1996

Institute Proceedings & Syllabus Summary

AMERICAN PSYCHIATRIC ASSOCIATION

48th Institute on Psychiatric Services

October 18-22, 1996 – Chicago, IL

Partners in Planning: Quality • Equity • Access

CERTIFICATE OF ATTENDANCE

This certificate provides verification of your completion of educational activities at the 1996 Institute on Psychiatric Services. It is for your personal records and may be forwarded to other organizations requiring verification.

This is to certify that

_____

Attended the 1996 Institute on Psychiatric Services of the American Psychiatric Association
October 18-22, 1996
Chicago, Illinois

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

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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 continuing medical education activity for up to 42 credit hours in Category 1 of the Physician's Recognition Award of the American Medical Association and for the CME requirement of the APA.

The Institute on Psychiatric Services has been approved by the American Psychological Association–Illinois Chapter to offer Continuing Education credits for psychologists. Up to 42 Continuing Education credits may be claimed for this activity.

DAILY LOG FOR ATTENDANCE AT CME FUNCTIONS AT THE 1996 INSTITUTE ON PSYCHIATRIC SERVICES, OCTOBER 18-22, 1996 CHICAGO, IL

Members are responsible for keeping their own CME records and certifying compliance with the APA CME requirement to the APA Office of Education *after* completing the necessary 150 hours of participation. Reporting is on an honor basis. No formal verification is needed.

DAY	TITLE OF SESSION	NUMBER OF HOURS/ CME CATEGORY
	TOTAL	

HOW TO OBTAIN CME CREDIT

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 1996 Institute sessions meet the criteria for Category 1 of the Physician's Recognition Award of the American Medical Association and 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: Allied Group Sessions; CME Courses; Full-Day and Half-Day Sessions; Industry Supported Symposia; Innovative Programs; Lectures; Symposia; and Workshops. Other Sessions are designated for Category 2 CME credit. These sessions include: the Debate; the Forum; Discussion Groups; Multimedia Sessions; the Panel Discussion; and Poster Sessions.

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.

APA REQUIREMENTS

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. Members will be reminded and sent blank compliance statements when they are next due to confirm compliance with the requirement. 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.

OBTAINING AN APA CME CERTIFICATE

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.

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.

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 cosponsored 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 Child Psychiatry of the ABP&N, in Administrative Psychiatry of the APA, and in Forensic Psychiatry of the American Board of Forensic 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 forms for exemption are available from the district branches, the Office of Education of the APA, or at the Office of Education exhibit in the APA Resource Center.

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 - ILLINOIS CHAPTER
CONTINUING EDUCATION CREDIT FORM

APA Institute on Psychiatric Services
October 18-22, 1996
Chicago, Illinois

In order to receive continuing education credits for this conference, you must complete, sign, and submit this form to the NASW-IL Chapter office by November 29, 1996. 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 # _____

_____ IL License # _____
(if applicable)

RECORD OF SESSIONS ATTENDED

DAY	*TITLE OF SESSION*	*NUMBER OF HOURS*

(continued)

DAY	*TITLE OF SESSION*	*NUMBER OF HOURS*

TOTAL HOURS _____

_____ _____

Participant's signature *Date*

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

Return completed form, by November 29, 1996, with check made payable to NASW-IL to:

Lisa C. Goodale, A.C.S.W., L.S.W.
Manager of Member and Program Services
NASW-Illinois Chapter
180 North Michigan Avenue, Suite 400
Chicago, IL 60601

CONTINUING MEDICAL EDUCATION

SYLLABUS

AND

PROCEEDINGS SUMMARY

FOR

THE FORTY-EIGHTH
INSTITUTE ON PSYCHIATRIC SERVICES
October 18-22, 1996
Chicago, Illinois

The American Psychiatric Association
Institute on Psychiatric Services
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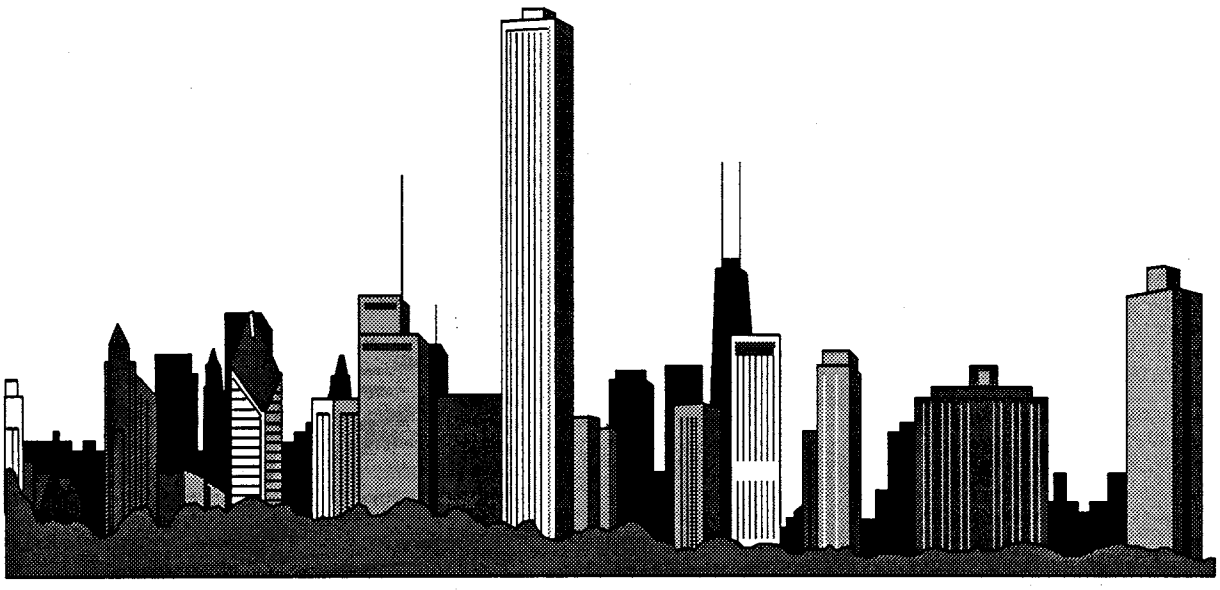

ALLIED GROUP SESSIONS

Allied Group Session 1 **Friday, October 18**
1:30 p.m.-3:00 p.m.

FACTORS AFFECTING SUCCESSFUL EMPLOYMENT OF PERSONS WITH PSYCHIATRIC DISABILITIES: THE ROLE OF PSYCHIATRISTS AND VOCATIONAL REHABILITATION SERVICE PROVIDERS

with the Therapeutic Education Association

Judith A. Cook, Ph.D., *Director, National Research and Training Center, Department of Psychiatry, University of Illinois at Chicago, Suite 900, 104 South Michigan Avenue, Chicago, IL 60603;* Richard K. Ries, M.D., Elizabeth L. Brumfield, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to discuss factors in successful employment of persons with psychiatric disabilities and describe the role of the psychiatrist in the successful vocational rehabilitation of persons with severe mental illness.

SUMMARY:

The psychiatrist's role in the vocational rehabilitation of persons with mental illness is critical. Effective coordination between psychiatrist and vocational rehabilitation staff is important to the success of persons with psychiatric disabilities. This workshop panel will examine the outcomes from five years of data involving state-funded vocational rehabilitation of persons with psychiatric disabilities. Summarized will be the results of collaborative research conducted by the University of Illinois at Chicago National Research and Training Center on Psychiatric Disability and the Illinois Department of Rehabilitation Services (DORS) examining the outcomes of clients with mental illness who received DORS-funded vocational rehabilitation services. In particular, outcomes of these clients at case closure and 12-month follow-up will be presented. Ways to forge better working relationships between psychiatrists and vocational rehabilitation counselors and administrators will also be discussed.

Another piece of this puzzle is the link between inpatient programs and community vocational rehabilitation programs. Also explored will be successful programs to help people leaving institutions become clients in state vocational rehabilitation operations and how psychiatrists can contribute to this effort.

REFERENCES:

1. Cook JA, Razzano LA: Discriminant function analysis of competitive employment outcomes in a transitional employment program. *J Voc Rehab* 5:127-139, 1995.
2. Cook JA, Razzano LA: Predictive validity of the McCarron-Dial testing battery for employment outcomes among psychiatric rehabilitation clientele. *Voc Eval Work Adj Bull* 27:39-47, 1994.

Allied Group Session 2 **Friday, October 18**
3:30 p.m.-5:00 p.m.

NEW DEVELOPMENTS IN DUAL DIAGNOSIS TREATMENT

with the American Academy of Addiction Psychiatrists

Richard N. Rosenthal, M.D., *Associate Chairman, Department of Psychiatry, Beth Israel Medical Center, First Avenue at Sixteenth Street, New York, NY 10003;* Lisa A. Razzano, Ph.D., Monica A. Bert, M.S.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to describe the impact on treatment utilization and outcome of illness severity, motivational stage, syndrome typology, and integration of mental health and addiction services for patients with schizophrenia and substance use disorders.

SUMMARY:

The high prevalence of comorbid substance use disorders and schizophrenia has been documented through epidemiologic methods. However, only recently have the problems associated with the clinical treatment of this group been addressed. 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 session will present findings by several groups of investigators who are examining the specific contributions of comorbidity to the clinical picture of substance-using schizophrenia patients and are 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) severity of illness as a predictor of type and intensity of services received and the relationship to adverse outcomes, c) the contribution of schizophrenia syndromes to capacity for treatment engagement and outcome, and d) the role of motivation in capacity for treatment. The 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. *Assessment and Treatment of Patients with Coexisting Mental Illness and Alcohol and Other Drug Abuse.* Golden Press, New York, 1995.

ALLIED GROUP SESSIONS

Allied Group Session 3 **Saturday, October 19**
8:00 a.m.-9:30 a.m.

PSYCHIATRIC ADMINISTRATION: LEARNING FROM EXPERIENCE
with the American Association of Psychiatric Administrators

Paul Rodenhauser, M.D., *Professor of Psychiatry, Department of Psychiatry and Neurology, Tulane University, Tulane University Medical Center, 1430 Tulane Avenue--SL23, New Orleans, LA 70112-2699;* A. Anthony Arce, M.D., Boris M. Astrachan, M.D., Gerald H. Flamm, M.D., Haydee C. Kort, M.D., L. Mark Russakoff, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to: a) discuss the history of and recent trends in psychiatric administration in private and public sector settings, including state offices of mental health, federal hospitals, state hospitals, community mental health clinics, private facilities, and academic departments, and b) describe the various ways in which psychiatrists are prepared for leadership roles and the contemporary opportunities for education in administrative psychiatry.

SUMMARY:

The modem history of psychiatric administration began in 1844 with the founding of the Association of Medical Superintendents of American Institutions for the Insane, now the American Psychiatric Association (APA). In 1953 the APA established a committee on certification of mental health administrators (the APA Committee on Administrative Psychiatry since 1981) "to emphasize psychiatric administration as a specialized area of medical practice, to encourage APA members to enter the field, and to appropriately recognize mental hospital directors." The American Association of Psychiatric Administrators (AAPA) was founded in 1961 to advocate leadership, promote knowledge, and foster skills in administration for psychiatrists. In the past three decades, the number of psychiatrists holding top administrative positions has declined except, perhaps, for medical directors in private hospitals, where their authority has diminished. Public sector positions have been redefined. This AAPA Allied Group Session will review trends in psychiatric administration. AAPA past presidents will discuss their perceptions of mental health administration and will comment on educational prerequisites for today's clinical administrators, particularly psychiatrists. As panel members, they will represent a wide range of experience within the public and private mental health care delivery systems and academia. Time will be managed to allow audience participation in the discussion.

REFERENCES:

1. Arnold WN, Rodenhauser P, Greenblatt M: Residency education in administrative psychiatry: a national survey. *Acad Psychiatry* 15:188-194, 1991.
2. Rodenhauser P, Bashook PG: On education in administrative psychiatry. *Admin Policy Ment Health* 18:285-298, 1991.

Allied Group Session 4 **Saturday, October 19**
8:00 a.m.-9:30 a.m.

TECHNIQUES FOR AUTOMATING THE GRANT-WRITING PROCESS
with the Association of Mental Health Librarians

George W. Wright, M.Ed., *Grants and Contracts Specialist, Department of Psychiatry, University of Missouri, 5247 Fyler Avenue, St. Louis, MO 63139*

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to save time and resources in the search for funding and to use technology in the grant-writing process to save time and eliminate technical mistakes in grant applications.

SUMMARY:

Remaining competitive in the arena of sponsored projects requires researchers and project directors to work smarter and more efficiently. The old and worn-out expression "do more with less" now takes on a startling reality that few of us wish to confront. This session will examine labor-saving techniques that are currently available to make grant research/writing tolerable. Participants will also explore approaching trends in grant development and submission.

Topics to be reviewed will include: a) locating and tracking funding opportunities by using the resources of the Internet; b) obtaining RFPs, RFAs, and PAs in a timely and cost-effective manner; c) locating and retrieving application form templates on the World Wide Web; and d) identifying future directions in proposal development and submission. Information will be presented in a discussion format, and participants will be encouraged to share their experiences. Discussion leaders will share practical firsthand successes and failures in making the system operational.

REFERENCES:

1. Frels L: Sources and means of acquiring grant support for selected projects. *AANA J* 60:362-364,
2. Pequegnat W, Stover E (eds): *How to Write a Successful Research Grant Application: A Guide for Social and Behavioral Scientists.* Plenum Press, New York, 1995.

ALLIED GROUP SESSIONS

Allied Group Session 5 **Saturday, October 19**
10:00 a.m.-11:30 a.m.

PARTNERING WITH FAMILIES: COMMUNITY-BASED TREATMENT
with the American Occupational Therapy Association

Marian K. Scheinholtz, M.S., O.T., *Mental Health Program Manager, American Occupational Therapy Association, P.O. Box 31220, Bethesda, MD 20814-1220;* Mary Jo Kostan, B.S., O.T., Diane M. Thompson, M.S.W., Stephen A. Gilbertson, M.S.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to: a) identify the rationale for and at least three benefits of moving mental health practice into the community; b) articulate an understanding of consumer-based treatment and of consumer-professional partnership and multiagency collaboration; c) identify assessment and therapy techniques useful in the community; d) design a strength-based treatment plan for a case illustration; e) describe how to build resources in the client's community to assist in preventing rehospitalization or out-of-home placement; f) relate community-based treatment to transference/countertransference issues, safety, exposure to poverty, and abuse; and g) identify at least three coping strategies for self-preservation.

SUMMARY:

This workshop is designed to broaden participants' perspective on the expanding role of mental health clinicians and the growing opportunities in community-based treatment. A multidisciplinary team will discuss their experience in an innovative community treatment program for children and adolescents. This program is based on the concept of "wrap-around" services, that is, services that are consumer centered. In this program, treatment services are provided in home, community, or school--wherever they are needed--and include a broad range of nontraditional interventions.

The audience will be provided with strategies and techniques they can incorporate into their practices to enhance and expand their skills, regardless of whether they are working in inpatient or community settings. There will be a special emphasis on therapeutic case management. Consumer-oriented treatment and collaborative, strength-based treatment planning will be highlighted. The unique challenges of community-based treatment and methods for provider self-care will also be addressed. The presentation will include lecture and audience participation and will use case illustrations to promote learning.

REFERENCES:

1. Bryant-Comstock S, Huff B, VanDenBerg J: Advocacy models for the wraparound process. In Stroul B et al: *A System of Care for Children and Families.* Paul H. Brooks, in press.
2. Chang H: Diversity: the essential link in collaborative services. *J Educ Urban Soc,* 1993.
3. VanDenBerg J: Integration of individualized services into the system of care for children with emotional disabilities. *Admin Policy Ment Health* 14:23-29, 1993.
4. VanDenBerg J: Individualized services and supports through the wraparound process: best practices. *J Fam Child Stud,* in press.

Allied Group Session 6 **Sunday, October 20**
10:00 a.m.-11:30 a.m.

INTERDISCIPLINARY PRACTICE SUCCESS IN MANAGED CARE
with the National Association of Social Workers

Richard J. Bond, Jr., M.S.W., *Consultant, R.J. Bond Associates, P.O. Box 2602, Westwood, MA 02090*

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to list managed care contracting interests of providers, payers, and managed care organizations and describe a truly integrated human services model with state-managed care.

SUMMARY:

This session will provide an overview of developments in the current public/private behavioral health care marketplace that promote interdisciplinary group practices and integrated systems of care. Models of contracting and specific requirements of managed care contracts between funding sources and providers will be presented to identify the services being purchased, special interests of the contracting parties, and the necessary skills providers need to master in order to survive in the new marketplace. Graphic presentation of public and private models of integrated systems of care will allow participants to identify where their current practice fits within these systems and to explore alternative models of practice that will expand their influence on the evolving models of managed care.

This session will provide participants with handouts, a slide presentation, and a facilitated discussion.

REFERENCES:

1. Dorwart RA: Managed mental health care: myths and realities in the 1990s. *Hosp Community Psychiatry* 41:1087-1091, 1990.
2. Jackson VH (ed): *Managed Care Resource Guide for Social Workers in Agency Settings.* NASW Press, Washington, DC, 1995.

ALLIED GROUP SESSIONS

Allied Group Session 7 **Sunday, October 20**
10:00 a.m.-11:30 a.m.

PARTIAL HOSPITALIZATION FOR TRAUMA VICTIMS
with the American Association for Partial Hospitalization

Lawrence L. Kennedy, M.D., *Director, Partial Hospitalization Services, Menninger Clinic, Box 829, Topeka, KS 66601;* Marianne Hund, M.S., A.T.R., Kay A. Kelly, M.S.W., L.C.S.W.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to list the advantages of treating trauma victims through partial hospitalization, describe the basic components of a partial hospital program for trauma victims with serious psychiatric problems, and identify specific strategies for dealing with treatment staff reactions to trauma patients.

SUMMARY:

Inpatient hospitalization is necessary for patients with serious psychiatric conditions resulting from trauma (post-traumatic stress disorder, dissociative states, multiple personality disorder) when they are in a crisis and need protection. Extended hospitalization may encourage non-therapeutic regression. A partial hospital setting offers a specialized environment for these patients. It can provide the array of treatments needed while maximizing the patients' active engagement and providing support and safe containment, when needed.

The partial hospital for these patients should be comprehensive and should offer the following: a multidisciplinary team, individual psychotherapy, family support, case management, medication, group psychotherapy, a structured activity program, crisis, backup, and residential programs. The activity program should include, but not be limited to, psychoeducation, expressive therapies (e.g., art, music, writing, bibliotherapy), and training in daily living skills.

This workshop will provide a theoretical framework and basic information on developing such a program. There will be time for discussion with participants after the presentation. Handouts will be provided.

REFERENCES:

1. Kelly KA: Multiple personality disorders: treatment coordination in a partial hospital setting. *Bull Menninger Clin* 57:390-398, 1993.
2. Lussier RG, DiPalma LM, Steiner JL: Treating victims of trauma in an acute care, short-term day hospital. *Dev Ambul Ment Health Care* 2:105-120, 1995.

Allied Group Session 8 **Monday, October 21**
8:00 a.m.-9:30 a.m.

ASSESSING RESIDENTS' EDUCATION: THE PRITE
with The American College of Psychiatrists

Pedro Ruiz, M.D., *Professor of Psychiatry and Behavioral Science, University of Texas, 1300 Moursund, Houston, TX 77030;* Jack W. Bonner III, M.D., James H. Scully, Jr., M.D., Alice Conde

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to describe the importance of conducting psychiatric residency in-service training at national and international levels. Moreover, directors of psychiatric training programs should be able to assess residents' educational needs and progress.

SUMMARY:

The Psychiatry Residency In-Training Examination (PRITE) was initiated in 1979 and has been annually offered by the American College of Psychiatrists since 1982. Moreover, in 1994 it was offered abroad for the first time in Madrid, Spain. The major goal of the examination is to provide educationally useful feedback for individual residents in the form of comparison with peers in specific areas of knowledge. The examination, which consists of 300 questions, is taken under secured, standardized conditions with proctors in attendance. In 1994 a total of 5,586 residents from 216 training programs throughout the United States took the examination. In Madrid, 26 residents took the examination in December 1994.

This panel will discuss the educational curriculum, the process for selecting the examination's questions, the correlation between the PRITE and the part I examination of the American Board of Psychiatry and Neurology, and international perspectives on the PRITE.

REFERENCES:

1. Leigh TM, Johnson TP, Pisacano NJ: Predictive validity of the American Board of Family Practice In-Training Examination. *Acad Med* 65:454-457, 1990.
2. Webb LC, Sexson S, Scully J, et al: Training directors' opinions about the Psychiatry Resident In-Training Examination (PRITE). *Am J Psychiatry* 149:521-524, 1992.

ALLIED GROUP SESSIONS

Allied Group Session 9 **Monday, October 21**
1:30 p.m.-3:00 p.m.

ADAPTING MAJOR DEPRESSION PRACTICE GUIDELINES TO THE VETERANS ADMINISTRATION
Cosponsored by the U.S. Department of Veterans Affairs, Mental Health and Behavioral Science, and the APA Committee on Veterans Affairs

Thomas B. Horvath, M.D., *Director, VA Mental Health and Behavioral Sciences Services, Veterans Health Administration, 810 Vermont Avenue, N.W., Washington, DC 20420;* Debby Walder, R.N., M.S.N., Richard R. Owen, Jr., M.D., Dale Cannon, Ph.D., Gary E. Berg, M.A., M.Div.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to describe approaches used by a large, diversified health care system to adapt practice guidelines to service delivery. They should be able to describe methods of outcome monitoring, the facilitating role of computers, and the role of spiritual issues in the practice guidelines for major depression.

SUMMARY:

Dr. Horvath will address the scope and process of the Department of Veterans Affairs (VA) Major Depression Practice Guideline Project and will present an overview of the project and its goals, *after* the presenters have described elements contributing to the project.

Ms. Walder, director of the VA Office of Risk Management, will discuss the VA's External Peer Review Program, a clinically oriented, cost-effective, system-wide external peer review program evaluating quality of care delivered by the VA.

Dr. Owen, of the VA's Field Program for Mental Health at the Little Rock VA Medical Center, will describe the Depression Outcomes Module, a brief, comprehensive tool with good reliability and validity for assessing outcomes of care for depressive disorders, including symptom severity, health status, and functioning.

Dr. Cannon, chief of VA Mental Health Program Automation and Evaluation, will present "Automation and the Depression Practice Guideline Project: Plans for a Treatment Planner," describing how automated records facilitate use of practice guidelines.

Mr. Berg, chief of the Chaplain Service at the St. Cloud VA Medical Center, will discuss practice guidelines as they relate to spirituality, reviewing the relationship between spiritual faith and major depression and sharing VA Chaplain Service research on depression.

REFERENCES:

1. Rost K, Smith GR, Burnam MA, et al: Measuring the outcomes of care for mental health problems: the case of depressive disorders. *Med Care* 30:MS266-MS273, 1992.
2. Walder D, Barbour GL, Weeks HS Jr, et al: VA's external peer-review program. *Fed Practitioner* 12(7):31-38, 1995.

COURSES

Course 1 **Friday, October 18**
8:00 a.m.-12 noon

PROVIDERS AND REVIEWERS TEACHING INFORMED MANAGED CARE

Co-Directors: Steven E. Samuel, Ph.D., *Department of Psychiatry and Human Behavior, Thomas Jefferson University Hospital, Sixteenth Floor, 1020 Sansom Street, Philadelphia, PA 19107*; and Vincenzo R. Sanguineti, M.D., *Department of Psychiatry and Human Behavior, Thomas Jefferson University Hospital, Sixteenth Floor, 1020 Sansom Street, Philadelphia, PA 19107*

Faculty: Janis G. Chester, M.D., William M. Glazer, M.D., Mary E. Roff, R.N., Stephen L. Schwartz, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this course, participants should be able to: a) describe the rationales and criteria involved in managed care systems, b) identify methods of review that realistically adapt to actual models of clinical care giving and clinical decision making, and c) use dialogue styles that facilitate the review outcome and foster collegial, rather than adversarial, interactions.

DESCRIPTION:

This course will examine the administrative skills necessary to practice clinically in a managed care environment. It will begin with a didactic presentation about specific issues in managed care utilization, with particular focus on assessment of severity and choosing the most appropriate and cost-effective type of care. A practical model to guide decisions about needs and levels of care will be detailed.

A provider will then present an actual clinical case, illustrative of the criteria for admission, acuity in emergency psychiatry, and documentation requirements. Small groups will be formed, each chaired by a faculty member, and the groups will attempt to reach a decision on the appropriateness of admission and treatment. Upon completion of the small-group sessions, the participants will reconvene and be presented with the actual outcome of the case. The provider and the faculty will discuss salient points in the documentation of the case.

Two faculty members will then present information that will include: a) the concept and the functions of hospital utilization management, and b) prevalent methods of review, the development of criteria for severity, the role and qualifications of the reviewers, and the process of appeal. A second case will be presented to illustrate multispecialty involvement complicating the clinical case, utilization management, length of stay, and options for alternative levels of care. The small groups will again be formed, each chaired by a faculty member, and they will attempt to reach a decision on the appropriateness of treatment and management. Upon completion of the small-group sessions, the participants will reconvene and be presented with the actual outcome of the case.

Time will be allotted at the end of the course for addressing controversial topics and questions generated by the participants.

REFERENCES:

1. Gabbard GO, Takahashi T, Davidson J, et al: A psychodynamic perspective on the clinical impact of insurance review. *Am J Psychiatry* 148:318-323, 1991.
2. Siegler J, Axelband M, Isikoff J: Psychiatry: taking a leadership role in managed health care. *Special Report: Managed Care,* 1993, p 32.

Course 2 **Friday, October 18**
9:00 a.m.-4:00 p.m.

MANAGEMENT AND TREATMENT OF THE VIOLENT PATIENT

Director: Gary J. Maier, M.D., *Director of Psychiatric Training and Forensic Programs, Mendota Mental Health Institute, 301 Troy Drive, Madison, WI 53704-1521*

EDUCATIONAL OBJECTIVE:

At the conclusion of this course, participants should be able to describe the following aspects of working with violent patients: a) the need for sophisticated management and treatment in both inpatient and outpatient settings, b) a comprehensive model for management and treatment, c) techniques for controlling acute violence, d) state-of-the-art psychopharmacologic approaches, e) legal issues, f) ambulatory restraints in cases of repetitive violence, and g) methods of identifying and working through countertransference feelings.

DESCRIPTION:

This course will present a comprehensive model for the management and treatment of the acutely and chronically aggressive/violent patient in both inpatient and outpatient settings. The need for clinicians to provide a safe working environment will be addressed. Architectural design for inpatient and outpatient units with a high incidence of violence will be reviewed. Management of verbal threats that usually precede physical aggression will be described; the discussion will include talk-down techniques for de-escalating a potentially violent patient. Medical/psychiatric diagnostic procedures leading to medical and psychopharmacologic treatment approaches will be presented in detail. The legal issues involved in the civil commitment process, the right to refuse treatment, and release issues, such as those related to *Tarasoff,* will be described. Building a case that will result in successful prosecution of a willfully aggressive patient will be presented. The pattern of aggression cycles that results from repetitive aggression will be presented from the

perspectives of both the staff and the aggressive patient. Ambulatory restraints, which can liberate a patient from seclusion, will be illustrated. Finally, but most important, countertransference reactions will be identified. Forums where staff feelings should be resolved and the process of resolution will be described. A model countertransference policy for institutions will also be presented.

REFERENCES:

1. Eichelman BS, Hartwig AC (eds): *Patient Violence and the Clinician.* American Psychiatric Press, Washington, DC, 1995.
2. Maier GJ: Managing repetitively aggressive patients. In Sledge WH, Tasman A (eds): *Clinical Challenges in Psychiatry.* American Psychiatric Press, Washington, DC, 1993, pp 181-213.

Course 3 **Friday, October 18**
1:00 p.m.-5:00 p.m.

PRACTICAL APPROACHES TO QUALITY IMPROVEMENT

Director: Roger L. Coleman, M.D., M.P.H., *Associate Clinical Professor of Psychiatry, University of Connecticut School of Medicine, and Chief of Professional Services, State of Connecticut Department of Mental Health and Addiction Services, Cedarcrest Regional Hospital, 525 Russell Road, Newington, CT 06111*

Faculty: Richard L. Elliott, M.D., Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this course, participants should be able to: a) describe variation and its relation to process stability, b) differentiate special and common causes of variation, c) use quality improvement methods to gain insight into process characteristics, and d) employ new methods in solving clinical, administrative, and quality improvement problems.

DESCRIPTION:

This course is designed for those who wish to go beyond the basic quality improvement standards required for accreditation and to explore the scientific and methodologic approaches found useful in industry. The course will provide practical instruction and a hands-on opportunity to use industrial quality improvement approaches to solve problems in clinical administration. Participants will be instructed in the use of quality improvement methods and presented with examples that demonstrate use of the methods. Emphasis will be placed on understanding variation as it relates to promoting stability of processes and to differentiating between common and special causes of variation. Approaches amenable to quantitative reasoning, including the control chart, runs chart, and regression analysis, will be explained.

This will be a practical, "how-to" course with the goal of providing participants with sufficient experience and guidance in the use of each method so that they will be able to employ the methods successfully as part of the quality improvement strategies at their facilities.

REFERENCES:

1. Coleman RL: Hospital quality assurance and risk management. In Tasman A, Riba MB (eds): *American Psychiatric Press Review of Psychiatry,* vol 11. American Psychiatric Press, Washington, DC, 1992, pp 585-600.
2. Coleman RL: Quantitative reasoning and quality care. *Ann Clin Psychiatry* 4:19-27, 1992.

Course 4 **Saturday, October 19**
8:00 a.m.-12 noon

COPING STRATEGIES FOR MANAGED CARE

Director: James M. Schuster, M.D., M.B.A., *Director of Psychiatric Managed Care Services, Allegheny General Hospital, 320 East North Avenue, Pittsburgh, PA 15212*

Faculty: Alan Daniels, Ed.D., Sheldon I. Miller, M.D., Ole J. Thienhaus, M.D., M.B.A.

EDUCATIONAL OBJECTIVE:

At the conclusion of this course, participants should be able to describe strategies for coping with the constraints imposed and the opportunities offered by managed care systems.

DESCRIPTION:

Managed care poses many challenges for clinicians. Changes are often required in treatment modalities and administrative organization. This course will help behavioral health clinicians understand how to work with managed care organizations and how to organize the delivery of care under the constraints of such organizations.

The rationales for managed care and ongoing changes in the delivery of mental health services will be outlined first. Successful practice in a managed care environment often involves group practice and new ways of managing patients' care. Many practice choices face clinicians in a managed care environment, and a strategic plan to address them must be developed; some of the issues to be considered are enrollment and participation in managed care networks, the benefits and risks of capitation, and the development of the required administrative infrastructure. The faculty will outline the formation of regional networks and the role of mental health professionals in multidisciplinary medical group practices.

Managed care has also caused constraints in the education of mental health professionals, and funding for research is declining. The current opportunities and problems in these areas will be presented.

REFERENCES:

1. Andrews G: Best practices for implementing outcomes management. *Behav Healthcare Tomorrow,* May/June 1995, pp 19-24.
2. Schuster J: Ensuring highest-quality care for the cost: coping strategies for mental health providers. *Hosp Community Psychiatry* 42:774-776, 1991.

Course 5 **Saturday, October 19**
9:00 a.m.-4:00 p.m.

INTRODUCTION TO BEHAVIOR THERAPY

Co-Directors: Robert M. Goisman, M.D., *Director, Outpatient Training and Research, Massachusetts Mental Health Center, 74 Fenwood Road, Boston, MA 02115*; and Philip G. Levendusky, Ph.D., *Vice President of Network Development, McLean Hospital, 115 Mill Street, Belmont, MA 02178*

EDUCATIONAL OBJECTIVE:

At the conclusion of this course, participants should be able to: a) summarize basic principles of learning theory; b) treat appropriate patients with behavioral techniques, including exposure therapies, cognitive approaches, social skills training, contingency management, and contracting; and c) combine behavioral methods with psychotropic medication and with psychodynamic psychotherapy.

DESCRIPTION:

This course will focus on behavioral approaches to a number of common psychiatric illnesses, including anxiety disorders, depression, eating disorders, borderline personality disorder, and chronic psychosis. The course will begin with a brief history of the development of learning theory and behavioral treatment, followed by a summary of principles of classical conditioning, operant conditioning, cognitive therapy, and time-efficient psychotherapy. Behavioral and cognitive approaches to disorders commonly seen in outpatient settings, especially panic disorder, phobias, generalized anxiety disorder, obsessive-compulsive disorder, depression, and bulimia and anorexia nervosa, will be examined. Behavioral treatments of serious and persistent mental illness, including psychosocial rehabilitation and social skills training for schizophrenia, dialectical behavioral therapy for borderline personality disorder, and contingency management on the inpatient service, will be discussed. Finally, the integration of these methods with other commonly used modalities, specifically psychotropic medication and psychodynamic psychotherapy, will be presented. The emphasis of this course will be on acquisition of concrete and practical skills that participants can incorporate into their current practices.

REFERENCES:

1. Goisman RM, Rogers MP, Steketee GS, et al: Utilization of behavioral methods in a multicenter anxiety disorders study. *J Clin Psychiatry* 54:213-218, 1993.
2. Levendusky PG, Dooley C: An inpatient model for the treatment of anorexia nervosa. In Emmett SW (ed): *Theory and Treatment of Anorexia Nervosa and Bulimia: Biomedical, Sociocultural, and Psychological Perspectives.* Brunner/Mazel, New York, 1985.

Course 6 **Saturday, October 19**
1:00 p.m.-5:00 p.m.

PSYCHIATRIC EMERGENCY SERVICE UPDATE
Joint Session with the American Association for Emergency Psychiatry

Director: Douglas H. Hughes, M.D., *Harvard Medical School, Boston VA Medical Center, 78 Monmouth Street, Brookline, MA 02146*

Faculty: Michael H. Allen, M.D., Todd R. Griswold, M.D., Michael J. Ostacher, M.D., M.P.H.

EDUCATIONAL OBJECTIVE:

At the conclusion of this course, participants should be able to: a) effectively assess suicidal and homicidal risk and behavior in the psychiatric emergency setting, b) outline the principles of using a mobile crisis service to treat difficult populations, and c) discuss the implications of managed care for the psychiatric emergency service.

DESCRIPTION:

Psychiatric emergency services are playing an increasingly central role within larger systems of psychiatric services. This course will provide a current review of the fundamental clinical tasks of violence and suicide assessment. It will also describe the usefulness and limitations of mobile crisis services in treating challenging populations. Finally, this course will review the current impact of managed care on psychiatric emergency services.

REFERENCES:

1. Hughes D: Assessment of the potential for violence. *Psychiatr Ann* 24:579-583, 1994.
2. Zealberg JJ, Santos AB, Fisher RK: Benefits of mobile crisis programs. *Hosp Community Psychiatry* 44:16-17, 1993.
3. Geller JL, Fisher WH, McDermeit M: A national survey of mobile crisis services and their evaluation. *Psychiatr Serv* 46:893-897, 1995.

COURSES

Course 7 **Saturday, October 19**
1:00 p.m.-5:00 p.m.

DYNAMIC GROUP TREATMENT FOR THE SERIOUSLY MENTALLY ILL
Joint Session with the American Group Psychotherapy Association, Inc.

Director: Walter N. Stone, M.D., *Professor of Psychiatry, Department of Psychiatry, University of Cincinnati, Apartment 8-D, 415 Bond Place, Cincinnati, OH 45206*

EDUCATIONAL OBJECTIVE:
At the conclusion of this course, participants should be able to: a) define a population and describe therapeutic goals for group treatment of seriously mentally ill patients, b) understand group dynamics and development for this population, and c) identify group leadership tasks.

DESCRIPTION:
This course is designed for those having clinical responsibility for a dynamically based outpatient group-treatment program for chronically mentally ill individuals. The areas that will be addressed will be defining the population, establishing goals, and forming and structuring therapeutic groups. The "flexibly bound group" model will be described as a basis for meeting the needs of this population in a respectful and cost-effective manner. The presentation will include discussion of strategies for screening and preparing patients, providing medications, and collaborating with other service providers. Dynamics of group formation and development that can be applied to this population will be addressed. The therapeutic goals of stabilizing patients and then helping them form reciprocal relationships will be examined in the context of patients' capacities. The therapists' tasks of: a) defining boundaries, b) bonding members, c) identifying themes, d) managing affect, e) understanding metaphors, f) promoting problem solving, and g) promoting self-understanding will be examined. Group processes will be demonstrated by videotapes.

REFERENCES:

1. Stone WN: Group psychotherapy with the chronically mentally ill. In Kaplan HI, Wolberg LR (eds): *Comprehensive Group Psychotherapy.* Williams & Wilkins, Baltimore, 1993, pp 418-429.
2. Stone WN: Group therapy for seriously mentally ill patients in a managed care system. In MacKenzie KR (ed): *Effective Use of Group Therapy in Managed Care.* American Psychiatric Press, Washington, DC, 1995, pp 129-147.

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

INTEGRATED MODELS FOR THE TREATMENT OF DUAL DIAGNOSIS PATIENTS

Director: Kenneth Minkoff, M.D., *Chief of Psychiatry, Choate Health Systems, Inc., 23 Warren Avenue, Woburn, MA 01801-4979*

EDUCATIONAL OBJECTIVE:
At the conclusion of this course, participants should be able to: a) apply specific diagnostic criteria to mentally ill substance abusers, b) distinguish between abuse and addiction in this population, c) describe the disease model and apply it to both addiction and mental illness, d) identify the steps in a program of recovery and apply them to both addiction and mental illness, e) outline the process of clinical intervention with dual diagnosis patients and families, f) discuss the importance of engaging the patient in his or her own recovery, and g) describe the basic components of structured treatment programs for dual diagnosis patients.

DESCRIPTION:
This course will provide a brief overview of the problem of dual diagnosis, with specific emphasis on substance abuse and dependence among the seriously mentally ill. Barriers to the development of integrated treatment will be described, followed by a presentation of an integrated disease and recovery model for both disorders that addresses those barriers. This model will then be used to organize a structured approach to assessment, diagnosis, and treatment. In this model, clinical interventions for this population can be individualized on the basis of phase of recovery, diagnosis, and levels of acuity, severity, disability, and motivation for treatment for each disease. This analysis will be used to describe the components of a comprehensive dual diagnosis system of care. Individual psychotherapeutic intervention and integrated program models will be described for each phase of recovery. Specific attention will be paid to psychopharmacologic strategies for psychiatrically symptomatic patients who are also using illicit substances. Participants are encouraged to bring clinical and programmatic case problems for discussion, in order to illustrate the application of the principles presented.

REFERENCES:

1. Minkoff K: Intervention strategies for people with dual diagnosis. *Innovations Res* 2(4):11-17, 1993.
2. Minkoff F: Models for addiction treatment in psychiatric populations. *Psychiatr Ann* 24:412-417, 1994.

COURSES

Course 9 **Sunday, October 20**
9:00 a.m.-4:00 p.m.

AN INTRODUCTION TO DISSOCIATIVE IDENTITY DISORDER

Director: Richard P. Kluft, M.D., *Department of Psychiatry, Institute of Pennsylvania Hospital, 111 North Forty-Ninth Street, Philadelphia, PA 19139*

Faculty: Bennett G. Braun, M.D., Roberta Sachs, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this course, participants should be able to: a) apply psychodynamic, cognitive-behavioral, and biologically oriented models to the treatment of dissociative identity disorder; and b) identify subgroups of dissociative identity disorder patients who can benefit from the application of each model.

DESCRIPTION:

This course will describe three approaches to the treatment of dissociative identity disorder in considerable depth. Participants should be familiar with the basic issues involved in the treatment of patients with dissociative identity disorder. Psychodynamic, cognitive-behavioral, and biological approaches to this patient population will be explored in depth. The application of each model to the psychopathology of dissociative identity disorder will be demonstrated, and the modifications necessary to accommodate each paradigm to the clinical realities of treatment for dissociative identity disorder will be addressed. The description of each model will be followed by a case illustration of its use in practice. The strengths and weaknesses of each of these models in work with dissociative identity disorder will be discussed. Subgroups of patients will be identified, and the indications and contraindications for the use of each model for each subgroup will be explored.

REFERENCES:

1. Braun BG: The Bask model of dissociation. *Dissociation* 1(1 & 2):4-23, 16-23, 1988.
2. Kluft RP, Fine CG (eds): *Clinical Perspectives on Multiple Personality Disorder.* American Psychiatric Press, Washington, DC, 1993.

Course 10 **Sunday, October 20**
1:00 p.m.-5:00 p.m.

INTEGRATING PSYCHIATRIC SERVICES INTO PRIMARY CARE

Co-Directors: Jonathan S. Davine, M.D., *East Region Mental Health Services, 2757 King Street East, Hamilton, ONT, Canada L8G 5E4;* and Marilyn Craven, M.D., *Evaluation Coordinator, Department of Psychiatry, McMaster University, 43 Charleston Avenue East, Hamilton, ONT, Canada L8N 1Y3*

EDUCATIONAL OBJECTIVE:

At the conclusion of this course, participants should be able to: a) describe the role of primary care physicians in delivering community mental health care, and b) work collaboratively and effectively with primary care physicians and within primary care settings.

DESCRIPTION:

One result of an increasing emphasis on the sharing of care between psychiatric services and primary care physicians has been the integration of mental health professionals within primary care settings. This course will help psychiatrists understand relevant issues and develop the skills necessary to work effectively with primary care physicians. The prevalence of mental health problems in primary care will be described, and current knowledge of the impact and outcome of shared care will be presented from the viewpoints of patients, providers, and systems. The faculty will present specific examples and outcome data from a region-wide program for shared care in Hamilton, Ontario, that they developed. The course will offer practical advice on how to work productively with primary care physicians, how to establish collaborative relationships, and how to adapt models of shared care to different settings. Finally, it will review the educational implications for both psychiatry and family medicine trainees and identify key research questions to be addressed.

REFERENCES:

1. Craven M, Kates N: Assessment of family physicians' knowledge of social and community services. *Can Fam Physician Med Fam Can* 36:443-447, 1990.
2. Kates N: Training psychiatric residents to work with primary care physicians: a national survey. *Can J Psychiatry* 38:79-82, 1993.

Course 11 **Monday, October 21**
8:00 a.m.-12 noon

VIOLENCE: ASSESSMENT AND TREATMENT IN THE EMERGENCY ROOM

Director: Victor G. Stiebel, M.D., *Department of Psychiatry, St. Francis Medical Center, 400 Forty-Fifth Street, Pittsburgh, PA 15201*

Faculty: Douglas H. Hughes, M.D., David L. Corwin, M.D., Joseph J. Zealberg, M.D.

COURSES

EDUCATIONAL OBJECTIVE:

At the conclusion of this course, participants should be able to: a) describe how to assess the violent patient in the emergency department; b) provide safe, effective, and medicolegally prudent management for these patients; c) use a range of treatment interventions and disposition options; and d) identify many potentially violent patients in the emergency department.

DESCRIPTION:

Few situations arouse as much anxiety in a clinician as a threatening and potentially violent patient. Emergency assessment and treatment of such patients is often quite difficult, as initial evaluations must be completed quickly and important information is frequently unavailable. Since clinical situations change rapidly, decisions and appropriate interventions must be made with a speed that compounds a clinician's distress. There are currently no definitive psychological or biological tests for assessing aggression and violence.

This course will present an in-depth, state-of-the-art look at the management and treatment of the violent patient in the emergency setting. Brief clinical vignettes will be presented by a faculty of national experts, and questions from the audience will be used to stimulate discussion of these high-risk patients. The course will begin with a general overview and outline of treatment goals. Specific areas to be addressed include domestic violence and the interface of mobile crisis units with community resources. Legal aspects of emergency treatment in the face of intensive managed care oversight will be presented.

REFERENCES:

1. Hughes D: Assessment of the potential for violence. *Psychiatr Ann* 24:579-583, 1994.
2. Mulvey EP: Assessing the evidence of a link between mental illness and violence. *Hosp Community Psychiatry* 45:663-668, 1994.

Course 12 **Monday, October 21**
9:00 a.m.-4:00 p.m.

ETHICAL ISSUES IN PSYCHIATRIC PRACTICE

Director: Jeremy A. Lazarus, M.D., *Speaker-Elect, American Psychiatric Association and Associate Clinical Professor, Department of Psychiatry, University of Colorado, 89095 East Prentice Avenue, Englewood, CO 80111-2705*

Faculty: Donna E. Frick, M.D., Maria T. Lymberis, M.D., Kathleen M. Mogul, M.D., Arthur Zitrin, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this course, participants should be able to: a) identify ethical dilemmas in psychiatry that affect the day-to-day practice of psychiatry, and b) describe how to apply ethical guidelines, practical approaches, and solutions to these dilemmas.

DESCRIPTION:

An overview of psychiatric ethics and methods of ethical problem solving will be followed by specific discussions of ethical problems involving informed consent, forced treatment, confidentiality, legal/ethical questions, sexual misconduct, boundary violations, relationships with other mental health professionals, financial issues, managed mental health, conflicts of interest, and other issues. Questions regarding specific cases will be used to demonstrate methods of ethical problem solving in cases involving conflicting ethical values. Pertinent applications, opinions, and positions of the APA Ethics Committee and of APA will be referred to in regard to these areas. Participants will have adequate time to present their own questions and cases in these or other areas of psychiatric ethics for discussion by the faculty.

REFERENCES:

1. American Psychiatric Association: *The Principles of Medical Ethics with Annotations Especially Applicable to Psychiatry.* American Psychiatric Association, Washington, DC, 1989.
2. Group for the Advancement of Psychiatry: *A Casebook in Psychiatric Ethics.* Brunner/Mazel, New York, 1990.

Course 13 **Monday, October 21**
1:00 p.m.-5:00 p.m.

COGNITIVE THERAPY: THE BASICS

Director: Dean Schuyler, M.D., *6280 Montrose Road, Rockville, MD 20852-4119*

EDUCATIONAL OBJECTIVE:

At the conclusion of this course, participants should be able to: a) describe the language of the cognitive model; b) apply the cognitive model to an individual patient or to a group of disorders; c) use interventive techniques based on this model; and d) build on this foundation with further reading, advanced course work, and supervision, to gain the requisite skills to do cognitive therapy.

DESCRIPTION:

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. Through clinical examples, role playing, and the participants' experiences, facility in identifying and working with automatic thoughts will be developed. 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.

REFERENCES:

1. Beck AT, Freeman A, et al: *Cognitive Therapy of Personality Disorders.* Guilford Press, New York, 1990.
2. Schuyler D: *A Practical Guide to Cognitive Therapy.* WW Norton, New York, 1991.

COURSES

Course 14 **Tuesday, October 22**
8:00 a.m.-12 noon

COGNITIVE THERAPY FOR SEVERE MENTAL DISORDERS

Director: 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*

Faculty: Monica R. Basco, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this course, participants should be able to: a) use cognitive therapy interventions for inpatients, b) apply cognitive therapy techniques to symptoms of psychosis and bipolar disorder, c) identify problems in treatment adherence by using the cognitive therapy approach, and d) maximize relapse prevention in patients with recurrent symptoms.

DESCRIPTION:

In recent years, cognitive therapy methods have been developed to meet the special needs of patients with chronic and severe psychiatric symptoms. This course will present these newer cognitive therapy applications for the treatment of inpatients, individuals with bipolar disorder, and those experiencing psychotic symptoms. Cognitive-behavioral conceptualizations and specific treatment procedures will be described for these patient groups. Several modifications of standard cognitive therapy techniques will be suggested for the treatment of severe or persistent mental disorders. Participants in this course will learn how to adapt cognitive therapy for patients with psychomotor retardation, paranoia, or hypomania and for those who not have responded to treatment or have not adhered to pharmacotherapy recommendations. Cognitive therapy procedures will be illustrated through case discussions, role playing, 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.

REFERENCES:

1. Wright JH, Beck AT: Cognitive therapy. In Hales RE, Yudofsky SC, Talbott JA (eds): *American Psychiatric Press Textbook of Psychiatry.* American Psychiatric Press, Washington, DC, 1994.
2. Wright JH, Thase ME, Beck AT, et al (eds): *Cognitive Therapy with Inpatients: Developing a Cognitive Milieu.* Guilford Press, New York, 1993.

DISCUSSION GROUPS

Discussion Group 1 **Friday, October 18**
10:00 a.m.-11:30 a.m.

PRIVATIZING PUBLIC PSYCHIATRIC SERVICES

Ted Lawlor, M.D., *Medical Director, Department of Mental Health, Western Massachusetts Area, P.O. Box 389, Northampton, MA 01061-0389*

SUMMARY:

Massachusetts has obtained a broad Medicaid waiver with the intention of decreasing the number of uninsured in its population. As part of this process, acute psychiatric services presently contracted for by the Department of Mental Health will now be subcontracted through the Division of Medical Assistance, the state Medicaid authority. However, the Department of Mental Health statutorily retains authority and responsibility for developing and maintaining a comprehensive system of mental health services for the state; therefore, this new partnership has required very careful planning involving all stakeholders.

The formal agreement stipulates how a single managed care organization will contract with the Department of Mental Health to manage a system of private providers responsible for all acute mental health and substance abuse services, and the Department of Mental Health will retain the responsibility for either directly providing or contracting for all continuing care mental health services. Access, equity, and quality have been addressed by putting into place a comprehensive management, oversight, and review process that includes using locally based, citizen planning groups that participate in overall system development; clinical criteria and standards; service coordination and integration; monitoring, licensing, and systemic quality management; an integrated information gathering and reporting system; and family and consumer involvement and education programs.

REFERENCE:

1. Hoge MA, Davidson L, Griffith EE, et al: Defining managed care in public sector psychiatry. *Hosp Community Psychiatry* 45:1085-1089, 1994.

Discussion Group 2 **Friday, October 18**
1:30 p.m.-3:00 p.m.

MEASURING MANAGED CARE

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 availability, quality, outcomes, and costs of mental health and substance abuse services has been limited because of 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.

REFERENCES:

1. Mechanic D, Schlesinger M, McAlpine DD: Management of mental health and substance abuse services: state of the art and early results. *Milbank Q* 73:19-55, 1995.
2. Wells KB, Astrachan BM, Tischler GL, et al: Issues and approaches in evaluating managed mental health care. *Milbank Q* 73:57-75, 1995.

Discussion Group 3 **Saturday, October 19**
8:00 a.m.-9:30 a.m.

PSYCHIATRIC ADVANCE DIRECTIVES AND COMPETENCE

Janet Ritchie, M.D., *Department of Psychiatry, Montreal General Hospital, 1650 Cedar Avenue, Montreal, PQ, Canada H3G 1A4;* and Warren Steiner, M.D., *Assistant Chief Psychiatrist, Montreal General Hospital, 1650 Cedar Avenue, Montreal, PQ, Canada H3G 1A4*

SUMMARY:

Advance directives are increasingly present in health care legislation and practice. The issue of advance directives for patients with recurrent psychiatric illness is more complex than for those with other medical illnesses. Such cases have a third dimension besides the traditional issues of diagnosis and treatment: that of process. A crucial element at every level of this process is competence. There must be: a) an initial competence to make informed

choices, b) a decision as to when to invoke advance directives, c) person(s) designated as substituted decision maker(s) who must be competent, d) a means for recognizing "islands of competence" (issue-specific competence) in an otherwise incompetent patient, and e) a means of recognizing a retum to competence. Competence is likely to be at issue whenever the use of advance directives is challenged. It is not, generally speaking, adequately addressed in legislation. In fact, some legislation permits advance directives to be revoked by the patient regardless of mental or physical condition. Other jurisdictions have introduced "Ulysses directives" to enable patients to protect themselves against fluctuating competence, making the means for determining baseline competence all the more relevant. Representative cases will be presented to stimulate discussion of these issues.

REFERENCES:

1. Cuca R: Ulysses in Minnesota: first steps toward a self-binding psychiatric advance directive statute. *Cornell Law Rev* 78:1152-1186, 1993.
2. Schneiderman LJ: Who decides who decides? When disagreement occurs between the physician and the patient's appointed proxy about the patient's decision-making capacity. *Arch Intern Med* 155:793-796, 1995.

Discussion Group 4 **Saturday, October 19**
10:00 a.m.-11:30 a.m.

ETHICAL ASPECTS OF TREATMENT REFUSAL IN COMMUNITY MENTAL HEALTH

Richard C. Christensen, M.D., *Assistant Professor, Department of Psychiatry, University of Florida, Lot 28K, Shaw Farms, Alachua, FL 32615*

SUMMARY:

There are few patient care issues in community mental health that are more clinically complex and ethically difficult than those involving the refusal of indicated treatment by individuals suffering from severe mental illness. Arguably, treatment refusal is one of the most common and pragmatic ethical dilemmas encountered by providers in the field of mental health.

Episodes of treatment refusal starkly highlight the interface between clinical assessment (e.g., determining decision-making capacity and obtaining valid consent or refusal) and ethical decision making (e.g., duty to respect autonomy and obligation to benefit and not inflict harm). Attempting to resolve these clinical and ethical tensions in the community mental health setting can be daunting for the provider.

This session will begin with a brief overview of the most common general categories of ethical conflict in psychiatry and will provide a methodological framework for addressing ethical dilemmas in community mental health. This methodological approach will then be applied to specific clinical vignettes involving treatment refusal that are relevant to a variety of community health treatment settings (i.e., inpatient crisis unit, outpatient clinic, case management, and outreach to the homeless). Clinical vignettes will be used to stimulate an interactive ethical analysis among participants who contend daily with the clinical and moral aspects of treating those who decline the provider's recommended interventions.

REFERENCES:

1. Christensen RC: Ethical issues in community mental health: cases and conflicts. *Community Ment Health J,* in press.
2. Wear A, Brahms D: To treat or not to treat: the legal, ethical, and therapeutic implications of treatment refusal. *J Med Ethics* 17:131-135, 1991.

Discussion Group 5 **Saturday, October 19**
1:30 p.m.-3:00 p.m.

PSYCHODYNAMIC ISSUES IN MANAGED CARE

Sidney H. Weissman, M.D., *Professor of Psychiatry, Loyola University, 2160 South First Avenue, Maywood, IL 60153*

SUMMARY:

This presentation will explore the unique psychodynamic issues in the relationship between psychiatrist and patient in managed care settings. The presentation will explicitly examine the special transferences and countertransferences that develop in therapies governed and funded by managed care. Attention will be focused on how these transferences can negatively affect therapy and on techniques to address them.

It is estimated that at least three quarters of all Americans will be covered by managed care, and so it is essential that each practitioner be acquainted with the psychological impact on psychiatric treatment.

At the conclusion of the presentation, each practitioner will be better able to keep the special transferences and countertransferences of managed care from adversely affecting treatment.

REFERENCES:

1. Weissman S: The managed care setting. In Schwartz H, Bleiberg E, Weissman S (eds): *Psychodynamic Concepts in General Psychiatry.* American Psychiatric Press, Washington, DC, 1995, chap 8.
2. American Medical Association: Policy 285.998. In *AMA Policy Compendium.* Chicago, American Medical Association, 1994.

DISCUSSION GROUPS

Discussion Group 6 **Saturday, October 19**
3:30 p.m.-5:00 p.m.

COMMUNITY PSYCHIATRY
For Residents Only

Michael A. Silver, M.D., *Medical Director, The Providence Center, and Clinical Assistant Professor, Department of Psychiatry and Human Behavior, Brown University, 492 Wayland Avenue, Providence, RI 02906-4654;* and Charles W. Huffine, Jr., M.D., *Medical Director, King County Mental Health Clinic, 3123 Fairview Avenue East, Seattle, WA 98102-3051*

SUMMARY:

Various aspects of community psychiatry will be discussed in an informal exchange of ideas. Specific topics will depend on the interests of the audience but may include the role of the psychiatrist in community psychiatry, dealing with managed care in the public sector, developing and maintaining a functional system of care for the treatment of the seriously mentally ill, managing difficult patients in the community, and clinical and administrative problems in community psychiatry.

REFERENCES:

1. Pollack DA, Cutler DL: Psychiatry in community mental health centers: everyone can win. *Community Ment Health J* 28:259-267, 1992.
2. Diamond RJ, Goldfinger SM, Pollack D, et al: The role of psychiatrists in community mental health centers: a survey of job descriptions. *Community Ment Health J* 31:571-577, 1995.

Discussion Group 7 **Sunday, October 20**
8:00 a.m.-9:30 a.m.

WHAT TO LOOK FOR IN PUBLIC HEALTH REFORM: LESSONS LEARNED FROM GEORGIA AND ELSEWHERE

Richard L. Elliott, M.D., Ph.D., *Professor of Psychiatry, Mercer University School of Medicine, 5481 Rivoli Drive, Macon, GA 31210*

SUMMARY:

In 1992 Georgia began a major reform of its public mental health services. Yet, despite high hopes, major administrative changes, and a cost of over $10 million to date, few results have been obtained.

The session will describe Georgia's reform briefly, its impetus, administrative and legislative changes, and problems encountered. Participants will be invited to share their experiences with reform in other systems. Several questions common among reform observers will be discussed by session participants. What pitfalls in reform are most common? How can they be avoided or minimized? How can the success or failure of system reform be assessed? What are essential aspects of successful reform?

This session should be of interest to many mental health administrators, especially those who are skeptical about promised results from reform and yet want to learn more about ways of improving the likelihood of success.

The moderator, a former medical director for Georgia's system, was awarded an inaugural Public Interest Pioneer Grant by the Stern Family Fund in 1995 to create a center for public mental health advocacy. Part of the center's mission is to monitor reform in Georgia and to help others learn from Georgia's experience.

REFERENCES:

1. Elliott RL, Cohen MD, Evans DL: Reforming Georgia's mental health system. *Community Ment Health J* 31:413-423, 1995.
2. Elliott RL: What's happened to Georgia's mental health reform? *J Med Assoc Georgia* 84:71-74, 1995.

Discussion Group 8 **Sunday, October 20**
8:00 a.m.- 9:30 a.m.

THE GROUP TREATMENT PROCESS AND OUT COMES FOR CLIENTS RECEIVING CLOZAPINE MEDICATION

Robert G. Childers, M.S.W., *Clinical Social Worker, Citywide Case Management, University of California at San Francisco, 251 Hyde Street, San Francisco, CA 94102*

SUMMARY:

Providing rehabilitation-oriented comprehensive care to patients with treatment-refractory schizophrenia is a complex problem for mental health treatment providers. The dilemma is how to provide services for improving this population's quality of life with dwindling fiscal resources. One response to this situation was the introduction of the first atypical antipsychotic, clozapine, in 1991. The significant improvement in both positive and negative symptoms of schizophrenia with clozapine use has profoundly increased the opportunities of the refractory schizophrenic population for improving their quality of life. This improvement challenges treatment providers to address multiple and complex issues for the successful treatment of this population.

This presentation will describe the use of an ongoing outpatient group psychotherapy program as a means to address the psychological and rehabilitative issues of patients receiving clozapine. The participants have taken clozapine for over one year and have experienced significant symptom relief. Clinical observations and interventions will be presented; examples of psychological

issues to be presented include profound depression about the lost years of being sick and coping with the memory and trauma of experiencing psychotic symptoms. Some of the rehabilitative issues that will be described are re-establishment of relationships with family members and the intrapsychic obstacles to linkage with educational and vocational programs.

REFERENCES:

1. Kane JM: Clinical efficacy of clozapine in treatment-refractory schizophrenia: an overview. *Br J Psychiatry* 160(suppl 17):41-45, 1992.
2. O'Connor FW, Sprunger JE, Petry SD: A clozapine treatment program for patients living in the community. *Hosp Community Psychiatry* 43:909-911, 1992.

Discussion Group 9 **Sunday, October 20**
10:00 a.m.-11:30 a.m.

PSYCHOTHERAPY IN PSYCHIATRY

Prakash N. Desai, M.D., *Chief-of-Staff, West Side Veterans Affairs Medical Center, and Professor of Psychiatry, University of Illinois at Chicago, 820 South Damen Avenue, Chicago, IL 60612-3740*

SUMMARY:

For the last several years, the place of psychotherapy in psychiatric practice and training has gradually eroded. With the explosion of psychopharmacology, in particular, and neurosciences, in general, the focus has shifted to biological treatments. The revolution in health care delivery ushered in by many forms of managed care has placed a greater emphasis on cost containment and has resulted in reliance on treatments that give quick results. Although rapid amelioration of a patient's health is a desirable goal, protracted psychotherapeutic interventions have a vital role in the restoration of a patient's well-being. Our profession needs to work with renewed vigor in establishing the role of psychodynamic psychiatry in psychiatric education and practice and in general medical training as well. This discussion group will explore ways in which a greater appreciation of both the process of erosion and the steps necessary for a redefinition of psychotherapy in psychiatry can be realized.

REFERENCES:

1. Gabbard G: Psychodynamic psychiatry in the "decade of the brain." *Am J Psychiatry* 149:991-998, 1992.
2. Sledge W: Psychotherapy in the United States: challenges and opportunities. *Am J Psychiatry* 151:1257-1260, 1994.

Discussion Group 10 **Sunday, October 20**
1:30 p.m.-3:00 p.m.

HIV/AIDS AND THE ETHNIC MINORITIES: CLINICAL AND SOCIOCULTURAL CONSIDERATIONS

Pedro Ruiz, M.D., *Professor of Psychiatry and Behavioral Science, University of Texas, 1300 Moursund, Houston, TX 77030*

SUMMARY:

Current trends in the HIV epidemic in the United States include a shift toward the ethnic minorities, particularly Hispanics, and users of intravenous drugs. This trend calls for better understanding and recognition of patterns of sexual practices among ethnic minority groups, especially Hispanics. Moreover, it is extremely important to design and implement programs geared toward early detection of HIV and rapid clinical intervention for recently infected patients. These programs also need to take into consideration the sociocultural characteristics of the ethnic groups being addressed. Furthermore, it is important to consider the unique problems presented by ethnic minority substance users, who have a pattern of intravenous drug use.

REFERENCES:

1. Ruiz P, Fernandez F: Human immunodeficiency virus and the substance abuser: public policy considerations. *Tex Med* 90(5):64-67, 1994.
2. Parra EO, Shapiro MF, Moreno CA, et al: AIDS-related risk behavior, knowledge, and beliefs among women and their Mexican-American sexual partners who used intravenous drugs. *Arch Family Med* 2:603-610, 1993.

Discussion Group 11 **Sunday, October 20**
3:30 p.m.-5:00 p.m.

PERSONAL AND PROFESSIONAL ISSUES FOR FUTURE PSYCHIATRISTS
For Residents Only

Leah J. Dickstein, M.D., *Professor, Department of Psychiatry and Behavioral Sciences, Associate Chair for Academic Affairs, Director of the Division of Attitudinal and Behavioral Medicine, and Associate Dean for Faculty and Student Advocacy, University of Louisville School of Medicine, ACB, 550 South Jackson Street, Louisville, KY 40202*

SUMMARY:

As residents complete professional training in an era of extraordinary changes in practice and burgeoning scientific knowledge, they must also consider their future personal lives and professional goals.

DISCUSSION GROUPS

This discussion group will focus on important personal goals: relationships, partners, whether to bear and/or raise children, living choices, time for the arts, exercise, and self. For many, the issue of loan repayment looms over practice choices as well. Other professional issues relate to managed systems of care, psychiatrists' current and desired roles in these systems, professional independence, subspecialty training, and relationships with other physicians in nonpsychiatric fields and with all other mental health professionals.

Finally, the discussion will include basic issues relating to the goals of psychiatric practice versus future realities and options, with constructive and appropriately creative decisions and goals outlined.

REFERENCES:

1. Remen RN: *Kitchen Table Wisdom: A Doctor Remembers What's Real.* Riverhead Books, 1996.
2. Reynolds R, Stone J (eds): *On Doctoring Stories, Poems, and Essays.* S&S Trade, 1991.

Discussion Group 12 **Sunday, October 20**
3:30 p.m.-5:00 p.m.

IS PSYCHOTHERAPY POSSIBLE UNDER MANAGED CARE?

Maria T. Lymberis, M.D., *Board of Trustees Member, American Psychiatric Association, and Associate Clinical Professor of Psychiatry, Department of Psychiatry, University of California at Los Angeles--Neuropsychiatric Institute School of Medicine, Suite 204, 1500 Montana Avenue, Santa Monica, CA 90403-1810*

SUMMARY:

Over the last 100 years, American psychiatry evolved the biopsychosocial model for the treatment of various psychiatric illnesses, dysfunctions, and disabilities. Dynamically informed long-term psychotherapy has been the cornerstone of psychiatric training in the United States. Under managed care these fundamentals are under attack. This discussion group will: a) explore the problems psychiatrists face when they are trying to provide appropriate psychotherapeutic treatment for their patients under managed care; b) improve psychiatrists' skills in advocating competent psychiatric treatment based on psychiatric ethical principles, informed consent, and the mobilization of the patient's family support system through links with the wider patient advocacy community; and c) educate psychiatrists about the need for active participation in their local psychiatric societies in order to obtain support and develop strategies for improving the quality of psychiatric treatment through public affairs and legislative action at local and national levels.

REFERENCES:

1. Borenstein DB: Does managed care permit appropriate use of psychotherapy? *Psychiatr Serv* 47(9), 1996.
2. Frank E, Kupfer DJ, Wagner EF, et al: Efficacy of interpersonal psychotherapy as a maintenance treatment of recurrent depression. *Arch Gen Psychiatry* 48:1053-1059, 1991; erratum 49;401, 1992.

Discussion Group 13 **Monday, October 21**
8:00 a.m.-9:30 a.m.

DEINSTITUTIONALIZATION IN THE 1990S

H. Richard Lamb, M.D., *Professor, Department of Psychiatry, University of Southern California School of Medicine, 1934 Hospital Place, Los Angeles, CA 90033-1071*

SUMMARY:

What can be learned from the successes and failures of deinstitutionalization? Has deinstitutionalization precipitated an increase in homelessness and in criminalization among mentally ill patients? Has deinstitutionalization gone too far in attempting to treat persons with long-term mental illness in the community? What kinds of programs--what specific services--are offered to individuals with long-term mental illness? This workshop will examine the issues suggested by these questions.

REFERENCES:

1. Lamb HR: Lessons learned from deinstitutionalization in the U.S. *Br J Psychiatry* 162:587-592, 1993.
2. Lamb HR, Bachrach LL, Kass FI: *Treating the Homeless Mentally Ill.* American Psychiatric Press, Washington, DC, 1992.

Discussion Group 14 **Monday, October 21**
10:00 a.m.-11:30 a.m.

RHETORIC OR REALITY? THE POLITICS OF MENTAL HEALTH CARE

Jay B. Cutler, J.D., *Director/Special Counsel, Division of Government Relations, American Psychiatric Association, 1400 K Street, N.W., Washington, DC 20005*

SUMMARY:

This discussion group will start with a brief introduction on how the 104th Congress began like a lion--with an unprecedented threat of overturning more than three decades of Medicare and Medicaid policy--and how it is winding down as the presidential election campaign heats up. The issues highlighted for this legislative session start with Medicare (end of fee-for-service medicine; threat to

psychiatric graduate medical education; relief from anti-trust measures) and Medicaid (block grant threat) and include the demise of the Department of Defense prescribing demonstration project, continued negotiations over confidentiality of medical records legislation, and, most important, the first-ever passage of parity coverage for mental illness in the Senate.

Emphasis will be on the importance of grass-roots psychiatry leadership on a constant basis. In one session of Congress, two years, the goals can rapidly shift, but with a consistent and ongoing relationship of psychiatry with Congress, positive goals can be achieved. Our patients need psychiatry's vision, professional integrity, medical skills, clinical effectiveness, and scientific achievements. With our patients and their families--allies essential for a coherent, unified image and force--we can forcefully, skillfully, and successfully advocate at every level of government--state and federal--treatment of persons with mental illness and addictive disorders that is equal to treatment of persons with other medical illness.

REFERENCES:

1. Cutler J, Cohen S: Influencing the political agenda on behalf of psychiatric research. In Pincus HA (ed): *Research Funding and Resource Manual: Mental Health and Addictive Disorders.* American Psychiatric Association, Washington, DC, 1995, pp 453-470.
2. Melek SP, Pyenson BS: *The Costs of Non-Discriminatory Health Insurance Coverage for Mental Illness: An Analysis of S. 298, the "Equitable Health Care for Severe Mental Illness Act" and the Watson Wyatt Worldwide Cost Analysis of S. 298.* Milliman & Robertson, April 11, 1996.
3. Health care reform for Americans with severe mental illnesses: report of the National Advisory Mental Health Council. *Am J Psychiatry* 150:1447-1465, 1993.
4. *Medicaid Emergency '96: Medicaid Tool Kit.* Families USA Foundation, Washington, DC, 1996.
5. *Medicare and Medicaid: A Sourcebook for Journalists,* vol 1. Alliance for Health Reform, Washington, DC.

Discussion Group 15 **Monday, October 21**
10:00 a.m.-11:30 a.m.

PARTIAL RESPONSE TO CLOZAPINE: ASSESSMENT AND MANAGEMENT

Richard H. McCarthy, M.D., *Assistant Professor, Department of Psychiatry, New York Hospital/Cornell Medical Center, 21 Bloomingdale Road, White Plains, NY 10605-1504;* and Bradford B. Perry, M.D., *Assistant Professor, Department of Psychiatry, New York Hospital/Cornell Medical Center, 455 Central Park Avenue, Suite 214, Scarsdale, NY 10583*

SUMMARY:

Clozapine is arguably the most important pharmacological advancement in the treatment of seriously ill schizophrenic patients since chlorpromazine. Unfortunately, many patients do not fully respond to clozapine. To date, most discussions concerning clozapine response have focused on a priori differentiation of responders from nonresponders, the appropriate interval for clozapine treatment, and the implicit, if not explicit, rationing of clozapine on the basis of cost-benefit considerations. There has been little discussion of the differential assessment and management of patients who respond only partially to clozapine. While the presenters support the use of clozapine for responders and its withdrawal from nonresponders, 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 for these partially responding patients without consideration of other methods of extending clozapine response is, in the presenters' view, premature.

Attendees will be invited to discuss issues relevant to clozapine partial response, including clozapine monotherapy and polypharmacy, the appearance of intervening psychopathology (e.g., obsessive-compulsive symptoms), observational biases due to persistent adverse effects, and the effects of psychosocial interventions on response.

REFERENCES:

1. Peacock L, Gerlach J: Clozapine treatment in Denmark: concomitant psychotropic medication and hematologic monitoring in a system with liberal usage practices. *J Clin Psychiatry* 55(2):44-49, 1994.
2. McCarthy RH, Terkelsen KG: Risperidone augmentation of clozapine. *Pharmacopsychiatry* 28:61-63, 1995.

Discussion Group 16 **Monday, October 21**
1:30 p.m.-3:00 p.m.

WHAT TO DO WHEN THE MEDIA CALL? INTERVIEW TIPS AND TECHNIQUES

John M. Blamphin, B.A., *Director, Division of Public Affairs, American Psychiatric Association, 1400 K Street, N.W., Washington, DC 20005*

SUMMARY:

Psychiatrists and other mental health professionals have a responsibility to expand and enhance public awareness of mental illnesses and psychiatric treatment. While television and other media continue as the most effective routes for transmission of this information, psychiatrists need special knowledge and training to use these media effectively. At each television opportunity, the psychiatrist must determine a communications objective,

identify messages (at least three), rehearse, link the discussion to his or her message points in the course of the interview, be positive and factual, and never make comments off the record. Although the process of message development is essentially the same for all media, the techniques vary with each. Representing psychiatry in the media can be a rewarding and beneficial experience if the psychiatrist prepares ahead of time and learns a few simple techniques.

REFERENCES:

1. Rubin R, Rogers HL: *Under the Microscope: The Relationship Between Physicians and the News Media.* Freedom Forum First Amendment Center, Vanderbilt University, Nashville, TN, 1993.
2. Blamphin J: How to handle the news media. *Psychiatric Research Report* 12(3), Summer 1996, pp 1, 8-11 (Office of Research, American Psychiatric Association, Washington, DC).

Discussion Group 17 **Monday, October 21**
1:30 p.m.-3:00 p.m.

