed care initiatives in the public sector and the typical forms of public sector managed care.

## SUMMARY:

There is a saying that "If you've seen one managed care program, you've seen one managed care program." Because each looks unique, our understanding of managed care is often limited to that of case examples, i.e., what was done in Massachusetts or Arizona. The purpose of this workshop is to provide participants with a model for understanding managed care as it is being implemented in the public sector. The workshop will begin with a brief presentation of the model that highlights the potential functions of managed care initiatives with public sector populations. This will be followed by a brief review of the most typical forms of managed care, such as managed Medicaid, capitation, and initiatives to develop best practices with the most severely ill populations. During the second section of the workshop the leaders will demonstrate the application of the model in understanding two managed care initiatives. The first will focus on an initiative in which cost containment through managing Medicaid dollars was the primary goal, while the second will focus on an initiative in which achieving greater flexibility and improved quality in service delivery were the primary objectives. The final section of the workshop will involve open discussion with participants about the ambiguity and conflicting agendas surrounding managed care in the public sector.

## TARGET AUDIENCE:

Clinicians, managers, trainees; employees of state mental health departments.

## REFERENCES:

1. Hoge MA: Understanding managed care. *Jrnl CA Alliance Mentally Ill.* 7:10–13, 1996.
2. Hoge MA, et al: Defining managed care in public sector psychiatry. *Hosp Com Psych*, 45:1085–1089, 1994.

**Workshop 50** **Monday, October 27**
**3:30 p.m.-5:00 p.m.**

## CHILDREN ON THE EDGE OF MANAGED CARE: THE DELAWARE STORY

Anita E.L. Amurao, M.D., *Director, Terry Children's Psychiatric Center, 10 Central Avenue, New Castle, DE 19720*; Richard L. Cruz, M.D., Samuel Blumberg, Ph.D., Michael Longo, M.A.

## EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to conceptualize crisis with a systems model, design a crisis model that "fits" their organization, identify key areas of organizational change needed to implement a community-based crisis model, and generate effective leadership necessary to implement these changes.

## SUMMARY:

Psychiatry is faced with increasing pressure from managed care to reduce the cost of services. This workshop will show how the state of Delaware and the Terry Children's Psychiatric Center have implemented a new model of acute treatment that is able to "do more with less" as response to the decision to assume risk by managing Medicaid clients through a 1115 waiver. This model expands the focus of care from the child to include the family, extended family, and treating professionals. Facing this increased pressure with a new and expanded model of treatment has enabled the Terry Center to shift dramatically from institution-based services to community-based services in a matter of months. Children who were hospitalized are now successfully treated in their home or school. The key ingredients of this model include a unique team approach, the use of countertranference, narrative concepts, and interventions that help patients and their helpers quickly refocus their efforts to produce dramatic change. Workshop participants will try out these ingredients through case discussion and role play. In small group discussion, participants will "custom fit" this model to their clinical setting in order to meet the unique financial and clinical pressures facing them.

## REFERENCES:

1. Oseroff C, Longo M: *Finding Our Way Home-Home and Community Based Care, The Handbook of Community Psychiatry*, American Psy. Press, 1997.
2. O'Hanlon W: *The Third Wave, The Family Therapy Networker*, 1994.

**Workshop 51** **Tuesday, October 28**
**8:00 a.m.-9:30 a.m.**

## 1-800-LIFENET: A NEW OPTION FOR COMMUNITY OUTREACH

Giselle Stolper, *Executive Director, Mental Health Association of New York City, 666 Broadway, Suite 200, New York, NY 10012*; John Draper, M.A., Michael S. Lesser, M.D., Helen G. Muhlbauer, M.D.

## EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to understand the use of a 24-hour seven-day, professionally staffed mental health referral service. The participant should recognize the varied uses of the resource database and risk-assessment software.

## SUMMARY:

1-800-LIFENET is a unique, free, and confidential telephone service of the Mental Health Association of New York City in partnership with the NYC Department of Mental Health. At all times of the day and night, people can call this toll-free number and reach trained social workers. The LIFENET workers assess the request or problem presented and match each caller's needs with the appropriate service from the LIFENET database of over 2,000 mental health and substance abuse services in New York. For callers in crisis, the LIFENET worker can perform a risk assessment using customized software for clinical decision support. Immediate referral can be made to 911 or a mobile crisis team.

This highly interactive workshop will allow the audience to explore the consumer/professional use of database and software resources. We will explore the first year's experience with LIFENET, including a public-private partnership to study outcome measures related to mental health service delivery. The audience will learn about software-assisted risk assessment in the telecounseling setting. The interaction of LIFENET with the emergency mental health resources of the city will be explored.

## TARGET AUDIENCE:

Psychiatric administrators, emergency service workers, public health workers.

## REFERENCES:

1. Sankar DV, Mintus J: An analysis of telephone referrals of a mental health association chapter. *Soc Sci Med* 12:63–66, 1978.
2. Feinstein R, Plutchik R: Violence and suicide risk assessment in the psychiatric emergency room. *Comprehensive Psychiatry* 31:337–343, 1990.

**Workshop 52** **Tuesday, October 28**
**10:00 a.m.-11:30 a.m.**

# THE IMPACT OF TRAUMA ON MOTHERS' PARENTING SKILLS AND IDENTITY

David W. Freeman, Psy.D., *Psychologist, Community Connections, 1512 Pennsylvania Avenue, S.E., Washington, DC 20003*; Lori Beyer, M.S.W., Sharon L. Miller, M.S.W.

## EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participants should be able to identify the impact of severe and repeated psychosocial trauma on the parenting identity and parenting skills of overwhelmed mothers in institutional and community settings. Participants will learn group therapy and individual case management interventions for these populations.

## SUMMARY:

The experience of repeated, complex psychosocial trauma can be profoundly disruptive to the development of parenting identity and skills. This workshop will explore the multigenerational experience of trauma; the development of abusive behavior in those who were abused; the struggle some abused women face in protecting their children from the abuse of others; the fears, anxieties, and defenses some traumatized women have about their role as mothers; the use of secrets in these women's families; the distrust of authority often held by these women; the difficulty in gratifying emotional needs through interpersonal relationships; the role of substance abuse in the lives of these women; and sexuality. Clinical experience with prison-based parenting groups and intensive clinical case management of families where the primary caretaker has a mental illness will be shared and discussed by workshop leaders.

The prison-based parenting group is based on a 12-session curriculum that focuses on the mothers' childhood experience of their caregivers; the expectations of motherhood these women had before the birth of their first child; the complex dynamics of being an absentee parent; the development of behavior management skills; the role of parent as moral, ethical, and practical teacher; communication skills; and decision-making skills. The intensive clinical case management program for families in the community is based on a strengths-oriented clinical model that emphasizes a rich clinical relationship with the parent(s), practical problem solving, multigenerational issues, and the sophisticated coordination of larger social networks.

Participation will include question-and-answer group discussion and the sharing of relevant experience by participants.

## TARGET AUDIENCE:

All mental health professionals, families, and consumers.

## REFERENCES:

1. Apfel RJ, Handel MH: *Madness and the Loss of Motherhood.* Washington, DC: American Psychiatric Press, 1993.
2. Herman JL: *Trauma and Recovery.* Basic Books, 1992.

*This page intentionally left blank*

# SYLLABUS INDEX

T



U



V



W



Y



Z