IMPLEMENTING PUBLIC SECTOR MANAGED CARE

Marylou Sudders, M.S.W., A.C.S.W., *Commissioner of Mental Health, Massachusetts Department of Mental Health, 25 Staniford Street, Boston, MA 02115;* and Paul J. Barreira, M.D., *Deputy Commissioner for Clinical and Professional Services, Massachusetts Department of Mental Health, 55 Lake Avenue North, Worcester, MA 01655-0001*

SUMMARY:

Massachusetts was the first state to implement a statewide Medicaid managed care mental health/substance abuse program carve-out in 1992 through a 1915b Health Care Financing Authority waiver. The contract with the managed care organization excluded payment for long-term nursing home care and mental health services provided by the Department of Mental Health.

Massachusetts began its second-generation carve-out on July 1, 1996. This statewide initiative is being collaboratively administered by the Massachusetts Division of Medical Assistance and the Department of Mental Health. Under the new arrangement the Department of Mental Health transferred dollars previously spent for acute services to the Division of Medical Assistance, which, in turn, awarded a $230 million fully capitated contract to the Massachusetts Behavioral Health Partnership to manage the acute care for both Medicaid recipients and consumers deemed eligible by the Department of Mental Health. The department is responsible for defining and monitoring the quality of acute services provided by Massachusetts Behavioral Health Partnership. In addition, the department continues to oversee a system of continuing care services for its eligible population.

The discussion will focus on the unique features of this public managed care contract. The presenters will discuss the use of incentives and penalties for meeting standards, the integration of acute and continuing care services, issues in developing a network, and the building of a working relationship among the Department of Mental Health, Division of Medical Assistance, and the managed care organization.

REFERENCES:

1. Dickey B, Norton EC, Normand SL, et al: Massachusetts Medicaid managed health care reform: treatment for the psychiatrically disabled. *Adv Health Econ* 15:99-116, 1995.
2. Mechanic D, Schlesinger M, McAlpine DD: Management of mental health and substance abuse services: state of the art and early results. *Milbank Q* 73:19-55, 1995.

Discussion Group 18 **Monday, October 21**
3:30 p.m.-5:00 p.m.

PSYCHIATRIC EMPLOYMENT: FINDING POSITIONS AND PHYSICIANS

Rebecca A. Kilmer, B.S.W., *Placement Coordinator, Psychiatric Placement Service, American Psychiatric Association, 1400 K Street, N.W., Washington, DC 20005*

SUMMARY:

Designed to take the sting out of a job search or the search for the right applicant, this question-and-answer presentation will be geared to address specific concerns of the participants present.

Topics for discussion will include, but not be limited to, steps involved in the recruitment process (for both physician applicants and employers), how best to present yourself or your facility, creating a win/win situation, current job opportunities, and resources available to psychiatrists and mental health employers.

In addition, information about current trends in employment, gathered through the operation of the APA's year-round physician placement program and the APA Managed Care Help Line, will be shared.

REFERENCES:

1. Molloy PJ: *Entering the Practice of Psychiatry: A Physicians' Planning Guide.* New York, 1994.
2. Kronhaus AK: *Choosing Your Practice.* Springer-Verlag, New York, 1990.

DISCUSSION GROUPS

Discussion Group 19 **Monday, October 21**
3:30 p.m.-5:00 p.m.

SUFISM AND MODERN PSYCHOTHERAPY: A COMPARISON

Abdul Basit, Ph.D., *Assistant Professor, Department of Psychiatry, University of Chicago Rehabilitation Center, 7230 Arbor Drive, Tinley Park, IL 60477;* and Laleh Mary Bakhtiar, Ph.D., *Director, Institute of Psychoethics, 3023 West Belmont Avenue, Chicago, IL 60618*

SUMMARY:

For thousands of years religious mystics have successfully used various techniques to modify people's behavior. This presentation will focus only on Sufis (Muslim mystics). Sufism is little known in the Western world, especially in the field of psychiatry, and what is known is a rather distorted version of Sufism. But Sufis gained worldwide recognition by showing how to gain peace and tranquility and attain deeper insights by "unsealing the soul." With the help and guidance of these Sufis, many criminals, drug addicts, and people riddled with guilt, anxiety, and depression have gained peace by purification of the soul and untying of spiritual knots. Any technique that helps individuals to ease pain, gain peace and tranquility, unlock the secret doors of the inner self, and empower themselves to achieve their potentials must be compared with modern techniques that claim to unlock complexes, untie psychic knots, and change maladaptive behavior patterns. Exposure to nontraditional methods and techniques, such as Sufism, provides us with valuable information that for centuries has been the occupation of the best minds of the East. The comparison of these approaches brings out many hidden and important aspects of both, and it also reveals how Eastern and Western psychotherapies can fertilize each other. It may compel us to reexamine current methods and systems and develop, if possible, new and creative ways of helping "disturbed" people.

REFERENCES:

1. Watts AW: *Psychotherapy: East and West.* Ballantine Books, New York, 1969.
2. Wilcox L: *Sufism and Psychology.* Abjad Book Designers, Chicago, 1995.

FULL–DAY SESSIONS

Full-Day Session 1 (Part 1) **Saturday, October 19**
8:30 a.m.-11:30 a.m.

CLINICAL CARE IN THE STATE HOSPITAL: EVOLVING TOWARD THE 21ST CENTURY

A. Brock Willett, M.D., *Director, Colorado Mental Health Institute at Fort Logan, 3520 West Oxford Avenue, Denver, CO 80236;* Linton S. Holsenbeck III, M.D., Keith M. LaGrenade, M.D., Albert O. Singleton III, M.D., Jonathan A. Olin, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to identify problems resulting from managed care in state hospitals, outline new opportunities in clinical care and administration, and describe services for two specific populations.

SUMMARY:

The evolution of the state hospital since deinstitutionalization has involved targeting services to seriously and persistently mentally ill patients. The presenters will discuss some of the consequences for the evolving state hospitals of Colorado in the context of an overall devolving mental health system. Opportunities for unique and rewarding psychiatric practice exist within the context of the entry of the marketplace into hospitals through public mental health managed care, the criminalization of the mentally ill not previously eligible for increasingly targeted services, and the opportunities attendant on privatization of and around treatment programs, including the development of new governance structures.

The presenters are all actively involved in the psychiatric administration of the care in the two mental health institutes in Colorado, including the recruitment, retention, and professional development of psychiatric staff. The individual presentations will cover programming for multisystem patients/child welfare and for mentally ill adults in corrections, programming to respond to managed care and how the evolving state hospital looks to the managed care organization, and governance of state mental health agencies when government is devolving.

REFERENCES:

1. Bachrach LL: The future of the state mental hospital. *Hosp Community Psychiatry* 37:467-476, 1986.
2. Becker FW: The politics of closing state mental hospitals: a case of increasing policy gridlock. *Community Ment Health J* 29:103-114, 1993.
3. Geller JL: "Anything but the state hospital": examining assumptions about the benefits of admission diversion. *Hosp Community Psychiatry* 42:145-152, 1991.

Full-Day Session 1 (Part 2) **Saturday, October 19**
2:00 p.m.-5:00 p.m.

CLINICAL CARE IN THE STATE HOSPITAL: EVOLVING TOWARD THE 21ST CENTURY

A. Brock Willett, M.D., *Director, Colorado Mental Health Institute at Fort Logan, 3520 West Oxford Avenue, Denver, CO 80236;* Robert R. Conley, M.D., Jerome V. Vaccaro, M.D., William R. McFarlane, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to identify cutting-edge treatments for persons in state hospitals.

SUMMARY:

Since the inception of deinstitutionalization, the role of the state hospital has become more targeted, focusing increasingly on persons suffering from the most severe, persistent, and treatment-refractory illnesses who cannot be treated elsewhere in the community-based system.

Part 2 of this full-day session will focus on state-of-the-art treatment approaches to persons treated in state hospitals. Dr. Conley will identify relevant new pharmacologic agents and discuss their use. Dr. Vaccaro will describe how psychosocial rehabilitation can help patients in their transition back to the community. Dr. MacFarlane will discuss how to involve families and others in admission, treatment, and discharge.

The presentations will be followed by a panel discussion to promote significant audience participation.

REFERENCES:

1. Bachrach LL: The future of the state mental hospital. *Hosp Community Psychiatry* 37:467-476, 1986.
2. Becker FW: The politics of closing state mental hospitals: a case of increasing policy gridlock. *Community Ment Health J* 29:103-114, 1993.
3. Geller JL: "Anything but the state hospital": examining assumptions about the benefits of admission diversion. *Hosp Community Psychiatry* 42:145-152, 1991.

Full-Day Session 2 (Part 1) **Saturday, October 19**
8:30 a.m.-11:30 a.m.

MENTAL HEALTH ASPECTS OF HIV DISEASE

Joint Session with the APA AIDS Project

Larry S. Goldman, M.D., *Director, Department of Mental Health, American Medical Association, and Department of Psychiatry, University of Illinois, 515 North State Street, Chicago, IL 60610;* Andrew Boxer, Ph.D., Nathan L. Linsk, Ph.D., Renslow Sherer, M.D., Judith A. Cook, Ph.D.

FULL–DAY SESSIONS

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to describe medical, epidemiologic, and psychological aspects of HIV/AIDS and to identify some of the special needs of individual patients.

SUMMARY:

To meet the challenges presented by the AIDS epidemic, clinicians across all disciplines need to understand the basic medical aspects of AIDS, as well as patterns of HIV infection in the various patient populations. Dr. Sherer will provide an overview of HIV disease, including epidemiology, pathogenesis, clinical manifestations, current monitoring, and treatment strategies.

As the HIV epidemic widens, its impact grows for communities of color, women and children, and older adults. Dr. Linsk will moderate a panel discussion by people living with HIV, who will provide personal testimonies, share a variety of experiences, and describe their adjustment to the realities of life with HIV infection.

Dr. Boxer will explore the psychosocial impact of HIV on the life course of infected patients. He will describe how the effects of HIV are mediated by factors such as developmental stage, medical status, and family and cultural factors, including sexual identity, ethnicity, religion, education, and socioeconomic status.

REFERENCES:

1. Cohen PT, Sande MA, Volberding PA: *The AIDS Knowledge Base: A Textbook on HIV Disease from the University of California, San Francisco, and the San Francisco General Hospital,* 2nd ed. Little, Brown, New York, 1995.
2. Quin TC: The epidemiology of the acquired immunodeficiency syndrome in the 1990s. *Emerg Med Clin North Am* 13:1-25, 1995.
3. Hays RB, Magee RH, Chauncey S: Identifying helpful and unhelpful behaviors of loved ones: the PWA's perspective. *AIDS Care* 6:379-392, 1994.
4. Hyman SE: A man with alcoholism and HIV infection. *JAMA* 274:837-843, 1995.
5. Amaro H: Love, sex, and power: considering women's realities in HIV prevention. *Am Psychol* 50:437-447, 1995.
6. *Face to Face: A Guide to AIDS Counseling.* University of California, San Francisco, AIDS Health Project, 1995.

Full-Day Session 2 (Part 2) **Saturday, October 19**
2:00 p.m.-5:00 p.m.

MENTAL HEALTH ASPECTS OF HIV DISEASE
Joint Session with the APA AIDS Project

Larry S. Goldman, M.D., *Director, Department of Mental Health, American Medical Association, and Department of Psychiatry, University of Illinois, 515 North State Street, Chicago, IL 60610;* Jay Callahan, Ph.D., Lisa A. Razzano, Ph.D., William S. Gilmer, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to discuss the relationship of HIV disease to the clinical, psychiatric, psychosocial, and treatment needs of the severely and persistently mentally ill.

SUMMARY:

Part 2 will highlight some of the interactions between HIV infection and chronic mental and/or developmental illness. The panelists will discuss these interactions by using a framework of illness stages, highlighting for each stage the relevant problems and proposed interventions. The session will include a discussion of risk factors for HIV infection among the severely and persistently mentally ill and will review treatment interventions and case management strategies.

REFERENCES:

1. Carmen E, Brady SM: AIDS risk and prevention for the chronic mentally ill. *Hosp Community Psychiatry* 41:652-657, 1990.
2. Kelly JA, Murphy DA: AIDS/HIV risk behavior among the chronically mentally ill. *Am J Psychiatry* 149:886-897, 1992.
3. Knox MD, Boaz TL, Friedrich MA, et al: HIV risk factors for persons with serious mental illness. *Community Ment Health J* 30:551-563, 1994.

Full-Day Session 3 (Part 1) **Sunday, October 20**
8:30 a.m.-11:30 a.m.

"PRACTICE MANAGEMENT 101"
Joint Session with the APA Office of Economic Affairs

Mary D. Graham, B.A., *Director, Office of Economic Affairs, American Psychiatric Association, 1400 K Street, N.W., Washington, DC 20005;* Thomas G. Hardaway II, M.D., Chester W. Schmidt, Jr., M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to improve the efficiency of their practices, provide the concise documentation required by managed care organizations, and bill payers more successfully.

SUMMARY:

Part 1 will provide participants with practical skills for implementing and enhancing their office management procedures in group practices. The target audience is clinicians who are considering or are new to group practices and those whose practices are not sufficiently sophisticated to keep pace with their groups' needs. The strategies that will be taught are essential to successful practice in this era of evolving health care delivery systems, increased penetration by the managed care industry, and rapid advancement in clinical and computer technologies. The presentations will provide pragmatic advice on basic business aspects of day-to-day practice.

In addition, the presenters will describe concrete strategies for enhancing the efficiency, comprehensiveness, and quality of clinical operations through appropriate documentation and use of tailored information system applications. Participants will have an opportunity to ask questions and request advice on problems they are facing in these and related areas of practice management.

Ms. Graham will focus on personnel, basic operational issues, utilization review, and referral relationships. Personnel issues include effective policies regarding employee recruitment, management, and retention and such specific areas as position descriptions, benefits, hiring, performance evaluations, and terminations. She will also present tactics to enhance practice efficiency, including advice on intake procedures, appointment scheduling, collections, utilization review, and management of relationships with referral sources. Sample letters and forms and a list of tips will be available as handouts.

Dr. Hardaway will address the content and maintenance of medical records, emphasizing documentation required by managed care organizations. Special attention will be paid to confidentiality, consent, patient history, treatment plans, progress reports, and communication with external parties. Strategies will also be provided for ensuring that medical records meet the practice's clinical, legal, and financial needs. Sample clinical vignettes, with appropriate documentation, will be provided as handouts.

Dr. Schmidt will outline practical strategies for billing third-party payers, with an emphasis on accurate and effective use of CPT codes. The managed care industry's use and misuse of CPT and other billing approaches will be described in detail, along with tactics for ensuring the most rapid, appropriate payment for these vendors. A handout containing tips will be available.

REFERENCES:

1. Cagney C, Woods DR: Clinician update: clinical MIS. *Behav Healthcare Tomorrow* 3(1):43-47, 1994.
2. Feldman JL, Fitzpatrick RJ: *Managed Mental Health Care: Administrative and Clinical Issues.* American Psychiatric Press, Washington, DC, 1992.
3. *Physicians' Current Procedural Terminology.* American Medical Association, Chicago, 1996.
4. Should my group practice accept capitation or risk-based contracts? *Behav Health Practice Advisor* 1(3):1-3.
5. Sargent S, Richardson D, Petrila J, et al: Dialogue: ethical hazards of capitation contracting. *Behav Healthcare Tomorrow* 3(4):40-46, 1994.
6. Before you sign "I do": make sure the managed care plan is one you can live with. *Am Med News,* Dec 13, 1993, pp 25-27.
7. Fruchter S, Oss M: Industry analysis: understanding the "risk" in an "at-risk" contract. *Open Minds,* Aug 1994, pp 4-5.
8. Daniels A, Dickman N, Zieman G: *The Comprehensive Group Practice Tool Kit.* CentraLink, Tiburon, CA, 1995.

Full-Day Session 3 (Part 2) **Sunday, October 20**
2:00 p.m.-5:00 p.m.

"PRACTICE MANAGEMENT 101"
Joint Session with the APA Office of Economic Affairs

Mary D. Graham, B.A., *Director, Office of Economic Affairs, American Psychiatric Association, 1400 K Street, N.W., Washington, DC 20005;* David K. Nace, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to describe managed care contracting and capitation and to select and customize computer applications for their practices.

SUMMARY:

Part 2 will provide participants with practical skills for implementing and enhancing their office management procedures in group practices. The target audience is clinicians who are considering or are new to group practices and those whose practices are not sufficiently sophisticated to keep pace with their groups' needs. The strategies that will be taught are essential to successful practice in this era of evolving health care delivery systems, increased penetration by the managed care industry, and rapid advancement in clinical and computer technologies. The presentations will provide pragmatic advice on basic business aspects of day-to-day practice. In addition, the presenters will describe concrete strategies for enhancing the efficiency, comprehensiveness, and quality of clinical operations through appropriate documentation and use of tailored information system applications. Participants will have an opportunity to ask questions and request advice on problems they are facing in these and related areas of practice management.

Ms. Graham will focus on key issues regarding managed care contracts, including terminology, hold-harmless clauses, and contract-termination language. She will also describe the basic steps in developing capitation rates for a group practice. Handouts will focus on definitions of terms and practical strategies for developing a fair and accurate capitation rate.

Dr. Nace will address strategies for improving practice efficiency and sophistication through computer applications. The topics will include selecting, installing, and customizing practice management software, electronic billing systems, computerized clinical records, clinical pathways, criteria, and practice guidelines. Key considerations and recommendations for each of these areas will be provided as handouts.

REFERENCES:

1. Cagney C, Woods DR: Clinician update: clinical MIS. *Behav Healthcare Tomorrow* 3(1):43-47, 1994.
2. Feldman JL, Fitzpatrick RJ: *Managed Mental Health Care: Administrative and Clinical Issues.* American Psychiatric Press, Washington, DC, 1992.

3. *Physicians' Current Procedural Terminology.* American Medical Association, Chicago, 1996.
4. Should my group practice accept capitation or risk-based contracts? *Behav Health Practice Advisor* 1(3):1-3.
5. Sargent S, Richardson D, Petrila J, et al: Dialogue: ethical hazards of capitation contracting. *Behav Healthcare Tomorrow* 3(4):40-46, 1994.
6. Before you sign "I do": make sure the managed care plan is one you can live with. *Am Med News,* Dec 13, 1993, pp 25-27.
7. Fruchter S, Oss M: Industry analysis: understanding the "risk" in an "at-risk" contract. *Open Minds,* Aug 1994, pp 4-5.
8. Daniels A, Dickman N, Zieman G: *The Comprehensive Group Practice Tool Kit.* CentraLink, Tiburon, CA, 1995.

Full-Day Session 4 (Part 1) **Sunday, October 20**
8:30 a.m.-11:30 a.m.

"MENTAL ILLNESS 101": A PRIMER FOR FAMILIES
Joint Session with the National Alliance for the Mentally Ill

Laurie M. Flynn, M.A., *Consultant, APA Institute Scientific Program Committee, and Executive Director, National Alliance for the Mentally Ill, Room 1015, 200 Glebe Road, Arlington, VA 22203;* Alan F. Schatzberg, M.D., Daniel J. Luchins, M.D., Jerry Dincin, Ph.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of this session, participants should be able to supply families of mentally ill patients basic information on schizophrenia, mood disorders, and psychiatric rehabilitation.

SUMMARY:
Families are important allies in the continuum of care for people with severe and persistent mental illnesses. Family education and support can significantly effect the success of the alliance between consumers and professionals. Sessions will cover the origins, symptoms, course and treatment of depression, bipolar disorder, and schizophrenia. Question and answer segments will follow presentations. Psychiatric rehabilitation and the impact that latest medications have on expected outcomes will be explored, including the importance of integrating family support into overall treatment plan.

Full-Day Session 4 (Part 2) **Sunday, October 20**
2:00 p.m.-5:00 p.m.

"MENTAL ILLNESS 101": A PRIMER FOR FAMILIES
Joint Session with the National Alliance for the Mentally Ill

Laurie M. Flynn, M.A., *Consultant, APA Institute Scientific Program Committee, and Executive Director, National Alliance for the Mentally Ill, Room 1015, 200 Glebe Road, Arlington, VA 22203;* Susan A. Pickett, Ph.D., Joyce Burland, Ph.D., Donna Mayieux

EDUCATIONAL OBJECTIVE:
At the conclusion of this session, participants should be able to identify and describe types of information useful to families of persons with mental illness.

SUMMARY:
This session will focus on a family-led course organized by the National Alliance for the Mentally Ill, "Journey of Hope." The course combines information about disorders and their management in the family. The session will cover information about obtaining services, dealing with professionals, handling crises, support groups, etc. Participants will have an opportunity to interact and will be given several handouts. Chicago-area Alliance for the Mentally Ill members will present their family experiences as part of a panel.

Full-Day Session 5 (Part 1) **Sunday, October 20**
8:30 a.m.-11:30 a.m.

UPDATE IN CHILD AND ADOLESCENT PSYCHIATRY: YOUTH AND VIOLENCE

Charles W. Huffine, Jr., M.D., *Medical Director, King County Mental Health Clinic, 3123 Fairview Avenue East, Seattle, WA 98102-3051;* Robert L. Klaehn, M.D., Carl C. Bell, M.D., Andres J. Pumariega, M.D., Markus J.P. Kruesi, M.D., Charles W. Popper, M.D., Rebecca Perbix, M.S.W., Roberta J. Apfel, M.D., M.P.H., Bennett Simon, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of this session, participants should be able to discuss the current theoretical and diagnostic concepts regarding violence in youth.

SUMMARY:
Part 1 will focus on current thinking regarding diagnostic and theoretical considerations in youth violence. Dr. Bell will give clinical examples illustrating cycles of violence in disadvantaged youth in Chicago. Dr. Pumariega will discuss the development of mental health services for

juvenile offenders and recent results from a diagnostic study of incarcerated youth. Dr. Kruesi will discuss findings on the neurobiology of violence. Ms. Perbix will present her work with unattached "systems" children, many of whom are victims of violence and at risk of being perpetrators of violence. Drs. Popper, Apfel and Simon will provide an overview of the issues presented. There will be time for audience discussion after the individual presentations.

REFERENCES:

1. Stone LA: Humpty Dumpty--presidential address. *J Am Acad Child Adolesc Psychiatry* 35:273-278, 1996.
2. Kilgus MD, Purmariega AJ, Cuffe S: Race and diagnosis in adolescent inpatients. *J Am Acad Child Adolesc Psychiatry* 34:67-72, 1995.
3. Jenkins EJ, Bell CC: Exposure and response to community violence among children and adolescents. In Osofsky J (ed): *Children, Youth and Violence.* Guilford Press, New York, in press.

Full-Day Session 5 (Part 2) **Sunday, October 20**
2:00 p.m.-5:00 p.m.

UPDATE IN CHILD AND ADOLESCENT PSYCHIATRY: YOUTH AND VIOLENCE

Charles W. Huffine, Jr., M.D., *Medical Director, King County Mental Health Clinic, 3123 Fairview Avenue East, Seattle, WA 98102-3051;* Robert L. Klaehn, M.D., Andres J. Pumariega, M.D., Charles W. Popper, M.D., Karl Dennis, Robert Caesar, Ph.D., Patricia McManus, Ph.D., R.N.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to identify effective treatments and systems of care for violent youth.

SUMMARY:

Part 2, chaired by Dr. Klaehn will focus on programs and treatment approaches for youth involved in violence. Mr. Dennis will present his innovative Kaleidoscope Program from Chicago. Dr. Caesar will describe the Hickory program, a corrections-based mental health program for juvenile offenders. Dr. Popper will discuss biomedical treatments for violent youth. Dr. McManus will present the Resilience in Black Families Program in Milwaukee, a family, school, and community intervention program aimed at reducing youth violence; her segment will include presentations by adolescent clients. Dr. Pumariega will be a discussant, and the audience will be invited to participate.

REFERENCES:

1. Stone LA: Humpty Dumpty--presidential address. *J Am Acad Child Adolesc Psychiatry* 35:273-278, 1996.
2. Kilgus MD, Purmariega AJ, Cuffe S: Race and diagnosis in adolescent inpatients. *J Am Acad Child Adolesc Psychiatry* 34:67-72, 1995.
3. Jenkins EJ, Bell CC: Exposure and response to community violence among children and adolescents. In Osofsky J (ed): *Children, Youth and Violence.* Guilford Press, New York, in press.

HALF–DAY SESSIONS

Half-Day Session 1 **Friday, October 18**
8:30 a.m.-11:30 a.m.

MENTAL HEALTH AND PRIMARY CARE INTERFACE IN PUBLIC SETTINGS

Joint Session with the American Association of Community Psychiatrists

David A. Pollack, M.D., *Medical Director, Mental Health Services West, 710 Southwest Second Street, Portland, OR 97204-3112;* Martin Arron, M.D., Fred C. Osher, M.D., Rupert R. Goetz, M.D., Rachel Jenkins, M.D., Kenneth S. Duckworth, M.D., Roger G. Kathol, M.D., Harold Alan Pincus, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to discuss the need for better collaboration between primary care providers and mental health providers, describe important conflicts associated with this interface, and identify potential solutions.

SUMMARY:

Discussions of health care reform and the advent of managed care in the public sector have brought the interface between mental health and primary care providers into greater focus and have forced examination of collaboration. Organized care delivery systems must have a smoother interface between mental health and primary care providers in order to more effectively and efficiently meet the needs of patients and payers. This session will address some of the most critical issues associated with this interface and the broad concept of interface management.

A key focus is what primary care providers want from mental health providers. This help may be in the form of consultation, improved access for referrals, or education about diagnosis or treatment methods so that primary care providers can provide some mental health services more effectively. How do the communications and confidentiality issues for the two arenas get worked out? Now that many primary care providers are functioning as gatekeepers, what are the conflicts between the mental health needs of patients and the referral or approval of payment for services? What kind of linkages can be developed to assure ongoing support and access to services? What consultation-liaison models work best in the outpatient setting? What resources are available to assist primary care providers in assessing the mental health needs of their patients, how easy are they to use, and will their use mean any improvement in the care of patients? These are some of the questions that will be addressed by the presenters, who reflect clinical and research experiences from various parts of the United States and the United Kingdom.

Dr. Pollack's overview will highlight the main issues that affect the interface between mental health and primary care providers, especially as it is manifested in the public sector. These issues include the need for effective communication, appropriate integration and use of mental health personnel in primary care settings, development of effective communication-liaison models, and the use of screening tools and other supports to help primary care providers work more effectively with persons with psychiatric disorders.

Dr. Arron will outline the kinds of support that primary care providers are most likely to want and use. Too often, mental health providers act as if they know what primary care providers want. The types of patients that are most commonly encountered in primary care settings and the types of evaluations, notes, training, and consultation services that would be most helpful will be described.

Dr. Osher will describe the tensions between primary care and mental health providers regarding communication and confidentiality, the need to look carefully at traditional reasons for resistance to information sharing, the risks of sharing information with providers who may not appreciate the sensitivity of the information and the effect of inappropriate releases, how to inform patients of the need for such communications, and how to protect information that probably should not be shared.

Dr. Goetz will focus on the impact of the primary care provider in the gatekeeping role. How can mental health providers influence the primary care providers' decisions? What arrangement can be developed to ensure that appropriate and clinically sound decisions are made?

Drs. Jenkins and Duckworth will provide a brief overview of the types of consultation models that have been developed in the United States and the United Kingdom, focusing on approaches that seem to work best with community/public facilities and patients. Specific methods for integrating mental health personnel into primary care settings will be emphasized.

Dr. Kathol will present an overview of screening tools. In recent years a number of screening instruments have been developed to address diagnostic and monitoring issues associated with psychiatric disorders in primary care settings. Several of the more useful tools will be described and evaluated in terms of their usefulness in public settings.

Dr. Pincus will describe how to use *DSM-IV-PC* in working with primary care providers. The recently introduced *DSM-IV-PC* has great potential for a variety of uses in the interaction between mental health and primary care providers. The presentation will identify these uses and will include recommendations for how the mental health consultant can best use the document as an adjunct to the consultation process.

REFERENCES:

1. Pincus HA: Patient-oriented models for linking primary care and mental health care. *Gen Hosp Psychiatry* 9:95-101, 1987.
2. Strathdee G: Primary care-psychiatry interaction: a British perspective. *Gen Hosp Psychiatry* 9:102-110, 1987.

3. *American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders,* 4th edition: Primary Care Version (DSM-IV-PC). American Psychiatric Press, Washington, DC, 1995.

Half-Day Session 2 **Friday, October 18**
2:00 p.m.-5:00 p.m.

INTEGRATING PSYCHIATRY WITH PRIMARY CARE
Joint Session with the American Association of General Hospital Psychiatrists

Richard J. Goldberg, M.D., *Psychiatrist-in-Chief, Rhode Island Hospital, 593 Eddy Street, Providence, RI 02903-4923;* Nada L. Stotland, M.D., Whitney W. Addington, M.D., Lesley M. Blake, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to describe specific strategies to enhance the psychiatrist-consultant's relationship with primary care physicians, recognize the steps necessary to achieve an effective collaborative mode of interaction, and discuss integrated models for interfacing with internists in diverse settings specific to the care of the aging population.

SUMMARY:

This session will feature three clinical-administrative leaders with hands-on experience in building bridges between--and networks including--psychiatric health care and primary care in both academic and clinical settings. They will share their vision and expertise on: a) how to establish productive collaboration with primary care physicians through the consultative model, b) current trends in educating current and future primary care physicians about the emotional and psychiatric needs of their patients, and c) specific ways of developing a team approach to the aging population through shared efforts of geropsychiatrists and internists.

Dr. Stotland will discuss what primary care physicians really want from psychiatrists. The presentation will include a history of the relationship between psychiatry and primary care, psychiatry's bad reputation with primary care physicians, unrealistic expectations of primary care colleagues, restructuring primary care providers' expectations of psychiatry, and how to work toward productive collaboration.

Dr. Addington will discuss mental health training in primary care. Specific issues will include psychiatric training for primary care residents, curriculum content and percentage of time allotted to psychiatry training, methods of providing supervision for primary care residents, and assessing the effectiveness of the psychiatric education received by primary care residents.

Dr. Blake will discuss how the geriatric psychiatrist and the primary care physician can work together. The presentation will cover the importance of the team approach and open lines of communication, respecting each other's area of expertise and limitations, the ongoing education of the two types of physicians, and interfacing in many settings, including inpatient psychiatric units, general medical units, nursing homes, outpatient clinics and offices, and home care.

The presentations will be followed by a presenters' panel and roundtable discussion, moderated by Dr. Goldberg, on the potential for future collaboration between psychiatry and primary care.

REFERENCES:

1. Garrick T, Stotland N: *Manual of Psychiatric Consultation.* American Psychiatric Press, Washington, DC, 1993.
2. Shah A: Cost comparison of psychogeriatric consultations: outpatient versus home based consultations. *Int Psychogeriatr* 6:179-184, 1994.
3. Shulman KI: The future of geriatric psychiatry. *Can J Psychiatry* 39(8 suppl 1):4-8, 1994.
4. Norquist G, Wells KB, Rogers WH, et al: Quality of care for depressed elderly patients hospitalized in the specialty psychiatric units or general medical wards. *Arch Gen Psychiatry* 52:695-701, 1995.
5. Novack DH, Goldberg RJ, Rowland-Morin P, et al: Toward a comprehensive psychiatric/behavioral science curriculum for primary care residents. *Psychosomatics* 30:213-223, 1989.

Half-Day Session 3 **Saturday, October 19**
8:30 a.m.-11:30 a.m.

THE UNDERTREATMENT OF DEPRESSION
Joint Session with the National Depressive and Manic-Depressive Association

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

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to describe and evaluate how excellence in diagnosis and treatment of depression conflicts with managing strategies for cost containment.

SUMMARY:

Depression is one of the most common medical illnesses. It is associated with long episodes; high rates of chronicity, relapse, and recurrence; psychosocial and physical impairment; and a 15% risk of death from suicide

for hospitalized patients. Nonetheless, patients with depression are being seriously undertreated even though effective treatments have been available for over 30 years. Studies have shown that the vast majority of patients with chronic depression receive inadequate treatment or no treatment at all.

In recent decades there has been an extraordinary expansion and refinement of an array of treatments for depression. The availability of effective pharmacological, other somatic, and psychosocial interventions greatly enhances the benefits of early identification and treatment. Given the prevalence and perniciousness of depression, the economic cost of the illness, its treatability, and previous public and professional educational efforts, why are so many people either receiving inadequate treatment or getting no treatment at all?

To help answer this question, the National Depressive and Manic-Depressive Association held the Consensus Conference on the Undertreatment of Depressive Disorders on January 17-18, 1996. The conference was co-chaired by Dr. Keller. Dr. Hirschfeld chaired a consensus panel that included experts in psychiatry, psychology, internal medicine, managed care, and public health, as well as consumers and public representatives. After a day of presentations by experts in the relevant fields and discussion from the audience, the panel considered the scientific and historical evidence and formulated recommendations and a consensus statement to respond to the following questions: a) Is depression undertreated in the community and in the clinic? How extensive is the gap between current knowledge and actual treatment? b) What is the economic cost to society of depression, including the cost of lack of treatment, inappropriate treatment, and inadequate treatment? c) What have been the efforts in the past to redress undertreatment? How successful have they been? What were the problems associated with those efforts? d) What are the reasons for the gap between our knowledge of the diagnosis and treatment of depression and actual treatment received in this country? e) What can we do to narrow this gap? and f) What can we do immediately to narrow this gap?

Dr. Schwenk will discuss the importance of the consensus conference, present patients' views on the need to improve health care for people with depression, and describe how the National Depressive and Manic-Depressive Association can work with the health care community.

Dr. Keller will provide background, review questions addressed at the conference, and distribute the monograph. He will also discuss the findings of the conference regarding whether depression is undertreated in the community and in clinics, the gap between current knowledge and actual treatment, and the economic costs of depression--including those related to lack of treatment, inappropriate treatment, and inadequate treatment--to society.

Dr. Michels will describe how the consensus statement responds to the questions regarding past efforts to redress undertreatment and the reasons for the gap between our knowledge of the diagnosis and treatment of depression and actual treatment received in this country. In response to the question "What can we do to narrow this gap?" the conference panel proposed research to better understand the reasons for the gap. To immediately to narrow this gap, the panel recommended programs to narrow the gap now while we gain more knowledge about reasons for the gap.

Dr. Schwenk will provide an update on the National Depressive and Manic-Depressive Association's progress in implementing the recommendations from the consensus conference. After the individual presentations, the panel will take questions and statements from the audience.

REFERENCES:

1. DeVane CL: Pharmacokinetics of the newer antidepressants: clinical relevance. *Am J Med* 97(suppl 6A):13s-23s, 1994.
2. Greenberg PE, Stiglin LE, Finkelstein SN, et al: The economic burden of depression in 1990. *J Clin Psychiatry* 54:405-418, 1993.
3. Rosenbaum JF, Fava M, Nierenberg AA, et al: Treatment-resistant mood disorders. In Gabbard GO (ed): *Treatments of Psychiatric Disorders,* 2nd ed. American Psychiatric Press, Washington, DC, 1995, pp 1275-1328.

Half-Day Session 4 **Saturday, October 19**
8:30 a.m.-11:30 a.m.

THE IMPACT OF MANAGED CARE ON PUBLIC MENTAL HEALTH SYSTEMS

David A. Pollack, M.D., *Medical Director, Mental Health Services West, 710 Southwest Second Street, Portland, OR 97204-3112;* Kenneth Minkoff, M.D., Michael A. Hoge, Ph.D., Richard H. Beinecke, D.P.A., Sharon L. Farmer, M.D., Julia F. Moore, M.D., Candace Nardini, M.P.A., Philip Micali

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to list the general principles of managed care, discuss how these principles are theoretically applied to public mental health service systems, describe several practical models of implementation of managed mental health care, and identify models that would be most applicable to their particular states or regions.

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 use more-efficient methods of service delivery while simultaneously demonstrating a commitment to quality of service. The mandate for publicly funded organizations to provide high-quality services may compromise their efforts to contain costs. Some providers believe that the principles of managed care are contrary to the principles of public mental health.

The purpose of this presentation is to identify some of the major issues related to managed care in the public sector and to discuss their effects on existing service systems at the state, program, and clinical levels.

The first three presenters will outline the history of public sector managed care, provide an overview of the principles of managed mental health care, and discuss the ideological basis for implementation of managed mental health care in the community and other public sector programs.

Dr. Hoge will provide a functional analysis and definition of public sector managed care and will begin by identifying the problems in unmanaged public sector systems. He will then review the form and function of each of the strategies that have been employed to address these problems. The distillation of these approaches will result in a definition of public sector managed care that provides a useful conceptual framework for planning and evaluating managed care initiatives for the severely and persistently mentally ill individuals typically served in the public sector.

Dr. Minkoff will highlight the parallels between the principles of public sector managed care and community mental health, compare areas of perceived incompatibility, describe the roots and evolution of community mental health ideologies, and propose acceptable principles of public sector managed care.

On the basis of his experience in coordinating a statewide program evaluation of the Massachusetts Medicaid managed care organization, Dr. Beinecke will discuss key issues in performance evaluation that are relevant to all states embarking on public sector managed care initiatives.

The second set of presenters will describe two different public systems and their current programs of managed mental health care. Drs. Farmer and Moore will discuss the experience in King County, Washington, and Ms. Nardini and Mr. Micali will describe the system in Iowa. Each of these two presentations will include one representative from the managed behavioral health care organization 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. The presenters will describe the development and progress of the initiatives and will provide current information on system design, evaluation, and outcomes. They will assess how well the projects are working and point out lessons for others.

REFERENCES:

1. Goldman W, Feldman S (eds): Managed Mental Health Care. *New Dir Ment Health Serv* 59, 1993.
2. Minkoff K, Pollack D (eds): *Managed Mental Health Care in the Public Sector: A Survival Manual.* Gordon & Breach, Newark, NJ, 1996.
3. Broskowski A, Eaddy M: Community mental health centers in a managed care environment. *Admin Policy Ment Health* 21:335-352, 1994.

Half-Day Session 5 **Saturday, October 19**
2:00 p.m.-5:00 p.m.

SPECIALIZED MENTAL HEALTH SERVICES FOR WOMEN

Joseph A. Flaherty, M.D., *Professor and Chairman, Department of Psychiatry, University of Illinois at Chicago, M/C 913, 912 South Wood Street, Chicago, IL 60612;* Kathleen M. Kim, M.D., Catherine A. Nageotte, M.D., Susan Adams, M.A., Carole L. Warshaw, M.D., Sonja Nelson, M.A., Laura J. Miller, M.D., Tonda Hughes, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to describe the latest findings from outcomes and services research on the treatment of mentally ill, substance-abusing, and victimized women and to discuss application of services research data to the treatment of this population.

SUMMARY:

Over the last 25 years, there has been considerable research regarding special psychiatric and psychosocial problems affecting women and the relationship of these problems to the availability, design, use, and outcome of psychiatric services and rehabilitation. The data from this research have been useful in the design of psychiatric services for women and have challenged the common assumption that services should be gender blind. The presenters' data and experience are derived from their efforts in establishing the Women's Mental Health Service at the University of Illinois and pilot data from their NIMH/RISP-sponsored program, "Mental Health Services Research: Women and Gender."

Women with chronic mental disorders face particular problems related to continuity of care during childbearing years and to the use of psychotropic medications. Dr. Miller will discuss gender differences in pharmacokinetics/dynamics, gender differences in diagnosis and compliance, and medication management through the childbearing years. Specific knowledge and skill are required for effective treatment of this population of women, data on haloperidol and risperidone will be used to illustrate this point. Particular problems in engagement and treat-

ment of special populations of psychotic women, e.g., the homeless and the dually diagnosed, will also be presented. A rehabilitation program for chronically mentally ill women will be described. Dr. Miller will also discuss assessment and enhancement of parenting skills for mentally ill mothers. The perinatal period is an ideal time to screen for psychiatric disorders and to plan intervention and prevention strategies.

Dr. Nageotte will discuss mental health services during the prenatal/perinatal period, including detection, assessment, and intervention for depression and for alcohol, tobacco, and other drug use in the primary care and prenatal care domains. The presentation will also cover assessment and treatment of postpartum psychosis and depression, use of psychotropic medication during pregnancy and lactation, and infant assessment and follow-up.

Ms. Adams and Ms. Nelson will describe mental health services and social issues for substance-abusing women. Female addicts encounter particular stigma, and their substance abuse is often denied by their families, partners, and primary care doctors. Adequate child care may be absent. Treatment issues include barriers to treatment for women, special treatments for women, and community and self-help resources (e.g., Alcoholics Anonymous). The presenters will also discuss prognosis for these women and assessment of dual diagnosis, particularly concurrent diagnoses of affective disorder and alcohol or of substance abuse and personality disorder.

Dr. Warshaw will discuss the epidemiology of domestic violence, the presentation and help-seeking behavior of female victims, and treatment options. The incidence of domestic violence against mentally ill women will be compared to the frequency for women in the general population, and the rates of rape, date rape, and sexual harassment will be presented.

Many victims are reluctant to admit the abuse because they fear punishment by battering, loss of their children, or homelessness. Structured intake interviews should include questions regarding abuse. Possible problems in treatment are "pathologizing" and blaming the victim and treating psychiatric symptoms (e.g., depression, anxiety), rather than the domestic violence, as the primary problem. Specialized interventions are needed to accommodate victims of domestic violence with mental illness and/or drug addiction. Dr. Warshaw will describe treatment and consultation programs that are attuned to the sensitive issue of "psychiatrizing" this group of women.

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Half-Day Session 6 **Saturday, October 19**
2:00 p.m.-5:00 p.m.

CULTURE, ETHNICITY, AND RACE: PSYCHIATRY'S CURRENT CHALLENGE

Maria T. Lymberis, M.D., *Board of Trustees Member, American Psychiatric Association, and Associate Clinical Professor of Psychiatry, Department of Psychiatry, University of California at Los Angeles--Neuropsychiatric Institute School of Medicine, Suite 204, 1500 Montana Avenue, Santa Monica, CA 90403-1810;* Manuel Trujillo, M.D., Carol L. Kessler, M.D., Silvia W. Olarte, M.D., Teruko S. Neuwalder, M.D., Robert T.M. Phillips, M.D., Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to provide data demonstrating the current impact of ethnicity and race on psychiatric practice and describe ways that these factors can be used to improve patient care.

SUMMARY:

In this world of ethnic, cultural, and racial diversity, psychiatrists are being challenged to apply the science and the art of psychiatry in ways that truly meet the needs of patients. This session will explore the effects of these factors on psychiatric practice. The presenters will demonstrate the effects of these factors on: a) psychiatric evaluation and diagnosis, b) forensic psychiatric practice, c) psychiatric treatment of children and their families, and d) the psychotherapeutic process, with special emphasis on transference-countertransference.

Current research data and will present seasoned clinicians' experiences in addressing the effects of ethnic, cultural, and racial factors in actual psychiatric practice in diverse settings will be highlighted. Both problems and solutions will be emphasized. Active audience participation will be sought.

Dr. Trujillo will discuss ethnicity and culture in psychiatric care. The science of cultural psychiatry is rooted in the early days of scientific psychiatry. In the early 1900s Kraepelin reported that both the symptoms and illness course of schizophrenic patients on the island of Fiji were different from those noted elsewhere. *DSM-IV* has boosted interest in this matter by addressing the cultural aspects of each axis I diagnosis, including a glossary of culture-bound symptoms, and providing an outline for cultural diagnosis. Additionally, symptoms research over the last two decades has enhanced understanding of culturally diverse patients, thereby improving clinical outcomes. Dr. Trujillo will review the results of recent research and will provide a clinical framework for systematic evaluation of the impact of cultural background in the assessment of patients (Mental Status Examination) and in the development of the therapeutic relationship and treatment strategies. Findings on the psychopharmacology of different ethnic groups will be discussed.

Dr. Kessler will discuss the psychiatric needs of immigrant children and their families in Bronx, New York. The South Bronx is home for a diverse group of families, whose places of origin include Ecuador, Mexico, Honduras, the Dominican Republic, Cuba, and Puerto Rico. The process of immigration profoundly affects the nature of psychiatric problems in children and adolescents and demands socioculturally sensitive treatment. Through clinical vignettes, this presentation will illustrate the psychiatric problems encountered in a community mental health center serving this immigrant population. Dr. Kessler will also address her own experience with immigration and will examine the complex patient-psychiatrist interactions that ensue when both patient and psychiatrist have crossed cultural lines.

Dr. Olarte will discuss diagnostic and treatment considerations for Latino monolingual and bilingual patients. Latinos are the fastest-growing minority in the United States. Their command of English varies from none to equality with their proficiency in Spanish. Language is psychiatry's main diagnostic and therapeutic tool. Bilingual mental health professionals continue to increase, but there are still too few bilingual professionals to meet the needs of this fast-growing patient population. This presentation will focus on: a) Latinos' different levels of proficiency in English and the relation of this proficiency to sociocultural, educational, and immigration status, and b) the impact of such variation on delivery of services, family dynamics, and adaptation to U.S. society. Clinical vignettes from work with first- and second-generation Latino immigrants of different socioeconomic backgrounds will be used to illustrate both diagnostic and treatment issues.

The grouping of persons who are from different Asian countries creates an expectation of commonality and mutuality among the Asian peoples. Dr. Neuwalder, who is a Japanese-American, will describe his experiences in treating Asians and Asian-Americans. He will present brief clinical vignettes to demonstrate some of the differences and surprises encountered during the initial encounter, the diagnostic evaluation period, the therapeutic relationship, and the course of treatment. The clinical material reveals how patients express themselves within the contexts of culture, ethnicity, and race. Expression of these factors in transference and countertransference will be described. The purpose of this presentation is to increase clinicians' sensitivity and understanding of some of the factors involved in treating Chinese, Japanese, Korean, Vietnamese, and other Asian patients and the children of these immigrant populations.

Dr. Phillips will discuss barriers to psychiatric services for minority patients in forensic systems. Through a variety of criminal and civil procedures, thousands of citizens are committed each year, typically to state mental hospitals, for involuntary psychiatric treatment. Among the more common groups of criminally committed patients are those adjudicated as not guilty by reason of insanity, defendants adjudicated incompetent to stand trial, and special offenders, particularly mentally disordered sex offenders. From the civil system thousands of patients are committed by regular and special (probate) courts, and a smaller number of seriously mentally ill offenders who have already served time in correctional facilities are subsequently involuntarily hospitalized by the courts in secure hospitals or units. Although states have been providing these services for well over a century, racial and ethnic minority patients continue to have limited access to mental health services within forensic systems and are often discriminated against because of their minority group status. This presentation will identify some of the key issues in the treatment of minority patients in forensic settings and will critically review barriers to treatment for such patients.

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3. Malgady RG, Rodriguez O (eds): *Theoretical and Conceptual Issues in Hispanic Mental Health.* Krieger Publishing, Malabar, FL, 1994.
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Half-Day Session 7 **Monday, October 21**
8:30 a.m.-11:30 a.m.

INNOVATIONS IN INTEGRATED PROGRAMMING FOR DUAL DIAGNOSIS

Kenneth Minkoff, M.D., *Chief of Psychiatry, Choate Health Systems, Inc., 23 Warren Avenue, Woburn, MA 01801-4979;* Kim T. Mueser, Ph.D., Fred C. Osher, M.D., Katherine E. Watkins, M.D., Richard A. Nance, M.S.W., Susan H. Godley, Rh.D., Sharon Zahorodnyj, M.S.W., M.B.A.

HALF–DAY SESSIONS

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to: a) identify innovative models of treatment and intervention strategies for dual diagnosis patients with serious mental illness, and b) be able to apply these models to their own clinical settings.

SUMMARY:

In recent years, efforts to provide integrated treatment to individuals with dual diagnosis of serious mental illness and substance use disorders have resulted in the development of more-integrated conceptualizations of the elements of a dual diagnosis system of care, implementation of an increasing variety of treatment methods and models, and an expanding database with which those models can be evaluated.

This session will identify the elements of a comprehensive dual diagnosis care system and describe a variety of innovative interventions: integrated dual diagnosis case management outreach, application of addiction methods to seriously mentally ill populations, an interagency integrated program involving state mental health and substance abuse agencies, and gender-specific strategies for engaging dual diagnosis patients. Each treatment model is supported by at least preliminary research data, and the most current research findings on treatment outcomes in innovative integrated dual diagnosis programs will be reviewed.

Dr. Minkoff will discuss innovations in dual diagnosis treatment, including development of a comprehensive, continuous, integrated care system. The system is based on an integrated disease and recovery model for mental illness and addiction, and program components will be related to diagnosis, phase of recovery, activity, severity, disability, and motivation for treatment addressed by each program. The presentation will describe how these concepts were applied to development of a dual diagnosis acute care continuum in collaboration with a Medicaid managed care organization.

Dr. Mueser will review recent research on clinical outcomes associated with treatment of substance abuse in patients with severe mental illness. Longitudinal outcomes of a variety of integrated continuous-treatment team programs will be discussed and compared. Innovative tools for assessing progress in the dual diagnosis population will be described, and predictors of programmatic success will be identified.

Dr. Osher will describe his community psychiatry program's response to the needs of individuals with severe mental illness and co-occurring addictive disorders. Building on the existence of strong assertive community teams, the system has integrated a comprehensive, longitudinal set of substance abuse interventions for all dually diagnosed clients, incorporating case management, vocational rehabilitation, medication monitoring, family psychoeducation, and housing services. Ongoing collection of data on client progress will be highlighted, and interim outcome data will be presented.

Dr. Watkins will discuss gender issues in engagement of people with both substance abuse and chronic mental illness. She will present study results that indicate important differences between men and women with dual diagnosis in terms of access to care, reasons for seeking treatment, and conceptions of treatment. After a brief literature review focusing on differences in epidemiology, access to care, and treatment course, the engagement process will be examined in more depth. Data from qualitative interviews with men and women both in and out of treatment will be presented, and gender differences will be noted. The results suggest that men and women seek treatment for very different reasons and that this fact has clinical implications for outreach and treatment.

Mr. Nance, Ms. Godley, and Ms. Zahorodnyj will discuss the development of an integrated interagency project for case management of combined mental illness and substance abuse (MISA) in Illinois. The presentation will present the history of and research findings from the six pilot specialized MISA case management sites jointly funded by the Illinois Department of Mental Health and Development Disability and the Illinois Department on Alcoholism and Substance Abuse. This overview will extend from the organization of the Illinois MISA task force to present-day operation of program activities at the six MISA case management sites. The presentation of research findings from this four-year initiative will cover consumer characteristics, barriers, successes, and consumer and staff recommendations.

At the conclusion of the session participants will be invited to challenge the faculty with difficult questions concerning clinical care, program development, research and evaluation, and systems integration of dual diagnosis patients.

REFERENCES:

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HALF–DAY SESSIONS

Half-Day Session 8 **Monday, October 21**
8:30 a.m.-11:30 a.m.

ASSESSING AND ASSISTING MENTALLY ILL PARENTS

Laura J. Miller, M.D., *Assistant Professor of Psychiatry, University of Illinois at Chicago, M/C 913, 912 South Wood Street, Chicago, IL 60612;* Teresa Jacobsen, Ph.D., Karen S. Budd, Ph.D., Maryanne Zeitz, M.Ed., Joanne Nicholson, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to identify ways that major mental illness can affect parenting, principles of parenting assessment and ways to avoid methodologic pitfalls in assessment, strategies for parenting rehabilitation, and effects on parenting of the design of mental health care delivery systems.

SUMMARY:

Mental health professionals are often called on to evaluate the parenting capabilities of mentally ill parents and to assess the risk of child abuse or neglect. Further, just as vocational rehabilitation can effect substantial functional improvement for people with severe mental illness, parenting rehabilitation can foster parenting capabilities. This session will address several aspects of parenting assessment and parenting rehabilitation.

Dr. Miller will compare the sexual and reproductive experiences of women with major mental illness and women without mental illness. The two groups differ in patterns of sexual partners, rates of rape and prostitution, and HIV risk and testing. Women with major mental illness also are less likely to plan their pregnancies, less likely to receive adequate prenatal care, and more likely to experience violence during pregnancy. Other implications of major mental illness for parenting include possible custody loss and poor child-rearing support networks.

Dr. Jacobsen will further discuss the effects of major mental illness on parenting capability and factors that influence this ability. Persons who suffer from major mental illnesses almost always show some impairment in their capacity for affectional bonding, an impairment that may be both severe and long lasting. In many cases this impairment profoundly affects parenting capabilities. In other cases, however, mentally ill persons are able to parent their children in a competent way. The presentation will begin with an overview of empirical studies on how different mental illnesses affect parenting ability. Specific parenting behaviors, attitudes, and feelings of some mentally ill mothers, and the effects on offspring, will be described. Two major determinants of responsibility and quality of caregiving are the environment in which the patient grew up, including early experiences with his or her own attachment figures, and the illness itself and its symptoms. Dr. Jacobsen will identify factors that influence parenting behavior in mentally ill persons and will briefly discuss interventions to help families with major mental illnesses.

Dr. Budd will discuss methodological flaws in the assessment of parenting ability. Hypothetical models for viewing parenting competence in relation to children's needs will be presented, and limitations of parenting assessments will be identified. Such limitations include lack of universal criteria regarding minimal parenting, use of traditional psychological tests (e.g., IQ) not designed to assess parenting, the dearth of direct measures for assessing parenting skills, situational influences on parenting assessment, and difficulties in predicting future behavior. Recommended ingredients of parenting assessments are observation of parent-child interactions (preferably in a naturalistic setting), measures directly related to caregivers' knowledge and skills in parenting, other measures tailored to referral concerns about parenting, recognition of specialized child needs, information on parents' responsiveness to previous interventions, and identification of parents' strengths as well as weaknesses. Strategies for increasing the usefulness of parenting assessments will be provided.

Dr. Miller will outline the basic principles of assessing parenting capability in mentally ill parents, which include direct assessment in the home, emphasis on behavior, use of multiple modalities and valid assessment tools, an interdisciplinary perspective, recognition of cultural context, reference to information on child development and mental illness, and use of parenting adequacy, rather than optimal parenting, as the standard. Dr. Miller will also identify specific components of a comprehensive assessment. In addition to psychiatric evaluation of the parent and assessments of the children, all pertinent records should be reviewed and collateral historians should be interviewed. Family functioning can be evaluated by assessing the family's social support network, conducting a home inventory, videotaping parent-child interactions, and having the parent fill out questionnaires on parenting. Findings of a parenting assessment should be scrutinized for patterns and inconsistencies and discussed with professionals in other disciplines. Dr. Miller will end the presentation by describing use of the assessment for written reports and court testimony.

Ms. Zeitz will present the Mothers' Project, a parenting rehabilitation program. Its essential features are a holistic case management system that treats the family while focusing on the mother and child. Home-based, center-based, and community-based services will be described. The goals of the program are to achieve psychiatric stabilization, to assure normal development in the growing child, and to resolve child welfare issues. Program components aimed at establishing a useful peer group, member empowerment, psychiatric rehabilitation, and ongoing assessment will be described.

Dr. Nicholson will identify barriers to service utilization for parents with mental illness, which contribute to poor outcomes for both parents and children. Barriers are presented by both individuals and by delivery systems. Providers may have negative attitudes toward pregnancy and parenting in persons with mental illness. Patients' own fears of loss may inhibit the development of trust in treatment relationships. Their families and significant others may be unsupportive of their parenting efforts. Problems involving service delivery systems include lack of patient involvement, a focus on the individual rather than the family, conflicts between treatment and the patient's needs or identity as a parent, and lack of appropriate services. Dr. Nicholson will describe the impact of these barriers, which may result in the parent's loss of custody if the parent appears to be noncompliant with treatment. She will also recommend solutions to these problems and describe how removal of children, when necessary, should be managed.

REFERENCES:

1. Apfel RJ, Handel MH: *Madness and the Loss of Motherhood: Sexuality, Reproduction, and Long-Term Mental Illness.* American Psychiatric Press, Washington, DC, 1993.
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Half-Day Session 9 **Monday, October 21**
2:00 p.m.-5:00 p.m.

QUALITY OF LIFE AS A FOCUS FOR CLINICAL WORK

Ronald J. Diamond, M.D., *Professor of Psychiatry, University of Wisconsin, 600 Highland Avenue, Madison, WI 53792-0001;* Anthony F. Lehman, M.D., Marion A. Becker, Ph.D., R.N., Jean Campbell, Ph.D., Harriet Lefley, Ph.D., Leonard I. Stein, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to describe how consumers, families, and clinicians view quality of life for persons with severe mental illness and should be able to apply these ideas to clinical practice.

SUMMARY:

There is growing interest in the quality of life of persons with serious mental illness. Clinical treatment, including both pharmacological and rehabilitation interventions, is increasingly focused on improving quality of life rather than just reducing symptoms or hospital recidivism. Unfortunately, while there is agreement that improving quality of life should be the focus of treatment, there has been little consensus about what it is or how to measure it. Families, consumers, and clinicians frequently disagree about what is most important in determining quality of life and, as a result, can disagree about the goals of treatment.

This session will start with a conceptual overview of what is meant by "quality of life" and will continue with a discussion about how we can apply these concepts in clinical practice. Consumers', clinicians', and families' points of view must be considered when assessing quality of life. The session will stress ways to integrate these different points of view into clinical practice and will identify instruments appropriate for assessing quality of life in non-research settings. A critical issue is how we can use current information about quality of life to better understand consumers' assessment of their own lives and to facilitate collaboration between consumers and treatment teams.

Dr. Lehman will provide a conceptual overview of quality of life, which encompasses a wide range of dimensions: "objective quality of life" refers to the observable conditions under which people live, whereas "subjective quality of life" refers to how people feel about their circumstances. There are at least three frameworks for assessing the effects of health care on quality of life. The "general quality of life" framework takes a very broad view of life experiences and is not limited to immediate or proximal effects of illness and health care. The "health-related quality of life" framework focuses on the effects of illness and health care on specific dimensions of a person's life. The "disease-specific quality of life" framework narrows the concept further to specific effects of a particular disease. The choice of framework depends on the goal of the particular study or evaluation. Dr. Lehman will end the presentation by reviewing challenges to quality of life assessment: How do we balance differing findings on objective and subjective quality of life? How can we improve the credibility of information obtained from persons with severe mental illness? How should we integrate others' views of a patient's quality of life with those of the patient? How should quality of life outcomes be used to evaluate health care and human services?

Dr. Becker will discuss how we can measure quality of life in clinical practice. The presentation will begin with background topics, including previous approaches to quality of life measurement, the relevance of using objective and subjective indicators, and measurement issues: deciding what domains to include, incorporating

evaluation of different domains, deciding who should be queried (clinicians, consumers, families), making quality of life measures accurate and sensitive, and deciding whether self-report instruments should be used for mentally ill persons. The second part of the presentation will be a detailed discussion of a specific instrument, the Wisconsin Quality of Life Index. The discussion will cover development of the index, study results, testing the impact of importance weighting, and interpretation of results.

Dr. Lefley will address the family's point of view. The family's quality of life is related to family burden and clinical correlates of the patient's illness, family gratification, satisfaction with service delivery systems, and legal and insurance barriers to hospitalization. The family's own level of expressed emotion also affects quality of life. Families from different racial and ethnic groups may vary in home caregiving, residential preferences, caregiving kinship roles, hospitalization practices, satisfaction with services, and perceived family burden. Quality of life also varies by kinship, i.e., parent, sibling, spouse, or child. Dr. Lefley will identify ways to enhance family quality of life, such as family psychoeducation, support groups, advocacy roles, and consumer services.

Dr. Campbell will focus on the service user and how quality of life assessment can be used to facilitate collaboration. The presentation will begin with an operational definition of collaboration and epistemological considerations in quality of life assessment. The recent paradigm shift in behavioral health care systems is related to the rise of consumerism and the role of quality of life, broadening measures of health, a focus on the community rather than hospital care, and consumer research and evaluation. Dr. Campbell will describe how collaboration can be developed through quality of life models at the system, clinical, and personal levels.

Dr. Diamond will discuss use of quality of life assessment to guide clinical work. He will begin by presenting critical questions, such as, What does "doing better" mean? and How can we measure improvement? It is clear that reduction of symptoms or hospital recidivism is not a sufficient measure. Function, in terms of employment or life skills, is closer to what is commonly meant by "doing better," but it does not cover the client's subjective sense of feeling better. Community burden, such as financial cost or number of arrests, is important for policy reasons, but it is an indirect measure of client outcome. The reasons for focusing on quality of life are its importance to clients and families, its ability to improve clinical collaboration and cooperation with treatment, and its usefulness as a consideration in choosing a particular intervention. Quality of life evaluation is a complex set of assessments that reflect the complexity of clinical work. It is helpful in evaluating treatment goals and increasing collaboration between clinician and client. Although quality of life often changes slowly, people do change and we need ways to indicate and at times celebrate this change.

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2. Lefley HP, Wasow M: *Helping Families Cope with Mental Illness.* Harwood Academic, New York, 1994.
3. Lehman AF, Burns BJ: Severe mental illness in the community. In Spilker B (ed): *Quality of Life and Pharmacoeconomics in Clinical Trials.* Lippincott-Raven, Hagerstown, MD, 1995.

Half-Day Session 10 **Monday, October 21**
2:00 p.m.-5:00 p.m.

HEALTH SERVICES RESEARCH AND ACADEMIC PSYCHIATRY

Sheldon I. Miller, M.D., *Lizzie Gilman Professor and Chairman, Department of Psychiatry, Room 561, Northwestern Memorial Hospital, 303 East Superior, Chicago, IL 60611-3015;* John S. Lyons, Ph.D., Marcia Slomowitz, M.D., John T. Vessey, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to describe mental health services research as it relates to academic psychiatry and to identify methods for obtaining additional information and training.

SUMMARY:

This session will provide a context for learning about mental health services research as it applies to researchers in academic medical settings. Beginning with a national overview of the role of health services research in the evolution of the service delivery system, the course will go on to define mental health services research. In concert with this definition, methodological strategies used in this field will be introduced. Language specific to this type of research will also be reviewed, providing the participants with a working knowledge of the field and knowledge of additional sources of information. Finally, a psychiatrist who has received additional training in mental health services research will present her experiences as a practicing clinician and administrator who has evolved into a researcher in this field. She will also discuss findings from research on inpatient psychiatric care.

The course is intended for a general audience of faculty in departments of psychiatry in medical schools. Although some basic knowledge of research design and measurement is desirable, no advanced methodological or statistical expertise is required.

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Half-Day Session 11 **Monday, October 21**
2:00 p.m.-5:00 p.m.

CLINICAL PRACTICE OF INPATIENT AND AMBULATORY ECT

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;* Conrad M. Swartz, M.D., Ph.D., Michael J. Schrift, D.O., Atul R. Mahableshwarkar, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to describe the following aspects of electroconvulsive therapy: history, indications, medical physiology, recent refinements in technique, management of side effects, outpatient application, medicolegal issues, changing negative attitudes, and techniques for minimizing risk.

SUMMARY:

Electroconvulsive therapy (ECT) was introduced in 1938 and was a major form of psychiatric treatment in the 1940s and early 1950s. With the introduction of psychotropic drugs, use of ECT declined; however, while most other early psychiatric treatments, such as insulin coma therapy and malarial fever therapy, fell by the wayside, ECT continues to be an effective and safe form of treatment for certain severe neuropsychiatric illnesses.

Dr. Srinivasaraghavan will provide a brief history of convulsive therapy and outline indications for ECT. The introduction of routine anesthesia, muscle relaxation, and oxygenation during the procedure reduced morbidity dramatically. Monitoring of cardiovascular and respiratory status has also added enormously to the safety of the procedure. Modern ECT apparatuses are also equipped with EEG and sometimes electromyographic (EMG) monitoring and use pulse electrical waves. Major depression with melancholia remains the major indication, but delusional depression, mania, schizophreniform disorder, schizoaffective disorder, and catatonia respond very well to ECT. Patients with Parkinson's disease, neuroleptic malignant syndrome, Huntington's chorea, and other neurological conditions can benefit from ECT. Whether to use ECT in a given case depends on several factors, including need for a rapid response because of severe psychiatric or medical symptoms, past poor drug response and good response to ECT, patient preference, adverse effects from other treatments, or deterioration of health.

Dr. Schrift will discuss hemodynamic and cardiovascular events associated with ECT, which are assessed by measuring heart rate, blood pressure, cardiac output, cardiac enzymes, and neurophysiological activity, e.g., changes in EEG and neuroendocrine variables. Further, he will discuss the methods of monitoring seizure duration and effectiveness of the seizure.

Remaining unchallenged by any other health care provider are the psychiatrist's skills in ECT. Refinements in anesthesia and technique have advanced ECT into a painless procedure that typically returns patients to their normal selves with only temporary and minor side effects. Dr. Swartz will address recent refinements in ECT anesthetic agents (e.g., propofol, etomidate), electrode placement (e.g., Swartz's asymmetric bilateral placement), stimulus characteristics (e.g., charge rate), stimulus dose administration (titrated versus age-based), and treatment frequency. The newer techniques will be compared with traditional methods.

The ability to recognize and manage side effects is an important element of any treatment. Dr. Mahableshwarkar will identify possible side effects and complications, including headache, muscle ache, confusion, delirium, cardiac dysrhythmias, and memory disturbances. He will also describe steps that can be taken to avoid, reduce, or manage side effects, following a chronological sequence of how they may arise during an individual treatment and during a course of ECT. The death rate from ECT is less than 4 per 100,000 treatments, the same as for anesthesia. Ample clinical examples will be used to facilitate understanding.

The saving of the high costs of an in-hospital stay is an attractive difference between ambulatory ECT and traditional inpatient ECT. Dr. Swartz will review the clinical factors that facilitate ambulatory ECT and distinguish it from inpatient ECT, as indicated in the recent task force report on ambulatory ECT. Prominent among the factors are clinical illness severity; the patient's capacity for self-care, dangerousness to self, tendency toward disorientation or disorganization, concurrent medical problems, and compliance and reliability; travel distance; caretaker availability; limitations on patient activities; and post-treatment monitoring. Several means of mitigating difficulties for outpatients will be described.

Dr. Srinivasaraghavan will stress the importance of making a proper diagnosis, documenting a valid indication for ECT, recognizing concurrent medical conditions and addressing the relevant issues in the risk-benefit analysis, obtaining a valid informed consent, and ensuring proper

administration of ECT. While the malpractice losses arising from the practice of ECT have been minimal, the negative attitude toward ECT persists. This presentation will include data on the few malpractice cases involving ECT and will briefly address reasons for the prejudice against it and how psychiatrists can attempt to change this prejudice.

REFERENCES:

1. Fink M: Who should get ECT? In Coffey E (ed): *Clinical Science of Electroconvulsive Therapy.* American Psychiatric Press, Washington, DC, 1993.
2. Abrams R: *Electroconvulsive Therapy.* Oxford University Press, New York, 1992.
3. *The Practice of Electroconvulsive Therapy: Recommendations for Treatment, Training, and Privileging: A Task Force Report of the American Psychiatric Association.* American Psychiatric Association, Washington, DC, 1990.
4. Swartz CM: Setting the ECT stimulus. *Psychiatr Times* 12(6):33-34, 1995.
5. Association for Convulsive Therapy: Task force report on ambulatory convulsive therapy. *Convuls Ther,* in press.
6. Slawson P: Psychiatric malpractice and ECT: a review of national loss experience. *Convuls Ther* 5(2):126-130, 1989.
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Half-Day Session 12 **Tuesday, October 22**
8:30 a.m.-11:30 a.m.

REVIEW OF APA PRACTICE GUIDELINES: NICOTINE DEPENDENCE, PANIC AND RELATED ANXIETY DISORDERS, AND SCHIZOPHRENIA

John S. McIntyre, M.D., *Chairperson, Steering Committee on Practice Guidelines, and Board of Trustees Member, American Psychiatric Association, and Chair, Department of Psychiatry, St. Mary's Hospital, Suite 210, 919 Westfall Road, Rochester, NY 14618-2670;* Deborah A. Zarin, M.D., John R. Hughes, M.D., Jack M. Gorman, M.D., Marvin I. Herz, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to discuss the overall progress of the APA practice guidelines effort and describe the development of the guidelines on nicotine dependence, panic and related anxiety disorders, and schizophrenia.

SUMMARY:

Practice guidelines are systematically developed documents in a standardized format that present patient care strategies to assist psychiatrists in clinical decision making. APA's practice guidelines are developed according to nationally recognized standards. Key features of the process include initial drafting by a work group that includes psychiatrists with clinical and research expertise in the specific disorder being addressed, a comprehensive literature review, the production of multiple drafts with widespread review and involvement of over 600 individuals and approximately 100 related organizations, approval by the APA Assembly and Board of Trustees, and planned revisions at intervals of 3 to 5 years.

While guidelines may be used for a variety of purposes, their express purpose is to assist psychiatrists in the care of patients. To date, APA has published five practice guidelines (on eating disorders, major depressive disorder in adults, bipolar disorder, substance use disorders, and psychiatric evaluation of adults), has one in press (nicotine dependence), and has six in various stages of development (Alzheimer's disease, anxiety and panic, delirium, geriatric psychiatry, mental retardation, and schizophrenia).

This presentation will outline the practice guidelines on schizophrenia, anxiety and panic, and nicotine dependence. Each begins at the point where the psychiatrist has established the diagnosis and has evaluated the patient for the presence of comorbid psychiatric conditions as well as general medical conditions that could mimic the disorder or be important to treatment.

Dr. Herz will discuss the practice guideline on schizophrenia. Treatment options for patients with schizophrenia include psychiatric management, pharmacologic treatments, psychotherapeutic treatments, and electroconvulsive therapy. Dr. Herz will review these treatments and the evidence for their efficacy. He will also discuss issues to be considered in choosing and implementing these treatment options (including the factors that underlie the choice of treatment setting) in the context of specific phases of the illness. Finally, the ways in which particular clinical features of the patient's illness alter the general treatment recommendations will be described.

Dr. Gorman will introduce the practice guideline on anxiety and panic. He will first describe treatment options for both behavioral and cognitive symptoms, including psychiatric management, pharmacologic treatments, and psychosocial treatments, along with the evidence for their efficacy. Second, issues to be considered in choosing and implementing these treatment options (including choice of treatment setting) will be discussed. Finally, the effects of particular clinical features on treatment recommendations will be described.

The practice guideline for the treatment of patients with nicotine dependence will be described by Dr. Hughes. It addresses issues common to nicotine use disorders and

also deals specifically with smokers already seeing a psychiatrist, smokers who fail first-line treatment, and smokers on smoke-free wards. This discussion will focus on assessment and appropriate goals of treatment for patients with nicotine dependence. Guidelines for choosing among the many treatment options, including psychiatric management and pharmacologic and psychotherapeutic interventions, and the evidence for their efficacy for selected patients will be explored. The factors influencing the choice of treatment setting will also be discussed.

REFERENCES:

1. Zarin DA, Pincus HA, McIntyre JS: Practice guidelines (editorial). *Am J Psychiatry* 150:2, 1993.
2. American Psychiatric Association: Practice guideline for treatment of patients with nicotine dependence. *Am J Psychiatry,* in press.
3. McIntyre JS, Zarin DA, Pincus HA: Practice guidelines and outcomes research. In Sederer LI, Dickey B (eds): *Outcomes Assessment in Clinical Practice.* Williams & Wilkins, Baltimore, 1995.

INDUSTRY SUPPORTED SYMPOSIA

Industry Supported Symposium 1 — **Friday, October 18, 12 noon-1:30 p.m.**

COMORBIDITY AND MIXED MANIA IN BIPOLAR DISORDER: COST-EFFECTIVE STRATEGIES

Supported by Abbott Laboratories

Paul E. Keck, Jr., M.D., *Associate Professor, Department of Psychiatry, University of Cincinnati, P.O. Box 670559, 231 Bethesda Avenue, Cincinnati, OH 45267*

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this session, participants should be able to identify the clinical features that distinguish mixed mania from agitated depression and classic mania, discuss the prevalence of mixed mania and comorbid substance use disorders in patients with bipolar disorder, list different treatment options for bipolar patients with mixed mania or comorbid substance use disorders, and describe the economic impact of bipolar disorder and the potential cost savings associated with different treatments.

OVERALL SUMMARY:

Bipolar disorder is a severe psychiatric disorder and a major public health problem. Data from recent epidemiologic and clinical studies indicate that in patients with bipolar disorder, comorbid substance use disorders are common and adversely affect prognosis. Similarly, patients with bipolar disorder who have acute mixed manic episodes appear to have a worse prognosis than do patients with acute classic mania. The distinction between mixed mania and agitated depression is often difficult to address clinically. Recent research regarding the diagnosis, treatment, and prognosis of patients with bipolar disorder and comorbid substance use disorders, and patients with mixed mania, will be critically reviewed.

The overall economic impact of bipolar disorder has only recently been studied. Data comparing the economic cost of bipolar disorder with the costs of other major medical illnesses will be presented. Several studies have addressed the cost savings associated with specific pharmacologic treatments. These studies indicate differences in cost savings between these medications that vary according to the method of drug administration, the type of presentation (manic, mixed, rapid cycling), and other factors associated with the likelihood of response, including comorbid substance use disorders.

No. 1A
AGITATION IN DEPRESSION: ASSESSMENT AND TREATMENT

Alan F. Schatzberg, M.D., Kenneth T. Norris, Jr. *Professor and Chairman, Department of Psychiatry and Behavioral Sciences, Stanford University School of Medicine, TD 114, Stanford, CA 94305-5490;* Charles DeBattista, M.D.

SUMMARY:

Agitation may be a core symptom in a depressed patient or may emerge with antidepressant therapy. This presentation will address assessment of agitation in depression and its treatment. The prevalence of agitation in two distinct samples of patients with major depression will be reviewed. The relationship between agitation and anxiety (psychic or somatic) will then be discussed. Agitation in a depressed patient may reflect a mixed state, particularly when it emerges with antidepressant therapy. Methods for differentiating agitated major depression and mixed states will be discussed. Commonly, benzodiazepines, lithium salts, and neuroleptics may be added to an antidepressant to control these symptoms. However, some patients do not respond to these strategies or cannot tolerate the side effects produced. The potential use of divalproex sodium will be discussed, and a small series of agitated depressed patients who were successfully treated with this medication at Stanford University Medical Center will be presented.

No. 1B
BIPOLAR DISORDER 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:

Bipolar disorder and substance abuse commonly co-occur. Epidemiologic studies indicate that over half of the individuals with bipolar disorder have substance use disorders at some time in their lives. Bipolar spectrum disorders occur commonly in treatment-seeking substance abusers, particularly cocaine abusers. Approximately 30% of treatment-seeking individuals with bipolar disorder have current substance use disorders. In spite of these facts, little is known about the clinical course or optimal treatment of individuals with comorbid bipolar and substance use disorders. There may be more episodes of mixed mania and rapid recycling among bipolar individuals who have substance use disorders. Dr. Brady will present data on six-month treatment of 24 patients with comorbid bipolar disorder and substance use disorders with valproic acid. The medication was well tolerated, the affective episode resolved, and there were no statistically or clinically significant changes in liver function during the follow-up period. There was a statistically, but not clinically, significant decrease in platelet function. Implications of these data and areas for further investigation will be discussed.

INDUSTRY SUPPORTED SYMPOSIA

No. 1C
HEALTH AND ECONOMIC IMPACT OF BIPOLAR DISORDER

Paul E. Keck, Jr., M.D., *Associate Professor, Department of Psychiatry, University of Cincinnati, P.O. Box 670559, 231 Bethesda Avenue, Cincinnati, OH 45267;* Susan L. McElroy, M.D., Jerry A. Bennett, Pharm.D.

SUMMARY:

The National Advisory Mental Health Council estimated that the costs of treating severe mental illness in the United States in 1990 were $76 billion. These costs were comparable to those of other major medical illnesses, such as AIDS and cardiovascular disease. Specific estimates of the economic costs associated with bipolar disorder suggest that over time, with greater diagnostic recognition and adequate treatment, the costs of the illness will greatly outweigh treatment costs. Five studies have addressed the cost savings associated with specific pharmacologic treatments, including lithium, divalproex, and carbamazepine. These studies, which will be discussed in detail, suggest that the introduction of lithium substantially reduced costs from the prelithium era. One study of patients with acute mania showed that divalproex or the combination of carbamazepine and lithium was associated with greater cost savings than was lithium or carbamazepine alone. A decision-analytic study showed even greater savings with lithium for classic mania and with divalproex for mixed mania and rapid cycling.

REFERENCES:

1. Brady KT, Sonne SC: The relationship between substance abuse and bipolar disorder. *J Clin Psychiatry* 56(3):19-24, 1995.
2. Keck PE Jr, McElroy SL, Stanton SP, et al: Pharmacoeconomic aspects of the treatment of bipolar disorder. *Psychiatr Ann* 26:1-6, 1996.

Industry Supported Symposium 2 — **Friday, October 18 7:30 p.m.-10:30 p.m.**

ANTIPSYCHOTICS IN THE CRISIS SITUATION
Supported by Janssen Pharmaceutica and Research Foundation

Douglas H. Hughes, M.D., *Harvard Medical School, Boston VA Medical Center, 78 Monmouth Street, Brookline, MA 02146*

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this session, participants should be able to assess the psychotic and aggressive patient; discuss the newer antipsychotic medications, including issues associated with long-term compliance; and identify some of the benefits of mobile crisis programs in treating the psychotic and aggressive patient.

OVERALL SUMMARY:

Treating the psychotic patient in crisis is one of the major challenges for the mental health clinician today. Increasingly, these patients are being aggressively managed with antipsychotic medications in the community, given managed care's strong emphasis on outpatient treatment. Several important new antipsychotics make this outpatient treatment more feasible. Crisis management must be seen as one point in the continuum of the patient's total care. In particular, the patient's long-term compliance with antipsychotic medication must be carefully considered if the long-term treatment is to be successful. Further, in order to safely care for these patients, the clinician must evaluate the potential for violence and consider creative interventions, such as mobile crisis programs.

No. 2A
PSYCHOPHARMACOLOGY AND COMPLIANCE

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

SUMMARY:

In the context of a psychiatric crisis, it is frequently reported that the patient had stopped taking medication some time ago. The association between such poor "compliance" and relapse may be spurious but is often presented as the explanation for the relapse. The patient is then held responsible for the recurrence of the illness. The concept of "compliance" is a poor tool for understanding the complex relationship among the patient, the illness, and the many physicians involved. A number of factors must be considered, including the severity and natural history of the illness, the risks and benefits of the medications available, the strength of the patient's relationships, and the ability of the patient to absorb information and act accordingly. Many widely used medications have significant toxicity. Secondary medications, used to treat the side effects of the principal medications, may also be toxic and result in complex regimens. This presentation will focus on newer, less toxic medications, which can lead to better collaboration and improved outcome. Furthermore, these medications make it safer and easier to initiate treatment for many disorders in emergency services, thereby reducing patients' suffering and minimizing costs.

No. 2B
MANAGING THE AGGRESSIVE AND VIOLENT PATIENT

Douglas H. Hughes, M.D., *Harvard Medical School, Boston VA Medical Center, 78 Monmouth Street, Brookline, MA 02146*

SUMMARY:

There have been approximately 1.3 million violent deaths in the United States since 1968. The United States is over eight times as violent as the second most violent country in the Western world. One study indicates that other countries have stronger mandates to identify and treat mentally ill people who are violent. The classic study by McNiel and Binder indicates that violent behavior may be predicted in 65% of select patients within 72 hours. The key predictive variables appear to be a history of violence and current agitation. The interaction of violence with a variety of diverse cofactors, including schizophrenia, alcohol abuse, and firearms, will be explored. Differences in characteristics of violent men and women will also be described. From 42% to 74% of psychiatrists are assaulted at some time during their careers, making them one of the most assaulted groups of physicians. Residents report high levels of physical assaults (40%-54%) and harassment (33%) by patients, and they feel that hospitals are basically unsafe (65%). Nonviolent self-defense training for staff will be presented. Also, the legal liability of failing to predict or properly document violence, and the psychopharmacological treatment of aggression, will be discussed.

No. 2C
BENEFITS OF MOBILE CRISIS PROGRAMS

Joseph J. Zealberg, M.D., *Director of Mobile Crisis, Department of Psychiatry, University of South Carolina, 1007 Cummings Circle, Mt. Pleasant, SC 29464-3505*

SUMMARY:

Compared with the usual procedure of detention by law enforcement officials and transportation to the local public emergency department for evaluation and treatment, the community-based mobile crisis team offers many advantages, some of which are accessibility of services, accuracy of assessments, efficiency and cost-effectiveness, liaison with other agencies, public relations, and education. In addition to these benefits, Dr. Zealberg will describe dangers associated with the operations of mobile crisis teams. Despite these dangers, the mobile crisis team is uniquely equipped to provide front-line mental health care when and where it is most needed. It can provide on-site assessment, crisis management, treatment, referral, and educational services to patients, families, law enforcement officers, and the community at large. Mobile crisis teams provide access to mental health care for even the most underserved populations efficiently and cost-effectively. The cost-effectiveness of the team's services is defined by savings in both monetary and human terms.

No. 2D
THE NEWER ANTIPSYCHOTICS

James R. Hillard, M.D., *Chairman, Department of Psychiatry, University of Cincinnati Medical Center, 3259 Elland Avenue, Cincinnati, OH 45267*

SUMMARY:

Acute psychotic symptoms are a major reason for emergency psychiatric visits, and stricter utilization review criteria have led to outpatient treatment of an increasing population of acutely psychotic patients. For many years the recommended approach was administration of high doses of high-potency antipsychotics. However, dose-response studies have consistently failed to show any advantage to using doses of antipsychotic medication equal in potency to more than 10 to 15 mg of haloperidol. Studies on the time course of response have shown that the maximum response to oral agents does not routinely occur for 2 hours, and maximum response to intramuscular administration does not routinely occur for about 1.5 hours. Response to intravenous antipsychotics is more rapid but may be associated with cardiac conduction defects. Injectable benzodiazepines are an excellent alternative for treating psychotic agitation and may be the treatment of choice for agitated patients without a history of neuroleptic treatment. Two promising agents for the rapid treatment of psychosis are droperidol and risperidone. Both have fewer extrapyramidal side effects than does haloperidol, but they do have a somewhat greater tendency to cause postural hypotension.

REFERENCES:

1. Allen MH, et al: In Kaplan HI, Sadock BJ (eds): *Handbook of Emergency Psychiatric Medicine.* Williams and Wilkins, New York, 1993.
2. Hughes D: Assessment of the potential for violence. *Psychiatr Ann* 24(11):1-6, 1994.
3. Zealberg JJ, Santos AB, Fisher RK: Benefits of mobile crisis programs. *Hosp Community Psychiatry* 44:16-17, 1993.
4. Hillard JR (ed): *Manual of Clinical Emergency Psychiatry.* American Psychiatric Press, Washington, DC, 1990.

Industry Supported Symposium 3 — **Saturday, October 19 6:30 a.m.-8:00 a.m.**

DEPRESSION IN SPECIAL/DIFFICULT-TO-TREAT POPULATIONS
Supported by Roerig Division/Pfizer, Inc.

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 FOR THIS SYMPOSIUM:

At the conclusion of this session, participants should be able to discuss issues pertinent to the efficient diagnosis and treatment of chronic depression and anxiety disorders and describe the role of serotonin in therapeutic efficacy.

INDUSTRY SUPPORTED SYMPOSIA

OVERALL SUMMARY:

Epidemiological data and clinical studies point to increasing public awareness and recognition of the incidence of major depressive and anxiety disorders. Attention has been focused on the chronic nature of major depressive disorder and obsessive-compulsive disorder (OCD). To promote efficient and effective care for patients with these illnesses, the psychiatrist must cultivate tools for appropriate diagnosis and treatment, including psychopharmacology and psychotherapy.

To improve recognition and management of chronically depressed patients, this symposium will provide a comprehensive understanding of the chronicity of depression, including such aspects as predicting and monitoring response, determining treatment length, and preventing recurrence.

The symposium will also address OCD, which can be chronic and present a host of challenges for practitioners. In particular, OCD is often present in patients suffering from chronic depression. Selective serotonin reuptake inhibitors (SSRIs) have demonstrated efficacy for OCD patients. This finding suggests that serotonergic transmission may be particularly important in the efficacy of antiobsessive agents.

New data on effective management of chronic depression and OCD will be presented. Practitioners will gain an improved understanding of diagnostic issues, greater ability to predict and evaluate response, and greater appreciation of treatment options for these disorders.

No. 3A
MANAGING COMORBID OBSESSIVE-COMPULSIVE DISORDER AND DEPRESSION

Steven A. Rasmussen, M.D., *Professor of Psychiatry, Brown University School of Medicine, 345 Blackstone Boulevard, Providence, RI 02906-7010;* Jane L. Eisen, M.D., Michele T. Pato, M.D.

SUMMARY:

Recent advances in the recognition, diagnosis, and treatment of OCD have significantly improved the prognosis of those suffering from this chronic and often disabling condition. SSRIs have proved effective, and a recent controlled trial has reaffirmed the efficacy of exposure with response prevention and has confirmed that a combination of a SSRI and behavior therapy leads to the best outcome.

Longitudinal follow-up studies have demonstrated the chronic course of OCD. Comparatively little is known about the naturalistic course or predictors of relapse, remission, and recurrence. Therefore, questions about length of treatment, minimum effective maintenance dose, and factors leading to recurrence are unanswered.

Although 70% to 80% of OCD patients respond at least moderately to drug and/or behavioral treatment, many are left with residual symptoms; 20% fail to respond. Although augmentation of an SSRI with lithium, a neuroleptic, a benzodiazepine, or buspirone can lead to further improvement, double-blind trials of these augmentation strategies have been disappointing overall. Neurosurgical procedures are sometimes effective for treatment-resistant patients, and a double-blind trial of anterior capsulotomy performed with the GAMMA knife is currently in progress.

No. 3B
STRATEGIES AND TACTICS TO TREAT CHRONIC DEPRESSIONS

A. John Rush, M.D., *Professor of Psychiatry, University of Texas Southwestern Medical Center, Suite 600, 5959 Harry Hines Boulevard, Dallas, TX 75235-7200*

SUMMARY:

Chronic depressions include recurrent major depression with poor interepisode recovery, chronic major depressive episodes, and depressive disorders not otherwise specified that are persistent or predictably recurrent with disability. Strategic decisions include: a) rapid identification of the course of illness, b) selection of agents with demonstrated long-term efficacy and tolerability, and c) selection of alternative treatments if the first treatment fails or is intolerable. Tactical issues include selection of dosing schedule, determination of length of acute-phase treatments, measurement of outcome, and identification and management of subsequent episodes.

This presentation will highlight new data on several antidepressants (e.g., sertraline, fluoxetine, tricyclics) from acute-phase trials to evaluate efficacy, dosing, and time to response. Continuation- and maintenance-phase data on the efficacy and tolerability of sertraline and imipramine will also be presented. The implications of these empirical findings for developing treatment algorithms for chronic depression will be discussed.

No. 3C
PSYCHOTHERAPEUTIC APPROACHES TO THE TREATMENT OF DEPRESSIVE DISORDERS

Robert Michels, M.D., *The Stephen and Suzanne Weiss Dean/Professor of Psychiatry, Cornell University Medical Center, Suite F-105, 1300 York Avenue, New York, NY 10021*

SUMMARY:

Several psychotherapies have been demonstrated to be effective in the treatment of depressive disorders. In addition, psychotherapy is a major tool in combating the demoralization and secondary psychopathology that are prevalent when these disorders are chronic. Furthermore, psychotherapy is helpful in enhancing compliance and adaptation to the patient role, which are important for the

successful treatment of these disorders. Finally, when these disorders are chronic, they are frequently accompanied by comorbid personality disorders, either because they have a shared genetic and/or developmental etiology or because the personality disorder is secondary to the childhood precursors of the depressive disorder. Psychotherapy is a mainstay in the treatment of these personality disorders. The principles of psychotherapy for these patients, with or without combined pharmacotherapy, will be discussed.

REFERENCES:

1. Rasmussen SA: Diagnosis and treatment of OCD: a clinician's perspective. *J Clin Psychiatry* 54(6 suppl):3-10, 1993.
2. Rush AJ, Kupfer DJ: Strategies and tactics in the treatment of depression. In Gabbard GO (ed): *Treatment of Psychiatric Disorders,* 2nd ed. American Psychiatric Press, Washington, DC, 1995, pp 1349-1368.
3. Beitman BD, Klerman GL (eds): *Integrating Pharmacotherapy and Psychotherapy.* American Psychiatric Press, Washington, DC, 1991.

Industry Supported Symposium 4 — **Saturday, October 19, 12 noon-1:30 p.m.**

MANAGED CARE AND DEPRESSION: CAN QUALITY BE ASSURED?

Supported by Eli Lilly and Company

William M. Glazer, M.D., *Associate Clinical Professor of Psychiatry, Yale University School of Medicine, 22 Linden Point Road, Stony Creek, CT 06405;* Jerrold F. Rosenbaum, M.D., *Chief, Clinical Psychopharmacology Unit, and Professor of Psychiatry, Massachusetts General Hospital, Suite WAC815, 15 Parkman Street, Boston, MA 02114*

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this session, participants should be able to appraise the impact of managed care on clinicians' ability to deliver high-quality treatment, describe how payers assess quality of care, and assure the quality of treatment they deliver in managed care settings.

OVERALL SUMMARY:

The claim of high-quality care at the lowest possible cost has become the mantra of the managed care movement. As the economic forces driving managed care expand their impact on psychiatric practice, important questions about our ability to respond remain unanswered. At the same time, some data indicate that managed psychiatric care can reduce costs *and* protect quality of care.

Using depression for the illness/treatment model, the symposium faculty will critically analyze psychiatry's ability to deliver quality service within a managed care context. The symposium will begin with a point/counterpoint discussion of critical clinical issues raised by managed care practitioners today. That discussion will be followed by consideration of two specific areas: the effectiveness of managed formularies and the role of the employer in the quality assurance process.

No. 4A
CAN WE TREAT PATIENTS UNDER CAPITATION?

Jerrold F. Rosenbaum, M.D., *Chief, Clinical Psychopharmacology Unit, and Professor of Psychiatry, Massachusetts General Hospital, Suite WAC815, 15 Parkman Street, Boston, MA 02114;* William M. Glazer, M.D.

SUMMARY:

The assumption of financial risk for a defined population is the crux of capitation, and mental health professionals are facing this challenge with trepidation, curiosity, optimism, and resistance. Drs. Rosenbaum and Glazer will debate and highlight central themes of the controversy that concern psychiatrists who face (or will face) capitated service contracts in their practices. Some of the issues of focus will include the following: Does capitation encourage undertreatment? Will its effects on service access, adequacy, and appropriateness help or harm patients? How will capitated contracts affect the income of psychiatrists? What will be capitation's effect on relationships between psychiatrists and other physicians? Will competition for reimbursement diminish or enhance the potential for collaboration? The presentation, which will follow a point/counterpoint format, will be provocative. It will prepare the audience for subsequent presentations in the symposium and will bring out psychiatrists' hopes and fears about managed care.

No. 4B
OF FORMULARIES, ANTIDEPRESSANTS, AND PATIENT OUTCOMES

David A. Sclar, Ph.D., *College of Pharmacy, Washington State University, Pullman, WA 99164-6510;* Tracy L. Skaer, Pharm.D., Linda M. Robison, M.S.P.H.

SUMMARY:

The effect of pharmaceutical formularies in controlling expenditures for the treatment of depression will be assessed from the perspective of a health maintenance organization (HMO). Research contrasted direct health service expenditures for patients who received the selective serotonin reuptake inhibitor (SSRI) fluoxetine and patients who received one of three tricyclic antidepressants (amitriptyline, nortriptyline, or desipramine). Multivariate findings indicated that receipt of a tricyclic antidepressant resulted in significant ($p < 0.05$) increases in the use of physician visits, psychiatric visits, laboratory tests, hospitalizations, and psychiatric hospital services

and a significant reduction in expenditures for antidepressant pharmacotherapy, for a total increase in health service utilization of $313.00 ($p < 0.05$) one year after the initiation of pharmacotherapy. For patients who received one of three SSRIs (fluoxetine, paroxetine, or sertraline), there was a temporal relationship between the need to titrate pharmacotherapy (paroxetine and sertraline) and an increase in the use of, and expenditures for, health care services.

No. 4C
ONE EMPLOYER'S APPROACH TO MANAGING BEHAVIORAL HEALTH

Bruce N. Davidson, M.S.W, *Digital Equipment, EAP, MSO2-1/C4, 111 Powdermill Road, Maynard, MA 01754*

SUMMARY:

Today's health plans struggle to maintain affordability without having to compromise quality and effectiveness. Digital Equipment Corporation began to design its managed care strategy in the late 1980s. It focused on organized systems of care, particularly HMOs. Detailed standards were established to foster greater consistency and accountability between plans in access to care, quality of care, data collection and analysis, behavioral health, and fiscal controls. A network management system assesses maintenance of these standards in some 50 HMOs.

The standards for behavioral health care were designed to ensure that this care is of high quality, is cost effective and provided at the appropriate level, uses a holistic approach, and is monitored through outcomes measurement and research. The standards include benefit design, access, triage, treatment approach, case management, alternative treatment settings, outcome measurement, quality management, and prevention, education, and early intervention. Each HMO assesses its compliance with the standards, and this scorecard is part of a periodic performance review. The presentation will include the consolidated results of these scorecards for the selected standards.

REFERENCES:

1. Leff HS, Mulkem V, Lieberman M, et al: The effects of capitation on service access, adequacy, and appropriateness. *Admin Policy Ment Health* 21:141-160, 1994.
2. Sclar DA, Robison LM, Skaer TL, et al: Antidepressant pharmacotherapy: economic outcomes in a health maintenance organization. *Clin Ther* 16:715-730, 1994.
3. Caldwell B: EAPS: survey identifies uses and administration. *Employee Benefit Plan Rev,* Dec 1994, pp 36-42.

Industry Supported Symposium 5 — **Saturday, October 19 7:00 p.m.-10:00 p.m.**

SCHIZOPHRENIA: BIOPSYCHOSOCIAL MANAGEMENT AND OUTCOMES
Supported by Eli Lilly and Company

Henry A. Nasrallah, M.D., *Department of Psychiatry, Ohio State University, 1670 Upham Drive, Columbus, OH 43210-1252;* Laurie M. Flynn, M.A.

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this session, participants should be able to identify recent advances in the pharmacotherapy of schizophrenia, discuss psychosocial behavioral and family treatment issues in schizophrenia, and describe outcome measures and quality of life for persons with schizophrenia.

OVERALL SUMMARY:

This symposium will provide psychiatrists and other mental health professionals with an update on the pharmacological and psychosocial management of schizophrenia. The introduction by Dr. Nasrallah will include discussion of the historical importance of a biopsychosocial approach to the management of schizophrenia. After the individual presentations, Ms. Flynn will provide a perspective on the needs and roles of families and consumers in the biopsychosocial management of schizophrenia.

No. 5A
PHARMACOLOGIC MANAGEMENT OF SCHIZOPHRENIA

Richard L. Borison, M.D., *Professor and Chairman, Department of Psychiatry, Medical College of Georgia, 1515 Pope Avenue, Augusta, GA 30912*

SUMMARY:

The new atypical antipsychotic agents that are currently available by prescription (clozapine and risperidone) and those likely to become available soon (olanzapine, seroquel, sertindole, ziprazidone) are viewed as atypical primarily because of their low propensity for producing extrapyramidal side effects at therapeutic doses, their possible amelioration of negative symptoms of schizophrenia, and their potential for not decreasing, and possibly enhancing, cognitive function. Dr. Borison will discuss whether the proposed pharmacology of potent serotonin, relative to dopamine, receptor blockade does, in fact, predict an atypical profile and whether the efficacy for negative symptoms involves improvement of primary or secondary symptoms. He will also consider whether the lower potential for extrapyramidal side effects differentiates the atypical agents from both high-potency and low-potency drugs and whether apparent cognitive enhancement is a primary effect or is secondary to other

pharmacological features that differentiate the atypical antipsychotics from conventional treatments. Finally, the role of the atypical antipsychotics in the pharmacological armamentarium for schizophrenia will be addressed.

No. 5B
INTEGRATING PSYCHOSOCIAL TREATMENT APPROACHES

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

SUMMARY:

Long-term treatment of schizophrenia requires the integration of medication and psychosocial treatment for optimal effects. Treatment delivery systems determine which treatments and services are offered, and clinical judgment determines which treatments an individual will receive. Ideally, experimental evaluation provides the basis for both construction of delivery systems and clinical decision making. Such evaluation is standard for pharmacologic treatments of schizophrenia but not for psychosocial treatments, although recent studies of family treatment in schizophrenia is a notable exception. Dr. Schooler will review studies of psychoeducational family treatment. The studies can be divided into those that compared family treatment approaches to other psychosocial treatments or to usual care and those that compared more than one family treatment approach. In general, studies that compared family treatment to other treatments or to usual care have shown substantial advantages for family-based approaches. In contrast, studies that compared family treatments have shown only limited differences between methods. Strategies for engaging families in treatment programs for schizophrenia will be proposed.

No. 5C
COGNITIVE BEHAVIOR THERAPY FOR SCHIZOPHRENIA

Patrick W. Corrigan, Psy.D., *Director, Center for Psychiatric Rehabilitation, 7230 Arbor Drive, Tinnley Park, IL 60477*

SUMMARY:

A cognitive behavior therapy program for schizophrenia addresses four processes that explain deficits in psychosocial functioning. (a) Patients may never have *acquired* various psychosocial skills because of prodromal symptoms that were active during adolescence and young adulthood. Training in social and coping skills helps in acquisition of these skills. (b) Patients who have learned these skills may never *perform* them because they do not perceive the natural incentives for these behaviors. Incentive therapies provide the necessary motivation for using these skills. (c) Social and coping skills learned in the training milieu may not *generalize* to other situations. Transfer training techniques facilitate generalization of skills. (d) *Cognitive* deficits common to schizophrenia diminish patients' ability to learn social and coping skills. Cognitive remediation strategies that target deficits in attention and memory are useful for helping patients overcome their information processing deficits and learn social and coping skills. Comprehensive cognitive behavioral approaches to schizophrenia include interventions that target all four of these processes.

No. 5D
OUTCOME IN SCHIZOPHRENIA: WHAT DO WE MEASURE?

Anthony F. Lehman, M.D., *Professor of Psychiatry, University of Maryland School of Medicine, 645 West Redwood Street, Baltimore, MD 21201*

SUMMARY:

Schizophrenia exerts complex effects on patients and their families. The assessment of outcomes must somehow reflect this complexity in order to meet the needs of treatment planning, outcomes management, policy development, and research. However, decisions about what outcomes to measure must be guided by the need at hand; the content, nature, and level of detail of assessment will vary across settings and purposes. Among the outcomes relevant to schizophrenia are: a) the dimensions of primary psychopathology, including positive symptoms, deficit symptoms, conceptual disorganization, and disturbances in interpersonal relations; b) secondary psychological disturbances, including demoralization/depression, anxiety, hostility/aggression, and so-called secondary negative symptoms; c) adverse treatment effects; d) impaired functional status; e) adverse effects on quality of life, including limited access to resources and opportunities and reduced life satisfaction; and f) adverse effects on families. This presentation will provide a framework for developing outcome assessments for schizophrenia across a variety of contexts and will be illustrated by examples from the literature.

REFERENCES:

1. Borison RL: Clinical efficacy of serotonin-dopamine antagonists relative to classic neuroleptics. *J Clin Psychopharmacol* 15(suppl 1):24S-29S, 1995.
2. Schooler NR, Keith SJ, Severe JB, et al: Maintenance treatment of schizophrenia: a review of dose reduction and family treatment strategies. *Psychiatr Q* 66:279-292, 1995.
3. Corrigan PW, Storzbach DM: Behavioral interventions for alleviating psychotic symptoms. *Hosp Community Psychiatry* 44:341-346, 1993.
4. Lehman A: Measuring quality of life in a reformed health care system. *Health Aff (Millwood)* 14:90-101, 1995.

INDUSTRY SUPPORTED SYMPOSIA

Industry Supported Symposium 6 — **Sunday, October 20 6:30 a.m.-8:00 a.m.**

RECENT DEVELOPMENTS IN THE NEUROBIOLOGY OF OBSESSIVE-COMPULSIVE DISORDER
Supported by Solvay Pharmaceuticals, Inc. and Pharmacia & Upjohn, Inc.

Michael A. Jenike, M.D., *Professor, Department of Psychiatry, Massachusetts General Hospital, Building 149, Thirteenth Street, Charlestown, MA 02129*

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:
At the conclusion of this session, participants should be able to discuss the clinical and treatment implications of recent research concerning the neurobiology of obsessive-compulsive disorder.

OVERALL SUMMARY:
Over the last two years, there have been major advances in our understanding of the neurobiology of obsessive-compulsive disorder (OCD) and related disorders. By collaborating with radiology and neurology and using state-of-the-art neuroimaging technologies, investigators are beginning to grasp the biological underpinnings of OCD. Functional neuroimaging modalities, including PET and functional MRI, have allowed researchers to visualize brain regions that are activated when patients are stimulated to have their obsessive thoughts. In addition, new precise morphometric MRI techniques have revealed that the brains of OCD patients are structurally different from the brains of carefully matched normal control subjects.

Besides structural and functional studies, pharmacologic data from clinical trials and challenge studies have implicated both serotonergic and dopaminergic systems in the pathophysiology of OCD. Careful neuropsychological testing has identified abnormalities in OCD patients that are similar to findings from neurologic populations with known striatal and/or frontal system dysfunction. Orbital frontal and basal ganglia regions are consistently implicated in neuroimaging studies of OCD patients, and certain basal ganglia neurologic disorders have been associated with symptoms of OCD.

No. 6A
NEUROIMAGING IN OBSESSIVE-COMPULSIVE DISORDER

Scott L. Rauch, M.D., *Director, Psychiatric Neuroimaging Research, Massachusetts General Hospital, and Assistant Professor, Department of Psychiatry, Harvard Medical School, Building 149, Thirteenth Street, Charlestown, MA 02129;* Hans C. Breiter, M.D., Cary R. Savage, Ph.D.

SUMMARY:
The mediating neuroanatomy of OCD will be reviewed against the backdrop of other anxiety disorders and so-called "OC-spectrum disorders."

Morphometric MRI data suggest that OCD is characterized by abnormalities in caudate size or laterality, as well as white matter volume; patients with Tourette disorder or trichotillomania exhibit volumetric abnormalities of the lenticulate. Functional neuroimaging studies demonstrate paralimbic and limbic system activation associated with the symptomatic state across a variety of anxiety disorders. In contrast, involvement of anterior orbitofrontal cortex and caudate may be specific to OCD.

These findings support the notion that the limbic/paralimbic system mediates anxiety nonspecifically. The pathophysiology of OCD and OC-spectrum disorders is hypothesized to entail corticostriatal dysfunction. There is mounting evidence of a striatal topography model of OCD, whereby the distribution of involvement within the striatum reflects, or governs, the clinical manifestations observed. OCD is proposed to reflect dysfunction within the fronto-caudate pathway; Tourette's disorder and trichotillomania may reflect pathology within the sensorimotor-putamen pathway.

No. 6B
NEUROPSYCHOLOGY OF OBSESSIVE-COMPULSIVE DISORDER: NEW FINDINGS

Cary R. Savage, Ph.D., *Department of Psychiatry, Massachusetts General Hospital, Building 149, Thirteenth Street, Charlestown, MA 02129;* Lee Baer, Ph.D., Scott L. Rauch, M.D.

SUMMARY:
Neuropsychological findings on OCD will be reviewed and related to current neurobiological and cognitive models of the disorder. Previous studies of OCD have shown difficulties in specific cognitive domains, including nonverbal memory, visuospatial ability, and executive functioning. Neuroimaging studies of OCD have most consistently demonstrated abnormalities in the striatum and frontal cortex. Studies of neurologic populations with lesions of the frontal lobes or with disorders affecting frontal-striatal system function (e.g., Parkinson's disease, Huntington's disease) indicate that apparent memory problems can actually be the outcome of impaired executive functioning. In this context the term "executive functioning" refers to planning and organizational strategies that are crucial for efficient encoding and retrieval of new memories. In additional to a general review, Dr. Savage will present findings from a recent study comparing 20 unmedicated patients with OCD to 20 matched control subjects. Results support the hypothesis that nonverbal memory impairment in OCD is mediated by executive aspects of learning and memory. Findings from this study provide a basis for a neuropsychological model to explain the impact of frontal-striatal system dysfunction on memory in OCD.

INDUSTRY SUPPORTED SYMPOSIA

No. 6C
NEUROPHARMACOLOGY OF OBSESSIVE-COMPULSIVE DISORDER

Wayne K. Goodman, M.D., *Professor and Chairman Department of Psychiatry, University of Florida, P.O. Box 100256, Gainesville, FL 32610*

SUMMARY:

The preferential efficacy of selective serotonin reuptake inhibitors (SSRIs) in OCD implies that serotonin (5-HT) is critically involved. It is less clear what changes in 5-HT function are associated with clinical response, given that several adaptive changes in neuronal function occur during chronic administration of SSRIs. Although studies of 5-HT function in OCD with the compound *m*CPP suggest hypersensitivity of 5-HT subsystems, these findings have not been consistent. Therefore, the pathophysiology of OCD may involve neurochemical dysfunction in addition to, or different from, that involving 5-HT. Dopamine function may be relevant to obsessive-compulsive behavior. It is speculated that OCD patients with a history of Tourette's disorder may have a subtype of the disorder in which both the dopamine and 5-HT systems are involved. In such cases it is unclear whether the primary abnormality is in dopamine function, 5-HT function, or a third, unidentified neurochemical system that affects the balance between the two. This presentation will review the neurobiological implications of drug response data and pharmacological challenge studies for the role of 5-HT and dopamine in OCD. The possible etiologic role of autoimmune factors in some forms of OCD and Tourette's disorder will also be discussed.

REFERENCES:

1. Rauch SL, Jenike MA, Alpert NM, et al: Regional cerebral blood flow measured during symptom provocation in obsessive-compulsive disorder using ^{15}O-labeled carbon dioxide and positron emission tomography. *Arch Gen Psychiatry* 51:62-70, 1994.
2. Savage CR, Keuthen NJ, Jenike MA, et al: Recall and recognition memory in obsessive-compulsive disorder. *J Neuropsychiatry Clin Neurosci* 8:99-103, 1996.
3. Goodman WK, McDougle CJ, Price LH, et al: Beyond the serotonin hypothesis: a role for dopamine in some forms of obsessive compulsive disorder? *J Clin Psychiatry* 51(8 suppl):36-43, 1990.

Industry Supported Symposium 7 — **Sunday, October 20, 12 noon-1:30 p.m.**

CURRENT ISSUES IN THE TREATMENT OF DEPRESSION
Supported by Wyeth-Ayerst Laboratories

Dwight L. Evans, M.D., *Professor and Chairman, Department of Psychiatry, University of Florida, P.O. Box 100256, Gainesville, FL 32610-0256*

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this session, participants should be able to identify and describe the pharmacologic strategies available for the treatment of complicated depression, including severe refractory depression and depression in the medically ill.

OVERALL SUMMARY:

Over the past 10 years, considerable advances in the acute and long-term treatment of uncomplicated major depressive disorders have been made. Information concerning the treatment of subgroups of depressive disorders has accumulated. The purpose of this symposium is to provide an update and overview of recent data on the antidepressant treatment of severe depression, including melancholia and psychotic depression, management of treatment-resistent depression, and diagnosis and treatment of depression in patients with comorbid medical illness. The presentations will cover the pharmacologic properties of the available antidepressant medications, including efficacy, side effects, and drug-drug interactions. The benefits of antidepressant medication will be discussed specifically; these include relief of depression, improved quality of life, and potential reduction of morbidity and mortality from comorbid medical illness.

No. 7A
DEPRESSION IN THE MEDICALLY ILL AND ELDERLY

Dwight L. Evans, M.D., *Professor and Chairman, Department of Psychiatry, University of Florida, P.O. Box 100256, Gainesville, FL 32610-0256*

SUMMARY:

There is increasing evidence that patients with medical illnesses have a high prevalence of major depression and that depressive symptoms are common in patients with chronic pain, tinnitus, fatigue, fibromyalgia, and premenstrual syndrome. Research also indicates that stress and depression are independent predictors of disease progression and mortality; they have been associated with alterations in immunity and may influence the clinical course of immune-based diseases. Depression is also an independent risk factor for mortality in patients who have suffered myocardial infarctions. Therefore, effective antidepressant treatment not only may relieve depression and improve quality of life, but also may influence the morbidity and mortality of the comorbid medical illness. However, traditional antidepressant medications are generally poorly tolerated by the medically ill. The selective serotonin reuptake inhibitors (SSRIs) and the newer antidepressants have relatively few adverse effects. Furthermore, these agents may be effective for anxiety disorders, panic disorder, obsessive-compulsive disorder, and premenstrual syndrome. Thus, the SSRIs and the newer antidepressant agents are effective and well-tolerated treatments for individuals with comorbid medical and psychiatric conditions.

INDUSTRY SUPPORTED SYMPOSIA

No. 7B
MANAGEMENT OF SEVERE AND REFRACTORY DEPRESSION

Charles B. Nemeroff, M.D, *Professor and Chairman, Department of Psychiatry, Emory University, Suite 4000, 1639 Pierce Drive, Atlanta, GA 30322*

SUMMARY:

Contemporary treatment of depression is very effective, and approximately 70% of patients respond to their first antidepressant treatment trial. However, patients with severe depression, including melancholia and psychosis, often require special treatment considerations. Furthermore, approximately 30% of patients do not respond to the initial antidepressant treatment trial. Multiple factors in this lack of response will be reviewed in this presentation. The treatment strategies that have been used for patients with severe and refractory depression include: a) switching to another class of antidepressant medication; b) augmentation with another pharmacologic agent, such as lithium or triiodothyronine (T_3); c) a combination of an SSRI and a tricyclic; and d) a high dose of a monoamine oxidase inhibitor. Recent studies indicate that pindolol, stimulants, and buspirone may be useful, and newer antidepressants, such as venlafaxine, have also shown promise in the treatment of severe and refractory depression. Finally, electroconvulsive therapy is very effective for the management and treatment of severe and refractory depression. Strategies for the treatment of the depressive phase of bipolar disorder will also be presented.

REFERENCES:

1. Evans DL, McCartney CF, Haggerty JJ Jr, et al: Treatment of depression in cancer patients is associated with better life adaptation: a pilot study. *Psychosom Med* 50:73-76, 1988.
2. Roose SP, Glassman AH, Attia E, et al: Comparative efficacy of selective serotonin reuptake inhibitors and tricyclics in the treatment of melancholia. *Am J Psychiatry* 151:1735-1739, 1994.

Industry Supported Symposium 8 — **Sunday, October 20 7:00 p.m.-10:00 p.m.**

MANAGEMENT OF SEXUAL DYSFUNCTION
Supported by Glaxo Wellcome Inc.

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

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this session, participants should be able to distinguish 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; and to describe current therapies and interventions for treating sexual dysfunction.

OVERALL SUMMARY:

Building on Masters and Johnson's pioneering efforts documenting 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, for the purpose of *DSM-IV* classification, will be presented. Review of common medical diseases and treatments, both surgical and pharmacologic, that cause sexual dysfunction demonstrate the need to partition organic from psychogenic causes. Psychotherapeutic and somatic treatments can then be planned. Dysfunctions due to psychotropic agents will be discussed, and approaches to ameliorate such problems will be presented. Injection therapy, mechanical treatments, and clinical interventions will also be reviewed to provide an update on the full range of treatment options for sexual dysfunctions.

No. 8A
SEXUALITY IN THE MEDICALLY ILL

Thomas N. Wise, M.D., *Professor and Chairman, Department of Psychiatry, Fairfax Hospital, 3300 Gallows Road, Falls Church, VA 22042-3352*

SUMMARY:

Sexuality is an important medium of interpersonal communication that can be compromised by psychological and physical factors. A variety of disease states and their treatments can modify sexual response and create dysfunctions in desire, arousal, and release. This presentation will provide a systematic structure that delineates how best to assess and treat the sexual disorders found in the physically ill or in those taking medications that cause sexual side effects. By recognizing the psychological reactions to an illness and understanding the impersonal effects of a disease on sexuality, the clinician can develop a rational treatment plan. Common disease states, such as cardiovascular disease, diabetes, and breast cancer, will illustrate this method.

INDUSTRY SUPPORTED SYMPOSIA

No. 8B
SEXUAL DYSFUNCTION DUE TO PSYCHOTROPIC DRUGS

Richard Balon, M.D., *Department of Psychiatry, Wayne State University, Suite 2000, University Square, Detroit, MI 48207*

SUMMARY:

Psychotropic drugs are used more and more frequently in the treatment of mental disorders. Recently we have broadened our appraisal of psychotropic drugs, from focusing only on efficacy to focusing on the overall quality of life and the frequency of medication side effects. Sexual dysfunctions were underreported in the original efficacy studies of various psychotropic medications. Howver, we have seen an increase in reporting of sexual side effects. Sexual dysfunctions have been reported with practically every psychotropic medication. The inherent problem of evaluating sexual dysfunction as a side effect of psychotropic medication is that sexual dysfunction could be a symptom of many mental disorders. Antidepressants are the best example; they are used in the treatment of mood and anxiety disorders, in which sexual dysfunction can be a symptom, and can reportedly cause various sexual dysfunctions.

This presentation will review sexual dysfunction associated with various psychotropic drugs and will provide some guidance for the management of this serious side effect. In addition, beneficial effects of antidepressants on human sexuality will be briefly described.

No. 8C
SEXUAL DYSFUNCTION: THE ROLE OF THE PSYCHIATRIST

Domeena C. Renshaw, M.D., *Professor of Psychiatry, Loyola University, 2160 South First Avenue, Maywood, IL 60153*

SUMMARY:

Sexual symptoms are not life threatening, but they may be severely disruptive or destructive to individuals or to their relationships with their partners. Causes and cures for the prevalent problem of sexual dysfunction have received attention for centuries from scientists as well as charlatans and ministers of religion.

Although the mechanics of male and female sexual function are well documented, the neurophysiology, endocrinology, hemodynamics, and psychic pathways are not fully understood and await further investigation. Women may participate in coitus without sexual arousal, but men lacking an erection cannot pretend or penetrate.

By the time a patient seeks sexual answers from his or her physician or psychiatrist, cause and effect are so enmeshed that the answer is not apparent. In this presentation Dr. Renshaw will describe the role of the psychiatrist in elucidating the cause of the sexual dysfunction and will suggest management techniques that have proven to be clinically effective. In addition, this presentation will provide an overview of injections used to maintain erection, prostheses, and commonly available drugs that may enhance sexual function.

REFERENCES:

1. Wise TN: Sexual dysfunction in the medically ill. *Psychosomatics* 24:787-801, 1983.
2. Balon R, Yeragani VK, Pohl R, et al: Sexual dysfunction during antidepressant treatment. *J Clin Psychiatry* 54:209-212, 1993.
3. Renshaw DC: Sexuality and depression. *J Psychiatr Treatment Eval* 5:451-455, 1983.

Industry Supported Symposium 9 — **Monday, October 21 6:30 a.m.-8:00 a.m.**

PART I: IMPROVING THE OUTCOME OF SCHIZOPHRENIA: ACUTE TREATMENT STRATEGIES
Supported by Zeneca Pharmaceuticals Group

Jeffrey A. Lieberman, M.D., *Professor of Psychiatry and Pharmacology, Department of Psychiatry, University of North Carolina, Campus Box 7160, 101 Manning Drive, Chapel Hill, NC 27599-7160;* David Pickar, M.D.

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this session, participants should be able to describe the pharmacologic and clinical efficacy of antipsychotic drugs for the treatment of acute psychotic disorders.

OVERALL SUMMARY:

The treatment of schizophrenia and related psychotic disorders is rapidly changing as new pharmacologic compounds are developed and greater understanding of the clinical and biological dimensions of the disease is achieved. This symposium will provide a focused update for clinicians on the optimal strategies for treating the acute and actively symptomatic phases of the illness at different stages of the disease and in different clinical situations. Dr. Pickar will discuss the presentations and their approaches to the acutely ill patient in the context of the most recent knowledge of disease pathophysiology, diagnostic methods, and treatments.

No. 9A
ATYPICAL ANTIPSYCHOTIC DRUGS: DEFINITION AND CLINICAL APPLICATION

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

SUMMARY:

The first of a new generation of antipsychotic drugs have just come over the horizon as psychiatry moves toward the twenty-first century. They promise to substantially alter the way and effectiveness with which we treat schizophrenia and related psychoses. However, as these compounds wend their way throughout the development and regulatory process, their optimal application remains unclear.

This presentation will define new atypical antipsychotic drugs and their pharmacology, clinical efficacy and safety, and clinical applications. It will also begin the discussion of how these compounds should be used and for which disorders in an environment of cost containment. The audience should come away understanding the difference between the different classes of compounds, how they should be used, and in what clinical situations.

No. 9B
TREATING THE FIRST EPISODE AND EARLY STAGES: SCHIZOPHRENIA

Diana O. Perkins, M.D., *Assistant Professor, Department of Psychiatry, University of North Carolina at Chapel Hill, Campus Box 7160, 101 Manning Drive, Chapel Hill, NC 27599-7160*

SUMMARY:

Traditional psychopharmacologic and psychotherapeutic treatments for schizophrenia and schizoaffective disorder are directed at patients with chronic illness. Dr. Perkins will discuss the possible differences in clinical symptoms and treatment responses between patients with new-onset psychosis and patients with chronic psychotic illness. In particular, patients with new-onset illness often have complete remission of positive symptoms and are at high risk for major depression. In addition, they may experience more side effects from antipsychotic medication and may require lower doses to achieve good symptom control. Psychotherapy, emphasizing a therapeutic alliance, symptom management, and medication compliance, may have substantial benefit early in schizophrenia, minimizing the risk of relapse. Brief family interventions using psychoeducational approaches may help families to respond better to residual symptoms and to support treatment. More-intensive treatment early in the illness may lead to substantial benefits later; several studies suggest that earlier interventions and fewer psychotic relapses may improve the prognosis of schizophrenia.

No. 9C
TREATMENT OF RELAPSE AND REFRACTORY PSYCHOSIS

Joseph P. McEvoy, M.D., *Associate Professor, Department of Psychiatry, Duke University Medical Center, and John Umstead Hospital, Twelfth Street, Butner, NC 27509-1695*

SUMMARY:

Determining the factors that precipitated a relapse is a prerequisite for fashioning optimal treatment. Noncompliance, the most frequent precipitant of relapse, may result from lack of insight, intolerance of distressing side effects, substance abuse, or other causes. The specific cause of noncompliance will influence the selection of the antipsychotic agent used for treatment. Relapse also offers an opportunity to (re)engage family members in supporting treatment and to determine, with outpatient treatment staff, whether more-assertive outpatient treatment is indicated after recovery.

Relapse despite medical compliance may occur because of substance abuse, environmental stress, or lack of response to pharmacologic treatment. Relapses induced by substance abuse or stress tend to resolve quickly, and the psychosocial treatments for substance abuse or for family or occupational stress are usually referred to outpatient treatment staff.

Novel antipsychotic agents offer advantages over conventional agents in treating refractory psychosis. Planning for aftercare of patients with refractory psychosis usually includes greater supervision and more-assertive community treatment.

REFERENCES:

1. Wirshing WC, Marder SR, Van Putten T, et al: Acute treatment of schizophrenia. In Kupfer DJ, Bloom FE (eds): *Psychopharmacology: The Fourth Generation of Progress.* Raven Press, New York, 1995, pp 1259-1266.
2. Csernansky JG, Newcomer JG: Maintenance drug treatment for schizophrenia. In Kupfer DJ, Bloom FE (eds): *Psychopharmacology: The Fourth Generation of Progress.* Raven Press, New York, 1995, pp 1267-1275.
3. Meltzer HY: Atypical antipsychotic drugs. In Kupfer DJ, Bloom FE (eds): *Psychopharmacology: The Fourth Generation of Progress.* Raven Press, New York, 1995, pp 1277-1286.

Industry Supported Symposium 10 — **Monday, October 21 12 noon-1:30 p.m.**

PART II: IMPROVING THE OUTCOME OF SCHIZOPHRENIA: STRATEGIES FOR COMPREHENSIVE AND LONG-TERM CARE
Supported by Zeneca Pharmaceuticals Group

Jeffrey A. Lieberman, M.D., *Professor of Psychiatry and Pharmacology, Department of Psychiatry, University of North Carolina, Campus Box 7160, 101 Manning Drive, Chapel Hill, NC 27599-7160;* Anthony F. Lehman, M.D.

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this session, participants should be able to identify state-of-the-art principles for comprehensive care of patients with schizophrenia.

INDUSTRY SUPPORTED SYMPOSIA

OVERALL SUMMARY:

This symposium will follow the themes established in the moming session on acute treatment strategies and will consider the comprehensive and (life) long-term care of patients. Dr. Lehman will discuss the presentations in the context of their real-world application in various clinical settings and in a cost-containment environment.

No. 10A
TREATMENT OF RESIDUAL SYMPTOMS IN SCHIZOPHRENIA

John G. Csernansky, M.D., *Gregory B. Couch Professor, Department of Psychiatry, Washington University, 4949 Childrens Place, St. Louis, MO 63110;* Bruce W. Vieweg

SUMMARY:

Acute antipsychotic drug treatment of patients with schizophrenia produces incomplete responses in many cases. Remaining symptoms may include many different forms of psychopathology, such as thought disorder, hallucinations, delusions, apathy, and flat affect. Dysphoria is also common after treatment with antipsychotic medications. In small-scale studies of inpatients who completed four4 weeks of haloperidol treatment and of outpatients who had been optimally treated for several months, the amounts of residual psychopathology, dysphoria, and extrapyramidal side effects were positively correlated. In addition, the results of a large-scale outcome study of inpatient treatment for patients with schizophrenia suggest that residual psychopathology is related to the intensity of inpatient care and that greater residual psychopathology is related to poorer functioning after discharge. Together, these studies suggest that many patients with schizophrenia have significant residual psychopathology due to several causes and that such psychopathology has deleterious effects on patients and their capacity for adjustment in the community.

No. 10B
WHY DO ANTIPSYCHOTIC MEDICATIONS FAIL?

Peter Weiden, M.D., *Department of Psychiatry, St. Lukes-Roosevelt Hospital Center, Suite 3B, 411 West 114th Street, New York, NY 10025;* Annette Zygmunt, M.S.

SUMMARY:

The first step in the recovery process for a person with schizophrenia is to stay out of the hospital. Only after the patient is consistently stable can rehabilitation issues be addressed. Unfortunately, under current treatment conditions, within a year half of all discharged patients with schizophrenia are rehospitalized. Approximately 40% of these rehospitalizations are due to medication noncompliance, and approximately 60% are due to other factors, such as loss of medication efficacy.

Dr. Weiden will discuss clinical strategies to improve the effectiveness of antipsychotic medication in preventing or delaying relapse under real-world conditions, with particular focus on medication noncompliance. Most of the information is from results obtained from a NIMH-funded longitudinal study of medication noncompliance. Assessment issues include interview techniques for assessing medication noncompliance, psychotic factors that are most associated with noncompliance, and side effects that are most associated with noncompliance. Specific behavioral, psychoeducational, and psychopharmacologic interventions that might improve compliance will be discussed.

No. 10C
PSYCHOSOCIAL ENHANCEMENT OF THE TREATMENT OF SCHIZOPHRENIA

Samuel J. Keith, M.D., *Professor and Chairman, Department of Psychiatry, University of New Mexico, Room 404, 2400 Tucker, Albuquerque, NM 87131*

SUMMARY:

The psychosocial treatment of schizophrenia has gone through several revolutions. Before 1960, when psychotherapies were about all that we had for schizophrenia, it reached a nadir. In the 1960s, so deep was the split between the newly developing pharmacotherapy of schizophrenia and the psychotherapies that charges of unethical treatment were frequently hurled at those not providing psychotherapy, and the central question was whether psychopharmacology *interfered* with psychotherapy. It is ironic that by the 1980s it was considered unethical to give *only* psychotherapy. With the striking efficacy of antipsychotic medication, many in the 1980s saw psychotherapy principally as a means of enhancing compliance. The evolution of psychosocial treatment would undergo yet another phase--this one a bit more positive--bringing it to the current day, when specific psychosocial treatments are seen as contributing to specific aspects of schizophrenia and as useful for augmenting the effects of pharmacotherapy. The studies and their outcomes will be reviewed in terms of their clinical relevance to the contemporary treatment of schizophrenia.

REFERENCES:

1. Csernansky JG, Newcomer JD: Maintenance drug treatment for schizophrenia. In Bloom FE, Kupfer DJ (eds): *Psychopharmacology: The Fourth Generation.* Raven Press, New York, 1995.
2. Weiden PJ, Mott T, Curcio N: Recognition and management of neuroleptic noncompliance in schizophrenia. In Shriqui C, Nasrallah H (eds): *Contemporary Issues in the Treatment of Schizophrenia.* American Psychiatric Press, Washington, DC, 1995, pp 411-434.
3. Keith SJ, Schooler NR: Psychosocial and pharmacotherapeutic strategies for long-term treatment of schizophrenia. In Costa e Silva JA, Nadelson CC (eds): *International Review of Psychiatry,* vol 1. American Psychiatric Press, Washington, DC, 1993.

INDUSTRY SUPPORTED SYMPOSIA

Industry Supported Symposium 11 — **Monday, October 21, 5:30 p.m.-8:30 p.m.**

CHOOSING AMONG OLD AND NEW ANTIPSYCHOTICS
Supported by Abbott Laboratories

John M. Kane, M.D., *Chairman, Department of Psychiatry, Hillside Hospital, 75-59 263rd Street, Glen Oaks, NY 11004-1150*

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this session, participants should be able to describe the differences in receptor binding profiles and the clinical effects of conventional and new antipsychotic drugs and to use this information in choosing among alternatives.

OVERALL SUMMARY:

Antipsychotic drugs are a critical modality in the treatment of schizophrenia. The fact that all effective antipsychotic drugs bind to some type of dopamine receptor has been a key aspect of the dopamine hypothesis. At the same time, however, influencing the functioning of other receptors may be important in improving the clinical effects of antipsychotic drugs. The introductions of clozapine and risperidone have added new treatment alternatives, and several other new drugs should soon be available as well (sertindole, olanzapine, seroquel, ziprazidone). Clinicians will then have a wide range of choices and will be confronted with the need to balance potential advantages and disadvantages in picking an antipsychotic for a given patient. This symposium will review preclinical and clinical data that can inform such a decision and provide a framework for choosing among alternative drugs.

No. 11A
BRAIN MECHANISMS OF ANTIPSYCHOTIC DRUG ACTIONS

Carol A. Tamminga, M.D., *Chief, Inpatient Program, Maryland Psychiatric Research Center, Department of Psychiatry, University of Maryland, P.O. Box 21247, Baltimore, MD 21228*

SUMMARY:

Traditional neuroleptics exert their antipsychotic action through dopamine receptor blockade and subsequent downstream cerebral actions. Each dopamine receptor, D_1 through D_5, has its own structure, regional distribution, and pharmacology. Most traditional neuroleptics block at D_2, D_3, and D_4 receptors. Because clozapine differentially blocks at the D_4 receptor and these receptors are located in brain regions thought to be important in schizophrenia, much interest has focused on the D_4 receptor. The D_3 receptor may also be an interesting candidate for therapeutics, because of its primary localization to ventral striatum. Whether one or another of these receptors might be active in alleviating a subset of schizophrenic symptoms or might be more potent overall is being specifically asked in ongoing clinical trials. New neuroleptics have distinct ratios of D_2, D_3, and D_4 affinities. Another pharmacologic action exhibited selectively by clozapine and certain other new antipsychotic drugs is anatomic selectivity of drug action: clozapine selectively affects the firing of some (the A10), but not all (the A9), dopamine neurons. Consequently, the extent of clozapine's activity is more limited to the limbic regions (the A10 projection areas) than to the striatal motor regions (the A9 projection areas). Of the new antipsychotics, sertindole was rationally designed to possess this selective action, and both olanzapine and seroquel possess this property. Also, clozapine demonstrates affinity at many different brain receptors. Serotonergic and noradrenergic antagonism may be involved in clozapine's unique antipsychotic effects. Indeed, clozapine's full spectrum of receptor antagonism might be operative in its unique antipsychotic properties. Clinical testing of these mechanisms may direct us to more potent and sensitive antipsychotic drugs.

No. 11B
CLOZAPINE AND RISPERIDONE: RECENT FINDINGS

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

SUMMARY:

Dr. Schooler will discuss recent findings on clozapine and risperidone. Clozapine has been available for clinical use since 1990 and risperidone since 1994. Both drugs have been called "atypical" antipsychotic medications, and they share some pharmacologic characteristics that distinguish them from the so-called "typical" neuroleptics. This presentation will review recent studies with both drugs that focus on significant clinical questions. What is clozapine's efficacy beyond six weeks? What are appropriate doses of clozapine and risperidone? How do clozapine and risperidone compare?

No. 11C
EXTRAPYRAMIDAL SYNDROMES RISK OF NEW ANTIPSYCHOTICS

Daniel E. Casey, M.D., *Chief, Research and Psychopharmacology, Psychiatry Service, VA Medical Center (116A), 3710 Southwest U.S. Veterans Hospital Road, Portland, OR 97207*

SUMMARY:

Neuroleptics produce motor side effects of acute extrapyramidal syndromes of akathisia, dystonia, and parkinsonism, as well as the late-onset symptoms of

tardive dyskinesia. These acute extrapyramidal syndromes are a common reason that patients stop taking their medicines, and the tardive syndromes are potentially irreversible. The traditional hypothesis regarding the mechanism underlying these disorders involved their ability to block the dopamine D_2 receptor. However, new drugs in development challenge this explanation. Of particular interest are the mechanisms of serotonin and alpha-adrenergic receptor subtype antagonism. Preclinical studies and clinical trials have been useful in determining the potential liability for extrapyramidal syndromes of these new agents. Both flexible-dose and fixed-dose studies show that it is possible to separate the dose-response curves for antipsychotic efficacy and adverse motor effects. Research results with the traditional neuroleptics (e.g., haloperidol, chlorpromazine), the new antipsychotics (e.g., clozapine, risperidone), and the novel drugs in development (e.g., sertindole, olanzapine, seroquel) will be presented. In addition to suggesting potential risks of extrapyramidal syndromes from the traditional and new medicines, the findings will increase knowledge about the underlying mechanisms of both extrapyramidal syndromes and antipsychotic drug actions.

No. 11D
CHOOSING THE IDEAL ANTIPSYCHOTIC: OLD OR NEW

John M. Kane, M.D., *Chairman, Department of Psychiatry, Hillside Hospital, 75-59 253rd Street, Glen Oaks, NY 11004*

SUMMARY:

Clinicians have considerable experience with conventional antipsychotics and increasing experience with newer compounds (e.g., clozapine and risperidone). Physicians treating patients with schizophrenia are all too aware of the deficiencies of pharmacotherapy. Newer drugs under development will add alternatives, and clinicians will have to choose which drug to prescribe for a given patient. Clinical efficacy, adverse effects, ease of administration, cost, and patient acceptance will have to be considered. This presentation will provide clinicians with a framework for making and then evaluating treatment decisions.

REFERENCES:

1. Lahti AC, Lahti RA, Tamminga CA: New neuroleptics and experimental antipsychotics: future roles. In Breier A (ed): *The New Pharmacotherapy of Schizophrenia.* American Psychiatric Press, Washington, DC, 1996.
2. Kane JM, Marder SR: Psychopharmacologic treatment of schizophrenia. *Schizophr Bull* 19:287-302, 1993.
3. Casey DE: Serotonergic and dopaminergic aspects of neuroleptic-induced extrapyramidal syndromes in nonhuman primates. *Psychopharmacology* 112:S55-S59, 1993.

Industry Supported Symposium 12 — **Tuesday, October 22 6:30 a.m.-8:00 a.m.**

DILEMMAS IN SCHIZOPHRENIA: MANAGING OBSTACLES TO RECOVERY
Supported by Janssen Pharmaceutica and Research Foundation

Leonard I. Stein, M.D., *Professor Emeritus, Department of Psychiatry, University of Wisconsin Medical School, 302 Cheyenne Trail, Madison, WI 53705*

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this session, participants should be able to discuss the concept of recovery in schizophrenia and the management of several common clinical dilemmas that, if not managed appropriately, can become obstacles to the recovery process.

OVERALL SUMMARY:

Recovery is the process of rebuilding personal, social, environmental, and spiritual connections that are disrupted by severe and persistent mental illness. The concept of recovery has proven useful for both consumers and the clinicians who treat them. A critical element of recovery is gaining more control over one's own life. Thus, recovery mandates that the consumer play an active role in the treatment process. Consumers will at times have points of view that differ from those of the clinician. This symposium will focus on several common clinical dilemmas that, if not managed appropriately, can become obstacles to the recovery process. They include career and educational expectations that appear to the clinician as unrealistic, unwise resistance to taking medications, and feelings of demoralization with their accompanying risk of suicide. The symposium will feature three short videotapes depicting these situations through simulations of consumer-clinician interactions. Each video will be followed by a brief presentation highlighting the issues and underscoring the problems for both clinician and consumer; possible strategies for their resolution will be offered. Ample time will be available for the symposium participants to engage in discussion.

No. 12A
"I DON'T THINK I NEED THIS MEDICINE"

David P. Greenfeld, M.D., *Clinical Professor, Department of Psychiatry, Yale University, Room 611, 25 Park Street, New Haven, CT 06519*

SUMMARY:

A consumer who informs a clinician about a wish to reduce or discontinue medication may be unwisely risking a relapse. The fact that the consumer raises the issue within the treatment context, rather than simply stopping the medication without discussion, indicates sufficient trust

in the clinician to engage in a dialogue. This dialogue is the crucial element in any strategy for dealing with this challenge. The clinician's approach should be based on the following concepts: (a) The clinician should solicit the consumer's views in detail, exploring the consumer's ideas about the illness and its treatment and, in particular, about the purposes and actions of the medication. If the consumer appears to be misinformed or unrealistic about these issues, it is also important to determine the degree of rigidity with which these ideas are held. (b) The presentation of the consumer's views should be followed by a dialogue and, if possible and necessary, negotiation about how to proceed together. If the clinician and consumer have significant differences of opinion, they might together devise a plan to test the differences (which might include decreasing or discontinuing the medication), enabling them to learn together about the importance of medication in the treatment process.

No. 12B
EMPLOYMENT: WHAT ARE REALISTIC GOALS?

Ronald J. Diamond, M.D., *Professor, Department of Psychiatry, University of Wisconsin, 6001 Research Park Boulevard, Madison, WI 53719-1179*

SUMMARY

Work in American society is much more than just a source of money. It is an important part of how we define ourselves and a primary way for us to meet friends, structure our time, and gain a sense of accomplishment. For many people with serious and persistent mental illness, any kind of a job is challenge enough. A variety of support strategies have proven effective in helping people with serious psychiatric impairment to achieve some level of competent employment. For those with problems in self-definition and self-esteem, however, the only acceptable employment is at a professional level that may seem unrealistic to treating clinicians or family members. This vignette will explore the dilemma of a person who continues to hold on to professional aspirations to work as an engineer despite persistent psychotic symptoms that seem to make such a goal extremely unlikely if not impossible.

No. 12C
"I DON'T WANT TO LIVE LIKE THIS": SUICIDALITY AND SCHIZOPHRENIA

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

SUMMARY:

A diagnosis of schizophrenia conjures up feelings of hopelessness and despair in clients, family members, and even clinicians. Afflicting 1% of the U.S. population, schizophrenia can ruin lives and leave individuals with unfulfilled dreams and a shattered existence. Historically, the treatment of schizophrenia has focused on the control of psychoticism and the prevention of hospitalization, while less attention has been paid to the discouragement and demoralization that many of these individuals experience. It is not surprising that suicidality is a major problem in this population, with 20% to 50% attempting and 10% successfully completing suicide. These numbers are 20 times the rate of suicidality in the general population.

In the past decade numerous scientific reports from 18 countries have addressed the issue of suicidality and schizophrenia. A review of this literature reveals several consistent associations between suicide and schizophrenia. The most predictive factor is past suicide attempts. Other correlates include history of depressive episodes, severe and progressive impairment, substance abuse, duration of illness, living alone, young age, and multiple hospitalizations. Most studies noted that clients were not psychotic at the time of their suicides. Findings from these studies suggest that the most critical period for suicide among persons with schizophrenia is the time following recovery from the illness.

REFERENCES:

1. Anthony WA: Recovery from mental illness: the guiding vision of the mental health service system in the 1990s. *Psychosoc Rehab J* 16:11-23, 1993.
2. Spaniol L, Koehler M: *The Experience of Recovery.* Boston University Center for Psychiatric Rehabilitation, Boston, MA, 1993.
3. Greenfeld D: *The Psychotic Patient: Medication and Psychotherapy.* Jason Aronson, Northvale, NJ, 1994.
4. Lehman AF: Vocational rehabilitation in schizophrenia. *Schizophr Bull* 21:645-656, 1995.
5. Malone KM, Szanto K, Corbitt EM, et al: Clinical assessment versus research methods in the assessment of suicidal behavior. *Am J Psychiatry* 152:1601-1607, 1995.

INNOVATIVE PROGRAMS

Innovative Programs **Saturday, October 19**
Session 1 **8:00 a.m.-9:30 a.m.**

SPECIAL POPULATIONS: PART 1

No. 1
DEMYSTIFYING PSYCHIATRIC ASSESSMENT IN THE WORKPLACE

Vera Mellen, M.A., *Executive Director, Psychiatric Rehabilitation Services, 2810 Dorr Avenue, Fairfax, VA 22031;* Eileen C. Weklar, M.A., *Supervisor of Vocational Services, Psychiatric Rehabilitation Services,* Thomas J. O'Connor, M.Ed.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to discuss: a) safety-related concerns of employers of persons with psychiatric disabilities, Americans with Disabilities Act compliance, and return-to-work issues, and b) the role of mental health professionals in distinguishing between diagnostic criteria and skills needed to function on the job.

SUMMARY:

Proliferation of managed care and third-party oversight of mental health care has required psychiatrists to collaborate with an ever-increasing field of rehabilitation, industry-based, and insurance personnel. As independent medical examiners, psychiatrists have been pressed to communicate patient needs and interventions beyond the traditional dyad of medication and psychotherapy. Specifically, as disability management in the private sector has become increasingly concerned about mental illness in the workplace, psychiatrists are being challenged to assess and communicate individual diagnostic criteria and functional capacity in nonclinical language, in an effort to generalize and demystify psychiatry and mental illness. Likewise, the Americans with Disabilities Act and the Family and Medical Leave Act have further pressed physician accountability in regard to diagnosis, treatment, and the prognosis of patients in the workplace.

After an overview of their experiences and the current literature, the panel will elicit questions from the group. To stimulate discussion and learning, the presenters will provide case histories that small groups will be asked to discuss in terms of return to work. Major issues will include work readiness, accommodation design, worker direct threat, privacy/confidentiality, and professional liaison with nonmedical personnel.

REFERENCES:

1. Akabus SH: Workplace responsiveness: key employer characteristics in support of job maintenance for persons with mental illness. *Psychol Rehab J* 17(3):91-101, 1994.
2. Anthony WA, Rogers ES, Cohen M, et al: Relationships between psychiatric symptomatology, work skills, and future vocational performance. *Psychiatr Serv* 46:353-358, 1995.

No. 2
CROSS-CULTURAL APPROACHES IN COLLABORATIVE PRACTICE

Marguerite M. Blythe, M.D., *Medical Director, Practical Psychiatry, Suite 203, 3131 Harvey, Cincinnati, OH 45229;* Judy H. Ribak, M.S.N., *Nurse Clinical Specialist, Practical Psychiatry,* Nancy J. Walker, M.S.W.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to identify: a) at least three situations in which cross-cultural differences may lead to incorrect assumptions about another person or the person's illness, b) at least two methods of solving cross-cultural problems, and c) at least one way in which a cross-cultural view of problem solving may help in the participants' own practices.

SUMMARY:

Mental health practitioners are often asked to evaluate and treat patients from different cultural backgrounds. Cross-cultural differences can make evaluations difficult. The individual with cross-cultural competency is able to move from one culture to another with some degree of understanding of how cultures differ and what transition from one to the other entails. The workshop will look at how to determine when the culture itself (and not the patient or the illness) may be a confusing factor. This workshop will examine four different cultures and how the mental health practitioner can approach each so as to avoid misunderstanding what is being presented; the situations will involve a Russian Jewish emigrant, a person with profound hearing impairment, a frail elderly person, and collaboration between physicians and other mental health practitioners for treatment of mental illness. The presenters will include a psychiatrist, a social worker, and a nurse clinical specialist, all of whom have experience working with the hearing impaired, Russian emigrants, and geriatric patients and who also work in an interdisciplinary collaborative practice. After brief presentations, the panel will facilitate audience discussion.

REFERENCES:

1. House JS, Landis KR, Umberson D: Social relationships and health. *Science* 241:540-545, 1988.
2. Babich KS, Bush MT: Cultural variation in clinical practice. In Long DC, Williams RA (eds): *Psychosocial Nursing: Assessment and Intervention.* Appleton-Century-Crofts, Norwalk, CT, 1986, pp 113-132.

INNOVATIVE PROGRAMS

No. 3
THE NATURALLY OCCURRING RETIREMENT COMMUNITY: A MODEL FOR UNDERSTANDING THE NEEDS OF THE FRAIL ELDERLY IN COMMUNITIES

Mark R. Nathanson, M.D., *Assistant Professor of Psychiatry, State University of New York Health Center in Brooklyn, Suite 930, 85 Fifth Avenue, New York, NY 10003;* Karen Strauss, M.S.W., *Director, Penn South Program for Seniors*

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to describe a new model of health services for the elderly in the community and apply this model to individual clinical settings.

SUMMARY:

This presentation will introduce the concept of "naturally occurring retirement communities," a term arising from the urban planning literature, which relates to the extent of the frail elderly living in the community. The presenters will review the important concept of "aging in place," i.e., the fact that nearly 30% of the over-65 group are living in housing that has no special senior designation. Because of the rapid aging of the population and the 30% prevalence of mental illness in the elderly, we need to develop outreach strategies on a broad scale to address the most serious cases of behavioral disturbances, including Alzheimer's dementia, depressive illness, delirium, and severe panic and anxiety disorders.

The presenters will describe a model of home-based and community-oriented services to the elderly. The model presented is from Penn South, a middle-income housing cooperative in New York City. The importance of multidisciplinary collaboration and the critical role of the psychiatrist in clinical, educational, and administrative roles will be stressed. Clinical outcome data will show that the psychiatrist is asked to respond to acute and semiacute clinical situations, and psychiatric hospitalization for brief stabilization is key in ultimately allowing persons to return to their homes. The presenters will review models for funding such a community-based program and will review the current Medicare and Medicaid changes in this context. The topic will be important to all mental health professionals, who will increasingly need to be competent and responsible in advocacy for the elderly, particularly the over-75 frail segment.

REFERENCES:

1. Hunt M: Naturally occurring retirement communities. *J Housing Elderly,* 1985.
2. Hunt ME, Merrill JL, Gilker CM, et al: Naturally occurring retirement communities in urban and rural settings. In Folts WE, Yeatts DE (eds): *Housing and the Aging Population: Options for the New Century.* Garland, New York, 1994, pp 107-120.
3. Meyers P: *Aging in Place: Strategies to Help the Elderly Stay in Revitalizing Neighborhoods.* Conservation Foundation, Urban Institute, Washington, DC, 1990.

Innovative Programs **Saturday, October 19**
Session 2 **10:00 a.m.-11:30 a.m.**

AN UPDATE ON CLUBHOUSES AND PSYCHIATRY: TOGETHER OR APART?

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to describe the clubhouse model of psychosocial rehabilitation, discuss the clubhouse as part of an integrated community service network in this time of managed care, and relate to their local clubhouses or help start a new one.

No. 4
FOUNTAIN HOUSE AND THE PSYCHIATRIST

Thomas J. Malamud, A.M., *Associate Director, Fountain House, 425 West Forty-Seventh Street, New York, NY 10036;* Ralph Aquila, M.D., *Department of Psychiatry, St. Luke's Hospital*

SUMMARY:

The clubhouse model facilitates integration of mentally ill persons into the community through supported opportunities to socialize, work, get an education, and live independently, allowing sufficient time for members to (re)gain comfort, competence, and confidence. Psychiatrists and clubhouse programs need to understand each other and find ways to work together to support consumers' recovery. It is especially important for psychiatrists and clubhouses to develop a "rehabilitation alliance."

This presentation will describe how a clubhouse in an inner city, where quality care and continuity are difficult to obtain, has contracted for services with a hospital center and has developed interactions in which the clubhouse autonomy is preserved and the clinical services are given in a neutral site. In addition, cost savings, over the traditional fee-for-service model, will be examined.

REFERENCES:

1. Beard JH, Propst RN, Malamud TJ: The Fountain House model of psychiatric rehabilitation. *Psychosoc Rehab J* 5(1):47-53, 1982.
2. Bachrach LL: Psychosocial rehabilitation and psychiatry in the care of long-term patients. *Am J Psychiatry* 149:1455-1463, 1992.
3. Links PS, Kirkpatrick H, Whelton C: Psychosocial rehabilitation and the role of the psychiatrist. *Psychosoc Rehab J* 18(1):121-130, 1994.
4. McCrory DJ: The rehabilitation alliance. *Psychosoc Rehab J* (3):58-66, 1991.

INNOVATIVE PROGRAMS

No. 5
GENESIS CLUB AND THE PSYCHIATRIST

Kevin Bradley, *Executive Director, Genesis Club, 274 Lincoln Street, Worcester, MA 01605;* Paul J. Barreira, M.D., *Deputy Commission for Clinical and Professional Services, Massachusetts Department of Mental Health*

SUMMARY:

The clubhouse model facilitates integration of mentally ill persons into the community through supported opportunities to socialize, work, get an education, and live independently, allowing sufficient time for members to (re)gain comfort, competence, and confidence. Psychiatrists and clubhouse programs need to understand each other and find ways to work together to support consumers' recovery. It is especially important for psychiatrists and clubhouses to develop a "rehabilitation alliance."

The psychiatrist's role in Genesis Club is one of a guest who runs a monthly "med-ed" group for both members and staff. No direct clinical service is given. The purpose of this system is to help members feel more comfortable in dealing with their treating psychiatrists and to educate them about asking the right questions to get the best possible services.

REFERENCES:

1. Beard JH, Propst RN, Malamud TJ: The Fountain House model of psychiatric rehabilitation. *Psychosoc Rehab J* 5(1):47-53, 1982.
2. Bachrach LL: Psychosocial rehabilitation and psychiatry in the care of long-term patients. *Am J Psychiatry* 149:1455-1463, 1992.
3. Links PS, Kirkpatrick H, Whelton C: Psychosocial rehabilitation and the role of the psychiatrist. *Psychosoc Rehab J* 18(1):121-130, 1994.
4. McCrory DJ: The rehabilitation alliance. *Psychosoc Rehab J* (3):58-66, 1991.

No. 6
YAHARA HOUSE AND PSYCHIATRY

Roger Backes, *Manager, Yahara House, 802 East Goorham Street, Madison, WI 53703;* Nancy Salzwedel, R.N., *Staff Member, Yahara House*

SUMMARY:

The clubhouse model facilitates integration of mentally ill persons into the community through supported opportunities to socialize, work, get an education, and live independently, allowing sufficient time for members to (re)gain comfort, competence, and confidence. Psychiatrists and clubhouse programs need to understand each other and find ways to work together to support consumers' recovery. It is especially important for psychiatrists and clubhouses to develop a "rehabilitation alliance."

Medication may be administered in a clubhouse program, and psychiatrists treat clubhouse members in the clubhouse itself. As in the program descriptions, the issue of the relationship of members with staff and, specifically, with psychiatrists, will be explained in this presentation. For many members the community adjustment process has been substantially enhanced.

REFERENCES:

1. Beard JH, Propst RN, Malamud TJ: The Fountain House model of psychiatric rehabilitation. *Psychosoc Rehab J* 5(1):47-53, 1982.
2. Bachrach LL: Psychosocial rehabilitation and psychiatry in the care of long-term patients. *Am J Psychiatry* 149:1455-1463, 1992.
3. Links PS, Kirkpatrick H, Whelton C: Psychosocial rehabilitation and the role of the psychiatrist. *Psychosoc Rehab J* 18(1):121-130, 1994.
4. McCrory DJ: The rehabilitation alliance. *Psychosoc Rehab J* 1(3):58-66, 1991.

Innovative Programs **Saturday, October 19**
Session 3 **1:30 p.m.-3:00 p.m.**

COMMUNITY PSYCHIATRY

No. 7
THE TRANSITIONS PROJECT: MANAGING SCHIZOPHRENIA IN THE COMMUNITY

Heather Milliken, M.D., *Clinical Director, Schizophrenia Service, Schizophrenia Clinic, Royal Ottawa Hospital, 1145 Carling Avenue, CB1, Ottawa, ONT, Canada K1Z 7K4;* Gail Yenta Beck, M.D., *Community Psychiatrist,* Lyn Williams-Keeler, M.A.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to describe the challenges involved in a clinical/research project including all stakeholders, to assess their needs through surveys, and to design an applicable model of shared community-based care.

SUMMARY:

The Transitions Project is an ongoing effort, initiated by the Schizophrenia Service of the Royal Ottawa Psychiatric Hospital, to address the need for a flexible system of care for those with schizophrenia. The goal of this project is the sharing of responsibility for continuity of care by a specialized tertiary care service and community-based family physicians in an integrated, multimodal system of service delivery. Surveys were distributed to "partners in care" to identify their needs, concerns, and insights. The groups surveyed included a broad base of community agencies and mental health centers, family doctors,

patients, and family members. The subsequent review of the surveys began with the patient responses to ensure that the transition strategy would be consistent with an individually tailored treatment plan. All of the surveys were analyzed to develop a comprehensive, flexible continuum of care encompassing intermittent access to tertiary care and extensive involvement of community-based medical care. The presenters will describe implementation of this model of shared care.

REFERENCES:

1. Wasylenki D, Goering P, MacNaughton E: Planning mental health services: I. background and key issues. *Can J Psychiatry* 37:199-206, 1992.
2. Goering P, Wasylenki D, MacNaughton E: Planning mental health services: II. current Canadian initiatives. *Can J Psychiatry* 37:259-263, 1992.

No. 8
CRISIS INTERVENTIONS IN THE COMMUNITY

Sharon G. Dott, M.D., *Associate Professor, Department of Psychiatry, University of Texas Medical Branch, Suite D28, 301 University Boulevard, Galveston, TX 77555-0428;* David P. Walling, Ph.D., *Assistant Professor Department of Psychiatry, University of Texas Medical Branch*

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to list the essential components of a community treatment program and to identify variables indicating appropriateness of community-based treatment versus those that suggest the need for hospitalization.

SUMMARY:

Changes within health care financing have necessitated the development of new programs for the chronic mentally ill. The hospital-based programs that were once the norm for the chronic mentally ill are no longer feasible in today's market. In response to these changes, Galveston County, Texas, developed a short-term crisis program to provide psychiatric care to individuals who would otherwise require hospitalization. The program is unique in several ways: a) patients are treated within the community; b) patients attend partial hospitalization sessions during the day to ensure that they receive many of the same services that would be offered in an inpatient setting; c) the program is financially attractive to the community mental health center ($200 per day versus $600 per day for hospitalization).

Success of the crisis program has been closely gauged both fiscally and humanistically. Patients now request admission to the crisis program rather than the hospital. Patients report that the unit feels more like a home and that they enjoy the structure provided by the program. In addition, they are able to receive psychiatric care, including medication evaluation, in a less restrictive environment. Development of similar programs and essential variables that contribute to program success will be discussed.

REFERENCES:

1. Vaccaro J, Young A, Glynn S: Community-based care of individuals with schizophrenia. *Psychiatr Clin North Am* 16:387-399, 1993.
2. Weismann G: Crisis-oriented residential treatment as an alternative to hospitalization. *Hosp Community Psychiatry* 36:1302-1305, 1985.

No. 9
COLLABORATION IN CREATING AN URGENT CARE CONTINUUM

Wesley E. Sowers, M.D., *Medical Director, Addiction Services, St. Francis Medical Center, 400 Forty-Fifth Street, Pittsburgh, PA 15201;* Mark G. Fuller, M.D., *Green Spring*

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to identify factors that facilitate or discourage partnerships between payers and providers, discuss principles important in the formation of a service continuum that is responsive to the evolving health care environment, and describe guidelines for developing services that are more effective than traditional psychiatric emergency services.

SUMMARY:

Evolving systems for treatment of mental illness and substance use disorders will need to provide care that is both efficient and effective. Only systems that respond proactively to this challenge will thrive. New partnerships between payers and providers will be required to provide such responses. In this workshop one such partnership will be examined. The first product of that collaboration, the Pittsburgh Assessment and Brief Intervention System, will be described. Entry points to psychiatric service systems often are resource intensive and provide few alternatives to persons in acute crisis. The Pittsburgh Assessment and Brief Intervention System is a multilevel urgent care continuum designed to replace traditional emergency psychiatric and crisis management services in a cost-effective and clinically appropriate manner. Both provider and payer perspectives will be represented. Early outcomes, in terms of both cost and clinical effectiveness, will be presented. Obstacles and issues encountered in the formation of this partnership will be discussed, and participants will be encouraged to share their own experiences, successes, and failures in attempts to form similar alliances.

REFERENCES:
1. Rubin SE, Ananth J, Bajwa-Goldsmith B, et al: Three-day crisis resolution unit. *Indian J Psychiatry* 32:30-34, 1990.
2. Bengelsdorf H, Alden DC: A mobile crisis unit in the psychiatric emergency room. *Hosp Community Psychiatry* 38:662-665, 1987.

Innovative Programs **Saturday, October 19**
Session 4 **3:30 p.m.-5:00 p.m.**

COMPREHENSIVE ASSESSMENT AND PREVENTION

No. 10
RELAPSUS INTERRUPTUS: WHAT WE KNOW ABOUT RELAPSE

Joel S. Feiner, M.D., *Professor, Department of Psychiatry, University of Texas, Southwest Medical Center, Suite 9 South, 5909 Harry Hines Boulevard, Dallas, TX 75235;* Ronald J. Diamond, M.D., *Professor, Department of Psychiatry, University of Wisconsin,* G. Darlene Warrick McLaughlin, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to summarize the literature regarding relapse prevention, develop interventions and programs to address the relapse potential of patients, and anticipate and recognize early signs and symptoms of relapse.

SUMMARY:

While we cannot yet prevent major mental illness, we do know a great deal about preventing and interrupting relapse. There is increasing evidence that multiple psychotic episodes take their toll on the brain, the mind, the family, and society. The stress vulnerability model provides a conceptual framework for assessing environmental factors that both promote and protect against relapse. Intervention strategies can provide opportunities to avoid full-blown psychotic exacerbations and hospitalization. Techniques for educating the patient, the family, and the network exist and have been shown to make a difference. Repopulating the lives of patients with supporting persons enhances the potential for preventing relapses. Similarly, the nature of relationships with providers and programs is a significant factor in early interventions. Finally, programmatic interventions include various forms of crisis and respite care and peer supports as well as hospital-based "Extend" and assertive community treatment teams. Relapse prevention is also the linchpin of the coordinated treatment of major mental illness and chemical dependency. Anticipation of relapse and recognition of early signs and symptoms by patient, providers, families, and networks are crucial.

REFERENCES:
1. Kavanaugh DJ: Schizophrenia. In Wilson PH (ed): *Principles and Practice of Relapse Prevention.* Guilford Press, New York, 1992.
2. Dixon LB, Lehman AF: Family interventions for schizophrenia. *Schizophr Bull* 21:631-643, 1995.

No. 11
IDENTIFYING HOMELESS, MENTALLY ILL VETERANS IN JAIL

Lea Cloninger, Ph.D., *Operations Research Analyst, Health Care for Homeless Veterans/Supported Housing Program, West Side Veterans Affairs Medical Center (116A1), 820 South Damen Avenue, Chicago, IL 60612;* Jeffrey G. Stovall, M.D., *Community Healthlink, Outpatient Department, University of Massachusetts Medical Center,* Lawrence Appleby, Ph.D., J.D., Surinder S. Nand, M.D., Tab Martin, R.N.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to describe methods for identifying mentally ill veterans in jail and for engaging them in services provided by Veterans Affairs Medical Centers after release from jail.

SUMMARY:

There is an association among homelessness, mental illness, and detention in jail. The Department of Veterans Affairs (VA) has made few attempts to connect with detained veterans, and this group is poorly understood. As part of the national VA Health Care for Homeless Veterans Program, outreach staff work at the Cook County Jail in Illinois to identify and engage in treatment veterans who are homeless and mentally ill. This presentation will describe these efforts and will provide preliminary data on 32 detained veterans.

A major goal of the program is to assist veterans in obtaining permanent housing and psychiatric treatment while providing case management services. It is proposed that the jail recidivism rates of homeless veterans might be reduced if they could be engaged in community programs that serve their needs.

Fifty percent of the 32 veterans were homeless at the time of arrest. Seventy-five percent have serious psychiatric illness, while 78% have histories of psychiatric hospitalization. The majority (69%) were charged with felony crimes.

Participants will explore possibilities for improving treatment engagement of homeless, mentally ill veterans in jail and will discuss the difficulty of maintaining these veterans in the community.

REFERENCES:
1. Rosenheck RR, Koegel P: Characteristics of veterans and nonveterans in three samples of homeless men. *Hosp Community Psychiatry* 44:858-863, 1993.
2. Teplin LA: The prevalence of severe mental disorder among male urban jail detainees: comparison with the Epidemiologic Catchment Area Program. *Am J Public Health* 80:663-669, 1990.

No. 12
JAIL DIVERSION: EMPLOYING THE ASSERTIVE COMMUNITY TREATMENT MODEL

Dave K. Delap, M.S.W., *Program Coordinator, Community Treatment Alternatives, Mental Health Center of Dane County, 124 West Mifflin, Madison, WI 53703;* Kimberly S. Nestler, M.D., *Psychiatrist, Community Treatment Alternatives,* LuAnne C. Rosa, M.S.N.

EDUCATIONAL OBJECTIVE:
At the conclusion of this session, participants should be able to identify advantages of using an assertive community treatment model to provide jail diversion services and describe some of the obstacles involved in using this approach.

SUMMARY:
The presenters will describe the Community Treatment Alternatives program and present outcome data from five years of operation. Community Treatment Alternatives is an outpatient treatment program operated by the Mental Health Center of Dane County, Wisconsin. This program has demonstrated that the assertive community treatment model described by Stein and Test (1980) can be successfully employed as a jail diversion program for people with serious mental illnesses. At admission, 66% of clients were homeless, and now all have places to live. Only seven clients (13%) required hospitalization in their first year of treatment. All of these clients had been arrested before their admissions; the number of arrests ranged from 1 to 35. Preliminary data indicate a 73% reduction in the number of days spent in jail.

The audience will be invited to join the panel members in discussing obstacles to using assertive community treatment, why previous attempts to use this model did not produce a reduction in days spent in jail (Solomon, 1994), and ethical issues involving boundaries with probation and parole agents.

The experience of this program demonstrates that people who are incarcerated and suffer from serious mental illness respond well to the same community treatment that has proven to be effective for other persons will serious mental illness.

REFERENCES:
1. Delap D: Community treatment alternatives: a jail diversion program. *Relapse: Issues in the Management of Chronic Psychosis* 3:7-8, 1993.
2. Torrey EF, et al: *Criminalizing the Seriously Mentally Ill: Model Programs for Mentally Ill Persons in Jails.* Public Citizen's Health Research Group and National Alliance for the Mentally Ill, Washington, DC, 1992.

Innovative Programs **Sunday, October 20**
Session 5 **8:00 a.m.-9:30 a.m.**

CLINICAL PRACTICE AND MANAGED CARE

No. 13
SOLO PRACTICES: ALIVE AND WELL

Suhayl J. Nasr, M.D., *President, Nasr Psychiatric Services, 2814 South Franklin Street, Michigan City, IN 46360-1843;* Norma J. Nasr, M.S., *Nasr Psychiatric Services*

EDUCATIONAL OBJECTIVE:
At the conclusion of this session, participants should be able to identify factors that contribute to success in solo practice.

SUMMARY:
The practice of psychiatry has been changing rapidly over the past few years. There is a strong debate about the survivability of the solo practitioner in this day and age, although the specialty of psychiatry has one of the highest percentages of solo practitioners.

The presenters will describe a model of expense sharing and mutual support that allows three different practices to grow within the constraints of managed care. The presentation will include some practical tips about the personnel, software, hardware, and support networks needed for successful operation of these practices.

REFERENCES:
1. Schlesinger M, Dorwart RA, Epstein SS: Managed care constraints on psychiatrists' hospital practices: bargaining power and professional autonomy. *Am J Psychiatry* 153:256-260, 1996.
2. Simon GE, Grothaus L, Durham ML, et al: Impact of visit copayments on outpatient mental health utilization by members of a health maintenance organization. *Am J Psychiatry* 153:331-338, 1996.

INNOVATIVE PROGRAMS

No. 14
QUALITY ASSURANCE IN PSYCHIATRY: A SYSTEM THAT WORKS

Geetha Jayaram, M.D., *Assistant Professor, Department of Psychiatry, Johns Hopkins University School of Medicine, Meyer 101, 600 North Wolfe Street, Baltimore, MD 21287;* Judy Rohde, M.S.N., *Director of Nursing, Department of Psychiatry, Johns Hopkins University*

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to establish a multidisciplinary quality assurance program, with clear delineation of privileges and responsibility for each discipline, and to organize, measure, and present data for quality outcomes.

SUMMARY:

The theory of continuous practice improvement has been around since the 1930s. The concept of statistical analysis of outcomes and variation in a process has been studied vastly in the manufacturing field. In health care we have shifted in the 1990s from merely examining outliers and trends to studying the process of care.

Setting up a comprehensive quality assurance program involves multidisciplinary effort. The presenters will discuss how this was accomplished in the Department of Psychiatry at Johns Hopkins Hospital. They will provide examples of critical indicators, their monitoring mechanisms for reporting, resultant change in the care system, and process and quality control procedures.

It is possible to revolutionize medicine by continuous practice improvement. The presenters will explain how they have begun to accomplish such change. Exercises for application to the participants' programs will be provided.

REFERENCES:

1. *The Complete Guide to the Hospital Survey Process.* Joint Commission on Accreditation of Healthcare Organizations, Oakbrook Terrace, IL, 1995.
2. Horn SD, Hopkins DS: *Clinical Practice Improvement: A New Technology for Developing Cost-Effective Quality Health Care.* Faulkner & Gray, New York, 1994.

No. 15
CHANGING IDENTITIES IN A CHANGING REIMBURSEMENT WORLD

James J. Feldman, M.D., *Medical Director, Massachusetts Mental Health Center Day Hospital, 74 Fenwood Avenue, Boston, MA 02115;* Hudie B. Siegel, M.D., *Department of Psychiatry, Massachusetts Mental Health Center,* Kenneth S. Duckworth, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to plan, design, and implement the transition of a public sector partial hospital program with resident training to make it compatible with managed care and pursuit of third-party-payer dollars.

SUMMARY:

One of the pervasive changes occurring in the mental health service delivery system is increased reliance on privatization of services previously funded by state and local tax dollars. For decades the Massachusetts Mental Health Center Day Hospital was a public program supported by a department of mental health. It also serves as a major teaching site of the Harvard Longwood Residency Training Program; all residents in the program rotate through each year. The program serves 60 patients and provides respite and shelter beds for 50 individuals. Its location on the site of state-supported services has resulted in extremely limited reimbursement income. In October 1995, in response to a statewide privatization initiative, the program undertook a reorganization of services in an effort to become third-party reimbursable and to pursue managed care contracts.

This presentation will focus on issues in the transition from a publicly funded cost-reimbursement program to an economically competitive freestanding day hospital. It will include a synopsis of the planning process and necessary changes in the service delivery system and describe how refocusing needs in a competitive marketplace has changed individual and group programming. Major successes and failures over the past year will be presented. The department's medical director, the senior attending physician in the day hospital, and a line physician on that service will participate as workshop panel members. Active involvement from the audience will be expected and encouraged.

REFERENCES:

1. Harper G: Focal inpatient treatment planning. *J Am Acad Child Adolesc Psychiatry* 28:31-37, 1989.
2. *Medicare's Partial Hospitalization Benefit: Eligibility and Scope of Services Covered Under Part B,* Medicare Memo H95-39. U.S. Department of Health and Human Services, Washington, DC, July 20, 1995.

INNOVATIVE PROGRAMS

Innovative Programs **Sunday, October 20**
Session 6 **10:00 a.m.-11:30 a.m.**

PSYCHIATRIC EDUCATION

No. 16
RECRUITING MEDICAL STUDENTS INTO PSYCHIATRY

Brenda J. Roman, M.D., *Department of Psychiatry, Wright State University School of Medicine, P.O. Box 927, Dayton, OH 45401-0927;* Ann K. Morrison, M.D., *Assistant Professor, Department of Psychiatry, Wright State University School of Medicine*

EDUCATIONAL OBJECTIVE:
At the conclusion of this session, participants should be able to describe the tools used in a department of psychiatry to facilitate medical students' interest in psychiatry.

SUMMARY:
In a community-based medical school where students are selected for admission partly on their expressed interest in primary care, and where they receive nearly constant encouragement to seek careers in primary care, encouraging students to consider psychiatry as a career can be difficult. As a result of many efforts, the percentage of graduating medical students entering psychiatry has increased from approximately 2% to 10% over the last 5 years at Wright State University. The following factors have likely contributed to that success: a) active involvement of department of psychiatry faculty in key school of medicine committees, including the admissions committee and the curriculum committee; b) a strong behavioral science course in years one and two under the leadership of a psychiatrist; c) a strong clerkship experience in psychiatry, with increasing emphasis on ambulatory psychiatry; d) an active psychiatry club, with both resident and faculty participation; and e) a task force on medical student recruitment into psychiatry, whose efforts include active encouragement to join the APA and resident-student mentorship.

The presenters will explain such efforts in detail and will discuss perceived obstacles. There will be time for discussion, and participants will be encouraged to share their own experiences and ideas.

REFERENCES:
1. Szenas PL: Graduates' interest in generalist specialties nearly doubles in three years. *Acad Physician Scientist,* Nov 1995, pp 2-3.
2. Bland CJ, Meurer LN, Maldonado G: Determinants of primary care specialty choice: a non-statistical meta-analysis of the literature. *Acad Med* 70:620-641, 1995.

No. 17
DEVELOPING EVALUATION AND REVIEW SKILLS

Brenda J. Roman, M.D., *Department of Psychiatry, Wright State University School of Medicine, P.O. Box 927, Dayton, OH 45401-0927;* Ann K. Morrison, M.D., *Assistant Professor, Department of Psychiatry, Wright State University School of Medicine*

EDUCATIONAL OBJECTIVE:
At the conclusion of this session, participants should be able to identify the skills necessary for psychiatrists to participate in evaluation and review activities and describe how residents might be educated in these areas.

SUMMARY:
Psychiatrists' roles in both community mental health and managed care organizations depart from the traditional and limited role of physicians, which primarily involves directing individual patient care and is the focus of medical education. Effective future psychiatrists will not be able to maintain such a circumscribed role. One program develops residents' skills in evaluation and review by using both didactic and experimental methods in community mental health and managed care settings. Didactic sessions take place throughout residency and include teaching the process and content of utilization review, program evaluation, peer review in multidisciplinary settings, and physician roles and relationships with managed care organizations and community mental health centers. Experiential education also occurs throughout residency and includes utilization review of one's own patients on inpatient services, peer review activities in a community mental health center, and reviewing inpatient care for an insurance company. All of these activities are supervised by on-site faculty. Reception of and resistance to these educational efforts will be described. Participants will be encouraged to share their own experiences in teaching about non-traditional physician roles, especially in emerging managed care settings.

REFERENCES:
1. Tischler GL: Utilization management of mental health services by private third parties. *Am J Psychiatry* 147:967-973, 1990.
2. Hoge MA, Davidson L, Griffith EEH, et al: Defining managed care in public-sector psychiatry. *Hosp Community Psychiatry* 45:1085-1089, 1994.

No. 18
PSYCHIATRY AND FAMILY MEDICINE COLLABORATION

Ann K. Morrison, M.D., *Assistant Professor, Department of Psychiatry, Wright State University School of Medicine, P.O. Box 927, Dayton, OH 45401-0927;* Brenda J. Roman, M.D., *Department of Psychiatry, Wright State University School of Medicine*

INNOVATIVE PROGRAMS

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to describe the educational linkages developed between a psychiatric residency and a family medicine residency and to identify how these linkages improved the relevance of the psychiatric training experience for family medicine residents and provided better coordination of services for patients.

SUMMARY:

Wright State University, with a primary care mandate, has had little collaboration between the departments of psychiatry and family medicine. Additionally, the hospital's mental health clinic and family medicine clinic have often treated patients in isolation, although it is known that many patients seen in family practice clinics have psychiatric disorders and many mental health patients have medical needs that are underrecognized and undertreated. An educational effort to enhance education and improve services has included: a) a family medicine rotation in an outpatient psychiatric clinic, which includes participation in outreach to the seriously mentally ill, diagnosis and assessment of patients seen in a psychiatric clinic, supportive psychotherapy, and basic psychopharmacologic education; b) family medicine case conferences about patients seen in a family practice clinic who may have psychiatric diagnoses, led by a psychiatrist; c) availability of on-site psychiatric consultation to residents in a family medicine clinic; and d) participation by a psychologist from the department of family medicine in community psychiatry work groups.

There will be ample time for discussion about the obstacles and benefits in such collaboration, and participants will be encouraged to discuss their own experiences.

REFERENCES:

1. Adler LE, Griffin JM: Concurrent medical illness in the schizophrenic patient: epidemiology, diagnosis, and management. *Schizophr Res* 4:91-107, 1991.
2. Rodin G, Voshart K: Depression in the medically ill: an overview. *Am J Psychiatry* 143:696-705, 1986.

Innovative Programs **Sunday, October 20**
Session 7 **1:30 p.m.-3:00 p.m.**

ASSERTIVE COMMUNITY TREATMENT

No. 19
OUTREACH TO HOMEBOUND HIV/AIDS PATIENTS

Lawrence B. Jacobsberg, M.D., *Staff Psychiatrist, AIDS Mental Health Team, Community Mental Health Services, Visiting Nurse Service, 2170 McDonald Avenue, Brooklyn, NY 11229;* Robert P. Parkin, M.D., *Staff Psychiatrist, Visiting Nurse Services*

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to discuss the importance of using interventions that are specific for homebound individuals with HIV/AIDS.

SUMMARY:

Patients with HIV/AIDS are often homebound as a result of their illness. Although medical care has been adapted to serving such individuals in their homes, psychiatric consultation to these patients and their caregivers has been underused.

Interventions need to be tailored to the specific needs of the particular case and circumstances. The referral request is often for crisis intervention, consisting of psychoeducation and linkages to community services. The acute problem is frequently an indication that earlier intervention could have averted an emergency.

Although crisis intervention can stabilize a situation, ongoing psychotherapeutic work with individual patients usually requires differentiating the depression and dementia components of the clinical situation. Appropriate interventions can then be tailored to the existing clinical situation.

Work with the individual patient often needs to be supplemented with family interventions. The identified patient is frequently part of a system, many of whose members have HIV disease. Although children who have been infected since birth are particularly poignant, those who do not carry the virus are equally moving, since they are destined to become orphans.

The presenters will be clinicians experienced in the implementation and administration of a psychiatric consultation-liaison program with homebound HIV/AIDS patients. By engaging a varied audience of caregivers, each of whom has unique experiences with individuals who have AIDS/HIV, the presenters will expand the treatment repertoires of all participants.

REFERENCES:

1. King MB: *AIDS, HIV and Mental Health.* Cambridge University Press, Cambridge, England, 1993.
2. Hurley PM, Ungavarski PJ: Mental health needs of adults with HIV/AIDS referred for home care. *Psychosocial Rehab J* 17(4):117-126, 1994.

No. 20
A MENTAL HEALTH CONSULTATION AND TREATMENT SERVICE FOR HOMEBOUND MEDICAL PATIENTS

Neil Pessin, Ph.D., *Clinical Director, Visiting Nurse Service, Community Mental Health Services, Third Floor, 1250 Broadway, New York, NY 10001;* David C. Lindy, M.D., *Chief Psychiatrist, Visiting Nurse Service, Community Mental Health Services*

INNOVATIVE PROGRAMS

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to describe the services available to health care workers that can provide patients with less-expensive at-home treatment to improve the quality of their lives.

SUMMARY:

Patients with chronic medical illnesses are long-term users of the health care system. Many patients can be treated at home at lower cost and with improved quality of life. However, they also have high rates of comorbid psychiatric disorders, which can complicate their physical health status and home care treatment. The Visiting Nurse Service of New York, the largest certified home health care agency in the United States, has an average daily census of 15,000 patients, approximately 7% of whom have secondary psychiatric diagnoses. Nurses in this agency estimate that 30% of the home care patients could benefit from mental health assessments not currently offered. The program's Mental Health Consultation and Treatment Service is an interdisciplinary mental health team designed to assess and treat home care patients referred by nursing staff. In addition, the team provides consultation regarding problems in systems of care and education and support for the home care staff.

This presentation will provide an opportunity to discuss a variation of the traditional consultation/liaison service with colleagues interested in adapting this model to new settings.

REFERENCES:

1. Burns T: A home based assessment study. In Tyrer P, Creed F (eds): *Community Psychiatry in Action: Analysis and Prospects.* Cambridge University Press, Cambridge, England, 1995.
2. Levy JS, Lewis A: Psychiatric consultation liaison nursing. In Beck CK, Rawlins RP, Williams SR (eds): *Mental Health-Psychiatric Nursing.* Mosby, Washington, DC, 1988.

No. 21
ASSERTIVE COMMUNITY TREATMENT IN NEW YORK CITY

Neil Pessin, Ph.D., *Clinical Director, Visiting Nurse Service, Community Mental Health Services, Third Floor, 1250 Broadway, New York, NY 10001;* Howard W. Telson, M.D., *Director, Outpatient Commitment in Psychiatry, Bellevue Hospital*

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to discuss the principles and practice of assertive community treatment for the seriously and persistently mentally ill; identify challenges in adapting this model to specific subpopulations in New York City, specifically, the homeless; and describe the role and responsibility of each member of the assertive community treatment team.

SUMMARY:

Assertive community treatment is widely used for persons with serious and persistent mental illness. It is a client-centered approach to comprehensive mental health care provided in a client's community that has been shown to reduce hospital stays and improve client and family satisfaction and quality of life. A recent research goal has been isolation of effective components of the treatment to find out what works, with whom, and why.

Although the general principles of this model have been clearly outlined by its innovators and others, successful implementation of new initiatives must be innovatively adapted to communities and specific target populations. Since July 1995, assertive community treatment teams have been implemented in New York City with a mandate to treat a challenging and diverse community of the seriously and persistently mentally ill. The presenters will describe experiences in using the model to treat various subpopulations, such as homeless clients and those with both mental illness and substance use disorders, in a culturally and ethnically diverse environment. Participants will be encouraged to: a) share their own experiences with adapting assertive community treatment to inner-city populations, and b) compare and contrast inner-city teams with those operating in different settings.

REFERENCES:

1. Burns BJ, Santos AB: Assertive community treatment: an update of randomized trials. *Psychiatr Serv* 46:669-675, 1995.
2. McGrew JH, Bond GR, Dietzen L, et al: A multisite study of client outcomes in assertive community treatment. *Psychiatr Serv* 46:696-701, 1995.
3. Bachrach L: On exporting and importing model programs. *Hosp Community Psychiatry* 39:1257-1258, 1988.

Innovative Programs **Sunday, October 20**
Session 8 **3:30 p.m.-5:00 p.m.**

MEDICATION MANAGEMENT ISSUES

No. 22
RECOVERY CENTER: OPENING THE DOOR TO CLOZAPINE

Steven A. Fekete, M.D., *Medical Director, Recovery Center, Case Management Services, Central Psychiatric Clinic, 3259 Elland Avenue, Cincinnati, OH 45229;* Diana M. McIntosh, M.S.N., *Director, Supportive Treatment Service, Clozaril Treatment Program, Central Psychiatric Clinic*

INNOVATIVE PROGRAMS

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to: a) describe the guiding principles and practical applications for treatment in the Recovery Center, an innovative program for patients taking clozapine; b) cite interventions that enhance treatment of such patients; and c) identify useful outcome measures.

SUMMARY:

Although health care is undergoing a major revolution in funding, structure, and philosophy, the fundamental principles that caregivers must master remain unchanged. These principles are easily described but are not so easily operationalized. The presenters will use the clozapine treatment program at the Recovery Center, an innovative treatment approach for patients taking clozapine, as a paradigm for practical application of these underlying principles. They will discuss how the program was initiated, presenting the purpose, target population, design, system of staffing (particularly role development and communication), and marketing. During this discussion the audience will receive specific recommendations for maximizing resources and fostering growth among staff, consumers, and program economics. In presenting the treatment philosophy, the presenters will explain how the program incorporates convenience, community, consolidation of services, consumer and caregiver empowerment, commitment, continuity of health, and collection of outcomes--a combination of features that allows patients to achieve the optimal benefits of clozapine treatment. Panel members will summarize various positive outcomes obtained, as shown by patient satisfaction surveys, hospitalization rates, scores on the Positive and Negative Syndrome Scale and the Brief Psychiatric Rating Scale, and anecdotal accounts. The audience will be invited to discuss their experiences and exchange information on the effectiveness of other treatment strategies and interventions.

REFERENCES:

1. Meltzer HY, Cola PA: The pharmacoeconomics of clozapine: a review. *J Clin Psychiatry* 55(9 suppl B):161-165, 1994.
2. Johnson CG, Littrell KH, Magill AM: Starting patients on clozapine in a partial hospitalization program. *Hosp Community Psychiatry* 45:264-268, 1994.

No. 23
TREATING POLYDIPSIA IN A STATE HOSPITAL

Gerald F. McKeegan, Ph.D., *Clinical Psychologist, Department of Psychology, Western State Hospital, P.O. Box 2500, Staunton, VA 24401-2500;* Glenn R. Yank, M.D., *Professor of Psychiatry, University of Virginia,* Josephine Wagner, R.N., Garland Wampler, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to assess the occurrence of polydipsia, manage the associated complications, and treat the behavior with staff available in institutional settings.

SUMMARY:

Polydipsia with self-induced water intoxication is a behavior that occurs in a large percentage of institutionalized patients with chronic mental illness. The behavior is characterized by the ingestion of large amounts of fluid that exceed the body's ability to excrete the fluid. The result of such excessive fluid intake is hyponatremia with concomitant severe physical complications.

The presenters will report on a biopsychosocial treatment approach to the management of this problem. The intervention was carried out by ward staff with patients on a long-term rehabilitation ward at a state psychiatric facility. Each member of a multidisciplinary team had a role in the development and implementation of the intervention. Nursing and medical interventions minimized the physical sequelae of hyponatremia, while psychiatric management minimized the effects of medication-induced polydipsia. The program included behavioral interventions (e.g., self-monitoring and reinforcement) to help each patient avoid exceeding a criterion for rate of weight gain due to excessive fluid intake over a 16-hour day. The results showed that the intervention reduced the rate of weight gain due to excessive fluid intake by as much as 75%.

REFERENCES:

1. Leadbetter RA, Shutty MS, Higgins PB, et al: Multidisciplinary approach to psychosis, intermittent hyponatremia, and polydipsia. *Schizophr Bull* 20:375-385, 1994.
2. Godleski LS, Vieweg WVR, Leadbetter RA, et al: Day-to-day care of chronic schizophrenia patients subject to water intoxication. *Ann Clin Psychiatry* 1:179-185, 1989.

Innovative Programs **Monday, October 21**
Session 9 **8:00 a.m.-9:30 a.m.**

SPECIAL POPULATIONS: PART 2

No. 24
THE PRIMARY PSYCHIATRIC CARE TEAM: A PROGRAM FOR INTEGRATED CARE

Bradford L. Felker, M.D., *Director, Outpatient Services, Department of Psychiatry, Veterans Affairs Medical Center, 1970 Roanoke Boulevard, Salem, VA 54153;* Jean G. Shelor, R.N., *Associate Chief of Nursing for Psychiatry, Veterans Affairs Medical Center,* Carolyn A. Stanley-Tilt, M.S.N., R.N., C.S.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to identify common medical problems and clinical obstacles that can interfere with comprehensive care, to create primary psychiatric care teams for their own clinical settings, and to implement various medical outcome studies and clinical monitors.

SUMMARY:

Psychiatric patients have been shown to have greater than average rates of mortality and medical illness. The reasons for these high rates are unclear, but they are thought to be due to both patient- and physician-related issues. In many cases these illnesses are unknown and exacerbate the primary psychiatric condition. In addition, the psychiatrist is often the only health care provider directing care for these patients.

In order to address the primary medical and psychiatric care of these patients, a primary psychiatric care team was created. Enrolled psychiatric patients undergo a comprehensive multidisciplinary evaluation that results in a biopsychosocial treatment plan. The progress of both the patients and the clinic are tracked with specific medical outcome studies and clinical monitors. In addition, the team serves as an educational and research platform.

Participants will discuss the unique issues of medical and psychiatric care for these patients. The structure and objectives of the primary psychiatric care team will be discussed, particularly with respect to implementation in various clinical settings. Different medical outcome studies and monitors will be reviewed with regard to choice and application.

REFERENCES:

1. Hall RC, Popkin MK, Devaul RA, et al: Physical illness presenting as psychiatric disease. *Arch Gen Psychiatry* 35:1315-1320, 1978.
2. McConnell SD, Inderbitzen LB, Pollard WE: Primary health care in the CMHC: a role for the nurse practitioner. *Hosp Community Psychiatry* 43:724-727, 1992.

No. 25
GROUP PROCESSING OF TRAUMATIC EXPERIENCES

Kathleen M. Fortier, C.A.S., *SR Clinician, Children's Unit, Acadia Hospital, 268 Stillwater Avenue, Bangor, ME 04401;* Kelli B. Mills, M.S., *Children's Unit, Acadia Hospital*

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to describe specific group therapy methods used in treating children who have experienced traumatic events.

SUMMARY:

The presenters will discuss the methods used in co-leading psychotherapy groups composed of children ages 4 to 12 years in an inpatient setting. The following areas will be addressed: a) determination of significant patient or milieu distress, b) development of group structure, c) experiential processing of the target problem and its relationship to the traumatic events, d) confrontation and feedback provided by staff or other child patients, e) facilitation of expression by other children of similar feelings and experiences, f) empathy and encouragement from group leaders, and g) closure and reinforcement through the use of token chips.

Outcomes of the preceding strategies include acknowledgment of problems, improvement in socialization skills, feelings of universality, instillation of hope, increased self-esteem and confidence, ability to describe traumatic events in a supportive environment, development of trust and resulting continued treatment with outpatient therapists, and increased understanding of how problem behaviors are related to past traumas.

Children are capable of dealing with profoundly painful life experiences when therapists use the presented strategies.

REFERENCES:

1. Karterud SW: Community meetings and the therapeutic community. In Kaplan HI, Sadock BJ (eds): *Comprehensive Group Psychotherapy.* Williams & Wilkins, Baltimore, 1993, pp 598-607.
2. Yalom I: *Inpatient Group Psychotherapy.* Basic Books, New York, 1983.

No. 26
AN INPATIENT MODEL FOR TRAUMA SURVIVORS

Sandra L. Bloom, M.D., *Medical Director of Sanctuary, Universal Health, 13 Druim Moir Lane, Philadelphia, PA 19118;* David C. Wright, M.D., *Program Psychiatrist, Homewood Health Center,* Lyndra J. Bills, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to describe the importance of milieu therapy and the addressing of traumatic reenactment in the inpatient treatment of posttraumatic stress disorders, borderline personality disorder, and dissociative disorders in adult survivors.

SUMMARY:

Dealing with the symptoms of adult survivors of childhood trauma poses many challenges for the clinician. This workshop will focus on inpatient treatment and the value of using a trauma model within a therapeutic community. By comparing and contrasting the experiences of three different clinical settings, a private hospital and a state hospital in the United States and a hospital in Canada, the following points will be discussed: a) the presenting diagnoses of the adult survivors, b) Herman's theory of healing from trauma, c) the therapeutic value of viewing behavior as traumatic reenactment, d) the community milieu as an important aspect of treatment, and e) how understanding the dynamics of parallel processes

influences the team's choice of intervention and how the team functions. In addition, outcome data will demonstrate the efficacy of this model and will provide opportunities for discussion in light of managed care's dismantling of many inpatient programs across the country.

REFERENCES:
1. Bloom SL: The sanctuary model: developing generic inpatient programs for the treatment of psychological trauma. In Williams MD, Sommer JF (eds): *Handbook of Post Traumatic Therapy.* Greenwood, New York, 1994.
2. Herman JL: *Trauma and Recovery.* Basic Books, New York, 1992.
3. van der Kolk BA: The compulsion to repeat the trauma: re-enactment, revictimization, and masochism. *Psychiatr Clin North Am* 12:389-411, 1989.

Innovative Programs **Monday, October 21**
Session 10 **10:00 a.m.-11:30 a.m.**

CHILDREN, ADOLESCENTS AND YOUNG ADULTS

No. 27
PARTIAL HOSPITALIZATION PROGRAM FOR TREATING YOUNG ADULTS WITH SEVERE MENTAL ILLNESS

Vinod Kumar, M.D., *Professor and Assistant Chairman, Department of Psychiatry, University of Miami, Suite 204, 4300 Alton Road, Miami Beach, FL 33140;* Celeste Northrop, D.N.Sc., Lynn Roberts, M.S.N.

EDUCATIONAL OBJECTIVE:
At the conclusion of this session, participants should be able to discuss the efficacy of treating the young adult with a severe and persistent mental illness in a partial hospitalization program, identify outcome measures used in a partial hospitalization program, and cite one screening procedure for evaluating appropriateness of admission to a partial hospitalization program.

SUMMARY:
Partial hospitalization for the young adult with severe and persistent mental illness is increasingly seen as a viable treatment option. One such program was developed as a result of an established interface between a medical school and a large metropolitan teaching hospital. Although initially focusing on the middle-aged adult, the program found itself with a core of young acutely ill patients with schizophrenia and bipolar disorders. Establishing an organizational structure and a core of staff to work with these challenging young adults was vital for success. The program focused on psychopharmacology, milieu, one-to-one relationships, and patient support systems to help the patients assume responsibility for their own health care. The focus on roles of the medical practitioners, hospital staff, students, and patients themselves is essential. The administrative, fiscal, and clinical components will be described. Program evaluation and research opportunities, ongoing and planned, will also be discussed.

REFERENCES:
1. Brandes NS, Moosbrugger L: a 15-year clinical review of combined adolescent/young adult hospital group therapy. *Int J Group Psychother* 35(1):95-107, 1985.
2. Corder BF, Haizlip TM, Walter PA: Critical areas of therapists' functioning in adolescent group psychotherapy. *Adolescence* 15:435-442, 1980.

No. 28 - WITHDRAWN

No. 29
HOW TO INVOLVE AND TREAT PARENTS AND FAMILIES OF LATENCY-AGE AND PREADOLESCENT PSYCHIATRIC INPATIENTS

Daniel C. Johnson, C.A.S., *Clinician, Children's Unit, Acadia Hospital, 268 Stillwater Avenue, Bangor, ME 04401;* Geraldine M. Kenny, B.S., *Children's Unit, Acadia Hospital,* Elizabeth H. Lander, M.S.W.

EDUCATIONAL OBJECTIVE:
At the conclusion of this session, participants should be able to describe the steps in supporting, educating, and treating parents and families of inpatient children.

SUMMARY:
Several specific interventions are used with the parents and families of inpatient children. Initially, a three-four-hour assessment is done to obtain a complete psychosocial history of the children, parents, siblings, grandparents, and significant others in the children's lives. Parents are involved in traditional family therapy with the child and/or siblings as well as in psychoeducational parent therapy to review the fundamental issues identified during the assessment and subsequent family sessions. As a support and extension of the parent therapy, the parents may practice and refine skills suggested in these meetings through an active parent education program called "shadowing." As the child moves from the inpatient setting back into the home environment, the family receives additional support from the transition program. This team provides in-home support of the treatment goals identified during treatment. Finally, the parents are assisted in obtaining appropriate community services to maintain the goals achieved.

REFERENCES:
1. Dulcan MK, Popper C: *Concise Guide to Child and Adolescent Psychiatry.* American Psychiatric Press, Washington, DC, 1991.
2. Henggeler SW, Borduin CM: *Family Therapy and Beyond: A Multisystemic Approach to Treating the Behavior Problems of Children and Adolescents.* Brooks/Cole, Belmont, CA, 1990.

LECTURES

Lecture 1 **Friday, October 18**
3:30 p.m.-5:00 p.m.

IS THERE A DOCTOR IN THE HOUSE (OF MEDICINE)?

Larry S. Goldman, M.D., *Director, Department of Mental Health, American Medical Association, and Department of Psychiatry, University of Chicago, 515 North State Street, Chicago, IL 60610*

SUMMARY:

For a variety of reasons--temperamental, conceptual, clinical, and economic--psychiatrists and psychiatric care in the United States have gradually moved away from organized medicine and from the general health care system. These moves have contributed to ambiguity in professional identity and a diminution of economic and political power, and perhaps they have been factors in recruitment into the field. They have also left our potential patients even more stigmatized and vulnerable than they might otherwise have been.

There are three current trends in health care to which psychiatry should bring its expertise and experience. For decades psychiatry has been exceptionally rigorous in the development of diagnostic criteria, and more recent guidelines on assessment and treatment of mental disorders are major contributions to the *establishment of standards.* Psychiatrists have long been part of *multidisciplinary teams* on inpatient units, in community mental health centers, on consultation-liaison services, and elsewhere. And our *population-based and systems approaches to care,* particularly in public sector psychiatry, are the counterparts to public health approaches and care within general medicine. Thus, a prodigal return to medicine and public health--educationally, clinically, and organizationally--may allow us to define ourselves more clearly and to regain some of the ground we and our patients have lost. We will reciprocate by offering the health care system and our colleagues more of our knowledge and hard-learned lessons.

REFERENCE:

1. Vergare MJ, McIntyre JS (section eds): History of Psychiatry in America. In Oldham JM, Riba MB (eds): *American Psychiatric Press Review of Psychiatry,* vol 13. American Psychiatric Press, Washington, DC, 1994, pp 5-128.

Lecture 2 **Saturday, October 5**
10:00 a.m.-11:30 a.m.

WHY BE CONCERNED ABOUT RECRUITMENT?

James H. Scully, Jr., M.D., *Deputy Medical Director, and Director, Office of Education, American Psychiatric Association, 1400 K Street, NW, Washington, DC 20005*

SUMMARY:

The economic forces affecting psychiatry are also causing distress in education. How will we face the issues of recruitment, workforce numbers and the funding of education? Will psychiatrists continue to practice psychotherapy and how do we make our case? Stigma still affects psychiatry and these decisions.

Excellence in teaching is the critical factor in recruitment. If we convey to our students the importance and the excitement of psychiatry, there are two god possible outcomes. Either the students will choose a career in psychiatry or they won't. If they do, we can select from the best qualified; if they don't, they still will have an appreciation of the importance of psychiatry for their patients, leading to good referrals and addressing the still real problem of stigma.

REFERENCE:

1. Scully, JH. "Why be concerned about recruitment?" AmJPsychiatry 152:10, October 1995.

Lecture 3 **Saturday, October 19**
10:00 a.m.-11:30 a.m.

HOMELESSNESS: FROM SOCIAL MOVEMENT TO TREATMENT TO SOCIAL PROGRAM

Marsha A. Martin, D.S.W., *Coordinator for Homeless Veterans Initiatives, Department of Veterans Affairs, 810 Vermont Avenue, N.W. (10C5), Washington, DC 20005*

SUMMARY:

In 1979, Robert Hayes, a New York City lawyer, filed a lawsuit against the state of New York on behalf of six homeless men. *Callahan v. Carey* charged that the charter of the state of New York required the governor, through the state Department of Social Services, to provide shelter for homeless men.

A year later, the Coalition for the Homeless was founded in response to the removal of homeless people from the vicinity of the Democratic National Convention at New York City's Madison Square Garden. Grass-roots organizations, community activists, and sympathetic service providers gathered at a nearby church courtyard for 4 days in silent protest of the treatment of homeless people by those coordinating the Democratic National Convention.

LECTURES

In the spring of 1981, the Community Service Society published the report *Private Lives/Public Spaces: Homeless Adults on the Streets of New York City.* That report, written by graduate student researchers at the Columbia University School of Public Health, brought to public awareness the plight of homeless persons with serious mental illness who were living on the streets of New York City.

The National Coalition for the Homeless was formed to focus attention on the plight of homeless men, women, and children nationwide. Homelessness was not just a New York City phenomenon but an American social problem, which would indeed require national problem solving. The first attempt at a solution was the creation of the Emergency Food and Shelter Program in 1983 by the Federal Emergency Management Agency, which provided federal dollars to assist localities with the development of emergency shelters and food programs.

Five years after *Callahan v. Carey* was filed, the American Psychiatric Association issued *The Homeless Mentally Ill* task force report, which once again brought special attention to the needs of homeless persons with serious mental illness. The report contained several recommendations for addressing homelessness among adults with mental illness.

This lecture will trace the origins of the movement to address homelessness and will give an overview of the treatment, housing, and clinical service responses to date and the subsequent institution of programs to address homelessness.

REFERENCES:

1. Baxter E, Hopper K: *Private Lives/Public Spaces: Homeless Adults on the Streets of New York City.* Community Service Society, New York, 1981.
2. Lamb HR (ed): *The Homeless Mentally Ill: A Task Force Report of the American Psychiatric Association.* American Psychiatric Press, Washington, DC, 1984.
3. Blau J: *The Visible Poor: Homelessness in the United States.* Oxford University Press, New York, 1992.
4. *Priority Home: The Federal Plan to Break the Cycle of Homelessness.* Interagency Council on the Homeless, Washington, DC, 1994.

Lecture 4 **Saturday, October 19**
1:30 p.m.-3:00 p.m.

THE LOSS THAT IS FOREVER: THE LIFELONG IMPACT OF THE EARLY DEATH OF A MOTHER OR FATHER

Maxine Harris, Ph.D., *Co-Director, Community Connections, 1512 Pennsylvania Avenue, S.E., Washington, DC 20003*

SUMMARY:

Mental health professionals need a language and a framework to understand the lifelong impact of the early loss of a parent. The metaphors that children use to describe their feelings at the time of a parent's death provide us a window into how that early loss is understood and how that experience becomes the backdrop against which all future development unfolds. Such loss represents absolute catastrophe, it divides the world forever into a before and after, it presents the child with terrifying insecurity, and it leaves a profound emptiness, what Pulitzer-Prize-winning author Richard Rhodes called "a hole in the world." Early loss significantly affects all of the major domains of adult functioning: the development of the self, the nature of one's relationships, success and achievement in the world, and the understanding of one's mortality. The effect may not be detrimental--but it is always characteristic and profound. As they become adults, men and women who lost parents in childhood must find a way to accept and integrate their loss while maintaining a meaningful connection to the past.

REFERENCE:

1. Harris M: *The Loss That Is Forever.* Dutton, New York, 1995.

Lecture 5 **Saturday, October 19**
3:30 p.m.-5:00 p.m.

BEFRIENDING DEMONS: HEALING ACROSS CULTURES

Terry Tafoya, Ph.D., *Executive Director, Tamanawit Unlimited, Suite 575, 1202 East Pike Street, Seattle, WA 98122*

SUMMARY:

This presentation will focus on verbal and nonverbal elements of cross-cultural communication that can impede or enhance the delivery of health care services. Even with the best of intentions, not only can communications interfere with interactions, but well-intentioned communications can completely end relationships. The speaker will draw on over two decades of cross-cultural experiences in professional arenas in the United States, Canada, Mexico, northern Europe, Turkey, and Indonesia. Using slides, humor, Native American story telling, and elements of systemic family therapy, participants will examine how these differences function and will work with the L.E.A.R.N. model from medical anthropology in establishing harmony across cultures.

REFERENCE:

1. Tafoya T: Epistemology of native healing and family psychology. *Fam Psychologist,* Spring 1994, pp 28-31.

LECTURES

Lecture 6 **Saturday, October 19**
3:30 p.m.-5:00 p.m.

RECENT ADVANCES IN REFRACTORY MOOD DISORDERS

Alan F. Schatzberg, M.D., Kenneth T. Norris, Jr. *Professor and Chairman, Department of Psychiatry and Behavioral Sciences, Stanford University School of Medicine, TD 114, Stanford, CA 94305-5490*

SUMMARY:

Recent years have witnessed the introduction of a number of effective pharmacological agents for patients with mood disorders. Still, many patients fail to respond to or cannot tolerate these agents. This presentation will address a variety of treatment strategies for those patients.

With regard to patients with major depression, the presenters will discuss the current status of a number of strategies, including combining tricyclic antidepressants with selective serotonin reuptake inhibitors (SSRIs), addition of pindolol to SSRIs, and lithium augmentation. They will also address a knotty problem in more-severe depression, viz., the treatment of emergent or co-occurring agitation. Emphasis will be placed on the use of divalproex sodium. Treatment strategies for these patients, including gabapentin, lamotrigine, and clozapine, will be discussed.

REFERENCE:

1. Achatzberg AF, Nemeroff CB (eds): *Textbook of Psychopharmacology.* American Psychiatric Press, Washington, DC, 1995.

Lecture 7 **Sunday, October 20**
1:30 p.m.-3:00 p.m.

THE PURSUIT OF RATIONAL PSYCHIATRIC SERVICES SINCE 1960

Donald W. Hammersley, M.D., *Deputy Medical Director (retired), American Psychiatric Association, 5925 Rossmore Drive, Bethesda, MD 20814-2231*

SUMMARY:

Looking back over 35 years at the very substantial efforts to improve the care and treatment of the mentally disabled, one finds a mixture of accomplishment and disappointment. One step forward, three to the side, three in place, and one-half step backward--or some such--is the rhythm and cadence of the dance of progress. Progress is difficult to sustain, as it turns out, for a variety of reasons. From his own experiences Dr. Hammersley will touch on many of these reasons and urge better understanding of where and why we succeed or fail.

REFERENCE:

1. Winter WR: The changing times of psychiatric services and care. *Dir Psychiatry,* May 4, 1994, pp 1-4.

Lecture 8 **Monday, October 21**
8:00 a.m.-9:30 a.m.

MANAGING CARE: GOVERNMENT AND CORPORATE STRATEGIES

Richard C. Surles, Ph.D., *Executive Vice President for Operations, Merit Behavioral Care Corporation, 60 Eagle Rim Road, Upper Saddle River, NJ 07458*

SUMMARY:

This lecture will compare and contrast the efforts of public sector leaders with those of private sector entrepreneurs in creating systems of care for persons seeking treatment of mental illness. Governmental efforts have focused on comprehensive state plans, with priority given to patients with the most severe mental illness. Private efforts have structured easily accessible networks of providers primarily for persons able to self-refer. Now both sectors appear to be exploring the technology and resources, including financial, managed by the other with the goal of collaborations involving reallocation of resources.

Dr. Surles will draw from his over 20 years as a senior government official and two years in the private sector as a director of operations for one of the nation's largest private managed behavioral health companies. The audience should gain an understanding of the cultural expectations and strategies of leaders in both sectors.

REFERENCE:

1. Surles RC: Broadening the ethical analysis of managed care. *Health Aff (Millwood)* 14(3):29-33, 1995.

Lecture 9 **Monday, October 21**
10:00 a.m.-11:30 a.m.

LOOK! THE EMPEROR REALLY ISN'T WEARING ANY CLOTHES, BUT THE PRINCE IS! AN EXPLORATION OF MANAGED CARE DEFICIENCIES AND PSYCHIATRIC REHABILITATION

Jerry Dincin, Ph.D., *Executive Director, Thresholds Business Office, 4101 North Ravenwood, Chicago, IL 60613*

SUMMARY:

Managed care has many pitfalls, especially in the case of persons with serious mental illness who are poor and receiving Medicaid. Actually, "pitfalls" is not exactly the word; perhaps "disaster" and "tsunami" are better descriptors. This system, driven only by profit, cannot serve these patients well. Psychiatric rehabilitation operated by not-for-profit organizations has demonstrated its effectiveness in working with this group. The pragmatic approach to jobs, housing, medication compliance, physical health,

therapeutic relationships, preventing unnecessary hospitalizations, thorough evaluation of programs, and cost-effectiveness will be covered. The contrast between psychiatric rehabilitation and managed care will be highlighted.

REFERENCE:

1. Dincin J (ed): A Pragmatic Approach to Psychiatric Rehabilitation: Lessons from Chicago's Thresholds Program. *New Dir Ment Health Serv* 68, 1995.

Lecture 10 **Monday, October 21**
1:30 p.m.-3:00 p.m.

NORMALITY AND PSYCHOPATHOLOGY: THEORETICAL AND PRACTICAL DIMENSIONS

Melvin Sabshin, M.D., *Medical Director, American Psychiatric Association, 1400 K Street, NW, Washington, DC 20005*

SUMMARY:

Melvin Sabshin, M.D., is Medical Director of the 41,000-member American Psychiatric Association. As its chief executive, he is responsible for the day-to-day administration of a wide range of education, government relations, and service programs which seek to improve the quality and availability of psychiatric care. The American Psychiatric Association, founded in 1844, is the oldest medical specialty society in the United States and is headquarters in Washington, DC.

Dr. Sabshin was appointed APA Medical Director in September 1974, after a broad career in psychiatric practice, medical education, and research. He served as Acting Dean of the University of Illinois College of Medicine in Chicago from July 1973 until his APA appointment. He had served since 1961 as Professor and Head of the Department of Psychiatry at the school. In 1967, he took a year's sabbatical as a Fellow with the Center for Advanced Study in the Behavioral Sciences in Palo Alto, California.

Dr. Sabshin received his B.S. degree from the University of Florida in 1944 and his medical degree from Tulane University School of Medicine in 1948. He interned at Charity Hospital of New Orleans, served a psychiatric residency at Tulane from 1949 until 1952, and held a Public Health Service Fellowship in Psychiatric Research from 1952-53.

Active in international affairs, Dr. Sabshin is a Distinguished Fellow of the Egyptian, Hong Kong, and Royal Australian and New Zealand Psychiatric Associations and an Honorary Fellow of the Royal College of Psychiatrists and the World Association for Social Psychiatry. He is a past member of the Board of the World Federation for Mental Health. From 1983-89 Dr. Sabshin served on the Executive Committee of the World Psychiatric Association, and in 1993 was elected WPA Secretary for Finance.

Dr. Sabshin has been Chairperson of the *American Psychiatric Press, Inc.*, the nonprofit corporation which serves as the publishing arm of the APA, which he currently serves in ex-officio status. He is also Past President of the American College of Psychiatrists. In September 1981, he received the Carrier Foundation's 5th Annual Nolan D.C. Lewis Award for Outstanding Contributions to the Field of Mental Health. He also received the Distinguished Service Award from the American Psychiatric Association in 1986, which was established by the Trustees of the APA in 1964 to honor members whose distinguished careers have ennobled the profession of psychiatry. In 1988, he was the recipient of the Administrative Psychiatry Award given by the APA and the American Association of Psychiatric Administrators.

The author of over 140 scientific reports, Dr. Sabshin is the co-author of five books that encompass multiple areas of psychiatry, including studies of normal behavior, clinical phenomena of depression and anxiety, and science versus ideology in psychiatry.

Lecture 11 **Monday, October 21**
3:30 p.m.-5:00 p.m.

GETTING RID OF THE RAT

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

SUMMARY:

Dr. Bell will describe the professional socialization necessary to inculcate public health attitudes in health care practitioners. Aspects of the public health philosophy of the National Medical Association will be contrasted with aspects of the public health philosophy of the American Medical Association. Specific public health/mental health interventions will be offered as ways of getting rid of various "rats"; these interventions include perinatal medical care, removing lead dust from infants' environments, early family support programs, parental training, early childhood education, identification and treatment of children exposed to traumatic stress, HIV prevention efforts in juvenile correctional facilities, and treatment rather than incarceration of drug addicts. The relationship between the health/mental health care of the least of us and the health/mental health care of the greatest of us is illustrated by the African proverb "If your neighbor has a locust attacking his crops and you don't help him, sooner or later the locust will be attacking your crops." The need for research and marketing in the public health arena will be highlighted.

REFERENCE:

1. Bell CC: Getting rid of rats. In Lazarus A (ed): *Career Pathways in Psychiatry: Transition in Changing Times.* Analytic Press, Hillsdale, NJ, 1996, pp 23-34.

MULTIMEDIA PROGRAMS

Multimedia Program 1 **Friday, October 18**
8:00 a.m.-9:30 a.m.

VIDEO WORKSHOP: DEPRESSION AND MANIC-DEPRESSION

Chairperson: Kathleen M. Kim, M.D., *Associate Professor and Associate Director of Clinical Services, Department of Psychiatry, University of Illinois at Chicago, M/C 913, 912 South Wood Street, Chicago, IL 60612-7327*

1 DEPRESSION

SUMMARY:

Serious depression affects over 17 million Americans every year, and many of us will suffer from it at least once in our lives. Women are twice as likely as men to be diagnosed with it. In this videotape the causes and treatment are explored. Psychotherapy is explained, along with new drug treatments and the revised form of electroconvulsive, or shock therapy.

Since 1990 the Department of Visual Media at the Dartmouth-Hitchcock Medical Center has used the series, *The Doctor Is In*, which has aired on public television. This videotape and the following one are from this series.

2 DEPRESSION AND MANIC-DEPRESSION

SUMMARY:

Depression affects over 17 million Americans each year, and it has been estimated that only one third of those affected receive any treatment, largely because of stigma and fear. That lack of treatment results in a high number of suicides, making this illness as fatal as any other and a public epidemic.

This videotape will explain the disease through the experiences of several people, including CBS reporter Mike Wallace, psychologist and author of a book on her life with manic-depressive illness Kay Redfield Jamison, artist Lama Dejani, and Department of State official Robert Boorstin. An overview of medications and therapy and a list of resources will also be provided.

Multimedia Program 2 **Friday, October 18**
10:00 a.m.-11:30 a.m.

VIDEO WORKSHOP: THE HISTORY OF PSYCHIATRY

Chairperson: Jeffrey L. Geller, M.D., M.P.H., *Professor of Psychiatry, University of Massachusetts Medical Center, 55 Lake Avenue North, Worcester, MA 01655*

3 STATE HOSPITAL BETWEEN THE WARS: WALTER E. BARTON, M.D.

SUMMARY:

It is ironic that a field that concentrates so intently on individuals' histories to determine their treatment so consistently ignores its own history. But history surely has the capacity to inform us how we might venture forward. Walter Barton, M.D., former APA president and former APA Medical Director, talks about his years as a staff psychiatrist at Worcester State Hospital (Massachusetts) between World Wars I and II. This is living history, there are few alive today who can speak cogently of that area of psychiatry. Dr. Barton discusses not only what psychiatry and state hospitals were like 60 years ago, but also how that era can and should inform contemporary practices in psychiatry. He particularly focuses on what the role of the state hospital ought to be.

Discussant: Joel S. Feiner, M.D.

Multimedia Program 3 **Friday, October 18**
1:30 p.m.-3:00 p.m.

COMPUTER WORKSHOP: PSYCHIATRIC TREATMENT USING COMPUTER TECHNOLOGY

Chairperson: Donald L. Kerste, M.D., *Senior Attending Physician, Forest Hospital, 555 Wilson Lane, Des Plaines, IL 60016-4780*

4 COMPUTER-MEDIATED ADJUNCTIVE TREATMENT PROGRAMS

SUMMARY:

There are numerous elements of psychiatric treatment that can be aided by the judicious application of computer technology. Computers can be used to collect data, conduct psychological testing, determine diagnosis, suggest treatment alternatives, develop treatment plans, track progress, explore conflicting issues, and provide adjunctive therapy. The focus of this workshop will be computer-mediated therapy.

The beginnings of computer therapy were inadvertently provided by Weizenbaum's "Eliza" program in 1966 (designed to demonstrate that communication between human and machine is superficial and meaningless). Instead, users found that the Rogerian style of reflective responses facilitated their exploration of troublesome personal issues. Other programs followed, including Selmi's "CBT," Kolby's "Overcoming Depression (OD), Gould's "The Learning Program," and Wright's "Cognitive Therapy."

Patient attitudes regarding interaction with a computer are usually positive, as reported by Erdman et al. (1985). Sensitive personal issues are more likely to be initially revealed during an interactive computer session than with a clinician. In this workshop, a study will be presented that compared the use of "CBT" and "Overcoming Depression" versus controls for severely depressed hospitalized patients. Characteristics of successful treatment programs will be discussed. The clinical application of "Overcoming Depression" will be demonstrated, followed by discussion of the structure of this treatment plan.

MULTIMEDIA PROGRAMS

Multimedia Program 4 **Friday, October 18**
3:30 p.m.-5:00 p.m.

VIDEO WORKSHOP: COLLABORATIVE HEALTH CARE, PART I: COPING WITH ANTICIPATED LOSS IN LIFE-THREATENING ILLNESS

Chairperson: Anita Menfi, R.N., M.Ed., *Department of Psychiatry, New York Hospital/Cornell Medical Center, 15 East 94th Street, New York, NY 10028*

5 WHOSE DEATH IS IT ANYWAY?

SUMMARY:

This Program and Multimedia Program 11 focus on the collaborative delivery of health care as an endeavor among mental health professionals, other health care givers, patients and their families, and other community groups and agencies. This model is seen as a critically important biopsychosocial approach to the challenges of our changing health care system.

Using segments from this videotape, *Whose Death Is It Anyway?* and video material depicting several real family situations, Part I will provide an opportunity to discuss guidelines for helping families cope with the painful ambiguities of threatened loss during an illness. A systems model integrating different kinds and phases of illnesses with the family life-cycle and belief systems will be used to address such issues as denial, psychological/physical loss, difficulties surrounding end-of-life decisions, and transgenerational experiences.

Various issues highlighted in the videotape will be examined and the group will interact while sharing their collective expertise and experience in this unfolding and important field, where ethics and medicine seek to inform family and professional collaboration.

Discussant: John S. Rolland, M.D.

Multimedia Program 5 **Saturday, October 19**
8:00 a.m.-9:30 a.m.

***VIDEO WORKSHOP: WHAT YOU NEED TO KNOW ABOUT SCHIZOPHRENIA, PART I**

Chairperson: Michael A. Silver, M.D., *Medical Director, The Providence Center, and Clinical Assistant Professor of Psychiatry, Department of Psychiatry and Human Behavior, Brown University, 492 Wayland Avenue, Providence, RI 02906-4654*

6 SCHIZOPHRENIA: THE TREATMENT SPECTRUM

SUMMARY:

This videotape provides an overview of the kinds of treatment available for people with schizophrenia, from medication through training in basic skills to social and vocational rehabilitative measures. Consideration is also given to the difficulties that can be encountered in negotiating the health care system and the role of the family in advocating for the needs of patients.

This videotape is Part I in a series of tapes that address consumer and advocacy issues. All tapes in the series are aimed at a lay audience and use primarily the panel discussion format. Parts II and III of this series are featured in Multimedia Programs 8 and 10.

* *Supported by an unrestricted educational grant from Janssen Pharmaceutica and Research Foundation.*

Multimedia Program 6 **Saturday, October 19**
8:00 a.m.-9:30 a.m.

COMPUTER WORKSHOP: QUALITY IMPROVEMENT

Chairperson: H. James Lurie, M.D., *Clinical Professor of Psychiatry, University of Washington, 1417 East Aloha Street, Seattle, WA 98112-3931*

7 STATISTICAL QUALITY IMPROVEMENT WITH MINITAB

Presenter: Roger L. Coleman, M.D.

SUMMARY:

Statistical methods and software are now essential for effective quality improvement. Statistical approaches used in industry are equally important in psychiatric quality improvement. Available methods with appropriate software are necessary for evaluating clinical indicator data and for revealing problems in and providing opportunities to improve care. The two statistical tools found most effective in industrial quality improvement are the control chart and regression analysis. Control charts can reveal outlier events and patterns that require additional review, which can lead to changes that improve quality. Regression analysis can demonstrate factors that affect process characteristics.

This presentation will use examples derived from psychiatric quality improvement approaches relating to length of hospitalization, treatment planning, insurance coverage, patient characteristics, and clinical decision making. The concepts of statistical process control and regression analysis will be explained intuitively, by using computer graphics to enhance understanding. Minitab statistical software will be used to create control charts and to perform regression analysis. Essential Minitab commands will be demonstrated. Through the use of the methods demonstrated here, clinicians and managers can develop effective quality improvement programs.

MULTIMEDIA PROGRAMS

Multimedia Program 7 — **Saturday, October 19, 8:30 a.m.-11:30 a.m.**

COMPUTER WORKSHOP: VIRTUAL REALITY AND PSYCHIATRY

Chairperson: 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*

8 VIRTUAL REALITY: JUST ANOTHER HIGH-TECH TOY, OR A UNIQUE PSYCHOTHERAPEUTIC CATALYST?
Presenter: Rita Addison, Ph.D.

SUMMARY:

Dr. Addison, an artist with graduate degrees in psychology and training in clinical settings, discusses her award-winning autobiographical story rendered through virtual reality, "DETOUR: Brain Deconstruction Ahead!" Based on the brain trauma she sustained from an automobile accident in 1992, it attempts to experientially share an altered perceptual state as illustrated by visual, auditory, and balance anomalies.

Dr. Addison explains her goals of evoking empathy from within the participants, as well as creating a perceptual environment possible only through virtual reality technology. Her three-dimensional artistic experiences will be illustrated here by a large video projection of the virtual reality program "DETOUR," first experienced at the CAVE, a virtual reality environment at the Electronic Visualization Laboratory at the University of Illinois at Chicago.

9 FEAR OF FLYING: VIRTUAL REALITY ENVIRONMENTS FOR EXPOSURE THERAPY
Presenter: Larry F. Hodges, Ph.D.

SUMMARY:

Dr. Hodges is Associate Professor in the College of Computing, and Associate Director for Industrial Relations in the Graphics, Visualization, and Usability Center at the Georgia Institute of Technology. He earned a doctorate degree in computer engineering from North Carolina State University.

A team of therapists and computer scientists led by Dr. Hodges and Dr. Barbara Rothbaum, conducted the first controlled study of virtual reality in the treatment of a psychological disorder, acrophobia. Current work by these two innovators includes designing a virtual reality airplane and conducting preliminary studies on the use of reality exposure in the treatment of the "fear of flying."

This presentation will include an introduction to virtual reality, as well as a large-screen video demonstration of the applications of virtual environments to treatment of anxiety disorders.

Multimedia Program 8 — **Saturday, October 19, 10:00 a.m.-11:30 a.m.**

***VIDEO WORKSHOP: WHAT YOU NEED TO KNOW ABOUT SCHIZOPHRENIA, PART II**

Chairperson: Michael A. Silver, M.D., *Medical Director, The Providence Center, and Clinical Assistant Professor, Department of Psychiatry, and Human Behavior, Brown University, 492 Wayland Avenue, Providence, RI 02906-4654*

10 SCHIZOPHRENIA: MEDICATION

SUMMARY:

This videotape will focus on the role of medication in the treatment of schizophrenia, noncompliance as a major cause of relapse, the importance of collaboration among patient, family, and clinician in determining the right drug and dosage, coping with side effects, and maintaining compliance. Parts I and III of this series are featured in Multimedia Programs 5 and 10.

* *Supported by an unrestricted educational grant from Janssen Pharmaceutica and Research Foundation.*

Multimedia Program 9 — **Saturday, October 19, 10:00 a.m.-11:30 a.m.**

VIDEO WORKSHOP: PSYCHIATRIC TREATMENTS AND THE PAINFUL PLIGHT OF INSANE PATIENTS

Chairperson: H. James Lurie, M.D., *Clinical Professor of Psychiatry, University of Washington, 1417 East Aloha Street, Seattle, WA 98112-3931*

11 BACK FROM MADNESS
Winner of the 1996 Psychiatric Services Video Award

SUMMARY:

Back from Madness provides a view of the world of insanity that few ever see--a world that is not traditionally dealt with in television. It is a chronicle of four psychiatric patients that contextualizes their present-day treatments with archival footage gathered from the United States and the Netherlands.

The film follows individuals for one to two years from the time they arrive at Harvard's Massachusetts General Hospital. On one level it is a film about psychiatric treatment at a great hospital. On a broader level, it is about patients and the inner strength that is required of them as they search for some relief from their insanity.

The film was made for two reasons: to provide an accurate documentation of psychiatric treatments; and to depict the plight of patients in clear, albeit painful, detail. It is the filmmaker's hope that the film will show how fighting severe mental illness requires enormous personal

strength and commitment on the part of patients and their families, a struggle that is most difficult in light of the lack of clear-cut remedies, the social stigma and blame associated with the illnesses, and the diminishing resources available to the mentally ill.

Discussant: Kenneth Paul Rosenberg, M.D.

Multimedia Program 10 **Saturday, October 19**
1:30 p.m.-3:00 p.m.

***VIDEO WORKSHOP: WHAT YOU NEED TO KNOW ABOUT SCHIZOPHRENIA, PART III**

Chairperson: Michael A. Silver, M.D., *Medical Director, The Providence Center, and Clinical Assistant Professor, Department of Psychiatry and Human Behavior, Brown University 492 Wayland Avenue, Providence, RI 02906-4654*

12 PSYCHOSOCIAL REHABILITATION

SUMMARY:

This videotape describes the kinds of programs people with schizophrenia need during the process of recovery so that they can develop the skills, confidence, and self-esteem necessary to live a relatively normal life. Parts I and II of this series are featured in Multimedia Programs 5 and 8.

* *Supported by an unrestricted educational grant from Janssen Pharmaceutica and Research Foundation.*

Multimedia Program 11 **Saturday, October 19**
1:30 p.m.-3:00 p.m.

VIDEO WORKSHOP: COLLABORATIVE HEALTH CARE, PART II

Chairperson: Anita Menfi, R.N., M.Ed., *Department of Psychiatry, New York Hospital/Cornell Medical Center, 15 East 94th Street, New York, NY 10028*

13 LEADING SUPPORTIVE-EXPRESSIVE GROUP THERAPY FOR WOMEN WITH BREAST CANCER

SUMMARY:

This program and Multimedia Program 4 focus on the collaborative delivery of health care as an endeavor among mental health professionals, other health care givers, patients and their families, and other community groups and agencies. This model is seen as a critically important biopsychosocial approach to the challenges of our changing health care system.

Part II, featuring Dr. David Spiegel, will demonstrate supportive-expressive group therapy, an innovative, psychotherapeutic approach that is useful in working with people with severe medical illness. The workshop will provide the opportunity to discuss issues such as countering isolation, dealing with fears of death and dying, managing family relationships, and communicating with health care professionals.

Discussant: Stephanie van Ammon Cavanaugh, M.D.

Multimedia Program 12 **Saturday, October 19**
2:00 p.m.-5:00 p.m.

COMPUTER WORKSHOP: THE INTERNET

Chairperson: Russell F. Lim, M.D., *Clinical Instructor of Psychiatry, University of California at Los Angeles, 1525 Euclid Street, Santa Monica, CA 90404*

14 USING THE INTERNET: RESEARCH, TRAINING, AND TREATMENT

Presenters: Waguih W. Ishak, M.D., Robert C. Hsiung, M.D.

SUMMARY:

The Internet permits the exchange of most forms of data, including text, graphics, audio, and video, among geographically distant mental health clinicians, trainees, and researchers. The recent development of graphical interfaces with the Internet has made access to its resources much easier for individual users. This presentation will describe and demonstrate the Internet and hypertext network browsers, such as Netscape, which allow clinicians to use a mouse pointing device to quickly locate and retrieve information from a remote site.

Also described will be the procedure for becoming part of Interpsych, a rapidly growing international effort that is helping to organize mental health information resources, including information relevant to psychiatry residency training programs (e.g., description of sites, research, and curricular materials).

Participants will have ample time to ask questions, and it is hoped that there will be time to do searches on the Internet. Access to the Internet will be available for attendees who have a laptop computer with a color monitor and 14.4-kbit/s modem.

Multimedia Program 13 **Saturday, October 19**
3:30 p.m.-5:00 p.m.

VIDEO WORKSHOP: DSM-IV: NEW DIAGNOSTIC ISSUES

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

MULTIMEDIA PROGRAMS

15 MOOD DISORDERS

SUMMARY:

This video workshop will feature the work of Ellen Frank, Ph.D., Professor of Psychiatry and Psychology at the University of Pittsburgh School of Medicine, who participated actively in the development of *DSM-IV* as a member of the Mood Disorders Work Group. This videotape is one of the *DSM-IV: New Diagnostic Issues* series produced by the American Psychiatric Press, Inc.

It begins with an introductory discussion between the clinician and the moderator. Dr. Frank then conducts three, ten-minute psychiatric diagnostic interviews, and after these the clinician and the moderator discuss the issues raised during the interviews and their relationship to the diagnostic determination of mood disorders. Good interviewing techniques will be demonstrated, and the development of a good doctor/patient relationship is highlighted.

Ian E. Alger, M.D., is the moderator and the executive producer of this video series.

Multimedia Program 14 **Sunday, October 20**
8:00 a.m.-9:30 a.m.

VIDEO WORKSHOP: STIGMA

Chairperson: 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*

16 THE STIGMA OF MENTAL ILLNESS: A MODEL CURRICULUM
Presenter: Kenneth S. Duckworth, M.D.

SUMMARY:

Medical students often have little practical experience working with people who have mental illness. They have, however, considerable experience absorbing the American culture's portrayals of the mentally ill. This videotape is the core of a model curriculum designed to highlight ways in which the mentally ill are stigmatized; help medical students examine society's attitudes toward people with mental illness; and encourage students to reflect on their own experiences, fears, and stereotypes regarding mental illness.

Medical students following this model curriculum first take a mental illness quiz to assess their knowledge, beliefs, and attitudes about mental illness. Then they view the videotape, which highlights the "phenotypes" of stigma--the mentally ill as crazy or evil or foolish--and uses cartoons, quotations, newspaper headlines, and other media copy to illustrate how mental illness has been, and still is, viewed and depicted. It also includes portrayals of the mentally ill in movies for children, adolescents, and adults. This program and companion discussion questions are designed to stimulate discussion about mental illness, its portrayal by the media and the entertainment industry, and the impact of this portrayal on clinical work.

Multimedia Program 15 **Sunday, October 20**
8:30 a.m.-5:00 p.m.

***COMPUTER WORKSHOPS: HANDS-ON LEARNING.**

Co-Chairpersons: Robert S. Kennedy, M.A., *Department of Psychiatry, Albert Einstein College of Medicine;* and Thomas A.M. Kramer, M.D., *Arkansas Mental Health Research and Training Institute, University of Arkansas*

17 PSYCHIATRY ON THE WORLD WIDE WEB
Presenter: Milton Huang, M.D.

18 AMERICAN PSYCHIATRIC ASSOCIATION ON THE WORLD WIDE WEB
Presenter: Lea Mesner

19 INTERACTIVE DR. FREUD
Presenter: Robert A. Kowatch, M.D.

20 WORLD WIDE WEB PUBLISHING
Presenter: Robert A. Kowatch, M.D.

21 COGNITIVE THERAPY: A MULTIMEDIA LEARNING PROGRAM
Presenters: Jesse H. Wright, M.D., Andrew S. Wright, B.S.

22 CLINICAL PSYCHOPHARMACOLOGY AND THE *PHYSICIANS' DESK REFERENCE*
Presenter: Thomas A.M. Kramer, M.D.

23 ELECTRONIC SLIDE SHOW OF ELECTRONIC POSTER SESSION
Presenter: Robert S. Kennedy, M.A.

24 ELECTRONIC RESIDENCY TRAINING

BROCHURE AND THE AMERICAN PSYCHIATRIC ELECTRONIC LIBRARY
Presenter: Robert S. Kennedy, M.A.

25 PRESENTATIONS/GRAPHICS DESKTOP PUBLISHING
Presenter: Carlyle H. Chan, M.D.

26 FINDING AND USING MENTAL HEALTH SOFTWARE FROM THE INTERNET
Presenter: Marvin J. Miller, M.D.

MULTIMEDIA PROGRAMS

27 A DATABASE FOR COMMUNITY PSYCHIATRY PROGRAMS

Presenter: David B. Wait, M.D.

28 PSYCHOPHARMACOLOGY ON THE WORLD WIDE WEB

Presenter: Robert C. Hsiung, M.D.

29 COMPUTERIZED HEALTH ENHANCEMENT SUPPORT SYSTEM (CHESS)

Presenters: Suzanne Pingree, Ph.D., Renee Botta, Robert P. Hawkins, Ph.D.

SUMMARY:

This special full-day, walk-in event is designed for both the novice and the sophisticated computer user. Faculty have been invited from various medical schools and universities to demonstrate software that they use in clinical practice, have used to run their clinical or teaching programs, or find interesting and useful in their daily work.

The workshop will allow visitors either to casually observe a computer program or to sit at a computer and interact with new software and programs written with mental health professionals or patients in mind. It is an experience not to be missed!

* *Supported by an unrestricted educational grant from Roerig Division/Pfizer, Inc.*

Multimedia Program 16 **Sunday, October 20 10:00 a.m.-11:30 a.m.**

COMPUTER WORKSHOP: STRESS MANAGEMENT

Chairperson: Roger L. Gould, M.D., *Founder, Interactive Health Systems, and Associate Professor of Psychiatry, University of California at Los Angeles*

30 MASTERING STRESS: RESOLVING PROBLEMS IN LIVING

SUMMARY:

This computer-assisted therapy program is the latest in an innovative series developed by Roger L. Gould, M.D. On the basis of his pioneering work in educational theory related to learning and critical thinking, Dr. Gould has emphasized the capacity of human beings to solve their problems in living through gaining new awareness and skills. He has effectively related these principles to the development of these innovative, self-directed computerized programs for fostering personal change.

Dr. Gould will demonstrate software that can be used by patients at home between sessions. The software, which is contained on a single diskette, helps patients to think more clearly about everyday problems in living that they are experiencing, so that they can sort out what is causing them distress, become more objective in their reading of reality, and begin to think about healthy, realistic ways of addressing problems.

This tool supplements psychotherapy and helps patients to take more responsibility for their own progress. It also helps them to bring in fresh and important material to each session.

The five-page summary/worksheet printout is a valuable part of the program that strengthens the patient's resolve to experiment with new behavior.

The program is easy to use. The information is confidential, personal, and in the patient's control. The printouts can be shared easily with the therapist. The focus on real problems and real solutions provides a concrete basis for deeper psychological exploration as well as short-term therapy.

Multimedia Program 17 **Sunday, October 20 1:30 p.m.-3:00 p.m.**

COMPUTER WORKSHOP: COMPUTERIZED HEALTH ENHANCEMENT SUPPORT SYSTEM (CHESS)

Chairperson: Suzanne Pingree, Ph.D., *Professor of Family and Consumer Communication, University of Wisconsin at Madison, 610 Walnut Street, Madison, WI 53705*

31 INTERACTIVE COMPUTERS AND SUPPORT: HOW CHESS HELPS PEOPLE DEAL WITH A CRISIS

Presenters: Robert P. Hawkins, Ph.D., Renee Botta

SUMMARY:

This workshop will demonstrate the innovative, interactive program CHESS (computerized health enhancement support system) and will present research results from several pilot studies involving adult children of alcoholics, survivors of sexual assault, and parents/partners of substance abusers.

The presenters have all been deeply involved in the research on this important program at the University of Wisconsin at Madison in the departments of family, mass communication and journalism.

Multimedia Program 18 **Sunday, October 20 3:30 p.m.-5:00 p.m.**

VIDEO WORKSHOP: DSM-IV: NEW DIAGNOSTIC ISSUES

Chairperson: Joel S. Feiner, M.D., *Professor of Psychiatry, University of Texas, Southwest Medical Center, 5909 Harry Hines Boulevard, 9 South, Dallas, TX 75235*

MULTIMEDIA PROGRAMS

32 PSYCHOTIC DISORDERS

SUMMARY:

This video workshop features the work of Nancy C. Andreasen, M.D., Ph.D., Andrew H. Woods Professor of Psychiatry at the University of Iowa College of Medicine. Dr. Andreasen served in the DSM-IV Task Force and chaired the Work Group on Schizophrenia and Other Psychiatric Disorders. This videotape is one of the *DSM-IV: New Diagnostic Issues* series, produced by the American Psychiatric Press, Inc.

It begins with an introductory discussion. Dr. Andreasen then conducts three, ten-minute psychiatric diagnostic interviews, and after these the clinician and the moderator discuss the issues raised during the interviews and their relationship to the diagnostic determination of psychotic disorder. Good interviewing techniques will be demonstrated and the development of a good doctor/ patient relationship is highlighted.

Ian E. Alger, M.D., is the moderator and executive producer of the video series.

Multimedia Program 19 **Monday, October 21**
8:00 a.m.-9:30 a.m.

VIDEO WORKSHOP: BORDERLINE PERSONALITY DISORDER, PART I

Multimedia Program 20 **Monday, October 21**
10:00 a.m.-11:30 a.m.

VIDEO WORKSHOP: BORDERLINE PERSONALITY DISORDER, PART II

Chairperson: Richard D. Chessick, M.D., Ph.D., *Professor of Psychiatry and Behavioral Sciences, Northwestern University, 9400 Drake Avenue, Evanston, IL 60203-1106*

33/ THE DIALECTICAL APPROACH TO UNDER-
34 STANDING BORDERLINE PERSONALITY DISORDER

These two workshops will focus on the "dialectical approach" of Marsha M. Linehan, Ph.D., who is Professor of Psychology and Adjunct Professor of Psychiatry and Behavioral Sciences at the University of Washington.

Treatment of Borderline Personality Disorder is always challenging. Parts I and II of *Borderline Personality Disorder* provide an unusually comprehensive and helpful introduction to a cognitive-behavioral method of treating patients with this disorder.

The Chairperson, Dr. Chessick, is also the author of *Intensive Psychotherapy of the Borderline Patient.*

Multimedia Program 21 **Monday, October 21**
1:30 p.m.-3:00 p.m.

COMPUTER WORKSHOP: COGNITIVE THERAPY

Chairperson: Jesse H. Wright, M.D., *Professor of Psychiatry, University of Louisville, and Medical Director, Norton Psychiatric Clinic*

35 COMPUTER-ASSISTED COGNITIVE THERAPY

SUMMARY:

"Cognitive Therapy: A Multimedia Learning Program" is a computer program that has been developed as a new method for assisting therapists in the treatment of depression and anxiety. An interactive format is used to engage patients in the learning process and to provide a user-friendly system for computer-assisted psychotherapy. The computer program covers the core principles and procedures of cognitive therapy (e.g., the basic cognitive model, cognitive restructuring, behavioral methods, schema identification, and modification [self-help]). Multimedia technology is used to make the program suitable for patients with no previous computer or keyboard experience.

This presentation will outline computer-assisted therapy methods, demonstrate the multimedia learning program through the use of a video disc player and a large-screen video projector, and illustrate performance tracking of patients who have used the system. The data recording and analysis functions of the software are able to generate progress reports on individuals or groups of users. Clinical and research applications will also be detailed.

Multimedia Program 22 **Monday, October 21**
3:30 p.m.-5:00 p.m.

FILM WORKSHOP: "I'M STILL HERE": THE TRUTH ABOUT SCHIZOPHRENIA

Chairperson: Robert Bilheimer, *President, Worldwide Documentaries, Inc., 3741 Oakmount Road, Bloomfield, NY 14469*

36 I'M STILL HERE: THE TRUTH ABOUT SCHIZOPHRENIA

SUMMARY:

This film documents the experiences and lives of individuals, families, professionals, and others throughout the United States who have had experience in one way or another with Schizophrenia, a highly misunderstood psychiatric disorder. The film seeks to capture the democratic nature of the illness, with interwoven portraits and stories ranging from homeless persons in New York City's Central Park to musicians, computer programmers, and

ordinary middle-American families. The film's central purpose is to deconstruct the stereotypes that have been associated with this illness, not only in the twentieth century but throughout history, and to convey a simple but compelling message: Those living with schizophrenia are people too. They are not headlines or categories. They are still here, still living and struggling like the rest of us, often leading lives of extraordinary courage. By participating in their experience, we will hopefully learn more not only about them, but about ourselves.

* *Supported by an unrestricted educational grant from Janssen Pharmaceutica and Research Foundation.*

Multimedia Program 23 **Monday, October 21**
3:30 p.m.-5:00 p.m.

VIDEO WORKSHOP: DSM-IV: NEW DIAGNOSTIC ISSUES

Chairperson: Nada L. Stotland, M.D., *Consultant, APA Institute Scientific Program Committee, and Chairperson, Department of Psychiatry and Substance Abuse Services, Illinois Masonic Medical Center, 836 W. Nelson Street, Suite 3120, Chicago, IL 60657*

37 ANXIETY DISORDERS

SUMMARY:

This video workshop will feature the work of Andrew E. Skodol II, M.D., who is Associate Professor of Clinical Psychiatry at the College of Physicians and Surgeons of Columbia University. He is coauthor of the *DSM-IV Casebook* and is a member of the DSM-IV Multiaxial Work Group. This videotape is one of the *DSM-IV: New Diagnostic Issues* series, produced by the American Psychiatric Press, Inc.

It begins with an introductory discussion between the clinician and the moderator. Dr. Skodol then conducts three, ten-minute diagnostic interviews, and after these the clinician and the moderator discuss the issues raised. The discussion covers identification of criteria for panic attacks, issues of social avoidance, PTSD, and the differential diagnosis of acute stress disorder. Good interviewing techniques will be demonstrated, and the development of a good doctor/ patient relationship is highlighted.

Ian E. Alger, M.D., is the moderator and executive producer of the video series.

POSTER SESSIONS

Poster Session 1 **Saturday, October 19**
10:00 a.m.-11:30 a.m.

SCHIZOPHRENIA, AFFECTIVE DISORDERS, AND DUAL DIAGNOSIS

Poster 1
OUTCOMES OF DEPRESSED MALE ALCOHOLICS: PRIMARY VERSUS SECONDARY DEPRESSION

Saeed A. Shah, M.D., *Department of Psychiatry, University of Kansas Medical Center, 3901 Rainbow Boulevard, Kansas City, KS 66160;* Elizabeth J. Nickel, M.A., Elizabeth C. Penick, Ph.D., Barbara J. Powell, Ph.D., Barry I. Liskow, M.D., Stephen D. Samuelson, M.D.

SUMMARY:

In this one-year prospective, naturalistic study of alcoholism, major depression beginning before alcoholism (primary depression) was compared with depression beginning after the onset of abusive drinking (secondary depression). From 360 hospitalized alcoholic male veterans who were extensively investigated at intake into the study and systematically evaluated one year later, a subsample of 97 (30%) who also satisfied the *DSM-III-R* criteria for major depression were extracted. Of the 97, 41 subjects were eliminated: 28 subjects with co-occurring antisocial personality disorder and 13 subjects for whom the temporal relationship between the mood and substance use disorders could not be clearly determined. Concomitant anxiety disorders (N = 12) were allowed to vary. The remaining 56 subjects were then divided into three subgroups: (1) alcoholics with primary depression (N = 23), for whom the onset of depression preceded the onset of alcoholism by at least teo years; (2) alcoholics with concurrent depression (N = 13), for whom the onsets of depression and alcoholism were within plus or minus one year of each other; (3) alcoholics with secondary depression (N = 20), for whom the onset of depression followed the onset of alcoholism by at least two years.

At intake into the study, virtually no differences were found. Family history of psychiatric disorder including alcoholism and depression, age at alcoholism onset, medical and social problems associated with drinking, number of positive depressive symptoms, treatment history, and psychiatric comorbidity did not distinguish the three subgroups. One year later, only two of the 56 subjects were lost to follow-up. Outcome measures including abstinence rate, drinking sequelae, treatments received, psychiatric severity, and ratings of psychosocial functioning were comparable across all groups, although the entire sample improved significantly with respect to abusive drinking and its sequelae over the follow-up period. The results call into question the clinical utility of distinguishing primary and secondary depression in male alcoholics without antisocial personality disorder.

Poster 2
THE EFFECTS OF NALTREXONE ON PSYCHOTIC AND AFFECTIVE SYMPTOMS: A CONTROLLED STUDY IN THE DUALLY DIAGNOSED

Bradley M. Pechter, M.D., *Assistant Professor of Psychiatry, Department of Psychiatry, University of Illinois, Mail Code 913, 912 South Wood Street, Chicago, IL 60612;* Vida B. Dyson, Ph.D., *Assistant Professor of Psychology, Department of Psychiatry, University of Illinois, 1601 West Taylor Street, Chicago, IL 60612*

SUMMARY:

It has been reported that narcotic antagonists (naltrexone, naloxone), particularly when given in a single intravenous injection, have a beneficial effect on psychosis, especially on auditory hallucinations. Whereas some studies replicated this treatment finding, others failed to replicate it. Since naltrexone is an effective adjunctive treatment for alcoholism, it might be desirable to add naltrexone to a conventional psychotropic drug to treat patients with alcoholism and coexisting major mental illness (schizophrenia, mania, depression). If naltrexone does benefit or at least not worsen psychopathology, it might be a welcome additional treatment.

This poster reports a random-assignment, double-blind, placebo-controlled study of acutely ill inpatients admitted with an episode of psychotic or affective major mental illness with coexisting alcoholism. The patients were first stabilized with a psychotropic medication and were then randomly assigned to either naltrexone or placebo for the next 6 months. The effects of naltrexone versus placebo on scores on the Positive and Negative Syndrome Scale, the Hamilton Depression Rating Scale, and the CARS-Mania Scale were examined. No changes in schizophrenia or major depression were found. There were too few manic patients to be evaluated.

REFERENCES:

1. Volpicelli JR, Alterman AI, Hayashida M, et al: Naltrexone in the treatment of alcohol dependence. *Arch Gen Psychiatry* 49:876-880, 1992.
2. O'Malley SS, Jaffe AJ, Chang G, et al: Naltrexone and coping skills therapy for alcohol dependence: a controlled study. *Arch Gen Psychiatry* 49:881-887, 1992.

Poster 3
NALTREXONE IN THE TREATMENT OF ALCOHOL DEPENDENCE WITH COMORBID MAJOR MENTAL ILLNESS: A CONTROLLED STUDY

Vida B. Dyson, Ph.D., *Assistant Professor of Psychology, Department of Psychiatry, University of Illinois, 1601 West Taylor Street, Chicago, IL 60612;* Bradley M. Pechter, M.D., *Assistant Professor of Psychiatry, Department of Psychiatry, University of Illinois, Mail Code 913, 912 South Wood Street, Chicago, IL 60612*

SUMMARY:

Since naltrexone substantially reduces the relapse rate for alcoholics, it is important to examine whether these results can be extended to patients who have a major mental illness, such as schizophrenia, mania, or major depression, in addition to alcoholism.

This poster reports a random-assignment, double-blind trial of naltrexone or placebo for hospitalized alcoholic patients with an exacerbation of the major mental illness. After the major mental illness was stabilized with conventional psychotropic drugs for that illness (e.g., risperidone, paroxetine, valproic acid), the patients were randomly assigned to naltrexone or placebo. After discharge from the hospital, they were followed on an outpatient basis. All underwent a program of abstinence-based addiction counseling. The poster will report pilot data on the effects of naltrexone in comparison to placebo on the rate of return to alcoholism in this dually diagnosed population.

REFERENCES:

1. Volpicelli JR, Alterman AI, Hayashida M, et al: Naltrexone in the treatment of alcohol dependence. *Arch Gen Psychiatry* 49:876-880, 1992.
2. O'Malley SS, Jaffe AJ, Chang G, et al: Naltrexone and coping skills therapy for alcohol dependence; a controlled study. *Arch Gen Psychiatry* 49:881-887, 1992.

Poster 4
EFFECTIVENESS OF A RESIDENTIAL TREATMENT PROGRAM FOR DUALLY DIAGNOSED PATIENTS

Ramesh B. Eluri, M.D., *Computer Psychiatry Resident, Department of Psychiatry, Temple University Hospital, 3401 North Broad Street, Philadelphia, PA 19140;* Richard Roemer, D.M.S., *Professor of Psychobiology and Psychiatry, Department of Psychiatry, Temple University Hospital, 3401 North Broad Street, Philadelphia, PA 19140*

SUMMARY:

The study assessed the rate of relapse into drug use, number of psychiatric hospitalizations, quality of living conditions, and treatment costs for dually diagnosed patients treated in a residential treatment program.

Clients were evaluated after discharge from a long-term residential treatment program (average treatment, 12 months) for patients with concurrent mental illness and substance abuse. Of the first 93 dually diagnosed patients, 52 were assessed by using follow-up interviews, information from case managers, and a review of the medical records. Of the 52 patients evaluated, 41% completed the interviews, 8% refused evaluations, and 7% were deceased.

During the year before treatment, all patients in the study had been admitted to a psychiatric unit at least once ($z = -4.12$, $p < 0.05$). Seventy-eight percent of the clients drank alcohol daily before treatment, and 5% drank alcohol at follow-up ($z = -1.98$, $p < 0.05$). Eighty-eight percent of the clients used drugs daily before treatment (95% at least once a month), and 3% used drugs at follow-up (17% at least once a month) ($z = -5.69$, $p < 0.05$). Before treatment clients spent an average of $2,505 on drugs, compared to $33 a month at follow-up ($t = -14.9$, df = 17, $p < 0.05$).

This study indicates the high success rate of this residential treatment program for dually diagnosed patients and reflects the potential effectiveness of comprehensive substance abuse and psychiatric treatment. More studies are needed to examine the effectiveness of these programs and specific treatment modalities for various subtypes of dually diagnosed patients.

REFERENCES:

1. Greenfield SF, Weiss RD, Tohen M: Substance abuse and the chronically mentally ill: a description of dual diagnosis services in a psychiatric hospital. *Community Ment Health J* 31:265-276, 1995.
2. Alfs DS, McLean TA: A day hospital for dually diagnosed patients in a VA medical center. *Hosp Community Psychiatry* 43:241-244, 1992.

Poster 5
PREVALENCE AND NATURE OF SUBSTANCE USE IN PATIENTS WITH SCHIZOPHRENIA

Heather Milliken, M.D., *Clinical Director, Schizophrenia Service, Schizophrenia Clinic, Royal Ottawa Hospital, 1145 Carling Avenue, CB1, Ottawa, ONT, Canada K1Z 7K4;* John Peachey, M.D., *Director, Clinical Education, Royal Ottawa Hospital, 1145 Carling Avenue, Ottawa, ONT, Canada K1Z 7K4*; Lyn Williams-Keeler, M.A.

SUMMARY:

This poster will present preliminary data from an ongoing study of the prevalence and pattern of substance abuse within the population of the Schizophrenic Service of the Royal Ottawa Hospital. This study is intended to assess and compare prevalence data for this population to data for comorbid populations reported in the literature.

Among the 450 patients currently attending the schizophrenia clinic, over 250 have already been screened for substance use. A new insight assessment tool, the Scale to Assess the Unawareness of Mental Disorder, was used in this study to determine the relevance of the patient's awareness of the signs and symptoms of illness to the pattern of substance use and abuse. The level of denial in substance-abusing patients has also been assessed by using a denial rating scale. The presenters will share their experience in using these awareness/denial tools for this particular comorbid population and their reflections on the importance of awareness and denial for this dually diagnosed population.

REFERENCES:
1. Meuser KT, Yarnold PR, Levinson DF, et al: Prevalence of substance abuse in schizophrenia: demographic and clinical correlates. *Schizophr Bull* 16:31-56, 1990.
2. Drake RE, Osher FC, Noordsy DL, et al: Diagnosis of alcohol use disorders in schizophrenia. *Schizophr Bull* 16:57-67, 1990.

Poster 6
IMPLEMENTING COMPREHENSIVE DUAL DIAGNOSIS PROGRAMS

Carolyn Cassin, Psy.D., *Coordinator, Dual Diagnosis Program, West Side Veterans Affairs Medical Center, Suite 116A, 820 South Damen Avenue, Chicago, IL 60612;* Surinder S. Nand, M.D., *Chief, Psychiatry Service, West Side Veterans Affairs Medical Center, Suite 116A, 820 South Damen Avenue, Chicago, IL 60612;* Sajiv John, M.D.

SUMMARY:

This poster will review models of treatment for patients with comorbid addiction and other mental disorders and will present methods of establishing comprehensive dual diagnosis treatments in existing treatment services.

Dually diagnosed patients constitute a large proportion, if not the majority, of patients who are being treated in community mental health and addiction treatment settings. A comprehensive program for dual diagnosis treatment fully permeates both mental health and addiction treatment systems. Traditionally segregated, dichotomous mental health and addiction services are no longer acceptable.

Methods of implementing a dual diagnosis program at one Veterans Affairs medical center and patient outcomes will be described. Central to program creation and implementation was the formation of a cadre of clinicians to serve as full-time dual diagnosis program coordinators with no primary care responsibilities. As such, they functioned in several roles: a) program development consultants to existing services, b) time-limited patient case managers, c) cotherapists of dual diagnosis groups, d) in-service education coordinators, e) mental health consultants to addiction treatment staff, f) addiction consultants to mental health staff, and g) innovators of programs for subpopulations of dual diagnosis patients who were not responding to existing services.

REFERENCES:
1. Soloman J, Zimberg S, Shellar E (eds): *Dual Diagnosis: Evaluation, Treatment, Training, and Program Development.* Premium Medical Book, New York, 1993.
2. Leman AF, Myers C, Dixon LB, et al: Defining subgroups of dual diagnosis patients for service planning. *Hosp Community Psychiatry* 45:556-561, 1994.

Poster 7
SUBSTANCE USE BY SERIOUSLY MENTALLY ILL PATIENTS AND THEIR FAMILIES

Laura T. Rachuba, B.A., *Department of Psychiatry, University of Maryland, 645 West Redwood Street, Baltimore, MD 21201;* Lisa B. Dixon, M.D., Anthony F. Lehman, M.D., Leticia Postrado, Ph.D.

SUMMARY:

The prevalence and adverse sequelae of comorbid substance use disorders in persons with serious mental illnesses are well established. To elucidate the context of this comorbidity, the authors determined perceptions of familial substance use by patients receiving treatment for serious mental illness.

Eighty patients living in inner-city Baltimore (mean age = 39 years, 56% male, 61% schizophrenic) who were randomly recruited from inpatient (47%) and outpatient (53%) settings were interviewed about their substance use and their knowledge of substance use in their families. Twenty-eight families provided information on familial substance use.

Fifty-eight percent of the patients had a *DSM-III-R* substance use disorder. A total of 92% of all patients reported substance use by a family member (49% mother, 64% father, 77% sibling); 42% reported alcohol use only. A patient's report of family substance use was not associated with the presence or absence of a substance use disorder in the patient. A total of 57% of families reported substance use by a family member other than the patient. Although patients were more likely than families to report maternal substance use ($p < 0.001$), patients and families agreed on the presence of any family substance use in the majority of cases.

The extremely high rate of substance use in the families of inner-city patients with serious mental illness has important implications for treatment and prevention of substance use in seriously mentally ill patients. Further research in this area is essential.

Poster 8
TRENDS IN SUBSTANCE USE AMONG PATIENTS WITH SCHIZOPHRENIA: A 10-YEAR STUDY OF EMERGENCY ROOM VISITS

Ashwin A. Patkar, M.D., *Department of Psychiatry, Jefferson Medical College, 111 South Eleventh Street, Philadelphia, PA 19107;* Robert C. Alexander, M.D., Kenneth M. Certa, M.D., C. Boardman, Ph.D.

SUMMARY:

Most studies of substance use in schizophrenia have focused on prevalence, clinical and demographic correlates, and negative effects of substance use. The goal of this study was to investigate whether there was a change

in patterns of substance abuse among schizophrenic patients over 10 years.

The subjects were selected by a retrospective review of records of visits to the crisis center of a university hospital between 1984 and 1994. The sample comprised all individuals with a diagnosis of schizophrenia (*DSM-III* or *DSM-III-R*) who visited the crisis center during the first half of alternate years of the study period. Substance use was diagnosed and categorized on the basis of urine toxicology screens.

There was a significant increase in schizophrenic patients who tested positive for illicit drugs. Moreover, cocaine and cannabis use showed significant increases. Amphetamine and barbiturate use decreased significantly, while opiate and benzodiazepine use was unchanged. There were no significant racial differences in substance use.

These findings suggest that over the last decade there has been a significant increase in use of illicit drugs by schizophrenic patients and that this increase is due to an increase in cocaine and cannabis use.

Poster 9
DOUBLE DIAGNOSIS OF SCHIZOPHRENIA AND CHEMICAL ABUSE IN A PUBLIC GENERAL HOSPITAL IN SPAIN

Natalia Sartorius, M.D., *Clinical Psychiatrist, Hospitaliz 12 Octubre, Suite 4, Avenida Andalocia KM5.4, Madrid 28041, Spain;* Guillermo Ponce, M.D., Isabel Herman, M.D., Pablo Del Pino, M.D., Enrique Bernardo, M.D., Miguel A. Jimenez, M.D.

SUMMARY:

Although in the United States mentally ill chemical-abusing patients have received considerable attention, in most European countries little attention has been paid to this population. This poster will present the prevalence of comorbid schizophrenia and chemical abuse in a public general hospital in Spain and will describe the clinical, social, and service utilization profiles of these patients.

The psychiatric records of all patients (N = 709) hospitalized in the psychiatric inpatient unit of a public general hospital in Madrid, Spain, from January 1991 through December 1994 were reviewed by a team of psychiatrists. A total of 106 patients met the criteria for both substance use disorder and either an axis I or an axis II diagnosis. The most common diagnoses were personality disorder (53%) and schizophrenia (29%). Eighty percent abused alcohol, 60% abused cannabis, 25% abused heroin, 20% abused cocaine, and 74% abused multiple substances. Males were overrepresented (90%), as were single persons (85%) and the unemployed (90%). As a group, these patients consumed a disproportionate amount of mental health resources. Data for schizophrenic patients will be especially highlighted.

The prevalence of comorbid substance abuse and other psychiatric disorders among patients in this public general hospital in Madrid, Spain, is substantial. Preliminary analyses indicate that the clinical and social profiles of these patients are comparable to those of the mentally ill, chemical-abusing population described in the U.S. literature.

Poster 10
BRAIN MORPHOLOGY IN SCHIZOPHRENIA BY SEX AND AGE AT ONSET

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SUMMARY:

This poster will examine the frequency and type of qualitative brain morphologic anomaly as a function of sex and age at onset among 199 individuals with schizophrenia. Increasing evidence suggests that there may be more than one etiology for schizophrenia and that patients who fall into different sex-by-onset groups may reflect different psychopathologies. In previous studies the presenters found that men with schizophrenia had significantly more positive MRI findings than did women with schizophrenia. In looking at specific regions of interest (e.g., corpus callosum), it was found that sex and age at onset together explain a greater degree of the variation than does each separately.

In the current study, morphologic findings were based on the reports of five independent neuroradiologists blind to the purpose and design of the study. Findings of these raters were categorized as falling into one of five categories: a) deep white matter hyperintensities, b) volume loss, c) ventricular anomaly, d) other abnormality (e.g., secondary abnormal signal lesion), or e) negative scan. The presenters will analyze the morphologic findings by sex and age at onset. If the frequency of each type of anomaly differs according to sex and age at onset, differences in pathophysiology may be a partial explanation.

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POSTER SESSIONS

Poster 11
DOMAINS OF PSYCHOPATHOLOGY: IS SCHIZOPHRENIA DIFFERENT FROM OTHER PSYCHOSES?

Santhi S. Ratakonda, M.D., *Suite 87E, 177 White Plains Road, Tarrytown, NY 10591;* Xavier F. Amador, Ph.D., Jack M. Gorman, M.D.

SUMMARY:

Previous factor analytic studies of schizophrenic symptoms have consistently demonstrated the existence of three independent factors or psychopathological domains: positive, negative, and disorganization. Treatment response, course, and neuropsychological test findings provide some evidence that these domains may be pathophysiologically independent. However, the specificity of these domains for schizophrenia has not been adequately examined.

In this study, the authors used factor analysis to examine data from the *DSM-IV* field trial for 221 patients with a *DSM-III-R* diagnosis of schizophrenia and 191 patients with other diagnoses who were rated with the Scale for the Assessment of Positive Symptoms and the Scale for the Assessment of Negative Symptoms. Identical three-factor structures were seen in the schizophrenic and other-diagnosis groups. Subgroup analysis showed similar structures for primary mood disorders (N = 65) and schizoaffective disorders (N = 49). Individual domains were differentially associated with age at onset, premorbid function, and course of illness. Such associations were independent of diagnostic groupings.

Future research should examine the validity of these psychopathological domains and the degree to which they are independent of current diagnostic categorizations. Establishing the validity of these domains and their independence from current diagnostic groupings would have implications for psychiatric nosology, by indicating that these domains could form the basis for a more valid classification of psychotic disorders.

Poster 12
AN INTEGRATIVE MODEL FOR MALINGERING AND FACTITIOUS DISORDERS: IMPLICATIONS FOR DIAG NOSIS IN COMPLEX SITUATIONS

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SUMMARY:

According to *DSM-IV,* the essential axis I feature of malingering is the "intentional production of grossly exaggerated physical and psychological symptoms, motivated by external incentives." Malingering differs from factitious disorders in that the motivations for symptom production in factitious disorders are *generally* not external incentives, whereas they are in malingering.

DSM-IV is designed for examination of axis I diagnoses in light of axis II pathology. The presenters will suggest a new model that examines axis I and axis II in an integrative manner. The model uses several continua, including locus of motivation (self to other), locus of behavior (internal to external), and locus of control (nonvolitional to volitional). They may be expressed in the form of a matrix. For example, both malingering and antisocial behavior would fall in the box that represents volitional locus of control and external locus of behavior; however, antisocial behavior is more other-oriented and malingering is more self-oriented.

The presenters will suggest a model that takes into consideration axis I symptoms as well as symptoms of axis II disorders. The continua of this integrative model and their implications for diagnosis and treatment in complex situations will be discussed.

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2. Rogers R: *Clinical Assessment of Malingering and Deception.* Guilford Press, New York, 1988.

Poster 13
DEPRESSIVE DISORDER AS A MULTIVARIATE PREDICTOR OF TREATMENT OUTCOME FOR OUT PATIENT ADDICTIONS TREATMENT

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SUMMARY:

A multisite, longitudinal study of inpatients undergoing treatment for alcohol and drug dependence was conducted in private outpatient facilities; it consisted of 2,029 subjects from 33 independent programs. The subjects were enrolled in a national addiction treatment outcomes registry. The purpose of the study was to understand the effects of post-treatment versus pretreatment factors on major depression in patients with addictive disorders.

Structured interviews were conducted at admission, and consecutive structured interviews were conducted prospectively for treatment outcome at 6 and 12 months.

The prevalence of depressive symptoms lasting at least two weeks (major depression) was 28% in this sample. Multivariate analysis with stepwise multiple regression indicated that the most powerful predictors of

post-treatment alcohol or drug use were attendance at peer support group sessions and involvement in a continuing care program. Lifetime depression by itself and in interaction with each of these factors accounted for less than 2% of the variance in outcome. Logistic regression yielded similar results in the prediction of abstinence versus relapse.

Post-treatment variables may be more decisive than pretreatment factors in influencing risk for relapse.

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2. Hoffman NG, Miller NS: Treatment outcomes for abstinence based programs. *Psychiatr Ann* 22:402-408, 1992.

Poster 14
HOUSING SATISFACTION AMONG SEVERELY MENTALLY ILL ADULTS

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SUMMARY:

In 1989 the Illinois Department of Mental Health and Developmental Disabilities developed community integrated living arrangements in response to OBRA 87. Community integrated living arrangements provide two modes of supportive housing with varying treatment intensities: continuous care (24-hour on-site staff) and intermittent care (staff on site fewer than 24 hours). The presenters examined the quality of life reported by residents in these living arrangements and compared these results with earlier findings favoring less-restrictive care.

From nine randomly selected agencies, 31 residents receiving intermittent care and 23 residents receiving continuous care were randomly selected. In two of the nine agencies, all clients in community integrated living arrangements were selected. Demographic measures and scores on Lehman's Quality-of-Life Interview for satisfaction with housing and life satisfaction were collected. Responses ranged from one (terrible) to seven (delighted).

Most subjects were male (67%). The majority were white (65%), and the remainder were African-American (31%), Asian (2%), and Latino (2%). Most had schizophrenia (44%) or affective disorder (24%). The mean level of housing satisfaction was 5.53, comparing favorably with satisfaction scores from Lehman's review. Subjects in less-restrictive intermittent housing reported greater housing satisfaction, but this difference was not quite significant ($p < 0.10$). Further analysis incorporating rehospitalization rates is planned.

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2. Lehman AF, Slaughter JG, Myers CP: Quality of life in alternative residential settings. *Psychiatr Q* 62:35-49, 1991.

Poster 15
A CONTROLLED OUTCOME STUDY OF PATIENT EDUCATION

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SUMMARY:

Despite the preponderance of patient education programs, only meager attempts to study their efficacy have been made. In this short-term outcome study, 30 adult inpatients diagnosed with schizophrenia were assigned, in a stratified random manner, to a structured/didactic patient education program or to a semistructured/discussion group. The two groups met for 15 consecutive daily one-hour sessions at the same place, on the same dates, and with the same group leaders. The covered topics were identical and were discussed in the same sequence; they ranged from diagnosis, prognosis, and medication management to familial stress and legal issues. The structured/didactic group followed program guidelines, while the semistructured/discussion group explored participants' experiences and concerns related to the topic at hand. Participants responded to three pre- and postgroup measures: knowledge of schizophrenia, insight into the illness, and knowledge of medication intake. Pregroup assessment also included patient expectations of the group experience, and the postgroup evaluation was augmented by patient evaluation of the program. The data analysis included these variables and intelligence level, past adherence to medication regimen, current global assessment of function, substance use history, and other patient characteristics.

Results will be presented in terms of their implication for patient education and the search for its active therapeutic ingredients.

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2. Goldman CR, Quinn FL: Effects of a patient education program in the treatment of schizophrenia. *Hosp Community Psychiatry* 39:282-286, 1988.

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Poster 16
MULTIDISCIPLINE MEDICATION GROUPS AND SCHIZOPHRENIA

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SUMMARY:

This poster will present the development of medication groups consisting of patients, their peers, and multidisciplinary staff, who meet concurrently to foster rehabilitation and consider pharmacological options in light of the group participants' varying perceptions of the patient. These groups run in conjunction with symptom identification and management groups, which are, by design, separate from the prescribing process. Taken together, these groups address several chronic difficulties encountered in the outpatient treatment of schizophrenia.

Historically, the pharmacological treatment of schizophrenia patients rested on medications that had similar modes of action and equal, albeit limited, efficacy. Chronic underfunding fostered a narrow, dyadic approach to the physician-patient relationship, with which physicians treated increasingly large numbers of patients. The physician could neither develop a relationship with the patient nor begin evaluating and preparing patients for more-advanced pharmacological interventions as they have become available. The more-detailed information and perspectives necessary to foster alternatives to medication use as improved psychosocial methods became available were not incorporated into the treatments. The presenters have found that coordinating rehabilitation and medication in groups is effective in addressing these problems.

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2. Baldessarini RJ: *Chemotherapy in Psychiatry.* Harvard University Press, Cambridge, MA, 1985.

Poster 17
STIMULANTS IN POST-NEUROTRAUMATIC SYNDROMES

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SUMMARY:

Brain trauma occurs commonly and is supervened by a constellation of neurobehavioral dysfunctional subsyndromes. Stimulants, despite excellent response, are seldom prescribed. The usefulness of stimulants has been suggested by a few recent, mostly anecdotal articles assessing fewer than 100 subjects. These articles include two controlled methylphenidate trials and one open trial of amphetamine. Two 1936 articles summarized antidepressant response to prototypes of amphetamine. This poster will comprehensively review the literature on stimulants in the pharmacotherapy of post-neurotraumatic syndromes.

That stimulants improve attention, concentration, cognition, mood, memory, task performance, and vigilance in patients with mild-to-moderate post-neurotraumatic syndromes has been corroborated. In addition, they diminish disruptive behaviors, impulsivity, paranoid ideation, post-traumatic headaches, and physical indolence. One convalescence study proposed short-term beneficial effects and lasting improvement in cortical function with methylphenidate. Another study ruled out tangible changes, but methylphenidate's short half-life and twice-a-day dosings may have precipitated rebound effects that obscured the benefits of multiple dosings. Anger level has been propounded as a positive predictor. No noteworthy adverse effects, medication abuse, or tolerance have been reported. Clinical progress is reflected objectively in neuropsychological measures, self-regulatory skills, and overall functioning. Only a single-patient crossover trial has compared methylphenidate with dextroamphetamine, and it found the latter to be more efficacious. Methamphetamine recently improved the condition of one patient, while magnesium pemoline has not been investigated to date.

The literature on the use of stimulants for post-neurotraumatic syndromes, especially with regard to extended outcome, is inadequate. Nevertheless, they are highly effective and safe and have no tolerance and abuse risk. These agents warrant further research so that their immense potential for treating an otherwise debilitating and intractable condition can be realized.

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2. Gualtieri CT: *Neuropsychiatry and Behavioral Pharmacology.* Springer-Verlag, Berlin, 1990.

POSTER SESSIONS

Poster 18
MEDICATION COMPLIANCE AND SELF-STRUCTURE IN SCHIZOPHRENIA

Mary E. Witt, M.D., *Department of Psychiatry, Robert Wood Johnson Medical Center, 671 Hoes Lane, Piscataway, NJ 08855;* Stuart R. Schwartz, M.D., Michael Gara, Ph.D., Shula Minsky, Ph.D.

SUMMARY:

This poster will present a study of factors influencing medication compliance by patients with schizophrenia. Subjects with schizophrenia were assessed for self-structure by means of a questionnaire with hierarchical classes analysis (HICLAS) and were rated for compliance by the treatment team.

Eight subjects, who had had schizophrenia for at least 10 years, were rated as compliant with recommendations for medication. Of the eight subjects, all but one described being a patient in as elaborate a manner as the self. In fact, in half of the cases, the identity as patient could not be distinguished from the self. The self was described by most as having both positive and negative attributes. The ideal self and the psychiatrist were another pair perceived as very similar by all eight. One-fourth of the patients also perceived the psychiatrist as being like their parents. However, unlike the patient-self structure, the ideal self-psychiatrist pair was described in a positive manner.

The poster will contrast these findings with results for noncompliant subjects and will include other factors that may discriminate the groups (global assessment of function, family support, utilization of services).

Examination of the structure of self merits further investigation as a means of increasing the understanding of patients' compliance with medication recommendations for schizophrenia.

Poster 19
REFERENTIAL ACTIVITY OF LANGUAGE IN OUT PATIENTS WITH SCHIZOPHRENIA

Lisseth Rojas-Flores, M.A., *Derner Institute, Adelphi University, Hy Weinberg Building, Garden City, NY 11530;* Wilma Bucci, Ph.D., Lewis A. Opler, M.D., Jill R. Linder, M.D., Frank Cory, Psy.D.

SUMMARY:

The authors examined schizophrenic language and psychiatric symptoms by using computer-generated referential activity, a measure of linguistic and emotional features of texts based on the multiple-code theory. All three subscales of the Positive and Negative Syndrome Scale (PANSS) were rated to determine whether degree of general psychopathology or phenomenological positivity and negativity would covary with levels of referential activity.

Nineteen stable outpatients with schizophrenia or schizoaffective disorder were rated on the PANSS and asked to provide four monologues about their childhood memories. Narratives were analyzed by using computer-assisted procedures for measuring referential activity.

Results revealed inverse correlations between scores on the PANSS general psychopathology scale and the level of referential activity for each narrative provided. The total level of referential activity across texts yielded statistically significant findings ($r = -0.47$, $p = 0.05$). Contrary to expectations, no correlations between referential activity and degree of positive and negative symptoms were found.

Preliminary data analyses confirmed the application of multiple-code theory and computer-generated referential activity as a useful measure in schizophrenia research. Moreover, these results are congruent with contentions that cognitive functions fail with high levels of pathology, particularly with regard to affective expression.

Poster 20
MEDICAL ILLNESS IN RELATIVES OF PATIENTS WITH SCHIZOPHRENIA, PATIENTS WITH AFFECTIVE DISORDERS, AND NORMAL CONTROL SUBJECTS

Janet E. Johnson, M.D., *Department of Medical Geriatrics, New York State Psychiatric Institute, Unit 58, 722 West 168th Street, New York, NY 10032;* Elizabeth Squires-Wheeler, Ph.D., Simone A. Roberts, B.A., L. Erlenmeyer-Kimling, Ph.D.

SUMMARY:

Many studies have examined the prevalence of various medical disorders in psychiatric patients. A lower than average prevalence of rheumatoid arthritis in schizophrenic patients has been consistently demonstrated. Associations of migraine, diabetes, and cancer with affective illness and schizophrenia have also been reported but with less consistent results. However, few studies have examined the rate of medical illness in relatives of psychiatric patients.

The authors conducted family history interviews with schizophrenic and affectively ill probands, their spouses, and normal control subjects from the New York High Risk Project to obtain information about medical illnesses in their parents and siblings.

Migraine was found to be more common in the relatives of the schizophrenic patients than in the relatives of the patients with affective disorder, well spouses, and normal control subjects ($p < 0.05$). Asthma and thyroid disease also were significantly more common in the siblings of the schizophrenic patients.

Demonstration of familial patterns of medical illness in schizophrenia and affective disorders may help elucidate etiology. Of particular interest are the autoimmune disorders, given the recent report of a putative linkage of schizophrenia to chromosome 6 and the HLA region. Both asthma and thyroid disease involve autoimmune mechanisms.

REFERENCE:
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Poster 21
A COGNITIVE-BEHAVIORAL APPROACH TO PANIC ATTACKS IN CHRONIC SCHIZOPHRENIA

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SUMMARY:

Panic attacks contribute to overall severity and dysfunction in schizophrenia. The Epidemiological Catchment Area surveys found prevalence rates of 28% to 63%, depending on the site. In nonschizophrenic populations with panic disorder, cognitive-behavioral therapy is considered the treatment of choice, on the basis of reports of beneficial short-term and long-term effects. However, for schizophrenic patients with panic disorder, the efficacy of cognitive-behavioral therapy has not been established. This poster will report on an open clinical trial of cognitive-behavioral therapy for patients diagnosed with schizophrenia and panic disorder. A case study will also be presented.

In a 16-week clinical trial, eight patients were given cognitive-behavioral therapy. All met the *DSM-III-R* criteria for schizophrenia and panic disorder. The patients received the Westergaard (CBM-WASPA) at baseline (pretreatment) and 16 weeks posttreatment to systematically assess panic.

Pilot analyses demonstrated that cognitive-behavioral therapy reduced the frequency and intensity of overall panic symptoms, according to scores at 16 weeks posttreatment. There was a statistically significant reduction in panic symptoms and an overall diminution in panic attacks from baseline to 16 weeks posttreatment.

These results suggest that cognitive-behavioral therapy is a most promising component in the integrated treatment of patients with diagnoses of schizophrenia and panic disorder.

Poster 22 - WITHDRAWN

Poster 23
SEASONAL VARIATION AND ONSET OF ILLNESS IN MIXED VERSUS PURE MANIA

Sean P. Stanton, B.S., *Department of Psychiatry, University of Cincinnati, ML559, 231 Bethesda Avenue, Cincinnati, OH 45267;* Susan L. McElroy, M.D., Paul E. Keck, Jr., M.D., Stephen M. Strakowski, M.D., Kiki D. Chang, M.D., Cesar A. Soutullo, M.D.

SUMMARY:

Findings from studies of seasonal variation in the course of mood disorders have been difficult to interpret because bipolar patients have been included in depressive samples, diagnostic assessment has varied from study to study, and mixed mania has not been well studied. Mixed mania may be a distinct clinical state separate from pure mania, with poorer outcome and different response to pharmacological treatment. In this study, the authors examined the effect of season on the occurrence of episodes in patients with mixed versus pure mania.

Bipolar patients were diagnosed as having mixed mania (N = 64) or pure mania (N = 98) according to the Structured Clinical Interview for *DSM-III-R*. The onset of illness was also recorded for first-episode (N = 92) and multiple-episode (N = 70) patients. The sample consisted of patients recruited as part of the University of Cincinnati Mania and First Psychosis Projects. Demographic information was collected at admission and analyzed according to subgroup: first-episode pure mania (N = 56), multiple-episode pure mania (N = 42), first-episode mixed mania (N = 36), and multiple-episode mixed mania (N = 28). Season was designated as late winter/early spring, summer, late summer/early fall, and winter. The subgroups were analyzed according to the seasonal admission of the patients.

The patients with first-episode pure mania displayed a seasonal pattern. A third (34%) of the patients were admitted in late winter/early spring. The late summer/early fall (23%) and winter (25%) months showed lower numbers of admissions. The lowest incidence was during the summer (18%). Patients with multiple episodes of pure mania showed the greatest occurrence in late summer/early fall (38%), and smaller proportions occurred in late winter/early spring (29%) and winter (24%). First-episode mixed mania showed no consistent pattern across the seasonal groups: 25% of the episodes occurred in each season. Patients with multiple-episode mixed mania showed the greatest concentration in late summer/early fall (43%), whereas late winter/early spring (25%) showed another, smaller peak.

First-episode patients with pure mania showed seasonal patterns. Mixed mania had no seasonal pattern in the first-admission patients but had a robust seasonal pattern in the multiple-admission patients. Pure mania previously was reported to be more prevalent in summer months, but our results show a higher incidence in late winter/early spring and late summer/early fall. The difference between these results and those obtained previously may be due to our inclusion of only patients with pure or mixed mania and our use of structured interviews.

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Poster 24
ATYPICAL DEPRESSION: A CLUSTER ANALYSIS

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SUMMARY:

Cluster analysis was used to examine the relationships among atypical depressive symptoms in 109 patients diagnosed with *DSM-IV* major depressive episodes. The patients were examined by using the Atypical Depression Diagnostic Scale, a semistructured interview that rates mood reactivity, rejection sensitivity, and reverse vegetative symptoms (hypersomnia, hyperphagia, leaden paralysis). A hierarchical cluster analysis was conducted to determine cluster membership on the basis of these symptoms.

A five-cluster solution maximized the differences between groups and symptoms. In these clusters there appeared to be an association between rejection sensitivity and hyperphagia, but not hypersomnia or leaden paralysis. Mood reactivity was not always associated with the other atypical depressive symptoms. The largest cluster ($N = 51$) consisted of patients with moderate mood reactivity, low rejection sensitivity, and low reverse vegetative symptoms (melancholic pattern). There were two clusters with high levels of reverse vegetative symptoms: one with high levels of mood reactivity and rejection sensitivity ($N = 4$) and the other with low levels of mood reactivity and rejection sensitivity ($N = 11$). The remaining two clusters differed primarily on the severity of the reverse vegetative symptoms.

As there was no clear relationship among mood reactivity, rejection sensitivity, and reverse vegetative symptoms, there may be diagnostic and clinical heterogeneity in the *DSM-IV* concept of atypical depression.

Poster 25
THE EFFECT OF A WARM WATER BATH ON SUBJECTIVE SLEEP QUALITY IN DEPRESSIVE ILLNESS

Anne M. Miller, D.O., *Resident, Department of Psychiatry, Michigan State University, West Fee Hall, East Lansing, MI 48824;* Dale A. D'Mello, M.D., John R. Meyers, M.D., Dominic V. Barberio, D.O., Donald Athearn, R.N., Neha Shah

SUMMARY:

A passive body-heating procedure such as a warm water bath is known to increase the duration of slow wave sleep in normal subjects, but the effect on patients with severe depressive illness has not been previously demonstrated.

A prospective study of 45 patients hospitalized with major depression examined the effect of a single, 30-minute warm water bath two hours before bedtime on subsequent nocturnal sleep. Sleep variables were evaluated by using a sleep questionnaire.

The number of hours slept during the nights before and after the bath remained constant. However, there was a substantial decrease (15 minutes) in sleep latency ($t = 2.03$, df = 39, $p < 0.05$). There was a similar decrease in the number of nocturnal awakenings ($t = 3.06$, df = 41, $p < 0.005$), suggesting an increase in the depth of sleep. The patients also reported feeling more refreshed upon awakening the morning after the bath.

A warm water bath may serve as an effective, inexpensive, and practical adjunct in the management of patients with depression accompanied by insomnia.

Poster 26
LONGITUDINAL ASSESSMENT OF QUALITY OF LIFE IN PATIENTS WITH MAJOR DEPRESSION

Jeffrey M. Pyne, M.D., *Department of Psychiatry, University of California at San Diego, Mail Code 0603, 9500 Gilman Drive, San Diego, CA 92093;* Robert M. Kaplan, M.D., Thomas L. Patterson, Ph.D.

SUMMARY:

The authors examined the relationship between scores on a quality of life measure and depressive symptoms over a six-month period. A total of 163 patients with primary major depressive disorder and 82 control subjects from the San Diego Veterans Affairs Medical Center and surrounding community were followed for six months. Diagnoses were made by consensus on the basis of information gathered with the Structured Clinical Interview for *DSM-III-R.* In addition, the Diagnostic Interview Schedule, Interval Medical, Hamilton Depression Rating Scale, Beck Depression Inventory, and Quality of Well-Being scale were administered at entry and at six months.

The patients were divided into three groups on the basis of the Diagnostic Interview Schedule diagnosis of current depression: patients who were not depressed at entry and remained not depressed (N-N), those who were not depressed initially and became depressed (N-D), and those who remained depressed (D-D). In a multiple regression analysis, using the Quality of Well-Being score as the dependent variable and using age and Interval Medical score as the independent variables, the difference between groups was statistically significant at both time 1 ($p < 0.001$) and time 2 ($p < 0.001$). These differences remained significant after Interval Medical score and age were controlled for.

The Quality of Well-Being scale is sensitive to changing symptoms of depression in patients diagnosed with major depression. Its advantages are that it is useful in cost/utility analyses, it has been used in general medical settings for over 20 years, and it is based on a social preference weighting system. The use of the Quality of Well-Being in public policy will be discussed.

Poster 27
THYROID FUNCTION IN ADOLESCENTS WITH MIXED VERSUS PURE MANIA

Cesar A. Soutullo, M.D., *Department of Psychiatry, University of Cincinnati, ML0559, 231 Bethesda Avenue, Cincinnati, OH 45267;* Kiki D. Chang, M.D., Sean P. Stanton, B.S., Susan L. McElroy, M.D., Paul E. Keck, Jr., M.D., Scott A. West, M.D.

SUMMARY:

A number of previous studies have shown an association between subclinical hypothyroidism and mixed mania or rapid cycling in adults with bipolar disorder. Studies indicate that mixed mania may be a distinct clinical state separate from pure mania, with a poorer outcome and different response to pharmacological treatment. Abnormalities in thyroid function in adolescents with mood disorders similar to those found in adults have also been reported. This study examined possible differences in thyroid function in adolescents with mixed versus pure mania and compared these findings with those for adults.

The sample ($N = 65$) included bipolar patients admitted to the psychiatric wards at the University of Cincinnati Hospital. Patients were separated into two groups: adolescents, ages 12-18 ($N = 29$), and adults, ages 19-65 ($N = 36$). In each of these two groups, the patients were further separated into mixed and pure mania by the Structured Clinical Interview for *DSM-III-R*: adolescents with mixed mania ($N = 16$) or pure mania ($N = 13$) and adults with mixed mania ($N = 11$) or pure mania ($N = 25$). Plasma concentrations of TSH, T_3, and T_4 were measured in each group by immunoassay (Immunol, Technicon). Results of the comparisons of the two adult groups were previously reported.

The majority of the adolescent patients had thyroid hormone levels within the normal range. Grade II hypothyroidism was present in 12.5% of the adolescents with mixed mania and 0% of the adolescents with pure mania. However, there were no significant differences in the plasma concentrations of TSH, T_3, or T_4 in the groups with mixed and pure mania. Furthermore, there were no significant differences between the adolescents and adults with mixed mania in plasma concentrations of TSH, T_4, or T_3. However, among the adolescents and adults with pure mania there was a significant difference in T_4 levels (mean = 7.25, SD = 1.08, versus mean = 8.64, SD = 2.45, respectively; $p < 0.04$) but not in TSH or T_3.

Similar rates of subclinical hypothyroidism were present in adolescents and adults with mixed mania (12.5% versus 14%, respectively). However, although the adults showed differences in thyroid function between mixed and pure mania, the adolescent group did not. These results suggest that the differences in thyroid function between mixed and pure mania may emerge at a later age.

Poster 28
ONE-YEAR OUTCOMES OF MEN WITH FAMILIAL ALCOHOLISM

Sunil Chhibber, M.D., *Department of Psychiatry, University of Kansas Medical Center, 3901 Rainbow Boulevard, Kansas City, KS 66160;* Elizabeth C. Penick, Ph.D., Elizabeth J. Nickel, M.A., Barbara J. Powell, Ph.D., Jan L. Campbell, M.D., H. Mikel Thomas, M.D.

SUMMARY:

Retrospective studies comparing alcoholics who have positive family histories to those with negative family histories typically indicate that alcoholics with positive family histories and their close biological relatives have earlier onsets of problem drinking, more-disabling courses, and greater psychiatric comorbidity. In this one-year prospective study of 360 consecutively admitted hospitalized male alcoholics, 69% ($N = 247$) reported one or more first-degree relatives who drank abusively, while 31% ($N = 113$) denied alcoholism among any first-degree relatives.

The authors used information obtained at intake into the study to replicate results obtained earlier by them and by others. In comparison to the nonfamilial group, the alcoholics with familial alcoholism were younger, reported more unemployment, began drinking at an earlier age, were younger at alcoholism onset, and suffered a greater number of drinking-related sequelae. The group with familial alcoholism also reported more psychiatric illness among first-degree relatives and themselves satisfied inclusive diagnostic criteria for more lifetime psychiatric syndromes, namely, drug abuse and antisocial personality disorder.

A total of 319 (89%) patients participated in the one-year follow-up (five died). Although it was expected that the alcoholics with familial alcoholism would have poorer outcomes, there were no differences between the two groups for most of the outcome measures. Abstinence rates, alcoholism severity, psychosocial functioning, and psychiatric symptoms at follow-up were comparable for the groups with and without familial alcoholism. The group with familial alcoholism received significantly more treatment during follow-up (more medications and more weeks of outpatient treatment) and reported fewer drinking days in the six months before the outcome evaluation. Is it possible that more-intensive treatment offset the anticipated poorer prognosis for the familial alcoholics?

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2. Babor TF, Doinsky ZS, Meyer RE, et al: Types of alcoholics: concurrent and predictive validity of some common classification schemes. *Br J Addict* 87:1415-1431, 1992.

Poster Session 2 **Saturday, October 19**
4:30 p.m.-6:00 p.m.

SPECIAL POPULATIONS, SERVICES RESEARCH, AND POTPOURRI

Poster 29
SURVEY OF AIDS AWARENESS IN ADDICTED PATIENTS

Vasant P. Dhopesh, M.D., *Psychiatrist, Inpatient Detoxification Unit, Philadelphia Veterans Affairs Medical Center, University and Woodland Avenues, Philadelphia, PA 19104;* William Burke, M.D., *Department of Psychiatry, Veterans Affairs Medical Center, University and Woodland Avenues, Philadelphia, PA 19104;* Carrie Lainfester, M.H.T.

SUMMARY:

Drug addicts, especially users of intravenous drugs, are at high risk for HIV. This survey was undertaken to assess HIV awareness among inpatients on an addiction treatment unit. From August 1 to December 31, 1995, all of the 125 consecutively admitted inpatients were given a questionnaire that included questions about demographic characteristics and HIV.

All of the patients were men ranging in age from 26 to 71 years (mean = 45.5, SD = 6.0). Of the 125 men, 99 (79.2%) were high school graduates, 37 (29.6%) were homeless, and 83 (66.4%) had used intravenous drugs; 54 (43.2%) were current users of intravenous drugs. Fifty (40.0%) had shared needles in the past, and 6 (4.8%) were currently sharing needles. One hundred (80%) had been tested for HIV in the past; the number of tests ranged from 1 to 15 (mean = 2.9). Eighty-eight (70.4%) had had the HIV testing done because of AIDS awareness. Eighteen (14.4%) were known to be HIV positive at the time of admission.

A high percentage of these patients had had HIV tests because of AIDS awareness. This suggests a positive impact of AIDS education for this population. However, since 43.2% were still using intravenous drugs and 4.8% were sharing needles, a continued focus on AIDS education and prevention for this population is advisable.

REFERENCES:

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Poster 30
A CLINICAL STUDY OF RAGE ATTACKS AND EPISODIC DYSCONTROL IN CHILDREN AND ADOLESCENTS WITH TOURETTE'S SYNDROME

Kenneth S. Park, *Department of Psychology, Harvard University, 93 Leverett Mail Center, Cambridge, MA 02138;* Cathy L. Budman, M.D., Ruth D. Bruun, M.D., Madelyn Olson, M.D., Robert Araujo, Ph.D., Hermann Davidovicz, Ph.D.

SUMMARY:

The authors sought to determine whether episodic dyscontrol with rage attacks is related to other conditions known to be associated with Tourette's syndrome. In a pilot study, all 12 children with Tourette's syndrome seen in a movement disorders center for rage attacks and episodic dyscontrol met the diagnostic criteria for comorbid obsessive-compulsive disorder and for attention deficit/hyperactivity disorder (ADHD).

Fifty-six clinically referred children with Tourette's syndrome (ages 6-16 years) were assessed in joint parent-child diagnostic interviews. The rate of comorbid ADHD and obsessive-compulsive disorder in the 24 children with rage attacks was significantly higher than in the 32 children without rage attacks ($p < 0.05$). Comorbid oppositional defiant disorder and conduct disorder were also highly correlated with comorbid rage attacks, while tic severity was less in the children with rage attacks than in the children without rage attacks.

These findings suggest the existence of a distinct group of cases of Tourette's syndrome that require special treatment methods. Further research in this underexplored area of psychiatry is needed.

POSTER SESSIONS

Poster 31
LITHIUM AND LONGITUDINAL COURSE OF BIPOLAR ILLNESS

Joseph F. Goldberg, M.D., *Senior Clinical Associate, Department of Psychiatry, Payne Whitney Clinic, New York Hospital/Cornell Medical Center, 525 East Sixty-Eighth Street, New York, NY 10021*; Martin Harrow, Ph.D., *Department of Psychiatry, University of Illinois College of Medicine, 912 South Wood Street, Chicago, IL 60612*

SUMMARY:

For over two decades lithium has remained a first-line treatment of recurrent bipolar mood disorders. Randomized clinical trials in the 1970s established its efficacy under optimized conditions. However, recent naturalistic studies have challenged its effectiveness for preventing relapse when used in ordinary clinical settings.

This poster will explore issues pertaining to relapse, psychosocial outcome, and lithium treatment for bipolar patients followed up successively from one to ten years under naturalistic conditions. Data from a number of studies will be reviewed. One such study is the Chicago Follow-Up Study, from which a number of factors contributing to poor outcome despite lithium treatment have been identified. These factors include prior affective episodes, mixed affective states or rapid cycling, and the need for adjunctive long-term psychotropic medications. Longer-term lithium prophylaxis appears most effective when a favorable response is maintained throughout the first one to two years after an index episode.

Lithium-treated bipolar patients with recurrent illness at follow-up may more often require neuroleptics or other additional agents and may be at risk for poor outcome at later follow-ups as well. In contrast, those with good outcomes from lithium monotherapy at earlier follow-ups tend more often to remain well at later follow-ups. Subgroups of bipolar patients may respond best to lithium monotherapy and sustain their remissions when they are treated early in the course of their illness.

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1. Goldberg JF, Harrow M, Grossman LS: Course and outcome in bipolar affective disorder: a longitudinal follow-up study. *Am J Psychiatry* 152:379-384, 1995.
2. Sachs GS, Lafer B, Truman CJ, et al: Lithium monotherapy: miracle, myth, and misunderstanding. *Psychiatr Ann* 24:299-306, 1994.
3. Coryell W, Endicott J, Maser JD, et al: The likelihood of recurrence in bipolar affective disorder: the importance of episode recency. *J Affect Disord* 33:201-206, 1995.

Poster 32
DRUG-INDUCED MANIA: CLINICAL AND ETIOLOGICAL IMPLICATIONS

Rajiv P. Sharma, M.D., *Department of Psychiatry, Illinois State Psychiatric Institute, 1601 West Taylor Street, Chicago, IL 60612-4310;* Thomas Owley, M.D., *Psychiatry Resident, Illinois State Psychiatric Institute, 912 South Wood Street, Chicago, IL 60612*

SUMMARY:

Bipolar disorder is a chronic illness characterized by intermittent periods of depression and mania. The complex, antipodal nature of the illness has challenged investigators and clinicians both to develop strategies for studying this disorder and to develop optimal treatments. Of particular interest has been appropriate treatment of the depressed phase of a bipolar illness. The controversy emanates from the concern over whether antidepressant medication can precipitate mania or course acceleration and, if so, exactly which individuals are susceptible to these phenomena. This is a particularly difficult area of study because the possibility of drug-induced mania is confounded by variables such as the natural course of the illness, patient characteristics, and coadministration of mood-stabilizing drugs. This poster will review the evidence from the literature pertaining to drug-induced mania in both bipolar and unipolar affective disorders, suggest general treatment guidelines based on a review of empirical evidence, and make suggestions regarding the course of future research.

REFERENCES:

1. Altshuler L, Post RM, Leverich GS, et al: Antidepressant-induced mania and cycle acceleration: a controversy revisited. *Am J Psychiatry* 152:1130-1138, 1995.
2. Stoll AL, Mayer PV, Kolbrener M, et al: Antidepressant-associated mania: a controlled comparison with spontaneous mania. *Am J Psychiatry* 151:1642-1645, 1994.
3. Wehr TA, Goodwin FK: Can antidepressants cause mania and worsen the course of affective illness? *Am J Psychiatry* 144:1403-1411, 1987.

Poster 33
PSYCHOSIS IN BIPOLAR DISORDER: DIAGNOSTIC AND TREATMENT ISSUES

James R. Sands, Ph.D., *Assistant Professor, Department of Psychiatry, University of Illinois College of Medicine, 912 South Wood Street, Chicago, IL 60612-7327;* Michael E. Dieperink, M.D., Ph.D., *Department of Psychiatry, University of Illinois College of Medicine, 912 South Wood Street, Chicago, IL 60612-7327*

SUMMARY:

This poster will focus on the importance of psychosis in the course of bipolar disorder, with an emphasis on new developments in diagnosis and treatment. Research shows that over 50% of bipolar patients will experience psychotic symptoms at some point in their disorder. *DSM-IV* provides new criteria related to the role of psychotic symptoms and formal thought disorder in the differential diagnosis of psychotic mania and schizoaffective disorder. Psychotic symptoms have a significant impact on the course and outcome of bipolar patients; however, the factors related to psychosis in bipolar disorders are poorly understood. These diagnostic formulations, risk factors, and prognostic significance will be illustrated with research data and new clinical case material.

New developments in psychopharmacology, particularly the use of novel (or atypical) antipsychotic medications, present the clinician with a broader range of treatment options. The treatment of psychosis during acute episodes of mania and the management of psychosis during the interepisode phases will be outlined. The emphasis will be on guidelines for the use of combinations of mood stabilizers and antipsychotics, particularly the newer atypical antipsychotics. The interaction of these antipsychotics with lithium, carbamazepine, and valproic acid will also be outlined.

REFERENCES:

1. Janicak PG, Davis JM, Preskorn SH, et al: *Principles and Practice of Psychopharmacology.* Williams & Wilkins, Baltimore, 1993.
2. Bowden CL, McElroy SL: History of the development of valproate for treatment of bipolar disorder. *J Clin Psychiatry* 56(suppl 3):3-5, 1995.
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Poster 34
CHILDHOOD SEVERITY OF PSYCHIATRIC ILLNESS

John S. Lyons, Ph.D., *Associate Professor, Department of Psychiatry, Northwestern University, Suite 9-217, 303 East Chicago Avenue, Chicago, IL 60611;* Mina K. Dulcan, M.D., *Professor and Chairperson, Department of Child and Adolescent Psychiatry, Children's Memorial Hospital, Northwestern University, Fifth Floor, 303 East Superior, Chicago, IL 60611*

SUMMARY:

The development of a measure of psychiatric illness and associated complications in children that can be used for quality assurance, planning, and care management will be presented. The Childhood Severity of Psychiatric Illness assesses symptoms, risks, comorbid disorders, functioning, and systems factors. In a study of 360 emergency cases, the Childhood Severity of Psychiatric Illness was used to predict hospitalization (appropriate and inappropriate admissions and deflections). About 70% of admissions were reliably predicted with three risks: suicide, dangerousness, and running away. Next, in a study of high-risk admissions the characteristics measured by the Childhood Severity of Psychiatric Illness were used to predict extended stays in the hospital. Among 282 cases, systems factors were the most reliable predictors of extended stays.

The utility of the Childhood Severity of Psychiatric Illness for needs-based planning, quality assurance, and care management will be described.

REFERENCE:

1. Lyons JS, O'Mahoney MT, Doheny KM, et al: The prediction of short-stay psychiatric inpatients. *Admin Policy Ment Health* 23:17-25, 1995.

Poster 35
THE INFLUENCE OF GENDER IN OCCUPATIONAL THERAPY

Karen M. Romanowski, M.S., O.T., *Occupational Therapist, Meriter Hospital, 4 East, 309 West Washington Avenue, Madison, WI 53703*

SUMMARY:

One must examine various factors that influence decisions to engage in particular activities. These factors include moral convictions, symbolic meaning, and one's sociocultural and historical context. Occupational therapists, taking the role of care giver for persons in transitional life periods, are situated, not unlike parents, teachers, and other socializing agents, in a position to have a significant influence on the way clients assign meaning to their different domains of "occupation." Occupational therapists do this through modeling of attitudes and actions as well as through prescription (treatment objectives).

This poster will describe a study that examined the influence of gender in occupational therapy. The primary research question was whether gender bias influenced how occupational therapists prioritized treatment objectives for a hypothetical client. The secondary research question was whether other factors influenced how occupational therapists determined these treatment objectives. Mail surveys were sent to a representative sample of registered female occupational therapists in Wisconsin and to all registered male occupational therapists in Wisconsin. Each survey contained a vignette describing a hypothetical client and related treatment objectives to be rated. Respondents were asked to answer demographic questions and to complete the Bem Sex Role Inventory.

A review of theoretical application, survey data, conclusions, and implications will be presented.

REFERENCES:
1. Corcoran MA: Gender differences in dementia management plans of spousal care givers: implications for occupational therapy. *Am J Occup Ther* 46:1006-1012, 1992.
2. Karuntoz GT, Caddell JM, Dennis ML: Gender differences in vocational needs and outcomes for methadone treatment clients. *J Psychoactive Drugs* 26:173-180, 1994.
3. Levy JM, Botuck PH, Kraemer ME, et al: Differences in job placements between men and women with mental retardation. *Disabil Rehab* 16:53-57, 1994.
4. Nahmias R, Froelick J: Women's mental health: implications for occupational therapy. *Am J Occup Ther* 47:35-41, 1993.
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Poster 36
MATERNAL PSYCHOSIS AND OBSTETRIC ASSISTANCE NEEDS

Thomas F. McNeil, Ph.D., *Professor and Head, Department of Psychiatry, Lund University, University Hospital UMAS, Malmo 205 02, Sweden*

SUMMARY:

Standardized observations of women's experience of labor and delivery and their behavior during this time were made for 68 index women with a history of schizophrenic, schizoaffective, affective, or unspecified functional psychosis and for 87 demographically similar control women with no history of psychosis. The total index group and each specific diagnostic group evidenced significantly more anxiety during labor and delivery than did the control women, and both the total index group and the women with a history of schizophrenia or unspecified functional psychosis evidenced more-problematic behavioral styles of relating to other persons in that situation. Data collected prospectively during pregnancy showed that both high anxiety level and low behavioral control during labor and delivery could be predicted in the index group by a range of problems associated with the material life situation, interpersonal relationships, somatic complaints, fears about the future, and mental condition during pregnancy. Generally, similar pregnancy characteristics predicted greater anxiety and more behavioral difficulties during labor and delivery among the control group.

The findings indicate a need for increased support during labor and delivery for women with a history of serious mental disorder and suggest the possibility of identifying women among both index and control groups whose needs for such support are especially great.

REFERENCES:
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2. Sacker A, Done DJ, Crow TJ: Obstetric complications in children born to parents with schizophrenia: a meta-analysis of case-control studies. *Psychol Med* 26:279-287, 1996.

Poster 37
MODELS AND STRATEGIES FOR ACADEMIC-CORRECTIONAL LINKAGES

Donald H. Williams, M.D., *Professor of Psychiatry, Michigan State University, Room A223, East Fee Hall, East Lansing, MI 48824;* William Fowler, D.O., *Assistant Clinical Professor of Psychiatry, Michigan State University, 2462 Fletcher N.E., Grand Rapids, MI 49506;* Thomas S. Gunnings, D.O., Wanda D. Lipscomb, Ph.D.

SUMMARY:

The authors are faculty members who have developed clinical research and teaching projects in the Michigan state correctional system. These projects have included an epidemiologic survey of mental illness in the prison system and teaching programs for medical students, psychiatric residents, and other professional students. The presenters will also describe a developing contract with Michigan State University for multidiscipline treatment program consultation, in-service staff training, and treatment evaluation in the prison psychiatric hospital.

The poster will describe these programs and will highlight the clinical, educational, and system issues that must be addressed in developing successful academic-correctional collaborations.

REFERENCES:
1. Neighbors HW, Williams DH, Gunnings TS, et al: *The Prevalence of Mental Disorders in Michigan Prisons.* Michigan Department of Corrections, Lansing, MI, July 1987.
2. Phillips D, Rudestorm KE: Effect of nonviolent self-defense training on male psychiatric staff members' aggression and fear. *Psychiatr Serv* 46:164-168, 1995.

Poster 38
ANXIETY SENSITIVITY AMONG ELDERLY PERSONS SEEN IN A PRIMARY CARE CLINIC

William J. Apfeldorf, M.D., *Department of Psychiatry, Cornell University, 21 Bloomingdale Road, White Plains, NY 10605;* George F. Brady, M.A., M. Philip Luber, M.D., Barnett S. Meyers, M.D.

SUMMARY:

The purpose of this study was to determine whether high levels of anxiety sensitivity, a pathologic form of anxiety associated with panic disorder, are present in elderly patients seen in a primary care setting.

Patients receiving an initial evaluation at a university-based general medicine clinic were asked to complete a brief 1-page questionnaire. The questionnaire gathers demographic information and includes the following items: a) the 16-item Anxiety Sensitivity Index, scores on which range from 0 to 64; b) "Do you have any problems with your emotions or nerves?"; c) "Have you ever had an anxiety attack?"; d) "Have you ever had panic disorder?"; and e) "In the past month, have you seen a health professional for your emotions or nerves?" Kruskal-Wallis analysis of variance by ranks was chosen to test significance.

A total of 718 patients completed the questionnaire. For the entire sample, the mean score on the Anxiety Sensitivity Index was 20.8 (SD = 14.7). The elderly subsample had a mean score of 22.4 (SD = 15.9), and the younger subsample had a mean score of 20.5 (SD = 14.5), a nonsignificant difference (*t* test). Anxiety sensitivity showed a significant weak positive correlation with age ($r = 0.14$, $p < 0.001$). The percent of elderly patients reporting emotional problems was 29%; the mean score on the Anxiety Sensitivity Index of these subjects was 32.0 (SD = 16.1). This score was significantly higher than the score for the elderly who did not report emotional problems (mean = 17.7, SD = 14.5) ($H = 11.43$, $p < 0.01$). The percentage of elderly who reported anxiety attacks was 24%; their score on the Anxiety Sensitivity Index (mean = 31.8, SD = 17.1) was significantly higher than that of those who reported they did not have anxiety attacks (mean = 17.7, SD = 14.2) or were unsure (mean = 26.8, SD = 14.9) ($H = 11.13$, $p < 0.01$). Only 10% of the elderly subjects reported ever having panic disorder; the anxiety sensitivity scores of these subjects (mean = 31.8, SD = 15.9) and the subjects who said they were unsure (mean = 36.3, SD = 12.4) were significantly higher than that of the elderly subjects who reported not having panic disorder (mean = 18.7, SD = 15.1) ($H = 13.34$, $p < 0.01$). Nine (11%) of 85 elderly respondents reported seeing a health professional for emotions or nerves in the previous month; those subjects had a significantly higher anxiety sensitivity score (mean = 34.8, SD = 13.1) than did those who had not made such a visit (mean = 20.8, SD = 15.8) ($H = 5.99$, $p < 0.02$).

The study indicates that emotional problems are common among elderly primary care patients, may be self-identified, and are associated with greater anxiety sensitivity. For many elderly patients, anxiety attacks and panic disorder may also be self-reported, and their presence appears to be associated with higher anxiety sensitivity scores.

Poster 39

THE EFFECT OF RELIGIOUS/SPIRITUAL BELIEFS ON PSYCHOLOGICAL STATE AND COPING IN WOMEN WITH POSSIBLE BREAST CANCER

Ruth E. Johnson, M.D., *Department of Psychiatry, Mayo Clinic, 200 First Street, Rochester, MN 55905;* Catherine S. Riley, *Medical School, Mayo Clinic, 200 First Street, Rochester, MN 55905;* Teresa A. Rummans, M.D., Laura L. Bloomquist, M.D., Peter C. Wollan, Ph.D., Michelle L. Taylor, Ph.D.

SUMMARY:

Women with undiagnosed breast abnormalities experience a wide array of emotions and employ numerous coping mechanisms. Researchers discovered that 85% of women studied believed religion helped them cope with breast cancer. The authors examined religious beliefs and affiliations in women with possible breast cancer to determine whether such beliefs influenced the coping mechanisms employed.

The subjects were 199 women referred to Mayo Breast Clinic for undiagnosed breast abnormalities. Spiritual, emotional, cognitive, and physical state were assessed with the Systems of Belief Inventory, Religious Orientation Scale, Profile of Mood States (POMS), State Trait Anxiety Scale, COPE, Folstein Mini-Mental State, and Karnofsky rating.

The mean age of the women surveyed was 54.4 years (range, 19-87). Specific religious affiliation was reported by 181 (91%). Belief in God was cited by 191 (96%) on the Systems of Belief Inventory and was correlated with use of positive reinterpretation as a coping strategy ($p = 0.001$); it was inversely correlated with the use of alcohol and drugs ($p = 0.005$) as shown by the COPE and with anger/hostility ratings on the POMS ($p = 0.003$). A religious system of social support was also inversely correlated with alcohol and drug use ($p = 0.009$). There were no significant correlations between scores on the Religious Orientation Scale and POMS.

Among this group of women, religious beliefs and social networks resulted in less maladaptive coping through anger/hostility and use of drugs and alcohol.

Poster 40

ASYSTOLE INCIDENCE IN ELDERLY PATIENTS RECEIVING ECT

Jeremy A. Burd, M.D., *5531 Southwest Twenty-Fourth Street, Topeka, KS 66614;* Paul A. Kettl, M.D., *Department of Psychiatry, Milton S. Hershey Medical Center, P.O. Box 850, Hershey, PA 17033-0850*

SUMMARY:

Electroconvulsive therapy (ECT) is a very effective form of treatment for depression in the elderly. However, cardiac complications in elderly patients receiving ECT have been much debated in the lay and professional literature. The presenters prospectively investigated the incidence of asystole of five seconds or greater in 38 elderly patients receiving a total of 51 ECT treatments. The patients were examined for age, sex, medical history, medications, and ECG findings documenting rhythm and cardiac disturbance. Those who had asystole were compared with those who did not by means of chi-square analysis.

Of the 38 patients, 25 (65.8%) experienced asystole during the course of ECT. The asystole group was significantly younger (average age, 72.2 versus 77.0 years) and less likely to have ECGs showing cardiac rhythm disturbances ($p = 0.05$). Medical history, history of cardiac disease, thyroid disease, diabetes, hypertension, or the use of a wide variety of cardiac medications did not predict asystole. Unilateral/bilateral electrode placement, number of ECT treatments, and sex did not predict asystole either.

Asystole is a common side effect of ECT in the elderly. Those with cardiac disease are not more likely to experience asystole and may in fact be less likely to experience it. Clinically, among these subjects asystole was not medically relevant to any significant outcome. Asystole following ECT in the elderly is a common but clinically insignificant experience.

Poster 41
DETECTION OF DELIRIUM IN ELDERLY EMERGENCY ROOM PATIENTS

Francois Rousseau, M.D., *Department of Psychiatry, St. Mary's Hospital, 3830 Lacombe Avenue, Montreal, PQ, Canada H3T 1M5;* Michel Elie, M.D., Martin G. Cole, M.D., Francois J. Primeau, M.D., Jane McCusker, M.D., Francois Bellavance, Ph.D.

SUMMARY:

The purpose of this study was to determine the sensitivity and specificity of a conventional clinical assessment used by emergency room physicians to detect delirium in emergency room patients aged 65 years and over.

This poster will present a preliminary analysis of the first 250 patients out of an expected total of 500 consecutive elderly patients brought to the emergency room of a primary acute-care university-affiliated hospital between midnight and 3:00 p.m. Monday through Friday and moved to the observation room on stretchers because of severity of illness. All of these patients are screened for delirium by a psychiatrist using the Confusion Assessment Method. Diagnosis of delirium or an equivalent by the emergency room physician is noted if present. The charts of the 250 patients with delirium interviewed so far and of a randomly chosen subgroup of patients without delirium were reviewed systematically by an investigator blind to the screening results. The prevalence of delirium and the sensitivity and specificity of the Confusion Assessment Method were calculated with a 95% confidence interval (CI).

Among the 250 elderly emergency room patients, the overall prevalence of delirium was 10% (95% CI = 6.3%-13.7%). The sensitivity and specificity of the Confusion Assessment Method were 20% (95% CI = 11.3%-28.7%) and 94.7% (95% CI = 94.6%-94.8%), respectively.

Despite a relatively high prevalence of delirium in elderly emergency room patients, the sensitivity of a conventional clinical assessment for this condition is low. There is a need for a means to improve the detection of delirium in the emergency room.

Poster 42
UNNECESSARY PSYCHIATRIC CONSULTATIONS: A PILOT STUDY

Gregory C. Mahr, M.D., *Department of Psychiatry, Henry Ford Hospital, 1799 West Grand Boulevard, Detroit, MI 48202*

SUMMARY:

Capitated health care systems have created strong pressures for cost containment and "demand management." Instead of encouraging consultations, consultation/liaison clinicians must now justify the necessity of psychiatric consultation. The presenter and his colleagues developed detailed criteria for unnecessary consultations. To assess the reliability of these criteria, 10 case vignettes were sent to 10 senior full-time consultation/liaison clinicians. The clinicians were asked to use the new criteria to classify each vignette as either necessary or unnecessary, to identify the criteria by which the decision was made, and to rate the level of certainty of the decision.

At least 6 of 8 raters agreed on 7 of 10 vignettes. Raters tended to disagree on the necessity for psychiatric consultation in situations involving stable delirium, dementia, and psychosis. Raters expressed a high degree of certainty regarding their ratings.

Since the criteria appeared useful and reliable, a series of 100 consultations were retrospectively reviewed and were rated by the presenter as either necessary or unnecessary according to the new criteria. Thirteen percent were deemed to be unnecessary, 6 of 50 at one institution and 7 of 50 at another. Possible strategies for reducing unnecessary consultations will be explored.

REFERENCES:

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2. Langley GR, Trichtler DL, Llewellyn-Thomas HA, et al: Use of written cases to study factors associated with regional variations in referral rates. *J Clin Epidemiol* 44:391-402, 1991.

POSTER SESSIONS

Poster 43
ORDER EFFECTS ON A MENTAL HEALTH QUESTION IN THE BEHAVIORAL RISK FACTOR SURVEILLANCE SYSTEM SURVEY

Daniel P. Chapman, Ph.D., M.Sc., *Psychiatric Epidemiologist, Division of Adult and Community Health, Centers for Disease Control and Prevention, Mail Stop K-51, 4770 Buford Highway N.E., Atlanta, GA 30341;* Matthew M. Zack, M.D., *Medical Epidemiologist, Division of Adult and Community Health, Centers for Disease Control and Prevention, Mail Stop K-51, 4770 Buford Highway N.E., Atlanta, GA 30341;* Wayne H. Giles, M.D., M.S.

SUMMARY:

Because survey respondents may not openly disclose mental health concerns and because questions about mental health are perceived as potentially stigmatizing, such questions are not often placed at the beginning of instruments that assess global aspects of health and functioning. To determine whether placement of a mental health question within a survey affects responses, the presenters compared responses on the Behavioral Risk Factor Surveillance System survey in Missouri in 1993 and 1994. In both years respondents were asked to estimate the number of days in the past 30 days when they felt that their mental health was not good. This question was placed at the beginning of the survey in 1994 (N = 1,491) but was placed later in the survey in 1993 (N = 1,463).

The reported number of days on which the respondents' mental health was not good was approximately the same in 1994 (mean = 3.26) as in 1993 (mean = 3.17), when mental health was assessed later in the survey. The similarity of these results suggests that placing this mental health question at the beginning of the survey did not reduce disclosure of self-perceived mental health problems.

REFERENCES:

1. Hennessy CH, Moriarty DG, Zack MM, et al: Measuring health-related quality of life for public health surveillance. *Public Health Rep* 109:665-672, 1994.
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Poster 44
DOCTOR VERSUS MATH MODEL IN PREDICTING READMISSION

Chester P. Swett, Jr., M.D., *Professor of Psychiatry, Dartmouth Medical School, 105 Pleasant Street, Concord, NH 03301*

SUMMARY:

This study identified factors that would predict readmission within 30 days of discharge from a psychiatric hospital and compared the predictions with those of psychiatrists.

A total of 428 inpatients were evaluated at discharge by psychiatrists, and scores on the Nurses' Observational Scale for Inpatient Evaluation (NOSIE) and Brief Psychiatric Rating Scale, diagnosis, length of stay, and demographic variables were recorded.

The motor retardation factor of the NOSIE, the number of prior admissions, a diagnosis of borderline personality disorder, a diagnosis of substance abuse, and the lack of a significant other were significantly associated with subsequent readmission within 30 days of discharge. Psychiatrists correctly predicted the presence or absence of early readmission about 78% of the time, and the mathematical model made correct predictions 74% of the time. The psychiatrists tended to be better at predicting who would *not* be readmitted, and the regression model was better at predicting who *would* be readmitted.

The variables that correctly predicted readmission may be helpful adjuncts to clinical judgment in preventing readmission to other facilities.

REFERENCES:

1. Geller J: A historical perspective on the role of state hospitals viewed from the era of the "revolving door." *Am J Psychiatry* 149:1526-1533, 1992.
2. Swett C: Symptom severity and number of previous psychiatric admissions as predictors of readmission. *Psychiatr Serv* 46:482-485, 1995.

Poster 45
USING CARTOONS AS TREATMENT AND HABILITATIVE ADJUNCTS

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SUMMARY:

Posted cartoons and text will show how in the hands of a psychiatrist the everyday cartoon can promote growth, development, and healing in interpersonal and family relations; parent-child relations; emotions, ideas, and thinking; personal health, growth, and standards; history, heritage, governance, citizenship, and politics; and even the ordinary activities of daily living and the economic tasks of everyday life. The sources of the cartoons' effectiveness are multiple.

Cartoons connect with the social evolution of homo sapiens' communication skills and pictorially span time at least from cave drawings, through Egyptian and Mayan glyphs to monastic biblical drawings, and on to the printing press. Cartoons' roots include common handbills and

posters; cartoons evolved over time through single-frame drawings about life to multiple frames. A single-frame cartoon was used by Benjamin Franklin to motivate the American colonists to work through and settle differences, cooperate, and "Unite or Die," which is considered to be our first political cartoon.

Cartoons' populist roots remained, and their evolution was furthered by twentieth-century technological advances in printing, color inks, and distribution systems. Newspapers often select cartoons by reader surveys, which show a preference for healthier cartoons drawing on family life. Family life is enhanced by the after-work parental rejuvenation that occurs when the parent reads cartoons to the child in an interactive and interpretive manner. The rooting in homo sapiens' growth and development, the appealing pictures, and the ubiquitous availability make cartoons excellent but overlooked adjuncts to treatment plans for the mentally ill or habilitation plans for the mentally retarded. Studies of apes and children show new ideas for using pictures to circumvent the expressive language deficits common to many seriously retarded persons.

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Poster 46
OUTCOME MEASURES OF CUSTOMER SATISFACTION AND THERAPISTS' SKILL IN GROUP PSYCHOTHERAPY

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SUMMARY:

Measuring customers' satisfaction and therapists' skill is part of the quality assessment of group psychotherapy at the Houston Veterans Affairs (VA) Medical Center. In 1993 the presenters administered a semistructured survey regarding therapist behaviors perceived by group members (customers) and therapists themselves as "helpful" or "not helpful" during group sessions. The group members' and therapists' responses were clustered into nine distinct behavioral categories, from which were constructed in parallel format: a) a customer satisfaction scale, b) a group therapist self-rating scale, and c) a revision of the presenters' previously reported Houston VA Medical Center group psychotherapy observer rating scale. These instruments permit quantitative assessment and comparison of group psychotherapy from the vantage points of therapists, group members, and expert observers.

Data over three years show that customers' satisfaction with group therapy has steadily increased and that the therapists' performance improves by the second observation after educational feedback from the first observation. These inexpensive methods can contribute to outcome measures for managed care organizations and to staff competency measures for meeting accreditation standards.

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Poster 47
FAMILIES IN TRANSITION: A FOLLOW-UP STUDY

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SUMMARY:

Families with histories of homelessness are at risk for becoming "re-homeless." Programs attempting to prevent homelessness for at-risk families must attempt to identify both the specific risk factors involved and which services are most effectively used by these families. The presenters compared two supported housing programs operated by the Visiting Nurse Service of New York's Community Mental Health Services in the South Bronx of New York City. Intensive Case Management for Rehoused Families works with families transferring from homeless shelters into permanent housing (N = 31). The Short-Term Case Management Team works with families living in city-owned buildings who are experiencing crises that may put them at risk for homelessness (N = 18). Families receiving short-term case management do not always have histories of homelessness.

Comparisons of risk factors for homelessness revealed that the rehoused families receiving intensive case management had younger parents and children and greater psychiatric pathology except for substance abuse than the families receiving short-term case management. Data collected six months after discharge compared utilization of services provided by the Visiting Nurse Service with service utilization by clients at follow-up. Clients in the short-term case management program used more budgeting, parenting, and employment services than did the families receiving intensive case management, but they used fewer social services. Both groups showed large decreases in substance abuse, domestic violence, and education services.

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Poster 48
MEDICAL RESOURCE UTILIZATION BY THE SERIOUSLY MENTALLY ILL

Ralph Aquila, M.D., *Attending Psychiatrist, Department of Psychiatry, St. Luke's/Roosevelt Hospital, 910 Ninth Avenue, New York, NY 10019;* Marianne Emanuel, R.N., *Nursing Coordinator, Project Renewal, 448 West Forty-Eighth Street, New York, NY 10036*

SUMMARY:

Staff in the presenters' 57-bed supportive residence have been identifying medical pathology and providing medical treatment for persons who may not have had access to medical care or who avoided treatment because of their psychopathology. On admission to the residence, each person is required to complete a physical examination. Through this screening process, previously undiagnosed medical conditions can be evaluated and treatment can be prescribed, and treatment of existing illness can be continued. New patients often resist returning to medical clinics for follow-up care because of negative experiences with past hospitalizations. In many situations (other than medical emergencies) the on-site psychiatrist, with the medical-surgical nurse, will act as the primary care physician until the patient is ready to obtain care from a hospital's primary care clinic.

This study examined the medical pathology of 57 formerly homeless adults and the clinics used by them from January 1995 through December 1995. The results suggest that outpatient diagnosis and treatment in a supportive residence, coordinated with follow-up clinic care, decrease emergency room visits and hospitalizations, thereby reducing the cost of this population's medical care.

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Poster 49
CENTRAL INTAKE AND OUTCOMES OF SUBSTANCE ABUSE PROGRAMS

James E. Rohrer, Ph.D., *Professor, Hospital and Health Administration, University of Iowa, 2700 Steindler Building, Iowa City, IA 52242*

SUMMARY:

State governments are exploring the potential of various forms of case management to control the costs of substance abuse treatment programs. This poster will compare the experience of clients served by an intake-and-referral program used in one county to the experience of clients served elsewhere in Iowa.

All claims submitted by provider agencies to the Iowa Department of Public Health for substance abuse treatment of eligible candidates in 1994 were analyzed to test the impact of the experimental program on utilization and outpatient treatment, treatment completion, and abstention at discharge.

In the experimental county, 27% of the clients recommended for treatment actually attended treatment, versus 49% in other counties. Clients in the experimental county were also less likely to complete treatment. These differences persisted after adjustment for baseline client characteristics.

Lower utilization arising from failure to attend recommended treatment reduces treatment costs, but it is not the intended outcome of the program. Failure to complete treatment also is an adverse outcome. Outcomes of various types of case management programs should be carefully evaluated before statewide implementation.

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POSTER SESSIONS

Poster 50
MEDICAL COMORBIDITY AND PSYCHOTIC ILLNESS IN AN OUTPATIENT CLINIC SAMPLE

Calvin J. Flowers, M.D., *Department of Psychiatry, Los Angeles County Medical Center, 1937 Hospital Place, Los Angeles, CA 90033;* Lawrence S. Gross, M.D., Mina Tasic, M.D., George M. Simpson, M.D.

SUMMARY:

There is evidence from recent research that psychiatric patients may have a greater than average risk for certain chronic and serious comorbid medical conditions. There has been, however, relatively little work to determine the relationship between chronic psychotic illness (i.e., schizophrenia) and coexisting physical illness.

The authors collected data on 294 patients at a major urban outpatient psychiatric clinic who were identified as receiving maintenance therapy with antipsychotic medications. Demographic, diagnostic, and treatment data were collected cross-sectionally from chart reviews.

The sample included 138 men and 156 women with a mean age of 44 years (range, 18-84). The ethnic distribution was as follows: 17% white, 21% black, 54% Hispanic, and 7% Asian-Pacific. Of the 294 patients, 211 (72%) had one or more comorbid medical conditions. The most frequent medical diagnosis was hypertension (17%), followed by diabetes mellitus (9%) and hypothyroidism (3%). These prevalence figures are significantly higher than published estimates for the general population.

This study suggests that psychiatric patients receiving maintenance neuroleptic treatment for psychotic illness may be at greater risk for certain comorbid medical illnesses than is the general population.

Poster 51
PROFESSIONAL COURTESY: CURRENT ATTITUDES AND PRACTICES

Linda B. Nahulu, M.D., *Department of Psychiatry, University of Hawaii, 1356 Lusitana Street 4th Floor, Honolulu, HI 96813*

SUMMARY:

Traditionally, physicians have provided professional courtesy to other physicians and their families. Recently, there have been drastic changes in the way medical care is paid for and the way physicians are compensated. The last published study on professional courtesy surveyed physicians in 1991 and had a 46% response rate. The authors did a small pilot study with the hypothesis that changes in medical reimbursement are altering the way professional courtesy is viewed.

A copy of the 20-question survey used in the 1991 study by Mark Levy, M.D., et al. was obtained with permission. It was administered to nine child and adolescent psychiatrists practicing in Honolulu, seven of whom returned completed questionnaires.

The 1991 study by Levy et al. showed that there had been little change in physicians' attitudes and practices regarding professional courtesy since 1958. Surprisingly, the results in this small pilot study were very similar to those of the 1991 nationwide study. Because of the small sample, however, there was statistically poor reliability.

This pilot study suggests that even in 1996, despite drastic changes in the way medical care is paid for, psychiatrists' attitudes and practices involving professional courtesy may have remained constant.

Poster 52
DEPRESSION IN GENERAL MEDICAL SETTINGS, PART I: DIAGNOSTIC LIMITATIONS OF NON PSYCHIATRIC PHYSICIANS

David B. Arciniegas, M.D., *Instructor/Fellow, Department of Psychiatry, University of Colorado, 1055 Clermont Street, Denver, CO 80220;* Thomas P. Beresford, M.D., *Professor, Department of Psychiatry, Denver Veterans Affairs Medical Center, 1055 Clermont Street, Denver, CO 80220*

SUMMARY:

Evaluation of depression is a common reason for patient referral to psychiatric consultation services of general hospitals. Depressed mood is often recognized by nonpsychiatric physicians, but it is a nonspecific symptom, not necessarily indicating a true depressive disorder or the need for antidepressant therapy. Despite this, many general physicians, without benefit of a psychiatric consultation, prescribe antidepressant medication for a depressed mood alone, subjecting their patients to unwarranted medical risks. The presenters hypothesized that nonpsychiatric physicians recognizing depressed mood in their medially ill patients would overdiagnose depressive disorders and overprescribe antidepressants.

The presenters reviewed the cases of 49 patients in a university hospital who were referred for "depression." They determined the frequencies of the psychiatric consultants' diagnoses and the referring physicians' discharge diagnoses and examined the subsequent prescriptions for antidepressants made by the referring physicians.

Psychiatric consultants diagnosed depressive disorders (major depression or depression not otherwise specified) in 18.4% of the 49 cases. Seventy-five percent of the patients with consultant-diagnosed depressive disorder and 25% of the patients without diagnosable depression were prescribed antidepressants by referring physicians. Depressive disorder was excluded by the consultant but included by the referring physician in 28.6% of the cases; 43% of these patients were prescribed antidepressants by the referring physicians. There were

significant differences between the psychiatric consultants and the nonpsychiatric referring physicians in the rates of depressive diagnosis ($\chi^2 = 7.56$, $p < 0.01$) and antidepressant prescription ($\chi^2 = 10.21$, $p < 0.01$).

Nonpsychiatric physicians are not skilled at generating a mood-related differential diagnosis; hence, they overdiagnose depressive disorders and overprescribe antidepressants. These results support using psychiatric consultation for evaluation of depression and argue against the trend in managed care to increase the proportion of depressed patients treated by nonpsychiatric physicians.

Poster 53
DEPRESSION IN GENERAL MEDICAL SETTINGS, PART II: DIAGNOSIS, CODING, AND THE ROLE OF THE CONSULTATION/LIAISON PSYCHIATRIST

David B. Arciniegas, M.D., *Instructor/Fellow, Department of Psychiatry, University of Colorado, 1055 Clermont Street, Denver, CO 80220;* Thomas P. Beresford, M.D., *Professor, Department of Psychiatry, Denver Veterans Affairs Medical Center, 1055 Clermont Street, Denver, CO 80220*

SUMMARY:

Evaluation of depression is a common reason for patient referral to psychiatric consultation services of general hospitals. In another poster the presenters will report significant differences in diagnosis and antidepressant prescription patterns between psychiatric consultants and nonpsychiatric referring physicians. The results suggest that increased use of psychiatric consultation would benefit patients by avoiding inaccurate mental illness diagnoses. In the present study the presenters examined the frequency of coding of psychiatric diagnoses for reimbursement purposes by their hospital and the relationship of such coding to diagnoses listed by consulting and referring physicians. The same sample of 49 patients referred to the presenters' consultation service for evaluation of depression was used in this study.

Although the psychiatric consultants and nonpsychiatric referring physicians diagnosed depressive disorders (major depression or depression not otherwise specified) in 18.4% and 44.9% of the cases, respectively, medical records were coded for depressive disorders in only 36.7% of the cases. The diagnostic coding of depressive disorders varied significantly from diagnoses assigned by both the psychiatric consultants ($\chi^2 = 14.9$, $p < 0.01$) and the referring physicians ($\chi^2 = 4.13$, $p < 0.05$) and bore little relation to actual clinical status. The variance in coding may have been because coding for depression diagnoses did not change diagnosis-related groups (DRG) reimbursement patterns in that locale. By contrast, coding for alcohol or substance abuse for the same patient sample was done assiduously because it improved DRG reimbursement by 20% on average. Further, 30% of the sample cases were coded for DRG-reimbursement-increasing psychiatric diagnoses, whereas only 10% and 8% of the cases were assigned diagnoses justifying such coding by the psychiatric consultants and referring physicians, respectively. This coding pattern appeared to be driven solely by economic interest.

The marked discrepancies in diagnostic coding and subsequent billing suggest a need to increase the psychiatric consultant's role in the billing process, develop coding schemes that more accurately reflect patients' clinical conditions and physician diagnoses, and facilitate appropriate DRG reimbursement to hospitals for comorbid psychiatric disorders. It seems likely that, when linked to proper psychiatric diagnosis, well-documented coding schemes will reduce unnecessary health care costs in this area.

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Poster 54
IDENTIFICATION OF HIV HIGH-RISK BEHAVIOR AMONG A PRISON POPULATION IN INDIA: A PILOT SURVEY

Piyal Sen, M.B., B.S., D.P.M., *Clinical Lecturer; Professorial Department, Broadmoor Hospital, Crowthorne, Berkshire United Kingdom, RG457EG,* A.N. Choudhury, M.D., Ian Treasaden, M.B., Dhrubo J. Bagchi, D.P.M., K.K. Ghosh, M.B., K.D. Sen, D.P.M.

SUMMARY:

According to World Health Organization predictions, India will be the country with the largest number of HIV-positive cases by 2010. The prison population is highly vulnerable to HIV transmission because of the high prevalence of injection drug use and the higher prevalence of sexually transmitted diseases than in the general population. The present study, possibly the first of its kind in India, examined the prevalence of HIV high-risk behavior in a prison population and prisoners' knowledge and attitudes regarding AIDS.

A total of 110 randomly selected remand prisoners were interviewed. Fifty percent of the prisoners had been remanded for drug-related offenses. A structured questionnaire with six parts, viz., demography, tattooing, drug abuse, blood transfusions, sexual behavior, and knowledge and attitudes regarding AIDS, was administered to the prisoners by a specially trained team of investigators.

All of the prisoners in the sample were male, and their mean age was 30.7 years. Of the 110 inmates, 10.9%

were tattooed, and 50% of this group had shared tattooing equipment. Over a third (36.5%) had been regular drug abusers before entering prison, 11.8% had histories of injecting drugs, and 2.7% had ever shared needles. Although 44.4% had had multiple sexual partners, 43.6% practiced safe sex; 2.7% engaged in homosexual sexual activity. Only 10% had heard about HIV testing, and only 9.1% perceived themselves at risk of contracting HIV; 47.3% had no knowledge about AIDS.

According to the Indian National AIDS Control Organization, 42.2% of AIDS patients in India are from the heterosexually promiscuous group. The results of this study are in agreement with these findings. The study also shows extremely little knowledge regarding AIDS among a high-risk population, and this has important implications for future AIDS-control programs in India.

Poster 55
A PILOT STUDY TO EVALUATE A SIMPLE SCREENING TEST FOR DEPRESSION IN ELDERLY PATIENTS

Piyal Sen, M.B., B.S., D.P.M., *Clinical Lecturer; Professorial Department, Broadmoor Hospital, Crowthorne, Berkshire United Kingdom, RG457EG;* Elaine Arnold, M.B., Brian M. Kaveman, M.B., D. McCrea, F.R.C.P.

SUMMARY:

The Brief Assessment Schedule Depression Cards (BASDEC) provide a simple 19-question screening instrument validated for the elderly. Use of a single question, "Do you often feel sad or depressed?," also performed well in a New York Task Force study. This study evaluated a shortened form of the Brief Assessment Schedule Depression Cards as a screen for depression in the elderly and compared the results with those obtained with the single question from the New York Task Force study.

The eight-question short form of the depression cards was devised on the basis of sensitivity and selectivity of individual questions given to 595 elderly patients in hospitals and residential settings. The short-form depression cards were then administered to 96 elderly patients attending a day hospital who had mental test scores over 7/10. Those screening over 2/8 underwent a semi-structured psychiatric interview incorporating the Hamilton Rating Scale for Depression and the Montgomery-Asberg Depression Rating Scale. Results were compared with those obtained with the New York Task Force study single question for 53 subjects.

Included in the screening were 25 men (mean age, 78.5 years) and 71 women (mean age, 81.4 years). Of the 96 patients, 12 (12.5%) were shown by the short-form depression cards to be depressed. Six were deemed moderately to severely depressed by a psychiatrist; four met the *DSM-IV* criteria for major depression. Two were judged mildly depressed, and four were judged non-depressed. The New York Task Force single question elicited positive responses from 12 of 53 (22.6%) elderly patients, only three of whom were diagnosed as depressed by a psychiatrist.

From our pilot study, it appears that the short form of the Brief Assessment Schedule Depression Cards is a simple, easily administered, and reliable instrument for screening for depression in the elderly. The single question used in the New York Task Force study appears sensitive but is nonspecific.

Poster 56
ATTITUDES AND BELIEFS REGARDING MENTAL ILLNESS AMONG CARIBBEAN IMMIGRANTS

Sonia L. Cole, M.D., *3314 Farragut Road, Brooklyn, NY 11210;* Lisa B. Dixon, M.D.

SUMMARY:

The purpose of this study was to determine the attitudes, beliefs, nosology, and behavioral responses pertaining to mental illness among the English-speaking Caribbean community in an East Coast urban community in the United States.

The presenters created an anonymous 15-item, self-report survey that included choices from both the traditional and dominant American cultures. Three community sites were sampled: a West Indian grocery store, a nearby West Indian bakery, and the Baltimore-West Indian Carnival of 1995.

A total of 30 respondents described themselves as English-speaking Caribbean; 56% had been in the United States for more than 35 years, and 52% had been in the United States for more than 10 years. Two-thirds (67%) had some college education, 58% had annual incomes greater than $30,000, and 68% had been raised in rural settings. Stress (85%), childhood trauma (70%), drugs (70%), "loss" (61%), and hereditary factors (45%) were most frequently endorsed as causal factors for mental illness, whereas only 30% endorsed magical beliefs. Individuals with only high school educations tended to endorse magic more frequently ($p < 0.10$), and those in the United States for fewer than 10 years tended to endorse inheritance more frequently ($p < 0.10$) as causal factors in mental illness. Those who had been in the United States for fewer than 10 years ($p < 0.05$), the young ($p < 0.05$), and those raised in rural settings ($p < 0.02$) were more likely to believe that spiritual healing is an important treatment.

This study, although small, suggests that immigrants from Caribbean countries frequently assume beliefs and attitudes of the dominant American culture. However, variations in retention of traditional beliefs persist, and such retention may relate to demographic and economic characteristics.

POSTER SESSIONS

Poster 57
ETHNICITY AND SELF-INJURIOUS BEHAVIORS

Antonio A. Menchaca, M.D., *Department of Psychiatry, New York Hospital, 21 Bloomingdale Road, White Plains, NY 10605;* Harold W. Koenigsberg, M.D., Tatsuyuki Kakuma, Ph.D.

SUMMARY:

The purpose of this study was to determine the impact of culture and ethnicity on self-injurious behaviors in patients with borderline personality disorder.

The charts of 82 inpatients (40 Caucasians, 42 Hispanics) with discharge diagnoses of borderline personality disorder were reviewed retrospectively. The subjects were matched by sex, age, and discharge year. The presenters compared the rates of four types of self-injurious behavior: drug overdose, cutting, burning, and "other."

There were high rates of self-injurious behaviors in both the Caucasians (87.5%) and Hispanics (95.2%). There was a significant difference in the form of self-injurious behaviors between the groups: 70% of the Caucasians and 48% of the Hispanics cut themselves ($\chi^2 = 4.2$, df = 1, $p < 0.04$). If the seven patients who did not hurt themselves are eliminated, this difference is greater: 80% of the Caucasians versus 50% of the Hispanics ($\chi^2 = 7.29$, df = 1, $p < 0.007$). There was no difference in the frequency of burning, overdosing, or other self-injurious behaviors.

Self-injurious behaviors, particularly overdosing and self-cutting, are common in patients with borderline personality disorder. The significant difference in self-cutting behavior between Hispanics and Caucasians should be investigated in future research; this may help predict such events and may have treatment implications.

POSTER SESSION 3 **Sunday, October 20**
10:00 a.m.-11:30 a.m.

BIOLOGICAL PSYCHIATRY AND PSYCHOPHARMACOLOGY

Poster 58
PLACEBO AND ANTIDEPRESSANT RESPONSE IN CHILDREN AND ADULTS

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SUMMARY:

Several double-blind trials and meta-analyses have shown that tricyclics are not superior to placebo for the treatment of depression in children and adolescents. However, there has been no research on whether this lack of difference results from a lack of response to antidepressants or an unusually high rate of response to placebo in children. The authors reviewed the 13 published placebo-controlled trials of antidepressants in children and examined the seven that provided data on changes in scores on depression scales following treatment. Effect sizes for placebo and antidepressants, reflecting the rates of improvement with those conditions, were estimated separately, and weighted estimates for both conditions were calculated. Similar procedures were followed with 18 studies of changes in adults' depression scores after treatment with tricyclics or placebo, and the effect sizes were compared with those from the studies with children.

Children ($d = 1.73$, var = 0.03) respond significantly more than adults ($d = 1.16$, var = 0.003) to antidepressant therapy ($\chi^2 = 9.84$, df = 1, $p < 0.005$). Similarly, children ($d = 1.27$, var = 0.02) respond significantly more than adults ($d = 0.75$, var = 0.003) to placebo ($\chi^2 = 11.75$, df = 1, $p > 0.001$).

The available evidence suggests that the lack of difference between children's responses to tricyclic antidepressants and placebo is due to an unusually high rate of response to placebo and not to a low rate of response to tricyclics.

Poster 59
THE USE OF HALOPERIDOL DECANOATE FOR ELDERLY MINORITY PATIENTS

Indu C. Mirchandani, M.D., *Chief, Geropsychiatry Clinic, Department of Psychiatry, Bronx Lebanon Hospital, 1285 Fulton Avenue, Bronx, NY 10456;* Vinod R. Bhashyam, M.D., *Psychiatry Resident, Department of Psychiatry, Bronx Lebanon Hospital, 1276 Fulton Avenue, Bronx, NY 10456;* Ali Khadivi, Ph.D.

SUMMARY:

To date, there has been very little research on the efficacy of haloperidol for the treatment of psychosis in the elderly. The objective of this study was to assess the rehospitalization rate and the incidence and severity of tardive dyskinesia in elderly patients treated with haloperidol decanoate.

A retrospective chart review of all consecutive admissions to a geriatric psychiatric outpatient clinic in an inner-city area was conducted. Twenty-nine subjects who met the inclusion criteria of chronic psychiatric disorder and treatment with haloperidol were selected. The depot neuroleptic group contained 11 subjects, all of whom had histories of noncompliance with treatment. The control group consisted of 18 patients taking oral haloperidol. Almost all of the subjects were female (93%), and their mean age was 70 years. Fifty-two percent were African-

American, and 31% were Hispanic. The group did not differ in age, duration of illness, or Global Assessment of Functioning score.

Of the 29 total subjects, 24% had evidence of tardive dyskinesia as measured by the Abnormal Involuntary Movement Scale. The two groups were not different in either the incidence or the severity of tardive dyskinesia. Although the depot group had a significantly higher number of past hospitalizations than did the control group, the two groups did not differ in the number of rehospitalizations during the maintenance treatment.

Haloperidol decanoate appears to be effective in stabilizing noncompliant psychotic elderly patients with no greater evidence of tardive dyskinesia than with oral haloperidol.

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Poster 60

THE SAFETY AND TOLERABILITY OF SERTINDOLE IN ELDERLY PATIENTS WITH DEMENTIA

Randall J. Mack, B.S., *Clinical Project Manager, Abbott Laboratories, 200 Abbott Park Road, Abbott Park, IL 60064*

SUMMARY:

Sertindole is a novel atypical antipsychotic discovered and patented by H. Lundbeck of Copenhagen and under development by Abbott Laboratories in the United States, Latin America, and Canada. Sertindole demonstrates selective antagonistic activity at D_2, 5-HT_2, and α receptors, with no affinity for histaminic, muscarinic, or α_2 receptors. The efficacy of sertindole in psychosis, without extrapyramidal symptoms, has been attributed to its 100-fold greater selectivity for limbic D_2 receptors as compared to nigrostriatal D_2 receptors.

This double-blind, placebo-controlled, single-center study assessed the safety and tolerability of sertindole in elderly patients with dementia. Twenty patients, aged 65 years or older and meeting the *DSM-IV* criteria for dementia, were hospitalized, divided into two equal groups, and randomized within each group to receive sertindole ($N = 8$) or placebo ($N = 2$). For each group, the initial dose of 4 mg/day of sertindole was increased to a maximum of 16 mg/day in 4-mg increments. For group one, the medication dose was increased after four days of a given dose. Tolerability for group one was then assessed to determine one of three potential titration schedules for group two: dose increases every three, four, or five days. On the basis of observations of tolerability in group one, group two also received dose increases every four days; consequently, all patients received study medication for 16 days. Assessments of safety and tolerability included movement rating scales, measures of adverse events, laboratory tests, and ECGs.

Sertindole was generally well tolerated by these elderly patients. In this study, lasting 16 days, all measures indicated that sertindole produced minimal extrapyramidal side effects, for which medications were not needed.

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Poster 61

REDUCTION OF HOSPITAL DAYS FOR SERTINDOLE-TREATED PATIENTS: FINDINGS FROM A 1-YEAR STUDY

Mark B. Hamner, M.D., *Director, Posttraumatic Stress Disorder Program, R.H. Johnson Veterans Affairs Medical Center, 109 Bee Street, Charleston, SC 29401-5703*

SUMMARY:

Sertindole, discovered and patented by H. Lundbeck of Copenhagen and under development by Abbott Laboratories in the United States, Latin America, and Canada, is a novel antipsychotic for the treatment of the manifestations of psychosis. Any new therapy for schizophrenia should demonstrate cost-effectiveness by reducing the number and length of hospital readmissions. This retrospective analysis assessed the impact of sertindole on the number of hospital days during a one-year period.

Data were derived from a phase II, open-label, multicenter long-term safety study of sertindole, supplemented by review of medical charts. Analysis included 35 sertindole-treated patients (sertindole group) and 40 usual-care patients (comparison group). Hospital days for each group were calculated during the 12 months before the patients' initiation into the double-blind period (period one) and 12 months after the transition from the double-blind period to the open-label period (period two).

The two groups were similar in terms of demographic characteristics, clinical characteristics, and hospital days during period 1. Both groups had fewer hospital days during period 2 than during period 1. However, the number of hospital days in period 2, excluding the brief study-required dosing schedule, was significantly lower in the

sertindole group (mean = 4.3) than in the comparison group (mean = 18.4).

Sertindole appears to be cost-effective in the treatment of schizophrenia, as demonstrated by a reduction in the number of hospital days during one year of treatment, as compared to the previous year, and by fewer post-treatment hospital days for the sertindole group than for a similar group of patients receiving usual care.

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Poster 62
ONSET OF ANTIDEPRESSANT ACTIVITY FOR ONCE- VERSUS TWICE-DAILY VENLAFAXINE

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SUMMARY:

Response to antidepressants is well known to involve significant delay. Studies with venlafaxine have shown significant advantage over placebo after only 4 to 7 days of treatment. The present placebo-controlled, double-blind study assessed the onset of antidepressant activity in 46 depressed patients taking venlafaxine once (N = 23) or twice (N = 23) daily.

This poster will present data on the first 30 patients, 21 women and 9 men (age: mean = 43 years, SD = 14), who met the *DSM-IV* criteria for major depression, single or recurrent episode. Following a 1-week placebo period, venlafaxine was given at a dose of 37.5 mg/day, which was increased weekly by 37.5 mg, up to 225 mg/day, with either once- or twice-a-day dosing. The number of depressive episodes ranged from 1 to 12 (prior episodes: mean = 4, SD = 3). The Hamilton Depression Rating Scale (HDRS) and the Clinical Global Improvement scale were administered at each visit, and adverse events were recorded. Multiple Wilcoxon analyses of mean HDRS scores were performed to determine differences between baseline and all weeks of active medication.

Within both dosing groups there was a significant reduction in mean HDRS score after 2 weeks of active treatment (baseline score: mean = 24, SD = 4; week 2: mean = 18, SD = 8; p = 0.0003, N = 20). There were also significant differences from baseline at week 3 (mean = 15, SD = 7; p = 0.05, N = 17), at week 4 (mean = 14, SD = 7; p = 0.003, N = 16), and at week 6 (mean = 9, SD = 8; p = 0.02, N = 13). Side effects ranged from none to moderately severe; the most common was mild, transient nausea. No patients discontinued treatment because of adverse events.

Although these data are preliminary, they suggest that even low to moderate doses of venlafaxine may be capable of producing a rapid onset of antidepressant action and confirm earlier observations by Montgomery (1991).

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Poster 63
RAPID DOSE ESCALATION IN SERTINDOLE TREATMENT OF PATIENTS WITH SCHIZOPHRENIA

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SUMMARY:

The novel antipsychotic sertindole, discovered and patented by H. Lundbeck of Copenhagen and under development by Abbott Laboratories in the United States, Latin America, and Canada, has demonstrated efficacy in psychosis without extrapyramidal side effects. This profile has been attributed to its 100-fold greater selectivity for limbic D_2 receptors than for nigrostriatal $_2$D receptors. Sertindole also demonstrates nanomolar affinities for 5-HT_2 and α_1 adrenergic receptors.

In previous trials, the dose of sertindole was increased by 4 mg every third day. This study evaluated the safety, tolerability, and pharmacokinetics of two previously untested rapid dose escalations.

Sixteen hospitalized schizophrenic patients entered a four-day, single-blind placebo washout period in two consecutive groups. All patients received open-label sertindole with 4-mg dose increments either every other day (group 1, N = 8) or every day (group 2, N = 8), up to a maximum of 24 mg, maintained for 5 days. Adverse events were recorded, and ECGs, routine laboratory tests, and plasma sertindole analyses were performed.

The most frequent adverse events were tachycardia on orthostatic challenge and nasal congestion. The incidence of these was greater in group two than in group one. No clinically significant laboratory abnormalities were detected in either group.

An increase in sertindole dose by 4 mg every other day was well tolerated and allowed for a shorter overall titration period than do dose increases every third day.

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Poster 64
POSITRON EMISSION TOMOGRAPHY OF PATIENTS WITH SCHIZOPHRENIA WHO ARE TREATED WITH SERTINDOLE AND HALOPERIDOL

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SUMMARY:

In previous studies with positron emission tomography (PET) and fluorodeoxyglucose (FDG), an increase in striatal metabolic rate was observed after neuroleptic treatment. Treatment with clozapine showed less effect on the metabolic rate of the striatum and more change in the cortex than did treatment with haloperidol. In the present study, 16 patients were entered into a randomized, double-blind, 6-week crossover study of the new atypical neuroleptic sertindole, which was compared with haloperidol. Sertindole was discovered and patented by H. Lundbeck of Copenhagen and is under development by Abbott Laboratories in the United States, Latin America, and Canada.

PET scans, 4.5 mm full width at half maximum (FWHM) resolution, with FDG and a learning-memory work task designed to activate frontal-temporal regions, were obtained at the end of the 6 weeks. High-resolution spoiled-gradient recalled-echo in steady state (SPGR) magnetic resonance images (MRI) at 1.2-mm spacing were obtained and were co-registered with the PET scans. The basal ganglia were traced on the MRI, and the three-dimensional metabolic images were calculated and analyzed following morphing to the average contour of the group. The frontal and temporal lobes were analyzed with MRI-based tissue-segmentation templates.

Comparison of the results for the schizophrenic patients with previously unreported results for a companion cohort of identically scanned never-medicated patients (N = 18) and age- and sex-matched controls (N = 25) confirms earlier reports of a reduced metabolic rate in the striatum in schizophrenia. This sample will be used in additional group contrasts.

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Poster 65
THE ACTION OF SERTINDOLE ON NEGATIVE SYMPTOMS IN SCHIZOPHRENIA

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SUMMARY:

Sertindole, discovered and patented by H. Lundbeck of Copenhagen, is currently under clinical assessment by Abbott Laboratories in the United States, Latin America, and Canada for the treatment of schizophrenia. Sertindole's preclinical profile is atypical in that it possesses a relatively high ratio of affinity for serotonin 5-HT_2 receptors compared to dopamine D_2 receptors and electrophysiologically demonstrates selectivity for mesolimbic (A_{10}) compared to nigrostriatal (A_9) dopamine pathways. Clinically, sertindole is more effective than placebo for both positive and negative symptoms of schizophrenia, and it is indistinguishable from placebo in the production of motor side effects. Sertindole also demonstrated numerical superiority to haloperidol in the treatment of negative symptoms, although the difference did not reach statistical significance.

An analysis was undertaken to distinguish sertindole's effects on primary negative symptoms from secondary effects related to the treatment of positive symptoms, depressed mood, and extrapyramidal side effects. Covarying for these factors was consistent with a therapeutic effect of sertindole on primary deficit symptoms. Path analysis will also be reported.

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POSTER SESSIONS

Poster 66
THE EFFICACY AND SAFETY OF THREE DOSES OF SERTINDOLE VERSUS THREE DOSES OF HALOPERIDOL FOR PATIENTS WITH SCHIZOPHRENIA

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SUMMARY:

Sertindole is a novel antipsychotic with 100-fold greater selectivity for dopamine D_2 receptors within the limbic pathways of the brain than in the nigrostriatal pathway. D_2 blockade within the latter is thought to be responsible for the unwanted extrapyramidal symptoms seen with currently available antipsychotics. Discovered and patented by H. Lundbeck of Copenhagen and under development by Abbott Laboratories in the United States, Latin America, and Canada, sertindole also demonstrates 5-HT_2 and α_1 antagonist activity.

This landmark phase III placebo-controlled, double-blind study assessed the dose-response profiles of three doses of sertindole and three doses of haloperidol in 497 schizophrenic patients. After a single-blind placebo lead-in period, patients were randomly assigned to receive placebo, sertindole at 12, 20, or 24 mg/day, or haloperidol at 4, 8, or 16 mg/day for 8 weeks.

All doses of active drug were effective in treating psychosis, as demonstrated by significant improvement over placebo in scores on the Positive and Negative Syndrome Scale (PANSS), Brief Psychiatric Rating Scale, and Clinical Global Impression scale. The groups receiving 20 mg/day of sertindole and 8 mg/day of haloperidol showed the greatest response. Only sertindole at 20 mg/day was effective in the treatment of negative symptoms, as indicated by the score on the PANSS negative symptom subscale and the total score on the Scale for the Assessment of Negative Symptoms. Sertindole and placebo had clinically and statistically indistinguishable profiles of extrapyramidal symptoms. In contrast, all haloperidol doses caused significantly more extrapyramidal symptoms than either sertindole or placebo.

Sertindole is effective in the treatment of the positive and negative symptoms of schizophrenia, and it has an extrapyramidal symptom profile similar to that of placebo.

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Poster 67
LONG-TERM SAFETY, EFFICACY, QUALITY-OF-LIFE, AND RELAPSE FOR STABLE PATIENTS WITH SCHIZOPHRENIA WHO WERE TREATED WITH SERTINDOLE VERSUS HALOPERIDOL

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SUMMARY:

Discovered and patented by H. Lundbeck of Copenhagen and under development by Abbott Laboratories in the United States, Latin America, and Canada, sertindole is a novel antipsychotic with nanomolar affinities for 5-HT_2 and α_1 adrenergic receptors. Demonstrating a 100-fold greater selectivity for dopamine neurons within the limbic area than for those in the nigrostriatal area, sertindole has been hypothesized to effectively treat psychotic symptoms without causing unwanted extrapyramidal side effects.

The primary objective of this phase III double-blind study was to assess the chronic (one-year) efficacy and safety of sertindole (24 mg once a day) in comparison to haloperidol (10 mg once a day) for schizophrenic outpatients who had been stable during treatment with a neuroleptic agent (excluding clozapine) for at least three months. Secondary objectives included comparisons of negative symptoms, quality of life, and resource utilization in the two groups.

Efficacy assessments included the Positive and Negative Syndrome Scale (PANSS), Brief Psychiatric Rating Scale, Scale for the Assessment of Negative Symptoms, SDS, and Clinical Global Impression scale. Assessments of extrapyramidal symptoms were made by using movement rating scales, observing the incidence of adverse events related to extrapyramidal symptoms, and recording the use of medications for extrapyramidal symptoms. Adverse events, laboratory tests, and ECGs were used to assess safety, and a rating of quality of life and a questionnaire on resource utilization were used to assess secondary objectives.

Interim blinded data on 204 patients with up to six months of treatment showed that the greatest mean improvement from baseline in total PANSS score was apparent at the second month. Improvement remained relatively stable through the sixth month. One-year unblinded data on sertindole and haloperidol for efficacy, safety, quality of life, and resource utilization will be presented.

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POSTER SESSIONS

Poster 68
VALUES AND UTILITIES OF NEUROLEPTIC SIDE EFFECTS

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SUMMARY:

The purpose of this study was to estimate values and utilities associated with side effects of neuroleptics. Sixty patients with chronic schizophrenia who were taking neuroleptics were asked about their willingness to pay (WTP), i.e., how much of their income they were willing to pay, for a medicine to rid them of all their side effects; this amount was designated WTP1. They were also asked a standard-gamble question estimating utilities for having side effects for one year (SG). Patients who answered the standard-gamble question were asked about their willingness to pay for a medicine to get rid of side effects for one year considering the utility level (WTP2). Answers regarding willingness to pay were adjusted for level of income. Patients were also assessed for cognition (Mini-Mental State examination), symptoms (Positive and Negative Syndrome Scale [PANSS]), and relative bothersomeness of side effects.

Fifty-seven patients gave WTP1 values ranging from 0% to 23% of income. WTP1 was correlated with level of bothersomeness of side effects (Spearman $r = 0.4$, $p < 0.01$). Fifty-three patients answered the standard-gamble question. Utilities were correlated with WTP2 (Spearman $r = -0.44$, $p < 0.01$). WTP1, WTP2, and SG were not correlated with PANSS scores for positive and negative symptoms. Compared to the 53 patients who answered the standard-gamble question, the seven patients who did not answer had a lower Mini-Mental State score and higher PANSS scores for conceptual disorganization and difficulty in abstract thinking ($p < 0.05$).

It was concluded that schizophrenic patients are willing to pay and to take risks to get rid of distressing side effects induced by neuroleptic medication.

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Poster 69
CLOZAPINE PLASMA LEVELS AND TREATMENT STRATEGIES

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SUMMARY:

The purpose of this study was to assess the clinical utility of monitoring plasma clozapine levels in inpatients receiving maintenance doses of clozapine.

The plasma clozapine levels of 28 long-term inpatients with schizophrenia or schizoaffective disorder who were receiving steady doses of clozapine were measured. For patients with a level less than 410 ng/mL, the clozapine dose was increased by 25%; the remainder served as the control group. The Brief Psychiatric Rating Scale (BPRS) was administered at the beginning and end of the study.

The clozapine dose was increased for 13 patients; 2 patients could not tolerate the higher dose, and 2 were noncompliant. Six of the 9 patients who completed the protocol without incident showed a >20% decline in BPRS score. The group BPRS mean score decreased from 59.5 to 46.8, the plasma level increased from 307.6 to 509.8 ng/mL, and the clozapine dose increased from 586.1 to 732.6 mg/day. Only 3 of the 15 control patients showed a >20% decline in BPRS score; the group BPRS mean score decreased from 47.8 to 42.1. This group's mean clozapine dose was 656.7 mg/day, and their mean plasma level was 638.0 ng/mL.

This study shows that monitoring of the plasma clozapine level is clinically pertinent and that increasing the clozapine level to >410 ng/mL can assist in optimizing clozapine therapy for severely ill patients.

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Poster 70
DOUBLE-BLIND CROSSOVER STUDY OF MIRTAZAPINE, AMITRIPTYLINE, AND PLACEBO FOR PATIENTS WITH MAJOR DEPRESSION

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SUMMARY:

No single antidepressant is effective for all patients with major depression. There are limited data from prospective double-blind, controlled studies to guide physicians about what to do if a patient does not respond to one specific antidepressant. This study was carried out to address nonresponse to amitriptyline and the new antidepressant mirtazapine.

This study was a follow-up protocol for patients with major depression (*DSM-III* criteria) who did not experience a response during a six-week double-blind study of mirtazapine versus amitriptyline versus placebo. Without a break in the blind, amitriptyline and placebo nonresponders (N = 49 and 74, respectively) were crossed over to mirtazapine treatment; mirtazapine nonresponders were crossed over to amitriptyline treatment. At the end of eight weeks of treatment, the rates of response (defined as a 50% reduction in score on the 17-item Hamilton Depression Rating Scale at the time of the crossover) were 71% and 59%, respectively, for the placebo and amitriptyline nonresponders treated with mirtazapine and 55% for the mirtazapine nonresponders crossed over to amitriptyline. Rates of discontinuation due to adverse effects were 7% and 10%, respectively, for the placebo and amitriptyline nonresponders switched to mirtazapine and 17% for the mirtazapine nonresponders switched to amitriptyline. For each of the three groups, 6-7% of the patients were lost to follow-up.

These results indicate that there is not complete overlap in the antidepressant effects of amitriptyline and mirtazapine. This finding is consistent with the difference in their neuropsychopharmacological profiles.

Poster 71
SEXUAL DYSFUNCTION INDUCED BY SELECTIVE SEROTONIN REUPTAKE INHIBITORS

Jamie B. Grimes, M.D., *Department of Psychiatry, Walter Reed Army Medical Center, Borden Pavilion, Washington, DC 20307-5001;* Lawrence A. Labbate, M.D., Alan H. Hines, M.D.

SUMMARY:

The purpose of this study was to determine the effect of selective serotonin reuptake inhibitors (SSRIs) on sexual function over three months. Patients seen in a psychiatric clinic were enrolled in a 3-month prospective study of the effect of three SSRIs--fluoxetine (N = 4), sertraline (N = 24), and paroxetine (N = 14)--on five aspects of sexual function: libido, erection/lubrication, orgasm quality, orgasm delay, and sexual frequency. Measurements of the five variables were made at baseline and at each month with a 10-cm visual analogue scale (VAS). The VAS endpoints were 0, for "none or absent," and 10, indicating "normal for self."

Sixty-two patients entered the study; their mean age was 37.9 years (SD = 11), 36 were women, and 55 were Caucasian. To date, 32 have completed 3 months. The primary diagnoses of the 62 total patients were as follows: major depression (N = 33), panic disorder (N = 13), obsessive-compulsive disorder (N = 7), and social phobia (N = 9). For all five variables the depressed patients had lower baseline scores than did the anxious patients. Drug selection did not differ by diagnosis or baseline VAS scores.

At month 1, 62% of the patients suffered orgasm delay; the VAS rating was significantly lower than at baseline (t = 5.38, df = 42, $p < 0.0001$). For women, the orgasm delay gradually improved over 3 months, but the rating on the VAS scale remained lower (t = 2.2, p = 0.02). For men, the orgasm delay persisted through month 3 (p = 0.003). Orgasm delay persisted nearly unchanged over 3 months with sertraline and paroxetine ($p < 0.03$) but nearly returned to baseline with fluoxetine (p = 0.30). Three men (one in each drug group) reported that the orgasm delay helped premature ejaculation. For women, lubrication decreased nonsignificantly over one month and was nearly back to baseline at three months (p = 0.6). Ratings for erection decreased significantly in month one, but by month three they were only slightly less than at baseline (t = 1.5, p = 0.2). On average, sexual frequency and libido did not significantly change over time. Orgasm quality decreased for both sexes at one month ($p < 0.001$) and did not fully recover by month 3 ($p < 0.02$). Change in sexual dysfunction did not differ by diagnosis. The three drugs were equally likely to be associated with a clinically significant problem at each time point.

The SSRIs are commonly associated with sexual dysfunction. Orgasm delay and orgasm quality may not recover after three months, although erection and lubrication may decline and then improve. Libido and sexual frequency may not change significantly with SSRIs. SSRI-induced sexual dysfunction seems independent of drug or diagnosis.

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Poster 72
DIVALPROEX SODIUM AND THROMBOCYTOPENIA IN A PSYCHIATRIC POPULATION

Thomas J. Trannel, M.D., *Department of Psychiatry, Gunderson Lutheran Medical Center, 1836 South Avenue, LaCrosse, WI 54601;* Iqbal Ahmed, M.D.

SUMMARY:

This study explored the occurrence of thrombocytopenia in psychiatric patients taking divalproex sodium. The charts of 36 inpatients who started treatment with divalproex sodium over 38 months were reviewed. Psychiatric diagnoses and medications, valproic acid doses and serum levels, and general medical conditions and medications known to cause thrombocytopenia were noted. The patients' mean age was 53 years (range = 22 to 81 years). Baseline measures of hematologic function (WBC, RBC, platelets) were sought and then serially reviewed. The incidence of thrombocytopenia (platelet count < 100,000/mm^3) was recorded, as was the average change in platelet count over time.

The patients showed a decrease in platelet count throughout treatment, and this decrease was most significant in the geriatric population. Nine patients (25%) had at least one recorded episode of thrombocytopenia. The incidence of thrombocytopenia was much greater in the geriatric portion of our sample (54%, 7 of 13 patients) than among patients under age 63 (9%, 2 of 23 patients). Descriptive statistics, *t* tests, and Pearson correlation coefficients were used to analyze the data.

Thrombocytopenia may occur more frequently among geriatric patients taking divalproex sodium, and more frequent hematologic monitoring may be necessary for this population.

Poster 73 - WITHDRAWN

Poster 74
COMPUTER-ASSISTED PROGRESS NOTES

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SUMMARY:

By using a computer program for writing progress notes, a note tailored to the individual patient can be produced in a few minutes. Keyboard input can be accepted for free-form text, and the mouse is used to select from lists of choices. The program uses a single data-entry screen with sections labeled "Appearance & Impressions," "Issues Covered," "Interventions," "Response," and "Plan." Drop-down lists include the mode of therapy and the type of session.

The word-processing component allows the user to modify the note produced by the program, check spelling, save the note on a disk, load the saved note again later, and print a hard copy for the medical record. The spelling checker includes terms used by mental health professionals but likely to be rejected by many spelling checkers (e.g., "infantilize"). The program does not produce "canned" notes but is designed to save user time while improving the quality and legibility of documentation. It requires Microsoft Windows and more than 1 megabyte of disk space.

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Poster 75
RAPID CYCLING ASSOCIATED WITH A LOW CHOLINE LEVEL IN THE BASAL GANGLIA

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SUMMARY:

Choline may play an important role in neurochemical processes relevant to mood regulation. High brain choline levels have been reported in association with depressed mood, and in one open study, rapid-cycling patients resistant to lithium improved when receiving choline. This pilot study was undertaken to test the hypothesis that bipolar patients with a history of rapid cycling have a lower ratio of brain choline to creatine, as determined by proton magnetic resonance spectroscopy (MRS), than bipolar patients without a history of rapid cycling.

Investigators blind to the clinical diagnosis used proton MRS to determine the basal ganglia ratio of choline to creatine in 25 patients. Rapid-cycling subjects were matched for sex, age, and mood state with non-rapid-cycling patients, and mean choline/creatine ratios were compared by using a paired *t* test.

There was a trend toward a lower choline/creatine ratio in the rapid-cycling patients than in the bipolar patients without a history of rapid cycling.

Although the results did not reach the $p < 0.05$ level of significance, brain choline/creatine ratios may be a useful way to subtype bipolar patients. Proton MRS may be a useful technique for diagnostic assessment.

Poster 76
ELEVATED PLASMA CHLORIDE LEVELS IN PSYCHIATRIC PATIENTS

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SUMMARY:

This study involved comparisons of the plasma chloride levels of psychiatric and medical patients and of the levels of patients in the different psychiatric diagnostic categories.

The subjects were 60 psychiatric patients (aged 18-70 years) admitted consecutively over 10 weeks and 60 matched control patients, each of whom was admitted to a nonpsychiatric floor within 48 hours of admission of the matching psychiatric patient. None of the control patients had a psychiatric disorder. Patients who had illnesses or medications that affect chloride homeostasis or who abused substances were excluded from both groups. All analyses were performed by using the same analyzer within 48 hours after admission.

The mean plasma chloride level of the psychiatric patients (103.40 mEq/L) was significantly higher than that of the nonpsychiatric control patients (101.13 mEq/L) (t = 3.98, $p < 0.001$). The bipolar patients showed the highest mean serum chloride level (104.75 mEq/L) of all diagnostic groups; their level was significantly different from the mean of the unipolar depressed patients (101.00 mEq/L) ($t = 2.5$, $p < 0.05$).

This may be the first study demonstrating these findings. Previous studies have concentrated on cations (sodium, potassium, and calcium) in patients with affective disorders. These findings may reflect the respective anion movement but imply that it is consistent across diagnostic categories. The significant difference between patients with bipolar and unipolar disorders confirms that these are both clinically and biochemically separate disorders.

Poster 77
AN OPEN-LABEL STUDY OF RISPERIDONE FOR THE TREATMENT OF AGITATION IN DEMENTIA

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SUMMARY:

To determine the efficacy and side effects of risperidone for treatment of agitation in patients with dementia, the authors conducted a 10-week open-label clinical trial of risperidone for 15 elderly patients who met the *DSM-IV* criteria for a specific dementia subtype and met the minimum score criteria on the Cohen-Mansfield agitation scale. Neuropsychiatric assessment included behavioral rating scales (Cohen-Mansfield Agitation Inventory, Overt Aggression Scale, Clinical Global Impression [CGI]), cognitive scales (Mini-Mental State examination), side effect checklist, and the Unified Parkinson's Disease rating scale. The study included a 3-week dose-finding phase, followed by 6 weeks of extended treatment. The risperidone dose was adjusted during the first 3 weeks, according to efficacy and side effects.

Thirteen patients completed the 10-week trial. All 13 patients were improved or very much improved according to CGI ratings at week 10. One patient dropped out because of marked extrapyramidal side effects at the lowest dose, 0.5 mg/day. Four patients developed significant extrapyramidal side effects at the lowest dose. No patient required more than 1.5 mg twice a day. Overall, the patients showed 50% improvement on the Overt Aggression Scale after 2 weeks of treatment, and they showed 50% improvement on the Cohen-Mansfield Agitation Inventory and the CGI after 8 weeks. Mean scores on the Unified Parkinson's Disease rating scale increased and mean Mini-Mental State scores decreased over the 10 weeks.

These data suggest that risperidone is effective for treatment of agitation in patients with dementia. Aggressive behaviors responded to treatment before overall agitation did. Elderly patients with dementia are very susceptible to extrapyramidal side effects and may show decline in cognition with risperidone treatment.

Poster 78
NALTREXONE-RELATED DECREASE IN THE URGE TO DRINK ALCOHOL

Dena Davidson, Ph.D., *Department of Psychiatry, Brown University, 825 Chalkstone Avenue, Providence, RI 02908;* Robert M. Swift, M.D., Eric Fitz, B.Sc.

SUMMARY:

The authors investigated the effects of the opiate antagonist naltrexone on alcohol drinking, the urge to drink alcohol, and subjective measures of alcohol intoxication in social drinkers consuming alcohol ad libitum in a cocktail bar.

Sixteen college-age men and women participated in a double-blind within-subjects crossover study. The subjects were tested during each of three drug conditions: naltrexone at 50 mg/day p.o., inactive placebo, and no drug. Each drug condition lasted eight to 11 days. The subjects were tested in groups during three, two-hour evening drinking sessions, separated by approximately two weeks.

Naltrexone significantly increased latency (time in seconds) to first sip of the first ($p < 0.05$) and second ($p < 0.01$) alcoholic beverages consumed. End-of-session blood alcohol concentrations were significantly lower when the subjects were treated with naltrexone ($p < 0.05$). No differences in self-reported urge to drink alcohol were found; however, the urge to drink was always lower during the naltrexone period. The subjects reported more aversive effects during naltrexone treatment; these effects included fatigue and tension as shown by the Profile of Mood States before drinking ($p < 0.05$) and increased nausea ($p < 0.05$).

The increase in the latency before the first sip of alcohol may reflect the capacity of naltrexone to block the urge to drink alcohol. These data suggest that the effectiveness of naltrexone in reducing drinking among alcoholics may be partially due to anticraving properties of naltrexone.

POSTER SESSIONS

Poster 79
HIGHER SERUM GLUTAMATE LEVELS WITH CLOZAPINE THAN WITH CONVENTIONAL NEUROLEPTICS

Anne E. Evins, M.D., *Department of Psychiatry, Massachusetts General Hospital, 25 Staniford Street, Boston, MA 02115;* Donald C. Goff, M.D., Edward Amico, M.Ed., Vivian Shih, M.D.

SUMMARY:

In a previous study, the authors' group found that patients treated with clozapine had significantly higher serum glutamate concentrations than did patients treated with conventional neuroleptics. In addition, D-cycloserine, a partial agonist at the glycine modulatory site of the glutametergic NMDA receptor, significantly improved negative symptoms when added to conventional neuroleptics and worsened negative symptoms when added to clozapine. Baseline glycine concentrations predicted response of negative symptoms with D-cycloserine. The aim of this study was to prospectively measure the effects of switching from conventional neuroleptics to clozapine on serum concentrations of glutamate, aspartate, and glycine and to examine correlative relationships between these amino acid concentrations and changes in clinical measures.

After informed consent was obtained, blood was drawn from seven patients with schizophrenia (six men and one woman; mean age = 48 years, SD = 4) while they were receiving conventional neuroleptics and again 3 to 18 months after they were switched to clozapine (mean dose = 39 mg/day, SD = 61; mean duration of clozapine treatment = 8.4 months, SD = 3.6). The serum samples were stored at -80°C until the assays. Glutamate, aspartate, and glycine were measured by using a Beckman 6300 Amino Acid Analyzer quantitative ion exchange column. The Brief Psychiatric Rating Scale (BPRS) and Scale for the Assessment of Negative Symptoms (SANS) were administered at the time of phlebotomy.

Serum glutamate concentrations were significantly higher during clozapine treatment (mean = 71.1 •mol/L, SD = 28.7) than during treatment with conventional neuroleptics (mean = 49.2 • mol/L, SD = 27.0) (t = 2.34, df = 5, p = 0.03, one-tailed). The improvement in scores on the negative symptom subscale of the BPRS correlated significantly with baseline serum glycine concentration (r = 0.79, df = 5, p = 0.03) and at a trend level with glutamate (r = 0.67, df = 5, p = 0.1). Changes in the SANS scores did not correlate significantly with amino acid levels, nor did serum concentrations of aspartate correlate with ratings of clinical symptoms.

This small prospective study replicates the authors' previous finding that clozapine treatment is associated with an elevation of serum glutamate levels and further supports the hypothesis that clozapine's effects on amino acid concentrations reflect activity at glutametergic sites in the brain, which may contribute to clozapine's superior efficacy for negative symptoms of schizophrenia.

POSTER SESSION 4 **Sunday, October 20**
4:30 p.m.-6:00 p.m.

OTHER PSYCHIATRIC DISORDERS

Poster 80
THE RELATIONSHIP OF ADAPTIVE FUNCTIONING TO NEUROPSYCHOLOGICAL PERFORMANCE IN GERIATRIC PSYCHIATRY PATIENTS

Jovier D. Evans, Ph.D., *Department of Psychiatry, Veterans Affairs Medical Center, 3350 La Jolla Village Drive, San Diego, CA 92104;* Joshua C. Klapow, Ph.D., Barton W. Palmer, Ph.D., Jane S. Paulsen, Ph.D., Robert K. Heaton, Ph.D., Thomas L. Patterson, Ph.D., Dilip V. Jeste, M.D.

SUMMARY:

This study was designed to determine the relative importance of cognitive and clinical measures in predicting functional ability in a sample of geriatric psychiatry outpatients.

The subjects were 62 geriatric psychiatry outpatients with psychotic disorders and 31 normal comparison subjects, all over the age of 45. The *DSM-III-R* diagnoses of the patients included schizophrenia (N = 38), schizoaffective disorder (N = 5), and psychotic mood disorder (N = 19). All subjects underwent a comprehensive neuropsychiatric evaluation, which included an expanded Halstead-Reitan Neuropsychological Test Battery and clinical ratings of psychopathology. Functional ability was assessed by means of the Direct Assessment of Functional Status Scale.

Among the patient groups, the score on the Direct Assessment of Functional Status Scale was significantly correlated with age, education, duration of illness, and neuropsychological performance. Similar associations were noted among the normal subjects. Separate stepwise multiple regression analyses on the total score, with both neuropsychological and clinical ratings used as predictors, indicated that neuropsychological performance was a significant predictor of functional ability (R^2 range of 0.24-0.54). Clinical ratings of symptoms were not significant predictors.

Measures of neuropsychological functioning accounted for more variance in functional capacity than did psychiatric ratings of symptoms. These results extend previous findings by demonstrating the strong relationship between neuropsychological abilities and observed performance of daily living skills.

Poster 81
PSYCHOTHERAPY DURING OPIOID DETOXIFICATION

Philippe Cadilhac, M.D., *Psychiatric Hospital, Casselardit Purpan, Toulouse 3105G, France;* Laurent Schmitt, M.D., Henri Sztulman, M.D., Pierre Moron, M.D., Max Reinert, M.D.

SUMMARY:

Detoxification is a critical time for establishing a therapeutic alliance. Although interpersonal psychotherapy for opioid addicts remains controversial, it has been used to improve participation in maintenance therapy. Interpersonal psychotherapy is assessed through patients' written texts about the following interpersonal problem areas: transition, interpersonal disputes and deficits, and grief.

Five hospitalized opioid addicts who completed classical detoxification using an α_2 agonist were compared with six opioid addicts who received identical treatment plus interpersonal psychotherapy. Interpersonal psychotherapy was administered in four sessions over the 8 to 10 days of hospitalization. Interviews at the beginning and the end were assessed by using discourse data analysis. Only significant differences in essential words will be described.

The first interview was strictly oriented toward addiction and concrete concepts, such as "injection," "heroin," "to smoke," "to steal," and "to take." The last interview significantly differed on three dimensions: a) understanding addiction with words like "explain," "know," "question"; b) words that indicated painful perceptions of life, such as "punishment," "fear," "bad"; and c) interpersonal links, such as "discuss," "talk," "relations." These dimensions were related to duration of hospitalization, and there was a trend toward significance for the action of interpersonal psychotherapy.

Cognitive changes appeared through the interviews, depending on the point in hospitalization. Further study with a larger group is needed to evaluate interpersonal psychotherapy.

Poster 82
COMBINED BEHAVIORAL AND MEDICINAL TREATMENT OF INSOMNIA

Milton Kramer, M.D., *Medical Director, Sleep Disorders Center, Bethesda Naval Hospital, 619 Oak Street, Cincinnati, OH 45206;* Boris Dashevsky, Ph.D., *Bethesda Naval Hospital, 619 Oak Street, Cincinnati, OH 45206*

SUMMARY:

Residual intractable insomnia remains a serious problem for many profoundly ill psychiatric patients. The presenters will report on treatment of 48 severely psychiatrically ill patients with chronic insomnia who were referred to a program that combines behavioral and medicinal treatments. The patients had an average duration of insomnia of 9.4 years, complained of having insomnia nightly, and reported sleeping only 68.6% of the night. Twenty of the patients had been or were being treated for depression, and an additional 13 had other psychiatric diagnoses. Twenty-four of these patients were taking various psychotropic medications during treatment. In addition, 18 patients had been treated for pain. All of the patients had failed to respond to medicinal treatments for insomnia.

The patients were treated individually with progressive muscle relaxation, structured sleep hygiene, stimulus control procedures, and sleep restriction. Thirty-seven of the 48 patients were also treated with hypnotic medications. The patients had an average of 10 treatment sessions.

At 6-month follow-up, 72.9% rated themselves as improved, compared to 58.3% at 2 months. For the remaining patients, sleep efficiency had increased from a baseline of 71.9% to 89.6%, time to sleep onset had decreased from 67.2 to 26.8 minutes, and total sleep time had increased from 375.4 to 414.6 minutes.

Profoundly ill psychiatric patients with insomnia can benefit from the combined use of hypnotic medications and behavioral treatment in improving their sleep. Either treatment alone is unlikely to be successful.

REFERENCES:

1. Morin CM: *Insomnia: Psychological Assessment and Management.* Guilford Press, New York, 1993.
2. Lacks P, Morin CM: Recent advances in the assessment and treatment of insomnia. *J Consult Clin Psychol* 60:586-594, 1992.

Poster 83 - WITHDRAWN

Poster 84
PSYCHOEDUCATION FOR EATING DISORDERS

Naomi K. Miller, M.S.W., *Psychiatric Social Worker, Department of Social Work Services, Mount Sinai Medical Center, Box 1252, 1 Gustave L. Levy Place, New York, NY 10029-6574*

SUMMARY:

A needs-assessment survey conducted within an employee assistance program in a large urban hospital indicated that 76% of the employees were concerned about weight control. More women (64%) than men (48%) were motivated to participate in programs on the subject.

Psychoeducation has been used in eating disorders programs to effectively engage patients in structured learning about the nature, course, and treatment of the disease. The program designed for the female hospital employees focused on the psychological factors underlying eating disorders, with an emphasis on health rather than on pathology. The participants constituted a nondiagnostic group and represented diverse ages, ethnic groups, and family backgrounds.

The psychoeducation program provided clients with a nonstigmatizing way to learn about eating disorders. It acted as a form of early detection and prevention. The poster will include specific guidelines, techniques, and directions on how to design and implement psychoeducation programs for this and other populations.

REFERENCES:
1. Davis R, Olmsted MP: Cognitive-behavioral group treatment for bulimia nervosa: integrating psychoeducation and psychotherapy. In Harper-Giuffre H, MacKenzie KR (eds): *Group Psychotherapy for Eating Disorders.* American Psychiatric Press, Washington, DC, 1992, pp 71-103.
2. Zastowny TR, O'Brien C, Young R, et al: An outpatient eating disorder program in a CMHC. *Hosp Community Psychiatry* 12:1256-1258, 1991.

Poster 85
ATTENTION DEFICIT DISORDER ACROSS THE LIFE SPAN: MANAGEMENT STRATEGIES

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

SUMMARY:

Attention deficit disorder (ADD) in children has been treated for more than 30 years. Contrary to the past belief that children outgrow attention deficit hyperactivity disorder (ADHD) or ADD when they enter adolescence, current research shows that only one third of these patients outgrow it; the rest will have the condition during their adolescent years and also in adulthood. The combination of pharmacotherapy and psychotherapy for these individuals is unique.

This poster will present the evolution of ADD. The different symptoms across the life span, the differential diagnosis, the stages of discovery and recovery (course), the prognosis for treated and untreated cases, and treatment options will be elaborated. A comprehensive treatment approach, including single and combined psychopharmacology and cognitive-behavioral approaches, will be discussed. ADD is characterized by difficulties in sustaining attention, easy distractibility, forgetfulness, fidgetiness, a history of hyperactivity or hypoactivity during childhood, impulsivity, impatience, and 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 discussed.

The presentation will describe ADHD/ADD in childhood through adulthood and how to diagnose and treat it successfully. It will be suitable for general psychiatrists, child and adolescent psychiatrists, behavioral pediatricians, psychologists, and social workers. The good news is that ADD responds very well to treatment.

REFERENCES:
1. Zametkin AJ, Nordahl TE, Gross M, et al: Cerebral glucose metabolism in adults with hyperactivity of childhood onset. *N Engl J Med* 323:1361-1366, 1990.
2. Jasuja S: *Out of Chaos! Understanding and Management of A.D.D.: Its Relationship to Modern Stress.* Esteem House Publications, Palo Alto, CA, 1995.

Poster 86
IS ASTHMA A PREDICTOR OF BEHAVIORAL DYSCONTROL?

Pe Shein Wynn, M.D., *Department of Psychiatry, Psychiatric Institute, New York Medical College, Valhalla, NY 10595;* Lawrence E. Levy, M.D., Mohammad R. Khan, M.D., Catherine Karni, M.D.

SUMMARY:

A history of bronchial asthma has frequently been noted in children and adolescents seen in emergency services for psychiatric conditions. Many studies have shown that emotional factors exacerbate symptoms of bronchial asthma, but no studies have evaluated the association between asthma and behavioral dyscontrol (aggressive and disruptive behavior). This study examined the association between bronchial asthma and behavioral dyscontrol.

The authors compared 62 consecutively admitted patients who were under the age of 18 and had histories of bronchial asthma with a randomized age-, sex-, and race-matched control group. Demographic variables, admitting diagnoses, medication history, use of alcohol or illicit drugs, and psychiatric symptoms at admission were recorded. Chi-square tests and multivariate logistic regression analyses were used.

There were no significant differences between groups in age, education, living status, past history of violence, or use of alcohol or illicit drugs. A history of bronchial asthma was found in 60% of the patients with behavioral dyscontrol and 40% of the control group ($p < 0.001$). A history of bronchial asthma was significantly associated with behavioral dyscontrol (odds ratio = 3.3, $p < 0.05$, 95% confidence interval = 1.1 to 9.87) when sex, race, concurrent psychiatric symptoms, diagnostic categories, and history of taking asthma medications were controlled for.

Early interventions for asthma symptoms, proper use of asthma medications, and attention to comorbid emotional disorders are essential strategies for minimizing development of behavioral problems.

Poster 87
DISORDERS OF EXTREME STRESS IN PATIENTS WITH ANXIETY DISORDERS

Kevin B. Handley, M.A., *Department of Psychiatry, North Shore University Hospital, 400 Community Drive, Manhasset, NY 11030;* Juliana R. Lachenmeyer, Ph.D., Regina Ucello, Andrew Shack, M.A., David Pelcovitz, Ph.D., Fran Mandel

SUMMARY:

"Disorders of extreme stress" is a proposed diagnostic category designed to describe the impact of prolonged trauma on functioning. It is distinct from the current

diagnostic criteria for posttraumatic stress disorder (PTSD), which are limited to the effects of acute time-limited traumas. Symptoms of disorders of extreme stress are referenced in *DSM-IV* as possible complications associated with PTSD, particularly in individuals whose trauma experiences are interpersonal in nature (being a prisoner of war, prolonged physical or sexual abuse, torture). The clinical presentation of disorders of extreme stress includes symptom clusters involving problems with affect regulation, attention, self-perception, relations with others, somatization, and systems of meaning. The similarity between this symptom picture and symptoms associated with anxiety disorders raises questions about the specificity of the diagnosis of disorders of extreme stress.

The current study examined disorders of extreme stress in non-PTSD anxiety disorder patients. All 16 subjects had experienced high-magnitude traumas. Preliminary results offer support for the diagnosis of disorders of extreme stress. Subjects whose traumas were interpersonal in nature had a higher mean score on a structured clinical interview for disorders of extreme stress than did subjects whose high-magnitude traumas were not interpersonal in nature. The implications for the construct validity of the diagnosis of disorders of extreme stress and the ability of this diagnosis to discriminate between different types of trauma experiences will be discussed.

Poster 88
A CENTRAL HYPOTHESIS FOR CHARLES BONNET SYNDROME

Gil Lichtshein, M.D., *Department of Psychiatry, University of Maryland, 2811 Baneberry Court, Baltimore, MD 21209;* Antony Fernandez, M.D., Lisa B. Dixon, M.D.

SUMMARY:

Charles Bonnet syndrome is an underrecognized psychiatric syndrome characterized by vivid visual hallucinations without significant psychopathology or disturbed consciousness. The prevalence of this syndrome in geriatric populations ranges from 1% to 12%. The poster will review the literature on Charles Bonnet syndrome and will describe the case of an individual with Charles Bonnet syndrome who was evaluated with advanced neuroradiologic techniques and with single photon emission computed tomography (SPECT). The overall goal is to advance a new model for understanding the pathophysiology and diagnosis of Charles Bonnet syndrome.

The literature review was an extensive MEDLINE search from 1966 to 1995 with the key words "Charles Bonnet syndrome," "visual hallucinations," "elderly," and "eye disease." Experts in the field were consulted. The search revealed no consensus on the etiology and pathophysiology of Charles Bonnet syndrome and, in particular, on whether ophthalmologic and/or brain insults are necessary.

The SPECT study of the current patient revealed localizing cortical functional abnormalities, but no localizing CNS pathology was evident from a neurological examination or on scans made by standard computed tomography or by magnetic resonance imaging.

These findings suggest a possible cortical etiology of Charles Bonnet syndrome. Duplication of these findings by evaluation with functional neuroimaging techniques of other patients with Charles Bonnet syndrome could lead to reconceptualization of the etiology and pathophysiology of Charles Bonnet syndrome.

Poster 89
COMPUTER-AIDED PREPARATION OF TREATMENT PLANS

Barry A. Tanner, Ph.D., *Associate Professor, Department of Psychiatry, Wayne State University, UHC 9B, 4201 St. Antoine, Detroit, MI 48201*

SUMMARY:

A Windows program to assist in documenting treatment plans will be described. The program guides the professional or the trainee through the often-painful process of writing a plan, and it produces a basic plan in about 10 minutes, accepting keyboard input for free-form text and mouse clicks for selecting from a list of choices. The program is organized around on-screen file folders labeled "Goals & Objectives" and "Interventions & Providers." Drop-down lists include lists of statements regarding patient participation, mode of therapy, and frequency of therapy.

The word-processing component allows the user to modify the plan produced by the program, check spelling, save the plan to a disk, load the saved plan later, and print hard copies. The spelling checker includes terms used by mental health professionals but likely to be rejected by many spelling checkers, such as "tricyclic." The program does not produce "canned" treatment plans but is designed to save user time while improving the quality of documentation.

REFERENCES:

1. Tanner BA: Computer aided reporting of the results of neuropsychological evaluations of traumatic brain injury. *Comput Human Behav* 9:51-56, 1993.
2. Tanner BA, Marcolini RC, Howell E, et al: The Emergency Psychiatry Nursing Assessment Report Framework: a computer program to assist in preparing reports. *Behav Res Meth Instrum Comput* 27:166-168, 1995.

Poster 90
COGNITIVE IMPAIRMENT IN NONELDERLY PATIENTS

Gerard Gallucci, M.D., *Medical Director, Community Psychiatry, Department of Psychiatry, Johns Hopkins University School of Medicine, B-3 South, 4940 Eastern Avenue, Baltimore, MD 21224-4304*

SUMMARY:

The study of cognitive impairment remains an important area for clinical and epidemiologic investigation. Research in this area has focused on dementia in the elderly and on retardation in children. Despite important reviews of cognitive impairment obtained by using data from the Epidemiologic Catchment Area study, there remains a paucity of information about cognitive impairment among nonelderly adults (persons less than 56 years old).

The purpose of the present study was to investigate cognitive impairment in a population-based sample of respondents under 56 years of age, to look at demographic correlates, and to consider the possible interactions between cognitive impairment and other mental disorders in this age group. A scale (PROFOKS) was developed to assess cognitive status on the basis of the respondents' fund of knowledge, ability to interpret proverbs, and ability to describe similarities and differences between objects. The potential usefulness of the PROFOKS scale in the clinical setting will be discussed.

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1. George LK, Landerman R, Blazer DG, et al: Cognitive impairment. In Robins LN, Regier DA (eds): *Psychiatric Disorders in America: The Epidemiologic Catchment Area Study.* Free Press, New York, 1991.
2. Eaton WW, Kessler LG (eds): *Epidemiologic Field Methods in Psychiatry: The NIMH Epidemiologic Catchment Area Program.* Academic Press, Orlando, FL, 1985.

Poster 91
THE ART OF RECOVERY

Constance M. Kusiciel, M.A., *Art Therapy Intern, Department of Psychiatry, University of Illinois, 912 South Wood Street, Chicago, IL 60612*

SUMMARY:

Art therapy uses the visual and expressive arts to support a 12-step-based intensive outpatient recovery program. It is presented to patients in group sessions on a weekly basis. The primary therapeutic goal is to engage patients so that they will be motivated to continue treatment after completion of the outpatient program. To further this goal, two- and three-dimensional art work in a variety of media, drama, and movement exercises are introduced to patients in combination with verbal processing.

This poster will contain photographed examples of how these expressive art experiences are used to engage patients in treatment; reinforce program content; facilitate the expression, containment, and processing of emotions; support efforts to avoid relapse; and track progress toward recovery.

REFERENCES:

1. Allen PB: *Art is a Way of Knowing.* Shambhala Publications, Boston, 1995.
2. Beck AT: *Cognitive Therapy of Substance Abuse.* Guilford Press, New York, 1993.

Poster 92
ANTECEDENTS AND CURRENT PRACTICES IN COGNITIVE THERAPY

William G. Hughes, Ph.D., *Director, Department of Psychology, Virginia Military Institute, Lexington, VA 24450*

SUMMARY:

This poster will trace the development of the cognitive perspective from the Stoic philosopher Epictetus to the modern treatment systems of Albert Ellis (rational-emotive-behavioral therapy) and Aaron Beck (cognitive therapy). The contributions of the twentieth-century theorists George Kelly (personal constructs), Richard Lazarus (cognitive appraisal), Fritz Heider (attributional style), and Albert Bandura (internal reinforcement) will be considered as they affected the development of treatment systems. The presentation will conclude with a step-by-step outline of the synthesis of the basic processes in cognitive therapy as proposed by Ellis and Beck: 1) identify the problem (external event and negative symptoms); 2) assess fully the subjective experience of negative emotions; 3) assess fully the subjective experience of the participating event; 4) identify and assess secondary negative emotions; 5) instruct the patient regarding the connection between irrational beliefs and emotions; 6) assess fully the patient's irrational beliefs regarding the target problem; 7) connect the patient's irrational beliefs and negative symptoms; 8) dispute irrational beliefs with rational, appropriate facts; 9) encourage the patient to put rational beliefs into action through homework assignments (behavioral tasks); and 10) evaluate and interpret verbally the effects of steps 1 through 9.

REFERENCES:

1. Beck AT: *Cognitive Therapy and Emotional Disorders.* International University Press, New York, 1970.
2. Sheldon B: *Cognitive-Behavioral Therapy.* Routledge, London, 1995.

Poster 93
WHAT DO PSYCHIATRY RESIDENCY APPLICANTS WANT?

John C. Lindgren, M.D., *Department of Psychiatry, University of North Carolina, Campus Box 7160, Medical School Wing B, Chapel Hill, NC 27599;* Robert D. Ekstrom, M.P.H., Allan A. Maltbie, M.D., Susan G. Silva, Ph.D., Kristin A. Hardin, B.S., Robert N. Golden, M.D.

SUMMARY:

The authors surveyed psychiatry residency applicants to determine what the applicants considered to be the most important aspects of the interview day, the residency program, and psychiatry in general. Psychiatry residency applicants seeking positions for July 1996 in 22 programs were asked to complete an anonymous, standard questionnaire.

To date, 164 questionnaires have been analyzed in this ongoing study. For applicants completing more than one questionnaire, only data from the first questionnaire were included in the analyses. From a list of 22 items, the most interesting or appealing aspect of psychiatry for the respondents was "large amount of patient contact," followed by "mood disorders," "biological psychiatry," and "providing continuity of care." Of the 13 listed characteristics of psychiatry residency programs, "department attitude, style, and atmosphere" was the most important/influential, followed by "resident morale" and "program reputation." The most important part of the interview day was the interview with the residency training director, and applicants preferred two to three additional interviews with both faculty and residents, as well as lunch with residents.

Psychiatry resident applicants have clear preferences about the interview day and the program and have specific interests within the field of psychiatry. They report relatively little concern regarding specific curricula, attractive call schedules, or good location and are most interested in working in a pleasant, collegial environment that offers a large amount of patient contact.

Poster 94
PREVALENCE OF ADJUSTMENT DISORDERS AMONG MEDICAL STUDENTS AT A CARIBBEAN UNIVERSITY MEDICAL SCHOOL

Joseph V. Pergolizzi, Jr., M.D., *Department of Psychiatry, Ross University School of Medicine, 8390 Tamar Drive, Columbia, MD 21045;* Spencer Serras, David Sharma, M.D.

SUMMARY:

The purpose of this study was to determine the prevalence of adjustment disorders among medical students at a Caribbean University and to rate psychosocial stressors that may be causative factors. In October 1993, students in the Ross University School of Medicine were surveyed by means of a questionnaire that included a statement of confidentiality.

A total of 193 students were screened, and 72% were identified as having adjustment disorders. There was no significant gender difference in the results nor any significant difference between semesters. Separation from family and friends, educational demands, the grading system, and living conditions were found to be significant psychosocial stressors. Over 50% of the students suffering from adjustment disorders were also experiencing impairment in their academic performance. Five students of different semesters, three men and two women, were also experiencing suicidal thoughts.

The finding of a high prevalence of adjustment disorders indicates a need for adequate student preparation and student support programs.

Poster 95
A FOLLOW-UP STUDY OF RISPERIDONE TREATMENT FOR BREAKTHROUGH EPISODES IN BIPOLAR DISORDER: EVIDENCE FOR MOOD-STABILIZING PROPERTIES

S. Nassir Ghaemi, M.D., *Department of Psychiatry, Medical College of Virginia, Virginia Commonwealth University, Richmond, VA 23298;* Gary S. Sachs, M.D., *Department of Psychiatry, Harvard Medical School, and Massachusetts General Hospital, 25 Staniford Street, Boston, MA 02115*

SUMMARY:

The presenters assessed the outcome of openly adding risperidone to the medication regimen of 12 outpatients with rapid-cycling, mixed-episode, or severe-depression variants of bipolar disorder, type I, who suffered breakthrough episodes despite adequate maintenance treatment with lithium, valproate, and/or carbamazepine. Prospective ratings were made at each visit by using the Clinical Global Impression (CGI) and the Global Assessment of Functioning (GAF) scales.

Patients received risperidone for a mean of 6.0 months (23.96 weeks; range, 0.5-72 weeks) at a mean dose of 2.75 mg/day (range, 1-4.5 mg/day). Four patients discontinued medication (two because of lack of efficacy at weeks 6 and 64 and two because of adverse events at weeks 0.5 and 23). Among the eight patients given risperidone for more than 15 weeks, four were rated as much improved (CGI score = 6) when evaluated at 16, 23, 28, and 44 weeks, respectively, and their mean GAF scores showed improvements of 10-25 points. One was unchanged at 20 weeks, and two were mildly or much worse at 64 and 44 weeks, respectively. No patient experienced worsening of mania.

Four of eight patients treated for more than 15 weeks maintained good responses to risperidone for periods ranging from 16 to 44 weeks. These results suggest that adjunctive risperidone may be an effective long-term treatment for patients with severe bipolar disorder.

POSTER SESSIONS

Poster 96
SICKNESS BEHAVIORS AS MANIFESTATIONS OF IMMUNOENDOCRINE DYSREGULATIONS IN SOMATIC AND PSYCHOLOGIC ILLNESS

Andrew N. Dentino, M.D., *Center for Aging, Duke University Medical Center, 20 Catalpa Lane North, Pinehurst, NC 28374;* Mary E. Charlson, M.D., George S. Alexopoulos, M.D.

SUMMARY:

"Sickness behaviors" are the generalizable compendium of physical and psychologic symptoms that accompany any state of "dis-ease," be it major depression, chronic medical illness (e.g., diabetes or arthritis), acute infection (e.g., influenza), or even the normal physiologic process of aging itself. Evolutionarily, sickness behaviors potentially confer some protective organismal adaptational advantage under stress. Such behaviors include anergia, malaise, dysphoria, sleep dysfunction, appetite changes, weight loss, and somatic pain sensations, such as headache.

The authors surveyed the increasing body of literature etiologically implicating reciprocal dysregulated changes in several immunoendocrine variables, which act as multilevel, nonspecific mediators of various somatic and psychologic symptoms and behavior, in both animals and humans. The survey included a MEDLINE search of all articles in the English-language literature located with the key words "cytokines," "depression," and "aging" and a review of the supporting secondary literature (over 500 articles).

The poster will present a potential unitary psychopathophysiologic model of immunoendocrine dysregulation in major depression, referring to generalizable sickness behaviors in other illnesses and subsyndromal states and to aging in general. Prospective studies of rational antidepressant strategies for symptomatically and physiologically ameliorating these dysregulated processes in various conditions manifesting such sickness behaviors will be discussed.

Poster 97
STRESS AND DIET IN COMMODITY TRADERS

Michael N. Kessler, B.A., *University of Connecticut School of Medicine, 646 Bloomfield Avenue, Bloomfield, CT 06002;* Karin E. Kessler, M.S.

SUMMARY:

Studies have shown links between stress and health and between diet and health. To test the hypothesis that diet is a direct link between stress and health, the presenters attempted to show that stress and diet are significantly correlated.

For seven consecutive days, 20 male commodity traders completed the Perceived Stress Scale and a detailed food diary that allowed calculation of grams consumed and the percentage of daily calories coming from protein, carbohydrate, fat, and alcohol. Correlations between scores on the Perceived Stress Scale and the dietary variables were calculated.

While there was no correlation between any dietary variable and stress, there were positive correlations between the day of the week and fat consumption and between the day of the week and alcohol consumption. A negative correlation between the day of the week and carbohydrate consumption was found. Additionally, there was a negative correlation between the day of the week and stress.

Various confounders may have prevented the direct correlation between stress and diet from reaching statistical significance. Nevertheless, these results fail to contravene the belief that stress and diet are directly related. Further research is clearly warranted.

Poster 98
TREATMENT OF BITTERNESS IN PEOPLE WITH PSYCHOTIC ILLNESS

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SUMMARY:

People with psychotic disorder often feel bitter, lack motivation, and direct subtle and open hostility toward their treaters. Family members, grieved by the impact of the psychotic illness, may express desperate demandingness to professionals. These behaviors result from the effects of the illnesses themselves, the experience of society's stigma, and the perception that professionals are not always responsive to the needs of people with psychotic illness and their families. Professionals are also affected by society's stigma; the general public and patients and their families sometimes still think that mental health professionals are agents of social control.

Frequently, professionals experience considerable stress as they struggle with issues involving managed care. The current stresses within the system produce conditions for burnout. Treatment strategies that involve using recovery principles to strengthen the alliance of professionals, consumers, and their families, thus reducing their bitterness and hostility, will be presented. The presenters will share creative ways to deal with internalized stigma and oppression from society. They will also share innovative responses for professionals that can help them maintain dignity in the face of criticism and pressure from external funding sources.

REFERENCES:
1. Shulmen L: *The Skills of Helping: Individuals, Families, and Groups,* 3rd ed. Peacook, Itasca, IL, 1992.
2. Spaniol L, Hoehler M, Hutchinson D: *The Recovery Workbook: Practical Coping and Empowerment Strategies for People with Psychiatric Disability.* Center for Psychiatric Rehabilitation, Boston University, Boston, 1994.

Poster 99
PREMENSTRUAL DYSPHORIC DISORDER AND ITS RELATIONSHIP TO SEVERITY OF SCHIZOPHRENIC SYMPTOMS

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SUMMARY:

In this study, menstrually related affective, behavioral, and physiological changes were analyzed to determine whether cyclical biological and psychological changes covary with changes in the severity and frequency of symptoms in schizophrenic women. Premenstrual exacerbations in psychotic symptoms were expected.

The study included 39 female schizophrenic inpatients, who were examined at two consecutive menses to assess differences between pre- and postmenstrual phases in scores on the Brief Psychiatric Rating Scale (BPRS) and the retrospective and prospective versions of the Premenstrual Assessment Form. The data were examined by means of analysis of variance with repeated measures.

Like normal and depressed women, the women with schizophrenia experienced the greatest exacerbations in affective and somatic symptoms, rather than the psychotic symptoms that are characteristic of schizophrenia. Furthermore, most of the symptoms were increased perimenstrually and menstrually.

Overall, the findings suggest that, consistent with the *DSM-IV* research category of premenstrual dysphoric disorder, menstrually related changes are a discrete phenomenon with its own symptoms, which may be superimposed on psychiatric disorders, both those with and without a predominant affective component. However, clearer guidelines are necessary for determining the degree of associated impairment in functioning before this diagnosis can be made validly and reliability.

Poster 100
ATTENTION DEFICIT HYPERACTIVITY DISORDER AND BORDERLINE PERSONALITY DISORDER

Amar N. Bhandary, M.D., *Director, Mental Health Consultation Services, Department of Psychiatry, University of Oklahoma College of Medicine, Health Science Center, Fifth Floor, South Pavilion, P.O. Box 26901, Oklahoma City, OK 73190-3048;* Phebe Tucker, M.D., *Director, Anxiety Disorders Clinic, Department of Psychiatry, University of Oklahoma College of Medicine, Health Science Center, Fifth Floor, South Pavilion, P.O. Box 26901, Oklahoma City, OK 73190-3048;* Louise Dabiri, M.D.

SUMMARY:

Attention deficit hyperactivity disorder (ADHD) is a prevalent childhood syndrome and often persists chronically. Conventional wisdom regarding such a complex disorder would prognosticate adult psychopathology, irrespective of chronicity. Nevertheless, it is rarely diagnosed in adults, although surveys confirm a sizable presence, mostly as a nebulous constellation of chronicity, atypical features, multiple comorbid disorders, and resistance to treatment. Because of this prevailing lack of familiarity with adult ADHD, many such cases are inaccurately labeled. The pressures of an underlying ADHD stifle psychosocial development in most individuals, heralding major personality disorders, notably, borderline personality disorder; concurrent ADHD is estimated to be present in 25-50% of patients with borderline personality disorder. In this poster, five patients with borderline personality disorder and concurrent ADHD, who endured constantly changing diagnoses and chronic refractoriness, will be discussed.

Accurate diagnosis and treatment of ADHD can be impressively remedial in such patients. There is discernible overlap in the features of ADHD and borderline personality disorder, such as impulsivity, intolerance of frustration, angry outbursts, roller-coaster mood, lability, urge for stimulation, poor social skills, and omnipresent inconsistencies. Furthermore, comorbid disorders, such as anxiety disorders, affective disorders (notably dysthymia and cyclothymia), and substance abuse, have similar patterns and frequently respond atypically to medications. The inattentiveness of ADHD is coupled to the compulsive drive characteristic of borderline personality disorder. In predisposed ADHD subtypes, environmental pressures and, especially, traumatic circumstances exacerbate these traits, depredating their psychosocial composition and resulting in concomitant expression of both conditions.

Amelioration of ADHD symptoms profoundly benefits many patients with concurrent borderline personality disorder.

REFERENCES:
1. Hooberman D, Stern TA: Treatment of attention deficit and borderline personality disorders with psychostimulants: case report. *J Clin Psychiatry* 45:441-442, 1984.
2. Bhandary AN: The adulthood syndrome of attention deficit hyperactivity disorder. *J Practical Psychiatry Behav Health,* in press.

POSTER SESSIONS

Poster 101
ATTENTION DEFICIT HYPERACTIVITY DISORDER AS A FACTITIOUS DISORDER

Amar N. Bhandary, M.D., *Director, Mental Health Consultation Services, Department of Psychiatry, University of Oklahoma College of Medicine, Health Science Center, Fifth Floor, South Pavilion, P.O. Box 26901, Oklahoma City, OK 73190-3048;* Betty Pfefferbaum, M.D., *Chairperson, Department of Psychiatry, University of Oklahoma College of Medicine, Health Science Center, South Pavilion, P.O. Box 26901, Oklahoma City, OK 73190-3048*

SUMMARY:

Attention deficit hyperactivity disorder (ADHD), a common childhood condition, persists into adulthood, although it is diagnosed infrequently. In recent years the media have heightened the public's awareness of adult ADHD, resulting in a surge of self-diagnosed patients, many of whom have ADHD while others do not. Many incorrectly self-diagnosed patients who have genuinely misconstrued ADHD seem convinced of their mistake after assessment and conclusive opinion. Yet there are individuals who furnish convincing histories, even if done inadvertently, and reject competent medical judgment ruling out ADHD. A few patients even become irate when their own diagnoses of ADHD are contradicted. Their overinvestment in a nonexistent psychiatric disorder despite contradicting evidence and even, at times, their neglect of bona fide conditions spark curiosity. The histories of four such patients adhering tenaciously to nonexistent, self-assumed ADHD will be psychodynamically analyzed.

In addition to awareness, the media publicity has also resulted in confusion. Lay magazines and books abound with muddled information and examples of miserable lives that were turned around by Ritalin (methylphenidate). Some even incorporate self-rating questionnaires on everyday problems, sometimes equating a high score with an ADHD diagnosis. Not unexpectedly, many individuals struggling with disturbed lives, unfulfilled goals, or societal responsibilities become fixated on a prospective magical cure, although their problems are unrelated to biological impairment. Further introspection commonly discloses longstanding disapprobation and self-blame, which they believe will be automatically eliminated if their personal drawbacks can be transformed into constitutional deficiencies. Many overstressed families foster such convictions as well.

A convincing yet supposititious ADHD history is not uncommon among self-diagnosed patients. Such a self-diagnosis suggests psychologically based factitious symptoms and, therefore, the need for heedfulness.

REFERENCE:

1. Bhandary AN: The adulthood syndrome of attention deficit hyperactivity disorder. *J Practical Psychiatry Behav Health,* in press.

POSTER SESSION 5 **Monday, October 21**
10:00 a.m.-11:30 a.m.

SERVICES AND SYSTEMS OF CARE

Poster 102
PSYCHIATRIC EMERGENCY SERVICES AND MEDICAL COMORBIDITY

Thomas A. Armistead, M.D., *Department of Psychiatry, Jefferson Medical College, Suite 413, 317 North Broad Street, Philadelphia, PA 19107;* Kenneth M. Certa, M.D.

SUMMARY:

Currently, many managed care plans are attempting to devise plans and capitation rates for carving out mental health and substance abuse services. The authors' experience in an urban university psychiatric emergency service led them to question the amount of primary care needs identified (and sometimes treated) in that service.

The charts of all patients seen in the service for 6 months, representing over 1,000 visits, were retrospectively reviewed. Several indicators of the need for active current medical treatment were noted. Charts were also screened for evidence of the patient receiving that treatment.

Depending on the criteria used to indicate need for active medical treatment, 20% to 60% of the patients seen in the psychiatric emergency service were suffering from comorbid medical conditions. Fewer than half of those gave any evidence of receiving care outside of the psychiatric system.

Many patients in psychiatric emergency services have basic medical care needs that are either unmet or are met by the psychiatric care system. Those who design systems of care and reimbursement should consider this situation.

Poster 103
NOCTURNAL IN-SERVICES IN PSYCHIATRY

Zafar Y. Ibrahim, M.D., *Fellow in Schizophrenia, Department of Psychiatry, University Hospital, 11100 Euclid Avenue, Cleveland, OH 44106;* Sally A. Berry, M.D., Ph.D., *Resident, Department of Psychiatry, University Hospital, 11100 Euclid Avenue, Cleveland, OH 44106;* Joe N. Sangster, M.D.

SUMMARY:

Most psychiatric hospitals do business with the help of nursing staff in addition to physicians, psychologists, social workers, and other day staff. There are usually three shifts of work: day shifts, evening shifts, and night shifts. Nursing staff on the day shift are usually the beneficiary of educational and learning opportunities in the form of case conferences, grand rounds, and nursing in-services.

The presenters provided in-services for staff working the evening and night shifts and interviewed them about

their interest in psychiatric education. The staff was very interested in and curious about psychiatric education, they had many questions about psychiatric diseases, and they were virtually uninformed about new developments in psychiatry.

Staff on evening and night shifts have less access to psychiatric education. If psychiatric in-services are provided to evening and night staff, the quality of patient care will improve, staff morale will improve, and the staff will be able to communicate patients' needs and symptoms.

REFERENCES:

1. Gordon J: Training budgets: recession takes a bite. *Training* 28(10):37-45, 1991.
2. Carkhuff RR: *Human Processing and Human Productivity.* Human Resources Development, Amherst, MA, 1986.

Poster 104
ASSESSING VOLUME OF ELECTROCONVULSIVE THERAPY IN A LONG-TERM CARE VETERANS AFFAIRS MEDICAL CENTER

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;* Donna Bowerman, A.S., *Administrative Office, Psychiatry Service, Veterans Affairs Medical Center, 400 Fort Hill Avenue, Canandaigua, NY 14424*

SUMMARY:

Electroconvulsive therapy (ECT) has become safer, has shown efficacy for more indications, and has no absolute contraindication. Yet use of ECT in public hospitals is limited. The aim of this study was to assess the volume of ECT by four different methods.

The setting was a long-term-care Veterans Affairs (VA) medical center with 723 beds (294 psychiatric beds). The four methods used to estimate ECT use were: 1) calculating the use of ECT for eligible veterans in the catchment area from the use of ECT in the metropolitan statistical area; 2) determining the rate of ECT utilization at the presenters' VA hospital during the calendar years 1985, 1986, and 1987; 3) determining the rate of ECT utilization at the affiliated university hospital, the University of Rochester Medical Center; and 4) calculating utilization of ECT on the basis of patients' diagnoses. Added to the last three estimates were an additional ten patients from other VA hospitals in New York, six from the Albany VA medical center and four from the Syracuse VA medical center.

Method 1 indicates that, with 32,792 eligible veterans in the catchment area seeking treatment and a mean of 4.9 per 10,000 receiving ECT in the metropolitan statistical area, at least 16 VA patients a year will receive ECT. Method 2 involved examination of ECT use at the presenters' hospital during 1985, 1986, and 1987; ECT was used for 12, 16, and 9 patients, respectively, for a mean of 12 patients and 143 treatments. Because 6% of all psychiatric admissions received ECT at the University of Rochester Medical Center, method 3 indicates that 25.14 patients in 419 annual VA admissions may involve ECT. The rates of ECT for patients in the various diagnostic groups were 1% for schizophrenia, 4.8% for affective disorders, and fewer than 1% for other illnesses; method 4 therefore suggests that 9 patients will need ECT.

After addition of the 10 referrals to the last three estimates, the numbers of ECT cases calculated by the four methods are 16, 22, 35, and 19, respectively. With a mean of 23 veterans likely to require ECT in a year, the ECT workload is likely to be 184 to 276 treatments per year, thus justifying an on-site ECT program.

REFERENCES:

1. Thompson JW, Weiner RD, Myers CP: Use of ECT in the United States in 1975, 1980, and 1986. *Am J Psychiatry* 151:1657-1661, 1994.
2. Hermann RC, Dorwart RA, Hoover CW, et al: Variation of ECT use in the United States. *Am J Psychiatry* 152:869-875, 1995.

Poster 105
INNOVATIVE APPROACHES TO DELIVERING SERVICES

Andrea R. Bates, M.D., *Medical Director, Turning Point, Suite 111, 4600 Forty-Seventh Avenue, Sacramento, CA 95824;* Susan Stieber, M.S.W., *Director, Turning Point, Suite 111, 4600 Forty-Seventh Avenue, Sacramento, CA 95824*

SUMMARY:

Development of innovative approaches to delivering mental health services should be encouraged. Services to individuals with severe and persistent mental illness can frequently be privatized, through county or state contracting with independent agencies. Two main benefits are decreased bureaucracy and increased flexibility of services offered. This flexibility allows services to a difficult population to be increasingly consumer driven, with enhanced rehabilitation efforts and creative approaches to meeting individual needs. This approach can also dramatically reduce hospitalizations, increase compliance, and profoundly reduce costs.

Turning Point, ISA, is a private nonprofit agency that contracts with Sacramento County, California. It is a type of assertive community treatment program. It serves 108 consumers discharged in 1993 from long-term locked facilities into Turning Point's outpatient program. After 2.5 years of operation, 56% of the consumers were no longer on conservatorship, 15% lived independently in their apartments, and over 10% were employed. Twelve percent were residing in locked facilities. This overwhelming success is largely due to a consumer-driven philosophy and the intensity of community-based supports. Sacramento County saves over $2.5 million annually by privatizing these services.

REFERENCES:
1. Chandler D, Meisel J, McGowen M, et al: Client outcome in two model capitated integrated service agencies. *Psychiatr Serv* 47:175-180, 1996.
2. Santos A, Henggeler S, Burns B, et al: Research on field-based services: models for reform in the delivery of mental health care to populations with complex clinical problems. *Am J Psychiatry* 152:1111-1123, 1995.

Poster 106
INPATIENT TREATMENT PROTOCOL: DEVELOPMENT AND EFFECTS

Christopher A. Lamps, M.D., *Resident, Department of Psychiatry, Vanderbilt University, 2513 Devon Valley Drive, Nashville, TN 37221;* William Bernet, M.D., *Medical Director, Department of Psychiatry, Vanderbilt University, 1601 Twenty-Third Avenue South, Nashville, TN 37232*

SUMMARY:

One challenge psychiatrists face is coordinating and implementing care by a multidisciplinary team. This is particularly true for resident physicians, who frequently rotate between units. Treatment protocols help psychiatrists in and out of training improve patient care and be more effective team leaders. The presenters developed prototype treatment protocols for depressive disorders, behavior disorders, and eating disorders for the inpatient adolescent unit at their hospital.

The first step was investigation of current treatment recommendations for each diagnostic group. Representatives from each department involved in patient care were then interviewed to define the focus and scope of that department's role. The collected data were then synthesized into a single protocol describing each department's role in evaluation, treatment, and disposition of patients. After circulation and revision, the protocols were implemented. Flexibility was emphasized to allow for individual variations in patient presentation and physician preferences in treatment throughout the process.

In conclusion, treatment protocols improve communication among members of a treatment team, enable more efficient and focused patient care, and enhance the continuity and consistency of care by treating physicians.

REFERENCES:
1. American Psychiatric Association: Practice guideline for eating disorders. *Am J Psychiatry* 150:212-228, 1993.
2. *The Value Behavioral Health Manual: Clinical Protocols and Procedures,* 1995.

Poster 107
RELIABILITY OF PSYCHIATRIC EMERGENCY ASSESSMENTS

Bruce B. Way, M.A., *Evaluation Specialist, New York State Office of Mental Health, Unit B, 75 New Scotland Avenue, Albany, NY 12208;* Michael H. Allen, M.D., *Director, Psychiatry Emergency Services, Bellevue Hospital Center, GS11, 462 First Avenue, New York, NY 10016;* Jeryl L. Mumpower, Steven M. Banks

SUMMARY:

Thirty videotapes of psychiatric assessments conducted by physicians in four urban psychiatry emergency services were subsequently rated by eight senior emergency service physicians, two from each hospital. The doctors rated the videotaped assessments on 8-point Likert scales for 14 clinical variables, such as danger to self, psychopathology, depression, psychosis, benefit of inpatient treatment, and recommended disposition (discharge or admission).

The 14 judgments varied in their reliability, with client differences explaining more of the variation in psychosis (68.4%), substance abuse (64.9%), and social support (55.2%) and less of the variation in impulse control (30.6%), psychopathology (31.1%), and danger to self (32.9%). Six or more of the eight reviewing doctors agreed on recommended disposition (dichotomized in the middle of the 8-point scale) for 17 of the 30 interviews, whereas for the remaining 13 interviews the doctors were more divided. None of the correlations between the doctors' recommendations for disposition and the actual dispositions made by the treating psychiatrists was significant. Analysis of the recommended dispositions suggested that each doctor relied on a unique set of variables and weights in making dispositions.

Reliability varied among the concepts used in emergency psychiatric assessments. Doctors disagreed with each other on which clients should be admitted and disagreed with the treating psychiatrists. This suggests a need for clarification of underlying concepts in emergency psychiatric care and the criteria for inpatient admission.

REFERENCES:
1. Way BB, Evans ME, Banks SM: Factors predicting inpatient admission and referral to outpatient services of patients presenting to psychiatric emergency services. *Hosp Community Psychiatry* 43:703-708, 1992.
2. Rabinowitz J, Slyuzberg M, Salamon I, et al: A method for understanding admission decision making in a psychiatric emergency room. *Psychiatr Serv* 46:1055-1060, 1995.

POSTER SESSIONS

Poster 108
COMMUNITY CASE MANAGEMENT AND THE CHRONICALLY MENTALLY ILL

Stuart H. Levine, M.D., *Medical Director, Consultation/ Liaison, Department of Psychiatry, Little Company Hospital, 540 South Helberta Avenue, Redondo Beach, CA 90277;* Daniel D. Anderson, M.D., *515 Camino Real, Redondo Beach, CA 90277*

SUMMARY:

Currently, there is a strong movement throughout all of health care to contain costs while maintaining or even improving what has been termed "quality of care." The presenters are currently involved in a project to control costs for a population of severely impaired mental health clients. To begin formulating methods of measuring quality, clients will be assessed periodically by using two scales: a psychiatrist-administered BPAS and a self-report measure of perceived quality of life.

Initial data from one month and three months will be presented, and the setting and methods of the case-management program for these clients will be discussed.

REFERENCES:

1. Burns BJ, Santos AB: Assertive community case management. *Psychiatr Serv* 46:669-675, 1995.
2. McFarland BH: Health management and persons with severe mental illness. *Community Ment Health J* 30:221-242, 1994.

Poster 109
AN ALTERNATIVE TO ACUTE PSYCHIATRIC HOSPITALIZATION

James B. Lohr, M.D., *Chief, Psychiatry Service, Veterans Affairs Medical Center, 3350 La Jolla Village Drive, San Diego, CA 92161;* William B. Hawthorne, Ph.D., *Executive Director, Community Research Foundation, Suite 219, 444 Camino Del Rio South, San Diego, CA 92108*

SUMMARY:

Both public and private health care systems are struggling with pressures to contain costs while maintaining or improving quality of care. The measurement of outcomes and the examination of alternative models for providing needed services have been logical outgrowths of these pressures. This study focused on the San Diego County, California, crisis residential model, which provides a less costly alternative to acute psychiatric hospitalization.

This poster will present outcome data on five crisis residential facilities (N = 376). These data were compared with the results of psychiatric hospital outcome studies conducted by using the same research protocol (N = 186). A repeated-measures design, in which subjects served as their own controls, was used. Multiple standardized instruments were administered to quantify the status of patients at admission and to assess treatment gains at discharge and follow-up across a variety of dimensions. These included depression, psychosis, daily living skills, social functioning, emotional well-being, and satisfaction with services received. The two groups had similar levels of severity of symptoms upon admission, as well as similar robust improvements at discharge and follow-up.

The results of this study support crisis residential programs as a cost-effective alternative to hospitalization in the treatment of voluntary acutely ill adult psychiatric patients.

REFERENCES:

1. Brunton J, Hawthorne WB: The acute non-hospital: a California model. *Psychiatr Hosp* 20:95-99, 1989.
2. Warner R (ed): *Alternatives to the Hospital for Acute Psychiatric Treatment.* American Psychiatric Press, Washington, DC, 1995.

Poster 110
INDEPENDENCE HOUSE: A MODEL FOR RESIDENTIAL TREATMENT

Charles M. Barber, M.A., *Program Director, Independence House, 500 West 167th Street, New York, NY 10032;* Clarence Moore, *Project Coordinator, Independence House, 500 West 167th Street, New York, NY 10032;* Scott R. Masters, M.D.

SUMMARY:

This poster will demonstrate the efficacy of a particular model of residential treatment for the chronically mentally ill. This model is currently being implemented at Independence House, a 24-bed community residence in New York City. Independence House serves adults who have axis I diagnoses and histories of homelessness, medication noncompliance, and substance abuse. The model combines a clinical orientation with great respect for client self-determination. Clients are required to attend an outpatient clinic/day program. Clients meet with master's-degree-level case managers who provide intensive support in socialization, daily living skills, and symptom management, under the supervision of a supervising psychiatrist. The clients create their own service plans with their case managers. Case managers communicate weekly with the outpatient treatment team, ensuring that the clients' "home life" and treatment are integrated. Other services provided are 24-hour supervision, voluntary groups, medication monitoring, a newsletter, and client review of the house rules. This model has resulted in a massive decrease in hospitalizations--from 38 days per year before admission to 6 days per year after admission. Gains in quality of life have perhaps been even greater.

REFERENCES:

1. Bachrach LL: Issues in identifying and treating the homeless mentally ill. *New Dir Ment Health Serv* 35:43-62, 1987.
2. Martin MA: The homeless mentally ill and community-based care: changing a mindset. *Community Ment Health J* 26:435-447, 1990.

Poster 111
FUNCTIONAL OUTCOMES OF PATIENTS IN A PARTIAL HOSPITAL PROGRAM

Ralph A. Primelo, M.D., *Medical Director, Partial Hospital Program, Department of Psychiatry, Lehigh Valley Hospital, 1259 South Cedar Crest Boulevard, Allentown, PA 18103;* Thomas O. Miller, M.S.W., *Program Director, Department of Psychiatry, Lehigh Valley Hospital, 1259 South Cedar Crest Boulevard, Allentown, PA 18103*

SUMMARY:

Many short-term partial hospital programs have not conducted adequate outcome studies. The lack of such studies may be due to the belief that outcome studies are cumbersome, require additional staff, and are not clinically relevant to patient care. No prior published study has evaluated patient outcomes in such settings by using Global Assessment of Functioning (GAF) subscales, which can be easily used in a clinical environment.

Five GAF subscales--social, psychosocial, occupational, substance abuse, and dangerousness--were used to monitor outcomes of adult patients in a partial hospital program. The use of these subscales over 2 years will be described for over 300 patients, whose average length of stay was 21 days. These subscale assessments were integrated into the patients' initial and discharge assessments. Average improvement in each subscale will be described, and correlations with clinical and demographic data will be presented. Primary diagnosis, age, and family distress appear to be related to the magnitude of improvement seen in GAF scores between admission and discharge.

As partial hospitalization programs attempt to document their clinical and cost effectiveness, GAF subscales appear to be easy to administer, useful for clinical staff, and meaningful to administrative staff. Studies defining expectations for improvement in GAF subscales for patients within clinical and demographic groupings would be worthwhile.

REFERENCES:

1. Kennedy JA: *Fundamentals of Psychiatric Treatment Planning.* American Psychiatric Press, Washington, DC, 1992.
2. Turner RM, McGovern M, et al: A naturalistic assessment of partial hospital treatment. *Int J Partial Hospitalization* 1:311-326, 1982.

Poster 112
INTEGRATION OF INPATIENT AND OUTPATIENT MENTAL HEALTH SERVICES

Linda S. Godleski, M.D., *Associate Professor, Department of Psychiatry and Behavioral Sciences, University of Louisville School of Medicine, Suite 116A, 800 Zorn Avenue, Louisville, KY 40206;* Allan Tasman, M.D., *Board of Trustees Member, Americam Psychiatric Association, and Professor and Chairman, Department of Psychiatry and Behavioral Sciences, University of Louisville School of Medicine, Louisville, KY 40292-0001;* Robert E. Vadnal, M.D.

SUMMARY:

Many mental health delivery systems have separate inpatient and outpatient services. The community mental health centers were created in the 1960s as entities separate from the state mental hospitals. Since then, this traditional model of discrete inpatient and outpatient treatment has been perpetuated in many Veterans Affairs (VA) and academic settings. At the VA Medical Center in Louisville, Kentucky, such a traditional model was reorganized by integrating all inpatient and outpatient psychiatric services. Patients were reassigned to a single multidisciplinary treatment team, which provides all aspects of mental health care, including crisis intervention, outpatient psychotherapy and pharmacotherapy, and inpatient management.

Preliminary analysis of outcomes with this system of integrated inpatient and outpatient services showed that: a) some inpatient admissions were prevented because of intensive outpatient interventions by the comprehensive service team, b) some inpatients were discharged earlier because the comprehensive service team was already familiar with the patient and the treatment plan at the time of admission, c) consistency of care increased because the same team treated the patient during hospitalization and outpatient treatment, d) discharge planning and follow-up improved because the same team followed the patient immediately after release from the hospital, and e) patient satisfaction increased once patients no longer had to switch clinicians when they entered or left the hospital.

REFERENCES:

1. Mechanic D, Schlesinger M, McAlpine D: Management of mental health and substance abuse services: state of the art and early results. *Milbank Q* 73(1):19-55, 1995.
2. Fogel B: Mental health services and outcome-driven health care. *Am J Public Health* 83:319-321, 1993.

Poster 113
COURT DIVERSION FOR OFFENDERS WITH MENTAL ILLNESS

Samuel Packer, M.D., *Associate Professor, Department of Psychiatry, University of Toronto, St. Michael's Hospital, 30 Bond Street, Toronto, ONT, Canada M5B 1W8;* Ronald J. Heslegrave, Ph.D., *Associate Professor, Department of Psychiatry, University of Toronto, Wellesley Hospital, Toronto, ONT, Canada M4Y 1J3*

SUMMARY:

The purpose of this study was to examine the impact of a newly organized court diversion program on mentally ill arrested individuals. Those who are to be assessed for diversion are most often referred by the prosecuting

attorney or defense counsel. The case worker meets with the referred individual to determine whether diversion should be considered. Final approval for diversion is given by the prosecutor and is agreed to by a judge.

In the first four months of this program, 33 men and 17 women were referred for diversion. Fifteen are still awaiting a decision, and the remainder have had charges withdrawn or stayed. Although the program was proposed for nonviolent offenders, many of the program's clients were arrested for assault. It was originally believed that these individuals would need mental health referrals, but many were already being followed by mental health workers in the community and needed only to have these contacts reestablished.

Court diversion for mentally ill offenders seems to be a worthwhile service, removing them from the criminal justice system to receive treatment instead of punishment and saving the cost of trials for these individuals.

REFERENCES:

1. Laberge D, Morin D: The overuse of criminal justice dispositions: failure of diversionary policies in the management of mental health problems. *Int J Law Psychiatry* 18:389-414, 1995.
2. Brabbins CJ, Travers RF: Mental disorders amongst defendants in Liverpool's Magistrates Court. *Med Sci Law* 34:279-283, 1994.

Poster 114
EFFECTIVENESS OF SPECIALIZED TREATMENT PROGRAMS FOR SERIOUSLY MENTALLY ILL VETERANS

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SUMMARY:

Treating veterans with serious mental illness is a significant portion of the mission of the Department of Veterans Affairs. To evaluate the relative effects of alternative treatment approaches on hospital use, clinical outcomes, and quality of life, specialized treatment programs were funded at 14 Veterans Affairs Medical Centers in 1991. Three program types were established: inpatient rehabilitation (STAR II), day treatment, and intensive case management. Patients were enrolled in these programs or in a nonrandom comparison group (receiving standard treatment) if they had had at least 150 inpatient days or five or more admissions in the previous year and had a diagnosis of psychosis. Patient and clinician ratings were collected at enrollment and then at six-month intervals for two years.

A total of 1,632 patients have been enrolled to date; 1,200 have completed two-year follow-ups. Hierarchical linear modeling was used to test the relative effectiveness of the program types. Veterans in the specialized programs showed significant improvement in several measures of clinical and functional outcomes and in quality of life. The data strongly suggest that shifting treatment resources from traditional inpatient care to specialized programs promotes better clinical outcomes without increasing hospital use.

REFERENCES:

1. U.S. Department of Veterans Affairs: *Great Lakes Health Services Research and Development Field Program, Long-Term Mental Health Enhancement Program, Third Annual Progress Report.*
2. Bryk AS, Raudenbush SW: *Hierarchical Linear Models: Applications and Data Analysis Methods.* Sage Publications, Newbury Park, CA, 1992.

Poster 115
RAINBOW RECYCLING: A MODEL BUSINESS FOR INDIVIDUALS RECOVERING FROM MENTAL ILLNESS

Marianne DiTommaso, M.S.W., *Director, Residential Services, Department of Psychiatry, St. Vincent's Medical Center, QTRS, Suite 8, 75 Vanderbilt Avenue, Staten Island, NY 10304;* Joseph DeVivo, M.S.W., *Assistant Director, Residential Services, Department of Psychiatry, St. Vincent's Medical Center, QTRS, Suite 8, 75 Vanderbilt Avenue, Staten Island, NY 10304;* Michael P. Manna

SUMMARY:

Rainbow Recycling has received many awards, including the American Psychiatric Association's 1995 Significant Achievement Award, in recognition of outstanding commitment to providing integrated training and competitive employment opportunities for persons recovering from mental illness. This program was developed by the North Richmond Community Mental Health Center and the Residential Services department of St. Vincent's Medical Center in Staten Island, New York, in 1992. Rainbow Recycling currently employs 23 consumers.

One of the major barriers to recovery for many of the consumers served is their difficulty in finding meaningful employment because of their disability. This is especially true of the community residence clients, whose mental illness is severe and persistent. Most of the clients have little or no work experience, making it even more difficult to find employment. Rainbow Recycling is a business that was designed to address the work needs and the emotional needs of recovering individuals and to simultaneously operate as a free-standing business.

At the conclusion of this presentation participants should understand the value of consumer employment, appreciate the concept of meaningful employment, and recognize the need to develop similar consumer enterprises in their agencies.

REFERENCES:
1. MacDonald-Wilson KL, Revell WG, Nguyen NH, et al: Supported employment outcomes for people with psychiatric disability: a comparative analysis. *J Vocat Rehab* 1(3):30-44, 1991.
2. Bond G: Supported work as a modification of the transitional employment model for clients with psychiatric disabilities. *Psychosoc Rehab J* 11(2):55-73, 1987.

Poster 116
RETHINKING INPATIENT CARE: A COMMUNITY-BASED ALTERNATIVE

Suhayl J. Nasr, M.D., *President, Nasr Psychiatric Services, 2814 South Franklin Street, Michigan City, IN 46360-1843;* John A. Fayyad, M.D., *601 Franklin Street, Michigan City, IN 46360;* Ramune Kazenas, A.S.W., Shirley Morris, R.N., Linda Bechinski, R.N.

SUMMARY:

Michigan City, Indiana, is a rural community that has had a for-profit psychiatric hospital. After that hospital's acquisition by Charter, it was decided to close the acute services and to maintain the facility as a residential treatment center without regard for the needs of this small community for acute psychiatric care. A team of two adult psychiatrists, two child psychiatrists, and allied professionals quickly put together a program for the local community-owned hospital, Memorial Hospital of Michigan City, which was supported by the community physicians and the administration of the other acute-care hospital in town. The program comprises a four-bed pediatric psychiatry unit in the hospital, a separate unit for adults and adolescents, services for substance abuse and detoxification, and outpatient treatment for adolescents, adults, and geriatric patients.

The transition of the mental health team from the for-profit hospital to the community-based hospital, as well as the lessons learned from opening a psychiatric unit in an acute-care hospital, will be discussed. The presenters will discuss the multidisciplinary nature of this endeavor and the emotional, financial, and community value of psychiatric services provided by a not-for-profit hospital.

REFERENCES:
1. Schlesinger M, Dorwart RA, Epstein SS: Managed care constraints on psychiatrists' hospital practices: bargaining power and professional autonomy. *Am J Psychiatry* 153:256-260, 1996.
2. Simon GE, Grothaus L, Durham ML, et al: Impact of visit copayments on outpatient mental health utilization by members of a health maintenance organization. *Am J Psychiatry* 153:331-338, 1996.

Poster 117
COST OF INCIDENTS OF AGGRESSION IN A LARGE METROPOLITAN STATE HOSPITAL

Mohammed Y. Alam, M.D., *Clinical Assistant Professor, Department of Psychiatry, University of Chicago, Mail Code 3077, 5841 South Maryland Avenue, Chicago, IL 60637;* Asif A. Aleem, *575 Riva Court, Wheaton, IL 60187;* Daniel J. Luchins, M.D., Patricia Hanrahan, Ph.D.

SUMMARY:

There has been no research on the total financial cost of incidents of aggression among psychiatric inpatients. The purpose of this study was to estimate the direct public cost of such incidents in a large state hospital through cost accounting of services used for incidents of aggression for one year.

The sample consisted of all patients hospitalized during the calendar year 1993 at Elgin Mental Health Center in Illinois; the average daily census was 650. The direct public cost of staff time was estimated by multiplying the staff time involved in dealing with incidents of aggression by the wage rates for activities such as one-on-one observation, mechanical restraints, psychopharmacology consultations, and Workers' Compensation claims for staff who were injured.

The overall cost of aggression was substantial: $313,831 in 1993 dollars. The largest costs were due to constant observation, at $156,156, followed by restraints, at $99,717. Workers' Compensation costs totaled $30,676. Security costs were considerable, at $22,273. The remaining costs included $2,749 for psychopharmacology consultations and $2,259 for clinical advisory meetings. Costs will be reported for forensic versus nonforensic subgroups, diagnostic groups, and acute versus chronic units.

Aggression has important economic implications for state mental hospitals. Developing better treatments for aggression should be a major priority. Future research should assess other costs of aggression, such as longer hospitalizations, more admissions, and higher staff-to-patient ratios.

REFERENCES:
1. Tardiff K, Sweillam A: The occurrence of assaultive behavior among chronic psychiatric inpatients. *Am J Psychiatry* 139:212-215, 1982.
2. Depp FC: Assaults in a public mental hospital. In Lion JR, Reid WH (eds): *Assaults within Psychiatric Facilities.* Grune and Stratton, New York, 1983.

Poster 118
FACTORS ASSOCIATED WITH INJURIES IN A LARGE MENTAL HOSPITAL: A 5-YEAR STUDY

Adam Klass, B.A., *President, Saper Development, Suite 2804, 575 West Madison Street, Chicago, IL 60661;* David B. Klass, M.D., *Staff Psychiatrist, Illinois Department of Mental Health, Suite 2804, 575 West Madison Street, Chicago, IL 60661;* Mohammed Y. Alam, M.D.

SUMMARY:

In a 700-bed psychiatric hospital, records were kept for injuries occurring between January 1990 and May 15, 1995. In 16 stable units, there were 6,751 injuries during the study period (176-810 injuries per unit). The mean was 422 (SD = 183), and the average severity level, on a scale of 1-5, was 1.65 (SD = 0.08). A regression analysis was conducted with the mean values for each unit of the following variables: a) two measures of overcrowding, b) chronicity of patients (days in the hospital, number of previous admissions, age, and patient census), and c) drug index. The drug index was the sum, for each patient, of 41 psychoactive drugs over the hospital average for that particular day.

Stepwise regression indicated that for all injuries, the drug index alone accounted for 57% of the variance in the injuries across units ($p = 0.001$, multiple $r = 0.755$). For trivial injuries, overcrowding accounted for 57% of the variance ($p = 0.001$, multiple $r = 0.7669$, $p = 0.0008$). For moderately severe injuries, no variables were discarded because of the small number of injuries in this category. The spectral analysis (SPSS, Trends, Version 6.1) of 1,960 daily observations showed a peak of spectral density at 28 days.

REFERENCES:

1. Craig TJ: An epidemiological study of patterns associated with violence among psychiatric inpatients. *Am J Psychiatry* 139:1262-1266, 1982.
2. Carmen NE, Reiker P, Mills T: Victims of violence and psychiatric illness. *Am J Psychiatry* 141:378-383, 1984.

Poster 119
COMMUNITY PSYCHIATRY'S NEED FOR COMMUNITY DEVELOPMENT

Kenneth S. Thompson, M.D., *Medical Director, Division of Public Psychiatry, Western Psychiatric Institute and Clinic, 3811 O'Hara Street, Pittsburgh, PA 15213;* Stephen D. Mullins, M.D., M.P.H., *Medical Director, Hill Satellite Clinic, Western Psychiatric Institute and Clinic, 3811 O'Hara Street, Pittsburgh, PA 15213;* Ronald Gibson, Gary Lefebvre, Wesley E. Sowers, M.D., Denys Candy, John D. Kretzmann, Ph.D.

SUMMARY:

The rise of the community support system as a fundamental means of service delivery in community psychiatry has refocused psychiatry on the concept of "community." Efforts to procure and organize the resources necessary for persons with severe and persistent mental illness have demonstrated repeatedly the need for mental health professionals to work closely with community leaders. Often, however, the communities of concern are in great socioeconomic distress. As a result, they are underorganized and underresourced for the demands placed on them. Frequently, too, the strengths and capacities of these communities are unrecognized.

This poster will present a model of cooperation between mental health workers and community organizers, beginning with the community support system needed for persons with severe and persistent mental illness and proceeding to concepts and techniques current in the field of community development, including community conflict resolution and the identification and mobilization of community capacity.

REFERENCES:

1. Kretzman JP, McKnight JL: *Building Communities from the Inside Out: A Path Toward Finding and Mobilizing a Community's Assets.* ACTA Publications, Chicago, 1993.
2. Kenig S: *Who Plays? Who Pays? Who Cares? A Case Study in Applied Sociology, Political Economy, and the Community Mental Health Centers Movement.* Baywood Publishing, Amityville, NY, 1992.
3. Grob GN: *From Asylum to Community: Mental Health Policy in Modern America.* Princeton University Press, Princeton, NJ, 1991.

Poster 120
AN OPEN TRIAL OF PAROXETINE FOR POSTTRAUMATIC STRESS DISORDER

Randall D. Marshall, M.D., *Anxiety Disorders Clinic, New York State Psychiatric Institute, Unit 13, 722 West 168th Street, New York, NY 10032;* Franklin R. Schneier, M.D., Michael R. Liebowitz, M.D., Linda Abbate, B.A., Brian A. Fallon, M.D., David J. Printz, M.D.

SUMMARY:

The authors hypothesized that paroxetine, with possibly superior anxiolytic properties, might be an effective treatment for posttraumatic stress disorder (PTSD), given the high arousal levels of PTSD patients. This poster will summarize an ongoing, systematic 12-week open trial of flexible-dosage paroxetine for PTSD patients with non-combat-related trauma. The medication trial is preceded by a week of single-blind placebo treatment. Outcome is assessed from three perspectives: physician, patient, and independent evaluator.

Among the first patients studied, Clinical Global Impression (CGI) ratings identified 10 responders, one

nonresponder, and two early dropouts who were nonresponders. Data for six patients were available for preliminary statistical analysis. Scores on the Hamilton Anxiety Rating Scale, the Hamilton Depression Rating Scale, and the Davidson PTSD Scale subscales for avoidance, hyperarousal, and intrusion were analyzed by means of *t* tests. Despite the small sample size, the results of several *t* tests, including those for all three symptom clusters of PTSD, from all three rating perspectives were statistically significant. The improvement in hyperarousal was notable.

Given a low rate of response to placebo (10-20%) in previous studies, the high response rate in this study suggests true efficacy of paroxetine for PTSD, and a controlled trial is warranted.

Poster 121
THE NWHOME PROJECT, A SUPPORTIVE SERVICES PROGRAM FOR THE HOMELESS MENTALLY IN CHICAGO: PRELIMINARY FINDINGS

Katherine Edstrom, Ph.D., *Instructor of Psychiatry, Northwestern University Medical School, Suite 717, 30 North Michigan, Chicago, IL 60602;* Kenneth A. Cohen, M.D., *Instructor of Psychiatry, Northwestern University Medical School, Room 251, 259 East Erie Street, Chicago, IL 60611-2814;* Nancy Burke, Ph.D., Lisa Rouff, M.A.

SUMMARY:

The first 75 mentally ill persons consecutively admitted to the NWHOME Project who met the criteria for homelessness established by the U.S. Department of Housing and Urban Development were assessed with the SCID-P, the Personal History Interview, and measures of psychiatric symptoms, substance abuse, and quality of life. The last three measures were readministered at 3-month intervals. At each follow-up, changes in residential and vocational status were recorded and the Client Satisfaction Questionnaire was completed.

Preliminary findings indicate that homeless individuals with severe mental illness can be engaged in a service system, can benefit from mental health services, can obtain entitlements, and can improve the overall quality of their lives. The authors will discuss implications for delivery of mental health and social services to this population.

REFERENCES:

1. Boydell KM, Everett B: What makes a house a home? An evaluation of a supported housing project for individuals with long-term psychiatric backgrounds. *Can J Community Ment Health* 100-123, 1992.
2. National Institute of Mental Health: *Two Generations of NIMH-Funded Research on Homelessness and Mental Illness: 1982-1990.* National Institute of Mental Health, Rockville, MD, 1991.

Poster 122
PREDICTORS OF AFTERCARE COMPLIANCE IN A RURAL CLINIC

Robert R. Franklin, M.D., *1996-1998 APA/Mead Johnson Fellow, and Resident, Department of Adult Psychiatry, Tulane Medical Center, Sixth Floor, 1415 Tulane Avenue, New Orleans, LA 70112;* Moussa Ba, M.D., *1995-1996 Hubert H. Humphrey Fellow, Department of Adult Psychiatry, Tulane Medical Center, Sixth Floor, 1415 Tulane Avenue, New Orleans, LA 70112;* Constance Corson, M.D.

SUMMARY:

The authors determined the factors associated with keeping the first outpatient appointment after psychiatric hospitalization. The sample included 286 consecutive clients referred to a rural public mental health clinic for aftercare between January 1 and June 30, 1995. The data sources used were records routinely completed at the clinic, including: a) aftercare appointment forms completed by nurses on the basis of telephone conversations with hospital staff, b) dated financial summaries of all client transactions, and c) intake data for clients previously seen at the clinic. Compliance was defined as clinic attendance on or before the scheduled date of the aftercare appointment. A total of 28 factors were investigated, including selected sociodemographic variables, clinical data, and program factors (i.e., previous clinic attendance, client distance from the clinic, time between discharge and appointment, time and date of appointment).

Factors significantly associated with aftercare compliance were ethnic group, history of substance abuse, previous record of attendance at the mental health clinic, reason for hospitalization, length of hospital stay, and selected discharge diagnoses. These findings will be compared with those from similar studies in the literature. A method for using these findings to identify clients at greater risk for noncompliance with aftercare will be proposed.

REFERENCES:

1. Klinkenberg WD, Calsyn RJ: Predictors of receipt of aftercare and recidivism among persons with severe mental illness: a review. *Psychiatr Serv* 47:487-496, 1996.
2. Byers ES, Cohen SE: Predicting patient outcome: the contribution of prehospital, inhospital, and posthospital factors. *Hosp Community Psychiatry* 30:327-331, 1979.

POSTER SESSIONS

Poster 123
INTERDISCIPLINARY TEACHING AND LEARNING IN A PUBLIC-ACADEMIC LIAISON PROGRAM FOR COMMUNITY PSYCHIATRY RESIDENCY TRAINING

Kathleen A. Clegg, M.D., *Assistant Professor, Department of Psychiatry, University Hospital, 11100 Euclid Avenue, Cleveland, OH 44106*

SUMMARY:

Two innovative components have been incorporated into an existing public-academic liaison program. They are: a) a collaborative effort with the department of family medicine in which family medicine residents work with a community psychiatry faculty member in a community mental health agency serving homeless persons, and b) an ongoing series of community-based client conferences held on-site in the program's eight participating health centers. The collaboration with family medicine is beneficial to all parties. Family medicine residents have a concentrated experience in outpatient psychiatry, including clinical interviewing, psychiatric diagnosis, psychotherapeutic and pharmacologic intervention, and crisis intervention, with clinical supervision from a member of the psychiatry faculty. The client/agency system (which serves a medically needy population) benefits, both in patient care and staff development, from the on-site availability of medical and psychiatric experts and from their focused collaboration. The ongoing community case conferences have also handed a win-win situation to participants: Psychiatric residents participate in community-based conferences, with input from expert practitioners from throughout the community; agency staff receive on-site continuing professional development; guest discussants from a variety of settings appreciate the workings of other agencies; and, most important, clients have access to sophisticated clinical care.

REFERENCES:

1. Borus JF: Community psychiatry. In Nicholi AM (ed): *The New Harvard Guide to Psychiatry.* Harvard University Press, Cambridge, MA, 1988, pp 780-796.
2. Sabin JE: Clinical skills in the 1990s: six lessons from HMO practice. *Hosp Community Psychiatry* 42:605-608, 1991.

Poster 124
USING PHARMACEUTICAL INDIGENT PROGRAMS

Peggy E. Chatham-Showalter, M.D., *Mental Health Clinic Psychiatrist, Lehigh Valley Hospital, Suite 2800, 1243 South Cedar Crest Boulevard, Allentown, PA 18103;* Maureen C. McFarland, R.N., *Psychiatric Nurse Specialist, Lehigh Valley Hospital, Suite 2800, 1243 South Cedar Crest Boulevard, Allentown, PA 18103*

SUMMARY:

Many factors influence the pharmaceutical industry's increasing promotion of its programs that provide medications to indigent patients and the increasing utilization of these programs by health care organizations.

A mental health clinic's development of a system that uses a nurse to coordinate applications will be detailed. Some companies have programs with relatively liberal access to medications, but others have approval criteria that serve as barriers to access. In the past year the nurse has assisted 29 patients in applying for 43 separate medications from 13 different pharmaceutical companies. Of these patients requesting medications, working-poor patients without Pennsylvania Medicaid represented 27%, patients with Medicaid but with income making them ineligible for the Medicaid prescription component represented 27%, those awaiting a Medicaid determination represented 10%, and the remainder were ineligible for Medicaid for various reasons.

Over one third of the patients had a diagnosis of major depression, and one third had a diagnosis of schizophrenia or schizoaffective disorder. Only one patient had a diagnosis of bipolar disorder, which reflects the limited indigent programs for lithium formulations and divalproex. Overall, only four applications were rejected, but the psychiatrists' knowledge of which programs are "easy" and which programs are "hard" may influence prescribing selections and keep the rejection rate artificially low.

REFERENCES:

1. Pharmaceutical Manufacturers Association: *PMA Directory on Indigent Care Programs: 1992.* Pharmaceutical Manufacturers Association, Washington, DC, 1992.
2. Becane BE, Chapman J: Program for procurement of drugs for indigent patients. *Am J Hosp Pharm* 51:669-671, 1994.

Poster 125
COMPUTER REPORTING OF PSYCHOSOCIAL HISTORIES

Barry A. Tanner, Ph.D., *Associate Professor, Department of Psychiatry, Wayne State University, UHC 9B, 4201 St. Antoine, Detroit, MI 48201*

SUMMARY:

A computer program to assist in preparing reports of psychosocial histories will be described. The program guides the professional or trainee through the interview and reporting process and produces a nearly complete report of the history. A report can be produced in about 10 minutes; the program accepts keyboard input for free-form text and mouse clicks for selections from lists of choices. The program is organized around forms and on-screen file folders labeled "Presenting Complaint," "Prior Illness," "Personal & Family History," "Social Situation," and "Medical." The output can be combined with that

from related programs to prepare more-complicated reports; e.g., the psychosocial history can be combined with the mental status examination.

The word-processing component allows the user to modify the report produced by the program, check spelling, save the report to a disk, load the saved report again later, and print hard copies. The spelling checker includes terms used by mental health professionals but likely to be rejected by many spelling checkers, such as "psychosocial." The program is designed to save user time while improving the quality of documentation. It requires Microsoft Windows and more than 1 megabyte of disk space for the various files.

REFERENCES:

1. Tanner BA: Computer aided reporting of the results of neuropsychological evaluations of traumatic brain injury. *Comput Human Behav* 9:51-56, 1993.
2. Tanner BA, Marcolini RC, Howell E, et al: The Emergency Psychiatry Nursing Assessment Report Framework: a computer program to assist in preparing reports. *Behav Res Meth Instrum Comput* 27:166-168, 1995.

Poster 126
REPORTING MENTAL STATUS EXAMINATIONS WITH A COMPUTER

Barry A. Tanner, Ph.D., *Associate Professor, Department of Psychiatry, Wayne State University, UHC 9B, 4201 St. Antoine, Detroit, MI 48201*

SUMMARY:

A computer program to assist in preparing reports of the mental status examination will be described. The program guides the professional or trainee through the process and produces a nearly complete report of the examination in about 10 minutes, accepting keyboard input for free-form text and mouse clicks for selections from lists of choices. The program is organized around forms and on-screen file folders labeled "Appearance," "Mood & Affect," "Speech," "Perception," "Thought Content," "Cognitive Processes," and "Appetite, Sleep, & Sex." The output can be combined with that from related programs to prepare more-complicated reports; e.g., the mental status examination can be combined with the psychosocial history.

The word-processing component allows the user to modify the report produced by the program, check spelling, save the report to a disk, load the saved report again later, and print hard copies. The spelling checker includes terms used by mental health professionals but likely to be rejected by many spelling checkers, such as "anxiolytic" and "neuropsychologist." The program is designed to save user time while improving the quality of documentation. It requires more than 1 megabyte of disk space.

REFERENCES:

1. Tanner BA: Computer aided reporting of the results of neuropsychological evaluations of traumatic brain injury. *Comput Human Behav* 9:51-56, 1993.
2. Tanner BA, Marcolini RC, Howell E, et al: The Emergency Psychiatry Nursing Assessment Report Framework: a computer program to assist in preparing reports. *Behav Res Meth Instrum Comput* 27:166-168, 1995.

Poster 127
COMPUTER-ASSISTED QUARTERLY CASE REPORTS

Barry A. Tanner, Ph.D., *Associate Professor, Department of Psychiatry, Wayne State University, UHC 9B, 4201 St. Antoine, Detroit, MI 48201*

SUMMARY:

A computer program to assist in preparing quarterly case reports will be described. The program guides the professional or trainee through the preparation of the quarterly report, producing the report in several minutes. The program accepts keyboard input for free-form text and mouse clicks for selections from lists of choices. The program is organized around (on-screen) file folders and a word processor.

The word-processing component allows the user to modify the report produced by the program, check spelling, save the report to a disk, load the saved report again later, and print hard copies for the medical record. The spelling checker includes terms used by mental health professionals but likely to be rejected by many spelling checkers, such as "psychogenic." The program is designed to save user time while improving the timeliness and quality of documentation.

REFERENCES:

1. Tanner BA: Computer aided reporting of the results of neuropsychological evaluations of traumatic brain injury. *Comput Human Behav* 9:51-56, 1993.
2. Tanner BA, Marcolini RC, Howell E, et al: The Emergency Psychiatry Nursing Assessment Report Framework: a computer program to assist in preparing reports. *Behav Res Meth Instrum Comput* 27:166-168, 1995.

Poster 128
PHARMACOTHERAPEUTIC MANAGEMENT OF PRIMARY NONRESPONDER ADULTS WITH ATTENTION DEFICIT HYPERACTIVITY DISORDER

Amar N. Bhandary, M.D., *Director, Mental Health Consultation Services, Department of Psychiatry, University of Oklahoma College of Medicine, Health Science Center, Fifth Floor, South Pavilion, P.O. Box 26901, Oklahoma*

City, OK 73190-3048; Betty Pfefferbaum, M.D., Chairperson, *Department of Psychiatry, University of Oklahoma College of Medicine, Health Science Center, Fifth Floor, South Pavilion, P.O. Box 26901, Oklahoma City, OK 73190-3048*

SUMMARY:

Pharmacotherapy is the key treatment for attention deficit hyperactivity disorder (ADHD) in adults, and psychostimulants, especially methylphenidate, remain the mainstay, whereas amphetamines, such as dextroamphetamine and methamphetamine, are underused notwithstanding superior potency, duration, cost, and tolerance. Nevertheless, psychostimulants often fail, occasionally even exacerbating symptoms. At present, nonstimulants are increasingly prescribed, producing encouraging results and reflecting the disorder's heterogeneity. Antidepressants are dispensed extensively, with catecholaminergic agents, e.g., tricyclic antidepressants and bupropion, in a second-tier role, while venlafaxine, trazodone, and selective serotonin reuptake inhibitors (SSRIs) target comorbid symptoms. Antihypertensives, such as beta blockers (nadolol and propranolol) and α_2-receptor agonists (clonidine and guanfacine), attenuate disruptiveness, refractory symptoms, and premenstrual distress while potentiating psychostimulants and counteracting their hyperarousal. Mood stabilizers diminish intractable mood instability, dysphoria, and disruptiveness. Monoamine oxidase (MAO) inhibitors may redress refractory cases. Antipsychotics and benzodiazepines usually worsen symptoms.

Currently, ADHD treatment is not synonymous with monodrug therapy or a specific agent, because most cases require polymedication regimens. Their increasing use indicates greater proficiency in diagnosis and treatment, and such an accomplishment can remedy ADHD remarkably.

This poster will identify biological and pharmacotherapeutic reasons for psychostimulant failure in adults with ADHD. The discussion will include ADHD subtypes with comorbid conditions, nonstimulants, and extrapolations from child pharmacotherapy.

REFERENCES:

1. Wilens TE, Biederman J, Spencer TJ, et al: Pharmacotherapy of adult attention deficit/hyperactivity disorder: a review. *J Clin Psychopharmacol* 15:270-279, 1995.
2. Green WH: Non-stimulant drugs in treatment of attention deficit hyperactivity disorder. *Child Adolesc Psychiatr Clin North Am* 2:449-465, 1992.

Poster 129 **Monday, October 21**
10:00 a.m.-11:30 a.m.

CURRENT CONSIDERATIONS IN THE DIAGNOSIS OF ADULTS WITH ATTENTION DEFICIT HYPERACTIVITY DISORDER

Amar N. Bhandary, M.D., *Director, Mental Health Consultation Services, Department of Psychiatry, University of Oklahoma College of Medicine, Health Science Center, Fifth Floor, South Pavilion, P.O. Box 26901, Oklahoma City, OK 73190-3048;* Betty Pfefferbaum, M.D., *Chairperson, Department of Psychiatry, University of Oklahoma College of Medicine, Health Science Center, Fifth Floor, South Pavilion, P.O. Box 26901, Oklahoma City, OK 73190-3048*

SUMMARY:

Attention deficit hyperactivity disorder (ADHD) is a widespread neuropsychiatric syndrome resulting from catecholamine deficiency dysregulating frontal lobe functions and somatic homeostasis, manifested as impaired attention, cognition, sensorimotor coordination, impulsivity, and psychomotor overactivity. ADHD commonly endures into adulthood, impairing functioning. Typically, adults with ADHD manifest comorbid affective, anxiety, personality, and substance use disorders while the ADHD diagnosis is unacknowledged. Pharmacotherapy is the key treatment for ADHD in adults, and psychostimulants, especially methylphenidate, remain the mainstay.

This poster will identify the various syndromic subtypes among adults with ADHD, diagnostic issues (including differential diagnosis), common comorbid conditions and pharmacotherapeutic management (emphasizing nonstimulants and polymedication regimens), and recent advances in the field.

REFERENCES:

1. Bhandary AN: Attention deficit disorder: persistence into adulthood. *J Pract Psychiatry Behav Health,* in press.
2. Wilens TE, Biederman J, Spencer TJ, et al: Pharmacotherapy of adult attention deficit/hyperactivity disorder: a review. *J Clin Psychopharmacol* 15:270-279, 1995.
3. Green WH: Non-stimulant drugs in treatment of attention deficit hyperactivity disorder. *Child Adolesc Psychiatr Clin North Am* 2:449-465, 1992.

SYMPOSIA

Symposium 1 **Friday, October 18**
10:00 a.m.-11:30 a.m.

ROLES OF SPIRITUALITY IN COMMUNITY-BASED TREATMENT

For Residents Only

Roger D. Fallot, Ph.D., *Co-Director, Community Connections, 1512 Pennsylvania Avenue, S.E., Washington, DC 20003;* Jerry Dincin, Ph.D.

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this session, participants should be able to: a) identify and use current methods for assessing the function of spirituality in the lives of persons with severe mental disorders, and b) describe and implement with this population appropriate group interventions addressing spirituality and values.

OVERALL SUMMARY:

Recent surveys have confirmed the importance of spirituality and religion for many people with severe mental disorders. The relative neglect, then, of this dimension of experience in most community-based treatment programs is all the more striking. In order to offer culturally competent and responsive services, it is important for mental health professionals to develop a fuller understanding of the place of religious and spiritual perspectives in clients' lives. Ways to assess the diverse roles of spirituality for individual clients and to address issues of spirituality and values in a group setting will be examined. Dr. Dincin will discuss issues raised by the presentations.

No. 1A
COPING SKILLS AND THE FUNCTIONS OF SPIRITUALITY

Roger D. Fallot, Ph.D., *Co-Director, Community Connections, 1512 Pennsylvania Avenue, S.E., Washington, DC 20003*

SUMMARY:

The mental health literature is divided on the role of spirituality and religion in the lives of people with severe mental disorders. Some writers view spirituality as a key, often-underused resource in the development of coping and recovery skills. Others express concern about the potentially disorganizing effect of spiritual experiences and of possible conflicts between the approaches of religious groups and mental health professionals. This presentation will focus on the various *functions* of spirituality for those with mental illness, emphasizing the importance of a thorough assessment of how spirituality may strengthen or diminish the coping capacities of the individual client.

Dr. Fallot will briefly review central dimensions in spiritual assessment, drawing primarily on models currently used in health care settings. He will then examine several ways in which spirituality and religion may be important in coping with mental disorders and associated problems of substance abuse and trauma history. Using case material and survey results, he will then consider the impact of relationships with God or a higher power, relationships with a religious community, the experience of meaning and purpose, and problem-solving skills related to spirituality. Programmatic implications will be discussed.

No. 1B
REMOVING THE TABOO: SPIRITUAL BELIEFS GROUPS

Nancy C. Kehoe, Ph.D., *Department of Psychiatry, Cambridge Hospital, 113 Belmont Street, Belmont, MA 02178*

SUMMARY:

Taboo originally meant a sacred prohibition against certain people, things, or acts that made them untouchable and unmentionable. It has come to mean any social prohibition or restriction that results from convention or tradition. Something that was originally a sacred prohibition has become a prohibition against talking about the sacred or spiritual as it is experienced in the lives of patients.

Dr. Kehoe will describe what occurs when the taboo is lifted, what occurs when men and women with chronic mental illness discuss their spiritual beliefs and values. The focus for the discussion will be two long-term groups in two day treatment programs. She will describe the structure of the groups, the group process, the content of the groups, and ways in which the groups differ from other groups in the same setting. By using case material, she will illustrate ways in which the members experience the groups. She will also offer a model for networking mental health professionals and religious professionals in the community.

REFERENCES:

1. Sullivan WP: "It helps me to be a whole person": the role of spirituality among the mentally challenged. *Psychosoc Rehab J* 16:125-134, 1993.
2. Winicott DH: *Playing and Reality.* Tavistock/Routledge, London, 1971.
3. Lindgren K, Coursey RD: Spirituality and serious mental illness: a two-part study. *Psychosoc Rehab J* 18:93-111, 1995.
4. Schumaker JF (ed): *Religion and Mental Health.* Oxford University Press, New York, 1992.

Symposium 2 **Friday, October 18**
1:30 p.m.-3:00 p.m.

PSYCHOLOGICAL TESTING AND MANAGED CARE

David L. Pogge, Ph.D., *Director of Psychology, Four Winds Hospital, 800 Cross River Road, Katonah, NY 10536*

SYMPOSIA

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this session, participants should be able to list the current indications for psychological testing, describe its role in psychiatric treatment planning, and identify the uses of psychological testing in inpatient settings.

OVERALL SUMMARY:

In the current inpatient treatment environment, with pressure to reduce length of stay and contain costs, the role of psychological assessment and testing is rapidly changing. Managed care requires targeted assessment with very short turnaround time for reporting. Insurers now require psychological assessments to have demonstrable effects on treatment planning, rather than simply expanding the clinical database. Although much of the psychological testing performed in the past was clearly excessive, there are several situations where psychological evaluation is critical, either for treatment planning or for placement. The current state of the art in psychological assessment in the short-stay milieu will be reviewed.

No. 2A
PSYCHOLOGICAL TESTING OF ADOLESCENTS AND CHILDREN IN THE ERA OF MANAGED CARE

David L. Pogge, Ph.D., *Director of Psychology, Four Winds Hospital, 800 Cross River Road, Katonah, NY 10536*

SUMMARY:

Service utilization by children and adolescents is often difficult to control because of their shorter histories, atypical symptoms, and complex educational and placement needs. The need for specific kinds of psychological testing has increased, despite the apparent reluctance of third-party payers to reimburse for these services.

Arguments for briefer and more "focal" testing fail to take into account the complex needs of child and adolescent patients. General intellectual and achievement testing may be essential to discharge planning and placement. Additional neurocognitive testing is crucial to documenting learning disabilities and neuropsychological deficits, which are often important factors in problems in school and social functioning. Specific assessment of attentional functioning is essential to the differential diagnosis of attention deficits versus other psychiatric conditions that might affect attentional performance. Since the value of simple self-reports by children and adolescents is limited, complex psychometric scales and performance-based measures are critical to identification and quantification of mood disorders, psychotic disorders, and problems of impulse control or conduct. Abbreviated assessments produce misdiagnoses and fail to detect critical deficits and abnormalities. Given the needs for rapid diagnosis, initiation of specific treatments, and transfer of patients to alternative levels of care, a more complex and comprehensive assessment remains critical to high-quality care. Dr. Pogge will describe how such evaluation can be provided in an efficient and cost-effective manner.

No. 2B
RORSCHACH APPLICATIONS IN TREATMENT PLANNING

John E. Exner, Ph.D., *Executive Director, Rorschach Workshops, P.O. Box 9010, Asheville, NC 28815*

SUMMARY:

Treatment planning is often based only on presentation of symptoms and modest history data. Although this routine may be appropriate in some cases, it also creates a risk of inappropriate treatment planning and/or premature termination of treatment because it ignores individual differences and the fact that similar symptoms may have different psychological origins. Pretreatment personality assessment should accumulate information about the individual's assets, liabilities, and conflicts. The process is based on the premise that this information will contribute significantly to the therapeutic well-being of the subject if the findings are studied in light of the array of treatments available. The cost-benefit issues and risk for premature termination associated with each available treatment are considered.

Although various assessment approaches can be used to individualize treatment planning, most that focus on the patient as a unique entity include the Rorschach test. The Rorschach provides information about several basic personality features, such as coping styles, stress tolerance, thinking, emotion, self-perception, and information processing. The yield can be used easily, efficiently, and at reasonable cost as an important source of data in treatment decisions. Two cases will be discussed briefly to illustrate these applications.

No. 2C
FOCUSED PSYCHOLOGICAL TESTING IN PSYCHOGERIATRICS

Philip D. Harvey, Ph.D., *Associate Professor of Psychiatry, Mt. Sinai School of Medicine, P.O. Box 1229, New York, NY 10029;* Karen Dahlman, Ph.D.

SUMMARY:

Psychological assessment is crucial in the diagnosis and evaluation of geriatric psychiatric patients. Both American and World Health Organization diagnostic criteria require psychometric assessment of cognitive functioning before a definitive diagnosis of dementia can be made. Since dementia is a possible alternative diagnosis for many geriatric patients, they clearly require psychological evaluation; treatment and placement

options will differ as a function of this differential diagnosis. Despite the clear need, these diagnostic distinctions do not necessarily require extended (10- to 12-hour) neuropsychological assessment. Lengthy procedures are not cost-effective and cannot be tolerated by all patients; the latter problem affects the data collected. This talk will present a system for targeted assessment of acute-care psychogeriatric patients. In this system, testing and assessment decisions are based on clinical data, the possible diagnostic questions raised, and the patient's psychiatric and medical histories. These assessments typically focus on diagnosis of dementia, including differential diagnosis of depression versus dementia, in a system that provides two-day turnaround from referral to report. Aspects of the service that will be presented include typical referral questions, typical tests administered, staffing requirements, and the training used in order to produce valid assessment data.

No. 2D
A MANAGED CARE PERSPECTIVE ON PSYCHOLOGICAL TESTING

M.J. Werthman, Ph.D., *Psychologist, Utilization Management, Merit Behavioral Care Systems, Suite 313, 1625 Sheridan Road, Wilmette, IL 60091*

SUMMARY:

Managed care organizations emphasize the use of highly focused psychological and neuropsychological testing to define the patient "problem" to be treated, the degree of impairment, the level of care to be provided, and the treatment plan to be implemented. The high specificity and "problem-solving" approach of such assessment reflects a commitment to effecting therapeutic change.

In managed care organizations, testing is a tool to aid primary providers who have exhausted their own clinical expertise and diagnostic resources or who require greater clarity in complex differential diagnoses. To enhance therapeutic usefulness, managed care organizations have emphasized assessment of risk as well as practical clinical and behavioral applications of test results and determinations of patient care. A key approach has involved the use of specific parts of tests or individual tests, rather than entire batteries, to identify patient problems and assist in treatment planning. Managed care organizations, by fostering greater scrutiny and provider responsibility, have increased the value of testing for patients and providers, in hospitals and other mental health settings.

REFERENCES:

1. Meyer RG, Deitsch SE: *The Clinician's Handbook,* 4th ed. Allyn & Bacon, Boston, 1996.
2. Mohs RC: Neuropsychological assessment of patients with Alzheimer's disease. In Bloom FE, Kupfer DJ (eds): *Pharmacology: The Fourth Generation of Progress.* Raven Press, New York, 1995.
3. Exner JE: *The Rorschach: A Comprehensive System,* 3rd ed, vol 1: Basic Foundations. Wiley Interscience, New York, 1993.
4. Werthman MJ: A managed care approach to psychological testing. *Behav Health Management* 15(5):15-17, 1995.

Symposium 3 **Friday, October 18**
3:30 p.m.-5:00 p.m.

ASSESSMENT AND CARE OF PEDIATRIC GUNSHOT VICTIMS

D. Richard Martini, M.D., *Director, Intake and Mobile Services, Department of Psychiatry, Children's Memorial Hospital, Suite 10, 2300 Children's Plaza, Chicago, IL 60614*

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this session, participants should be able to identify psychosocial factors that affect the emotional adjustment of children who have received gunshot injuries, describe a model for collaboration among caregivers in a tertiary pediatric hospital that addresses the child's needs, and identify factors that may influence long-term outcome in these patients and possible interventions to improve prognosis.

OVERALL SUMMARY:

Children's Memorial Hospital has been treating increasing numbers of children and adolescents victimized by violence. Cases include patients who have been injured and others who have been traumatized by exposure. Among the most disturbing forms of trauma has been the use of firearms. The staff at Children's Memorial Hospital formed a multidisciplinary team to provide services for children victimized by gunshot injury. The Violence and Injury Prevention Program includes pediatric faculty, social work staff, child life personnel, hospital administration, art therapists, and nurses. Members recognize that trauma has significant psychosocial consequences for children, particularly when exposed to gunshot injuries. Such an event may precipitate acute stress disorder or posttraumatic stress disorder. The program brought in department of psychiatry staff as collaborators, to ensure appropriate services for a vulnerable population and present opportunities for education and research. The presenters in this symposium will discuss the establishment and implementation of this intervention.

SYMPOSIA

No. 3A
PSYCHIATRIC RISK FACTORS FOLLOWING GUNSHOT INJURY

D. Richard Martini, M.D., *Director, Intake and Mobile Services, Department of Psychiatry, Children's Memorial Hospital, Suite 10, 2300 Children's Plaza, Chicago, IL 60614*

SUMMARY:

Gunshot violence has become a prevalent and disturbing part of the lives of many children. Young American children are killed by gunshot wounds at a higher rate than in other countries; young, urban, African-American males are at greatest risk. Exposure to gunshot injury has emotional consequences. Among the most likely psychiatric conditions are acute stress disorder and posttraumatic stress disorder. Dr. Martini will present findings on relationships between exposure to violence and development of posttraumatic stress disorder, psychiatric symptoms, and developmental problems. Victims of violence are more likely to report distress both at home and in school, and the presence of physical injury further increases the likelihood of stress disorder symptoms. Children and adolescents should be assessed to prevent both immediate and more long-standing psychological sequelae. Patients may become more withdrawn and depressed or may try to master the traumatic event by becoming aggressive and violent.

No. 3B
CREATING A CARING ENVIRONMENT FOR THE PATIENT

Dana L. Wiltsek, L.C.S.W., *Social Worker, Children's Memorial Hospital, Suite 130, 2300 Children's Plaza, Chicago, IL 60614*

SUMMARY:

Violence can lead to significant medical, psychological, and social consequences for victims, families, and communities. Annual firearm injuries treated at Children's Memorial Hospital more than tripled between 1985 and 1994, and a program using a multidisciplinary team was developed to assess and treat victims of firearm injury. This program consists of physicians, nurses, social workers, trauma clinicians, the psychiatric consultation service, and child life and postvention staff. As the point person, the social worker notifies team members of the trauma and initiates an assessment of the victim within the context of his/her family and community. With medical and psychiatric consultation, the social worker coordinates discharge planning, linking patients and families to appropriate community and postvention resources. The team's efforts to address the psychosocial needs of victims and their families are based on open discussion across disciplines and consensus that firearm injury has significant psychosocial impact on patients, families, and the community.

No. 3C
PSYCHIATRIC ASSESSMENT OF PEDIATRIC GUNSHOT VICTIMS

Vanya Hamrin, M.S., *Clinical Nurse Specialist, Department of Psychiatry, Children's Memorial Hospital, Suite 10, 2300 Children's Plaza, Chicago, IL 60614*

SUMMARY:

The medical psychology/psychiatry consultation-liaison service is notified by an emergency room social worker whenever a gunshot victim is admitted to the hospital. A clinical nurse specialist performs a diagnostic psychiatric evaluation of the patient. Potential risk factors for posttraumatic stress disorder in these patients include the severity of the injury, circumstances of the shooting, level of consciousness after the shooting, and whether the patient knew the perpetrator. The psychiatric assessment also reviews past psychiatric history, educational history, family history, and mental status. Symptoms of acute stress disorder and posttraumatic stress disorder are explored more specifically in an attempt to learn more about the characteristics of this population. Adolescents are as likely to report symptoms of distress as younger subjects, even when they have acknowledged gang involvement. The assessments have provided additional information to nursing staff, ancillary personnel, and members of the medical/surgical team. Children and their families are educated about signs of acute stress and the importance of treatment by mental health services.

No. 3D
KIDSTART: AN APPROACH TO PREVENTING VIOLENT INJURY

Michael Barlow, M.F.A., *Coordinator and Artistic Director, Children's Memorial Hospital, VIP Center, Suite 88, 2300 Children's Plaza, Chicago, IL 60614*

SUMMARY:

KidStART is a secondary prevention program, i.e., one that occurs after an injury. The setting is a hospital-based open studio designed for victims of violence (and other hospital patients) to engage them in creating visual arts, including painting, drawing, mask making, and sculpting in clay. KidStART provides patients opportunities to enhance their self-image and self-esteem, factors critical to psychological healing. A successful pilot studio was implemented at Children's Memorial Hospital, and a more comprehensive program, including evaluation and assessment of outcomes, is now being planned. In addition, there are plans to try this program at Cook County Hospital and several community sites (community centers, boys and girls clubs, Cabrini Green Youth Program) for outreach and intervention. Critical to the success of the postvention program is the collaboration with other hospital departments and services, i.e., social work, child and

adolescent psychiatry, child life, and trauma services. Coordinated efforts among these departments ensure a better understanding of these individuals and the most comprehensive services to young people victimized by violence.

REFERENCES:

1. Cooley M, Turner S, Beidel D: Assessing community violence: the children's report of exposure to violence. *J Am Acad Child Adolesc Psychiatry* 34:201-208, 1995.
2. Pynoos R, Frederick C, Nader K, et al: Life threat and post-traumatic stress in school age children. *Arch Gen Psychiatry* 44:1057-1063, 1987.
3. Richters J, Martinez P: The NIMH Community Violence Project: I. Children as victims and witness to violence. *Psychiatry* 56:7-21, 1993.
4. Richters J, Martinez P: The NIMH Community Violence Project: II. Children's distress symptoms associated with violence exposure. *Psychiatry* 56:22-35, 1993.
5. Moran M: Public health strategies urged to prevent violence. *Psychiatr News,* Nov 18, 1994, pp 6-7.

Symposium 4 **Saturday, October 19**
10:00 a.m.-11:30 a.m.

A STATEWIDE SURVEY OF CLIENT COMMUNITY ADJUSTMENT

Larry Davidson, Ph.D., *Assistant Professor, Department of Psychiatry, Yale University School of Medicine, 34 Park Street, New Haven, CT 06519*

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this session, participants should be able to: a) design and implement a large-scale assessment of community adjustment of clients with serious and prolonged psychiatric disorders, and b) relate study findings to program and policy development to better meet the needs of these clients.

OVERALL SUMMARY:

During this symposium, a public-academic collaboration on a statewide assessment of clients with serious psychiatric disorders adjusting to life in the community will be described.

No. 4A
INTRODUCTION, OVERVIEW, AND DISCUSSION

Kenneth M. Marcus, M.D., *Medical Director, Department of Mental Health and Addiction Services, State of Connecticut, 90 Washington Street, Hartford, CT 06106*

SUMMARY:

This presentation will introduce the Client Community Adjustment Study conducted by the Connecticut Department of Mental Health and Addiction Services in collaboration with the Yale University Department of Psychiatry. He will describe the political and policy context that provided an impetus for this examination of the fate of clients with serious mental illness living in the community. Concerns about the possible premature discharge of severely disabled clients, in combination with a recent decrease in community tolerance of deviance, have led some states to reexamine their statutes regarding involuntary commitment, to experiment with the use of mandated outpatient treatment, and to reconsider long-term hospitalization for some clients. After outlining these concerns and introducing the other symposium presenters, Dr. Marcus will return to discuss program and policy implications of the findings presented and their relevance for future systems change in Connecticut.

No. 4B
STATEWIDE ASSESSMENT OF COMMUNITY ADJUSTMENT

Wayne F. Dailey, Ph.D., *Director, Quality Assurance and Improvement, Department of Mental Health and Addiction, P.O. Box 508, Norwich, CT 06360;* Lynne Garner, Ph.D., Eva Jakuba, Ph.D.

SUMMARY:

This presentation will describe the methods and preliminary findings of phase one of the Client Community Adjustment Study. Clients selected for inclusion were those receiving the most intensive community treatment, i.e., residential, case management, and assertive community treatment. Clinicians rated ten dimensions of community adjustment for 7,000 clients. The findings revealed that, despite intensive community support, many clients were having extreme difficulty or were unable to adjust to community life. Nearly one in three was seen as clinically unstable or evidencing significant psychotic symptoms. One in five was experiencing trouble or being victimized. More than one in ten had committed a violent felony at some time in the past. Six percent were likely to be perceived as threatening or menacing by the general public. Demographic and diagnostic profiles of clients having the most serious adjustment difficulties will be compared with those of clients doing well in community life. The effects of long-term hospital care on subsequent community adjustment will be explored. This presentation will conclude with a brief discussion of how these data could be used to develop clinical criteria for clients who might be candidates for involuntary outpatient commitment.

SYMPOSIA

No. 4C
CLIENT AND CLINICIAN INTERVIEWS: METHOD AND FINDINGS

Larry Davidson, Ph.D., *Assistant Professor, Department of Psychiatry, Yale University School of Medicine, 34 Park Street, New Haven, CT 06519;* Jacob K. Tebes, Ph.D., David Stayner, Ph.D.

SUMMARY:

This presentation will describe the methods and preliminary findings of phase two of the Client Community Adjustment Study. From the sample surveyed in phase 1, 150 pairs of clients and clinicians were randomly selected for in-depth interviews concerning their perspectives on the client's community adjustment; 50 clients were drawn from those rated as doing very poorly, 50 from those rated as doing well, and 50 from those in the middle. Clients and clinicians were involved in the development of the interviews, and these open-ended qualitative interviews were then combined with standard, quantitative clinical, functional, and outcome measures to yield an integrated approach. The preliminary findings of this phase of the study will be presented; client perspectives will be compared with those of their clinicians, and the experiences, attitudes, and characteristics of clients who have adjusted well will be compared with characteristics of those who have had difficulty. The program and policy implications of these findings will be discussed as an illustration of how this kind of research can be used to inform systems change.

REFERENCES:

1. Davidson L, Hoge MA, Merrill ME, et al: The experiences of long-stay inpatients returning to the community. *Psychiatry* 58:44-55, 1995.
2. Davidson L, Hoge MA, Godleski L, et al: Hospital or community living? Examining consumer perspectives on deinstitutionalization. *Psychiatr Rehab J,* in press.
3. Jones K, Robinson M, Golightly M: Long-term psychiatric patients in the community. *Br J Psychiatry* 149:537-540, 1986.

Symposium 5 **Saturday, October 19**
1:30 p.m.-3:00 p.m.

APA PRACTICE RESEARCH NETWORK: KEY FINDINGS AND STUDY UPDATE

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*

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this session, participants should be able to describe how the APA Practice Research Network is addressing gaps in psychiatric clinical research and informing routine clinical practice, identify the network's key findings on psychiatric practice patterns and characteristics of psychiatric patients, and list critical methodologic issues in conducting research on routine clinical practice.

OVERALL SUMMARY:

The APA has developed a Practice Research Network to conduct clinical and services research. During this symposium, an annual update will be provided on: a) key findings from the network's core studies, which characterize network members, their patients, and clinical practice patterns; b) studies of specific clinical issues; and c) methodologic issues in conducting practice-based research on routine clinical practice, such as data collection methods, instrument validation, informed consent, and longitudinal patient follow-up.

No. 5A
EVALUATION OF IMPLEMENTATION OF THE APA PRACTICE GUIDELINE ON MAJOR DEPRESSIVE DISORDER

John S. McIntyre, M.D., *Chairperson, Steering Committee on Practice Guidelines, and Board of Trustees Member, American Psychiatric Association, and Chair, Department of Psychiatry, St. Marys Hospital, Suite 210, 919 Westfall Road, Rochester, NY 14618-2670*

SUMMARY:

Although the APA practice guideline on major depression offers considerable promise in improving the quality and outcomes of care, research has demonstrated that specific efforts are needed to assure that the guideline is effectively implemented. The New York State Psychiatric Association, the APA, the RAND Corporation, the National Alliance for the Mentally Ill, and the National Depressive and Manic Depressive Association are studying the effectiveness of two strategies for practice guideline implementation.

The study will include 640 randomly selected psychiatrists in New York State. Each psychiatrist will report on 10 patients with major depression: five patients preintervention and five patients postintervention. A small sample of patients will also provide information.

Three types of intervention are planned: a) a patient guide based on the major depression guideline, b) a concise clinician guide based on the guideline, and c) a series of CME opinion leader meetings. Psychiatrists will be assigned to one of three groups: control group, low-intensity intervention, or high-intensity intervention. Study methods and preliminary findings from the study will be presented.

No. 5B
PSYCHOPHARMACOLOGIC TREATMENT OF CHILDREN AND ADOLESCENTS

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;* Julie M. Zito, Ph.D.

SUMMARY:

Children and adolescents with psychiatric disorders may be considered "pharmacologic orphans" since the range of medications evaluated for safety and efficacy is far narrower than the range of disorders that require treatment. There are no medications approved for treatment of any mood disorder or any psychotic disorder in this age group (although several neuroleptics are approved for the treatment of "severe explosive behaviors"). Drug marketing data suggest, however, that neuroleptics and other medications are widely prescribed for adolescents despite the lack of efficacy data or, worse, negative efficacy data or even evidence of serious risks. Little is known about such treatment aspects as dose, frequency, duration, and use of additional treatments, even in the case of medications and indications for which good efficacy data exist. Specific aims of this presentation are to: a) describe the patterns of medication use for children and adolescents; b) characterize psychiatrists' and parents' assessments of the safety, efficacy, and availability of alternative treatments; and c) characterize psychiatrists' and parents' assessments of the response to medication(s).

Study methods and preliminary findings will be described.

No. 5C
PRACTICE RESEARCH NETWORK STUDY OF PSYCHIATRIC PATIENTS AND TREATMENTS

Joyce C. West, M.P.P., *Research Manager, Office of Research, American Psychiatric Association, 1400 K Street, N.W., Washington, DC 20005;* Deborah A. Zarin, M.D., Harold Alan Pincus, M.D.

SUMMARY:

The core data of the APA Practice Research Network include detailed, linkable data on psychiatrists, patients, and treatments, thereby providing a unique and powerful analytic capability. This includes the ability to examine the relationship of various psychiatrist, patient, and financing/service delivery factors to clinical treatment patterns.

The data to be presented involve sociodemographic and diagnostic characteristics of a large sample of psychiatric patients, including mental and general medical comorbidities, personality disorders, and level of functioning. Details of the types and combinations of treatments provided to psychiatric patients, including psychiatric treatment settings, specific treatments, psychopharmacologic agents, and combinations of treatments, will be included. Variations in the types of psychiatric patients and treatments used in different service delivery systems (e.g., managed care and traditional fee-for-service health plans) will also be presented.

REFERENCES:

1. Mittman BS, Siu A: Changing provider behavior: applying research on outcomes and effectiveness in health care. In Shortell S, Reinhardt U (eds): *Improving Health Policy and Management: Nine Critical Research Issues for the 1990's.* Health Administration Press, Ann Arbor, MI, 1992.
2. Jensen PS, Vitiello B, Leonard H, et al: Design and methodology issues for clinical treatment trials in children and adolescents. Child and adolescent psychopharmacology: expanding the research base. *Psychopharmacol Bull* 30:3-8, 1994.
3. Riddle MA, Geller B, Ryan N: Another sudden death in a child treated with desipramine. *J Am Acad Child Adolesc Psychiatry* 32:792-797, 1993.
4. Schappert SM: *Office Visits to Psychiatrists: United States, 1989-90.* National Center for Health Statistics, Division of Health Care Statistics, Hyattsville, MD, 1993.
5. Zarin DA, West J, Pincus HA, et al: The American Psychiatric Association Practice Research Network. In Sederer LI, Dickey B (eds): *Outcomes Assessment in Clinical Practice.* Williams & Wilkins, Baltimore, 1995.
6. U.S. Congress, Office of Technology Assessment: *Identifying Health Technologies That Work: Searching for Evidence,* OAT-H-608. U.S. Government Printing Office, Washington, DC, September 1994.

Symposium 6 **Saturday, October 19**
1:30 p.m.-3:00 p.m.

EFFECTIVE CASE MANAGEMENT WITH LIMITED RESOURCES

Joel Kanter, M.S.W., *Senior Case Manager, Mount Vernon Community Mental Health Center, 207 Leighton Avenue, Silver Spring, MD 20901;* Ronald J. Diamond, M.D.

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this session, participants should be able to identify strategies for delivering effective case management with diminished resources.

OVERALL SUMMARY:

As mental health and social welfare programs across the United States are experiencing severe budgetary constraints, case managers and administrators working with persons with severe mental illnesses face difficult clinical and programmatic choices. Resource limitations are forcing administrators to increase caseload size, move high-risk clients to less intensive services, and use their staff in new ways. Similarly, case managers are expected to achieve comparable outcomes with larger caseloads.

During this symposium, methods for addressing these issues on administrative, supervisory, and practitioner levels, and for presenting creative strategies that staff on each level can use to address these difficult situations will be explored. These strategies include developing assessment methods for high-risk clients, mobilizing client and community resources, adjusting support and structure, and identifying opportunities for recovery and growth.

Dr. Diamond will provide discussion of these issues.

No. 6A
CASE MANAGEMENT IN MANAGED CARE SETTINGS

Alan Menikoff, M.S.W., M.B.A., *President, U.S. Behavioral Home Care, 3 Clover Lane, Westport, CT 06880*

SUMMARY:

The community care of adults with severe mental illnesses has traditionally been the responsibility of the public sector. Over the last 20 years, assertive community treatment teams, integrating case management and psychiatric care, have demonstrated considerable effectiveness in reducing recidivism and improving community functioning. However, in recent years, commercial insurance carriers and managed care companies have assumed increasing responsibility for patients with severe mental illnesses, a trend that is likely to accelerate. While the success of assertive case management programs in reducing inpatient utilization is appealing to cost-conscious managed care companies, the relative intensity of these services, compared to traditional mental health benefit packages, raises questions when adapted in managed care settings. Mr. Menikoff will discuss recent managed care initiatives adapting assertive case management models to the care and treatment of high-risk patients.

No. 6B
STRATEGIES FOR ADMINISTRATORS AND SUPERVISORS

Robert W. Surber, M.D., *Associate Clinical Professor, Department of Psychiatry, University of California at San Francisco, 529 Kirkham Street, San Francisco, CA 94122*

SUMMARY:

Program administrators and supervisors play a key role in assuring that the limited resources in case management programs are effectively allocated. This presentation will explore administrative strategies in case management that include: a) outcome evaluation measures for cost offsets, client and family satisfaction, and quality of life; b) organizational models for reducing service intensity for stabilized clients; c) interagency agreements to facilitate access to community resources; and d) establishment of explicit expectations for staff performance when community resources are inadequate. Case management supervisors provide a bridge between program leadership and direct service staff. This presentation will outline various supervisory strategies, including clarifying staff roles and expectations, setting priorities for service provision, educating staff about resources and treatment strategies, helping case managers cope with negative feelings about inadequate resources, and providing feedback to administrators about staff experiences and needs.

REFERENCES:

1. Kanter J: Titrating support in case management. *Tie-Lines,* Oct 1987, pp 7-8.
2. Geller JL: When less is more; when less is less. *Psychiatr Serv* 46:1105, 1995.
3. Surber R (ed): *Clinical Case Management.* Sage, Thousand Oaks, CA, 1994.
4. Kanter J: Case management with long-term patients: a comprehensive approach. In Soreff S (ed): *Handbook for the Treatment of the Seriously Mentally Ill.* Hogrefe and Huber, Seattle, WA, 1996.

Symposium 7 **Sunday, October 20**
10:00 a.m.-11:30 a.m.

MOBILE CRISIS TEAMS: CLINICAL AND LEGAL BOUNDARIES

Helen G. Muhlbauer, M.D., *Director, Comprehensive Psychiatric Emergency Program, Bronx Lebanon Hospital Center, 1276 Fulton Avenue, Bronx, NY 10456*

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this session, participants should be able to discuss legal, clinical, and ethical boundary and double-agency problems in mobile crisis intervention.

OVERALL SUMMARY:

Clinical and legal problems specific to mobile crisis intervention will be explored. The presenters will describe the range of services provided and the regulatory oversight of these services. They will consider the clinical, legal, and ethical conflicts of double agency as staff responds to patients, referral sources, and families. The conflicts of interest will be illustrated in general and special psychiatric populations (children and the elderly), and service delivery to multiethnic populations will be discussed. The legal implications of therapist and patient boundary problems and confidentiality in mobile crisis settings will be analyzed in light of recent federal and state court decisions and legislative trends. Risk management issues will be specifically addressed.

No. 7A
PROBLEMS OF DUAL ALLEGIANCE IN MOBILE CRISIS TEAMS

Helen G. Muhlbauer, M.D., *Director, Comprehensive Psychiatric Emergency Program, Department of Psychiatry, Bronx Lebanon Hospital Center, 1276 Fulton Avenue, Bronx, NY 10456;* Karamchand Rameshwar, M.D., Ali Khadivi, Ph.D.

SUMMARY:

Mobile crisis intervention is initiated by many different referral sources, including mental health professionals, police, schools, and families. The mobile crisis staff has the task of imposing on the privacy of a patient in the community. Therapeutic boundaries differ greatly from those in conventional office settings. The mobile crisis team must respect the needs and confidences of both patient and referral sources to perform rapid assessments in the field. This leads to sharp conflicts of interest in the emergency setting. Ethical questions of dual allegiance must be quickly resolved. This issue will be illustrated with case examples, and data from simultaneous surveys of patient and referral source satisfaction will be presented.

No. 7B
MOBILE CRISIS TEAMS AND THE MENTAL HYGIENE LAW IN NEW YORK STATE

Isaac Monserrate, C.S.W., *Assistant Commissioner, New York City Department of Mental Health, 93 Worth Street, New York, NY 10010*

SUMMARY:

In 1986 the New York City Department of Mental Health, Mental Retardation, and Alcoholism Services funded four mobile crisis teams. Today the City of New York has 15 mobile crisis teams and 16 homeless outreach teams. The crisis intervention service provides leadership and support to the teams and assists mental health professionals and the public by coordinating, implementing, and reviewing emergency and nonemergency requests for assistance of at-risk mentally disabled persons in the community who demonstrate behavior dangerous to themselves or others in New York City.

New York City is currently implementing the amended mental hygiene law, which empowers qualified mental health professionals (certified social workers, nurses, and psychologists) to direct the police to involuntarily remove a person in a psychiatric emergency. The presenter will focus on safeguards to assure quality assurance, due process, accountability, and interfacing with police departments, emergency rooms, and citizens.

No. 7C
MOBILE CRISIS: LEGAL AND CONSTITUTIONAL ISSUES

Michael L. Perlin, J.D., *Professor, New York Law School, 57 Worth Street, New York, NY 10013*

SUMMARY:

This presentation will cover legal, constitutional, and ethical issues associated with mobile crisis teams. Special attention will be given to recent state and federal court decisions.

No. 7D
CULTURAL AND ETHNIC ISSUES IN MOBILE CRISIS INTERVENTION

Daniel Garza, M.D., *Director, Mobile Crisis Team, Department of Psychiatry, Elmhurst Hospital, 79-01 Broadway, Elmhurst, NY 11373*

SUMMARY:

Outreach services such as mobile crisis teams must have a particular capacity to adjust to the community that they serve. Elmhurst Hospital's service area in Queens, New York, has one of the most ethnically diverse populations in the United States. The sheer multiplicity of cultures precludes tailoring work to any single group, but the immigrant populations require more psychoeducation and empathy. Consideration of cultural norms requires sensitivity and realization of the impact of a foreign medical and psychiatric tradition entering the home, in contrast to the more conventional experience of the patient conforming to the culture of the clinic or office. Staff discussion and patient psychoeducation are needed to clarify roles, expectations, and boundaries in a multicultural context. Dr. Garza will present data on experience with patients of different age groups.

REFERENCES:

1. Chiu TL, Primeau C: A psychiatric mobile crisis unit in New York City: description and assessment, with implications for mental health care in the 1990s. *Int J Soc Psychiatry* 37:251-258, 1991.
2. Cohen NL (ed): *Psychiatry Takes to the Streets: Outreach and Crisis Intervention for the Mentally Ill.* Guilford Press, New York, 1990.
3. Geller JL, Fisher WH, McDermeit M: A national survey of mobile crisis teams and their evaluation. *Psychiatr Serv* 46:893-897, 1995.
4. Perlin ML: *Law and Mental Disability.* Michie Butterworth, Charlottesville, VA, 1994, chaps 1-2.
5. Zealberg JJ, Santos AB, Fisher RK: Benefits of mobile crisis programs. *Hosp Community Psychiatry* 44:16-17, 1993.

Symposium 8 **Sunday, October 20**
10:00 a.m.-11:30 a.m.

RACE AND PSYCHIATRIC ISSUES IN THE PRISON SYSTEM

William B. Lawson, M.D., Ph.D., *Chief of CMI, Department of Psychiatry, North Little Rock Veterans Affairs Medical Center, 2200 Fort Roots Drive, North Little Rock, AR 72114*

SYMPOSIA

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this session, participants should be able to diagnose more accurately psychiatric disorders in a correctional setting and identify the needs of racial and ethnic minorities with mental illnesses in correctional settings.

OVERALL SUMMARY:

Some have referred to the prison system as the largest provider of mental health services in the United States. The growth of the U.S. prison population has also been associated with an increase in the incarcerated mentally ill and substance abusers. Moreover, diagnostic surveys show that prevalence rates exceed those within the general community. This large population of individuals in need of services for mental illness, substance abuse, and sometimes comorbid disorders raises questions about the ability of the correctional system to address these needs. Racial and ethnic minorities are substantially overrepresented in the prison system. Studies have shown that racial and ethnic minorities do not have access to the most desirable treatment in prison settings. Prevalence, access to psychiatric services (including pharmacotherapy), the role of gender, and the risks of being "triple diagnosed," i.e., having a psychiatric disorder, a substance use disorder, and a general medical condition will be addressed.

No. 8A
PHARMACOTHERAPY OF RACIAL AND ETHNIC MINORITIES IN JAIL

William B. Lawson, M.D., Ph.D., *Chief of CMI, Department of Psychiatry, North Little Rock Veterans Affairs Medical Center, 2200 Fort Roots Drive, North Little Rock, AR 72114*

SUMMARY:

Research over the past decade has shown that the psychopharmacotherapy of racial and ethnic minorities differs from that of Caucasians. African-Americans and Hispanics are more likely to receive antipsychotic medication, even when other medications are warranted, to receive higher doses, to receive more as-needed medication, to complain of medication side effects, and to be noncompliant with medication. These issues are complicated by emerging pharmacokinetic evidence that minority group members should receive less medication. The correctional system may exacerbate these issues because of overrepresentation of minorities, the need for control as well as treatment, the unpopularity of psychiatric approaches, and undesirable racial attitudes and beliefs. Case reports and preliminary findings from patients referred for psychiatric services in a regional jail will be presented. The discussion will be set in the context of how services can be better improved in the correctional setting.

No. 8B
SECURITY LEVELS, MENTAL ILLNESS, AND RACE IN A PRISON SYSTEM

Donald H. Williams, M.D., *Professor of Psychiatry, Michigan State University, Room A236, East Fee Hall, East Lansing, MI 48824*

SUMMARY:

This presentation will be based on the ongoing analysis of data from an epidemiologic survey of the prevalence of psychiatric disorders in the Michigan prison system. The researchers previously reported that lifetime prevalences of alcohol and substance abuse, schizophrenia, anxiety and mood disorders, and cognitive impairments were significantly greater than community rates. The more severely disabled mentally ill tended to be placed in higher-security prisons. Recent analyses have disclosed a bimodal racial distribution of severely and moderately disabled mentally ill prisoners: European-Americans tend to be located in the lower-security prisons, whereas African-American prisoners are located in the higher-security levels. The presentation will investigate the distribution of psychiatric symptoms by race and security level. The discussion will describe organizational processes, identify ethnic, racial, and social issues for majority staff and minority staff, and show how undiagnosed and untreated mental illness contributes to increased prison violence, staff and prisoner stress, and the demonization of the African-American prisoner.

No. 8C
HEALTH CARE FOR WOMEN OFFENDERS: CHALLENGE FOR THE NEW CENTURY

Phyllis A. Harrison-Ross, M.D., *Director of Psychiatry, Metropolitan Hospital, 1901 First Avenue and Ninety-Seventh Street, New York, NY 10029;* James E. Lawrence

SUMMARY:

The population of incarcerated women underwent profound change in the 1980s, as did the impact of women offenders on jail and prison systems. Some of this change is related to the fact that the jail and prison population in the United States became one of the world's largest during the past decade. However, the real change in focus on women is associated with the impact on correctional systems of increasing and intensified demand for specialized health care services hitherto not delivered on a large scale in prisons and jails. The combined effect of high rates of incarceration employed as the social sanction of choice and the increased involvement of poor and minority women in behaviors regarded as criminal has been concentration of unprecedented numbers of women with serious medical problems in state and local correctional institutions. The forces driving this change are unlikely to abate as the new century approaches. The

presenters will examine the changing demographics of women offenders, which drive health care service demand, the scope and prevalence of their health problems, and the current impediments to adequate services. Some recommendations for positive change will be discussed.

REFERENCES:

1. Lawson WB: Racial and ethnic factors in psychiatric research. *Hosp Community Psychiatry* 37:50-54, 1986.
2. Neighbors HW, Williams DH, Gunnings TS, et al: *Prevalence of Mental Disorders in Michigan Prisons* (final report). Submitted to the Michigan Department of Corrections, July 2, 1987.
3. Teplin LA, Abram KM, McClellan GM: Prevalence of psychiatric disorders among incarcerated women. *Arch Gen Psychiatry* 53:502-512, 1996.
4. Griffith EEH, Bell CC: Recent trends in suicide and homicide among blacks. *JAMA* 262:2265-2269, 1989.

Symposium 9 **Sunday, October 20**
10:00 a.m.-11:30 a.m.

CLINICAL SERVICES FOR PSYCHIATRIC COMORBIDITY

Bradley M. Pechter, M.D., *Assistant Professor of Psychiatry, University of Illinois at Chicago, 1601 West Taylor Street, Chicago, IL 60612;* Norman S. Miller, M.D.

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this session, participants should be able to discuss various aspects of clinical services for the patient with psychiatric and addictive problems--treatment models, diagnostic issues, medication management, and innovative psychosocial therapies--and to describe the current state of community resources.

OVERALL SUMMARY:

The mental health provider today faces an alarming number of patients with both addiction and psychiatric illness. These patients we term the "dually diagnosed." In the past these problems went unrecognized and untreated. Patients fell through the cracks of typical psychiatric or addiction service systems. Increasingly, effective services for this complicated population have used an integrated approach.

This symposium will explore the history of health care systems and their present status from clinical and practical standpoints. Assessment and diagnosis are critical for effective services and will be explored in depth. The psychiatrist's role will be examined.

Innovative treatment modalities for the dually diagnosed will be presented. Music and art therapies have been used to complement the basic psychosocial treatments, with interesting results and much promise.

Finally, strengths and weaknesses of community resources will be discussed. After all the hard work that takes place on an inpatient unit, recovery of the dually diagnosed often comes down to placement.

Dr. Miller will be a discussant for this symposium.

No. 9A
RIP VAN WINKLE (WAKING FROM A BIG SLEEP) AND THE MENTALLY ILL SUBSTANCE ABUSER PARADIGM

Vida B. Dyson, Ph.D., *Assistant Professor of Psychology, Department of Psychiatry, University of Illinois, 1601 West Taylor Street, Chicago, IL 60612;* Bradley M. Pechter, M.D., Cherise Chase, R.N., M.A.

SUMMARY:

The assessment and treatment of persons with both severe mental illness and addictive illness became a major concern of mental health professionals in the late 1980s. Several studies, including the National Institute of Mental Health Epidemiological Catchment Area study, found prevalence rates of comorbidity ranging from 30% to 80%. In most mental health settings, concurrent addictive illness was often misdiagnosed or underdiagnosed and the staff were unable to effectively treat their patients' substance dependence. In 1988 the Illinois Task Force on the Mentally Ill Substance Abuser was developed to address the multiple problems of these clients, to whom mental health and substance abuse professionals had not adequately responded in the past. The task force proposed an integrated and coordinated system of service delivery for this patient population. The development of an integrated treatment approach for an inpatient adult psychiatric research facility will be presented. Major issues regarding staff training, assessment of patients, and other essential program components will also be discussed.

No. 9B
THE PSYCHIATRIST'S ROLE IN INTEGRATED TREATMENT

Bradley M. Pechter, M.D., *Assistant Professor of Psychiatry, Department of Psychiatry, University of Illinois at Chicago, 1601 West Taylor Street, Chicago, IL 60612;* Norman S. Miller, M.D.

SUMMARY:

Psychiatric symptoms are nearly universal in purely addicted populations, but the incidence of diagnosable, independent psychiatric disorders is much lower. The most important task for a psychiatrist is to guide the assessment of new patients and ensure proper diagnosis in the dually diagnosed. Techniques and approaches for diagnosis in this complicated population will be discussed. Pharmacologic interventions for the dually diagnosed are

becoming increasingly sophisticated and effective. Medication and diagnostic issues will be discussed at various stages of treatment: intoxication, withdrawal, desire and compulsion, early abstinence, and extended recovery.

Finally, the psychiatrist's role will be explored. The psychiatrist is leader of the multidisciplinary team, consultant for psychosocial treatment groups, prescriber, and supervisor. The psychiatrist must be well versed in treatment of both addiction and general psychiatric populations to be effective with the dually diagnosed.

No. 9C
MUSIC THERAPY FOR THE DUALLY DIAGNOSED

Ellen B. Rayfield, RMT-BC, *Music Therapist, Department of Psychiatry, University of Illinois, 1601 West Taylor Street, Chicago, IL 60612*

SUMMARY:

One of the difficulties in treating dually diagnosed clients is engaging them in treatment in an integrated way. Most clients find it difficult to cope with recovery in both illnesses. The creative arts, especially music, are known to foster group cohesion and engage clients at all levels of functioning in a single group.

Music therapy has become an important component of the inpatient dual diagnosis program at the presenters' adult research unit. It facilitates group discussion, helps with stress management, and encourages insight through expression of feelings. The music therapy groups and individual sessions encourage clients to accept the dual illness and the impact of each disorder on the other.

This presentation will outline music therapy principles and identify specific goals for music therapy with this population. Case studies and published articles about the effect of music therapy on mentally ill and addicted clients will be explored. Finally, Ms. Rayfield will briefly evaluate the effectiveness of music therapy in the presenters' program.

No. 9D
VISUAL ARTS IN THE TREATMENT OF THE DUALLY DIAGNOSED

Constance Kusiciel, B.M., *Art Therapy Intern, Department of Psychiatry, University of Illinois, 1601 West Taylor Street, Chicago, IL 60612*

SUMMARY:

Art therapy uses the visual arts to support a 12-step-based recovery program. Therapy is provided through individual and group sessions for both inpatient and outpatient dually diagnosed populations. The primary therapeutic goal is to engage patients in treatment so that they will be motivated to continue their work toward recovery after discharge. The first step toward engagement is to confront patients with the consequences of addictive behavior and their mental illnesses. Patients' "recovery journals" will be presented. These journals will demonstrate how art making is used to provide patients with a permanent record of these consequences. How this permanent record allows patients to track their progress and set personal goals will also be addressed. In addition, art therapy's usefulness in preventing relapse will be explored. Individuals with comorbid psychiatric illness and addictions use substances to cope with strong negative emotions. Art is a powerful tool for uncovering and containing these strong emotions.

No. 9E
ASSESSMENT OF COMMUNITY RESOURCES: SO WHERE DO WE GO FROM HERE?

Suzanne Schmidtke, M.S.W., *Coordinator of Social Work, Department of Psychiatry, University of Illinois, 1601 West Taylor Street, Chicago, IL 60612;* Phyllis Lewis Robinson, M.S.W.

SUMMARY:

Treatments for persons with mental illness and addictive disorders are in the early stages of development. Systemic design of the treatment approach can significantly affect outcome. Attempts have been made to treat the dually diagnosed patient sequentially and in parallel fashion, both with questionable effectiveness. Integration of mental health and addiction treatments has demonstrated greater efficacy and is currently receiving much attention.

The presenters' facility, an inpatient adult research unit in an urban setting that is part of a state public sector system, has developed a dual diagnosis program based on an integrated model of treatment.

To provide aftercare services for persons who are addicted can be difficult enough given the lack of programs, long waiting lists, and funding requirements. For the dually diagnosed public sector patient, it is even more challenging and requires a great deal of knowledge, skill, and creativity. Public sector patients tend to need a wide range of basic services--funding, stable housing, and vocational and/or day programming--in addition to services that focus on the dual disorders. Different approaches to more effective linkage will be presented in detail.

REFERENCES:

1. Minkoff K: An integrated treatment model for dual diagnosis of psychosis and addiction. *Hosp Community Psychiatry* 40:1031-1036, 1989.
2. Miller NS (ed): *Treating Coexisting Psychiatric and Addictive Disorders.* Hazelden Educational Materials, Center City, MN, 1994.
3. Bednarz LF, Nikkel RE: The role of music therapy in the treatment of young adults diagnosed with mental illness and substance abuse. *Music Therapy Perspectives* 10(1):21-26, 1992.
4. Beck AT, Wright FD, Newman CF, et al: *Cognitive Therapy of Substance Abuse.* Guilford Press, New York, 1993.

SYMPOSIA

Symposium 10 **Sunday, October 20**
1:30 p.m.-3:00 p.m.

THE ROLE OF THE PSYCHIATRIST AS MEDICAL DIRECTOR

Jules M. Ranz, M.D., *Director, Public Psychiatry Fellowship, New York State Psychiatric Institute, 722 West 168th Street, New York, NY 10032;* David A. Pollack, M.D.

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this session, participants should be able to describe the opportunities inherent in the role of the psychiatrist as medical director, discuss how a public psychiatry fellowship trains psychiatrists to undertake the responsibilities of medical director, and describe the experiences of two graduates of the program.

OVERALL SUMMARY:

As the focus of care for most psychiatric patients has moved from the hospital to the community, psychiatric leadership has not kept pace. Outpatient programs and, increasingly, hospitals have seen leadership pass first from psychiatrists to other mental health professionals and, more recently, to professionally trained management personnel. However, because psychiatrists have special medical and legal responsibilities with regard to patient care, most mental health systems have a psychiatrist in the position of medical director, with specific responsibilities as spelled out in the American Association of Community Psychiatrists' recently proposed guidelines for organized mental health delivery systems. These leadership positions are often filled by psychiatrists with no special management training. Lacking such training, most psychiatrists do not really know how to cope with the demands or to fully use the opportunities that accompany these leadership responsibilities. This session will present the Public Psychiatry Fellowship of the New York State Psychiatric Institute and Columbia University, and graduates of the program will describe their experiences. Dr. Pollack will speak from the perspective of both a trainer of public psychiatrists and a medical director of a public sector agency.

No. 10A
TRAINING THE MEDICAL DIRECTOR

Susan M. Deakins, M.D., *Associate Director, Public Psychiatry Fellowship, New York State Psychiatric Institute, 722 West 168th Street, New York, NY 10032*

SUMMARY:

The Public Psychiatry Fellowship of New York State Psychiatric Institute and Columbia University trains psychiatrists to assume leadership roles in public sector mental health programs. Increasingly, that has meant explicit training for the role of medical director. Using the American Association of Community Psychiatrists' guidelines as points of reference, Dr. Deakins will describe the process and outcome of the training. The process consists of presentations on the role of the psychiatrist, talks by alumni and other psychiatrists functioning as medical directors in public sector agencies, and descriptions by the fellows themselves of their roles in field placement agencies. A yearly survey of fellowship alumni indicates that over 90% are pursuing careers in the public sector and over 50% have management positions.

No. 10B
THE ROLE OF MEDICAL DIRECTOR IN A COMMUNITY MENTAL HEALTH CENTER

Julia Eilenberg, M.D., *Medical Director, Ulster Community Services, 239 Golden Hill Lane, Kingston, NY 12401*

SUMMARY:

Dr. Eilenberg will discuss her role as medical director of a community mental health center. Some of the issues presented (with examples) will be negotiating the position of medical director, working with the executive director, medical-legal issues, and decision making vis-a-vis clinical psychiatrists in the agency. Dr. Eilenberg conducts a monthly seminar during which she consults with fellows and faculty concerning her work as medical director, and she will indicate how the fellowship in public psychiatry prepared her for this position.

No. 10C
THE ROLE OF MEDICAL DIRECTOR IN A SOCIAL SERVICE AGENCY

Hunter L. McQuistion, M.D., *Medical Director, Project Renewal, Inc., 200 Varick Street, New York, NY 10014*

SUMMARY:

Dr. McQuistion will discuss his role as medical director of a social service agency providing residential and support services to previously homeless adults with substance abuse and/or severe mental illness. He will describe working with the executive director and other members of the administration, program development, the role of research and evaluation, and training and supervision of psychiatrists working in nontraditional (for the psychiatrist) agencies; examples will be given. Dr. McQuistion serves as a field site supervisor in the fellowship, and he will describe how the fellowship helped him in his position.

REFERENCES:

1. Diamond RJ, Stein LI, Susser E: Essential and nonessential roles for psychiatrists in community mental health centers. *Hosp Community Psychiatry* 42:187-189, 1991.
2. Goldman CR, Faulkner LR, Breeding KA: A method for estimating psychiatrist staffing needs in community mental health programs. *Hosp Community Psychiatry* 45:333-337, 1994.

3. AACP guidelines for psychiatric leadership in organized delivery systems for treatment of psychiatric and substance disorders. *Community Psychiatry* 9:6-7, Autumn 1995.
4. Diamond RJ, Goldfinger SM, Pollack D, et al: The role of psychiatrists in community mental health centers: a survey of job descriptions. *Community Ment Health J* 31:571-577, 1995.

Symposium 11 **Sunday, October 20**
3:30 p.m.-5:00 p.m.

LEGAL AND ETHICAL ISSUES IN DIVIDED TREATMENT

Joint Session with the American Psychiatric Association Auxiliary

Jeremy A. Lazarus, M.D., *Speaker-Elect, American Psychiatric Association, and Associate Clinical Professor, Department of Psychiatry, University of Colorado, 8095 East Prentice Avenue, Englewood, CO 80111;* JoAnn E. Macbeth, J.D.

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this session, participants should be able to identify common ethical and legal dilemmas that result from divided treatment between a psychiatrist and another mental health professional and to describe strategies for dealing with these problems.

OVERALL SUMMARY:

Contemporary psychiatric practice includes the psychiatrist's participation in collaborative or divided treatment with other mental health professionals. Psychiatrists in the past, working in team or hospital settings, have developed guidelines and protocols for these relationships. Newer roles for psychiatrists presented by evolving health care systems and managed care often place the treating professionals in divided treatment situations. Multiple ethical and legal dilemmas can ensue from these relationships and their effects on patient care and interprofessional relationships. The symposium presenters will discuss the most common ethical and legal dilemmas encountered and the ethical and legal principles underlying solutions to these problems.

No. 11A
COMMON ETHICAL DILEMMAS IN DIVIDED TREATMENT

Jeremy A. Lazarus, M.D., *Speaker-Elect, American Psychiatric Association, and Associate Clinical Professor, Department of Psychiatry, University of Colorado, 8095 East Prentice Avenue, Englewood, CO 80111*

SUMMARY:

A thorough background of ethical principles underlying competent treatment, based on opinions of the American Psychiatric Association (APA), American Medical Association, and American Psychological Association, will serve as a stepping-off point in discussing common ethical dilemmas in divided treatment. The presenter's experience with over 20 years of involvement in the APA Ethics Committee, as well as clinical vignettes of cases, will serve as stimuli for further discussion with the audience. The relationship to ethical principles and potential legal problems will be highlighted and also differentiated.

No. 11B
LEGAL ISSUES IN DIVIDED TREATMENT

JoAnn E. Macbeth, J.D., *Special Counsel, American Psychiatric Association, 1400 K Street, N.W., Washington, DC, 20005*

SUMMARY:

Through a discussion of vignettes involving psychiatrists in divided treatment settings, presented initially in order to highlight ethical issues that may arise in such circumstances, the legal risks associated with divided treatment will be discussed and analyzed. The presentation will summarize the practice situations in which divided treatment occurs most frequently and will discuss the sources of legal exposure associated with those treatment situations. It will summarize the factors generally associated with lawsuits and ultimate liability in a psychiatric practice and will analyze the prevalence of these factors in common divided treatment situations. In addition to suggesting the practice situations a practitioner may wish to avoid or minimize in order to keep risk within acceptable limits, the presentation will suggest strategies that may help contain and limit risk, even in circumstances traditionally considered to have higher risk.

REFERENCES:

1. Appelbaum PS: General guidelines for psychiatrists who prescribe medications for patients treated by nonmedical psychotherapists. *Hosp Community Psychiatry* 42:281-282, 1991.
2. Woodward B, Duckworth KS, Gutheil TG: The pharmacotherapist-psychotherapist collaboration. In Oldham JM, Riba MB, Tasman A (eds): *American Psychiatric Press Review of Psychiatry,* vol 12. American Psychiatric Press, Washington, DC, 1993, pp 631-649.

SYMPOSIA

Symposium 12 **Sunday, October 20**
3:30 p.m.-5:00 p.m.

SUBSTANCE ABUSE SCREENING OF PSYCHIATRIC PATIENTS

Vida B. Dyson, Ph.D., *Assistant Professor of Psychology, Department of Psychiatry, University of Illinois, 1601 West Taylor Street, Chicago, IL 60612*

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this session, participants should be able to describe current research findings on the reliability, validity, and diagnostic accuracy of common measures used to screen for substance abuse, use systematic criteria for selecting a screening measure, and discuss the implications of screening practices for treatment of public psychiatric patients.

OVERALL SUMMARY:

The adverse impact of comorbidity on the treatment and prognosis of mentally ill individuals has been well documented. For example, patients' length of hospital stay, rehospitalization rate, and aftercare treatment have been found to be adversely affected by substance abuse. Access to treatment is often limited by misdiagnosis or underdiagnosis of comorbidity. Accurate assessment of substance abuse problems, therefore, is critical for providing appropriate treatment. Furthermore, it is necessary to document its prevalence in a given population. Most screening instruments have been well validated for addictive populations, but there is a paucity of research on their utility and efficiency with public sector psychiatric patients.

No. 12A
RELIABILITY AND VALIDITY OF SCREENING INSTRUMENTS

Vida B. Dyson, Ph.D., *Assistant Professor of Psychology, Department of Psychiatry, University of Illinois, 1601 West Taylor Street, Chicago, IL 60612;* Lawrence Appleby, Ph.D., J.D., Daniel J. Luchins, M.D.

SUMMARY:

Identification of substance abuse problems in the severely mentally ill is critical for accurate diagnosis and appropriate treatment. In spite of the findings of the Epidemiological Catchment Area and other studies, substance abuse in psychiatric patients is often undercounted or misdiagnosed. This may be due to the selection of scales that were not validated for the study population or the failure to account systematically for the effect of prevalence. The findings of a current study of 100 public sector psychiatric patients, which compared several common alcohol and drug abuse screening instruments to the Structured Clinical Interview for DSM-III-R, Patient Version (SCID-P), will be presented. This study demonstrated the reliability and validity of these scales for a public psychiatric population by using a comprehensive clinical epidemiological approach. The discussion will cover significant methodological issues (e.g., point of evaluation) raised by the study, limitations of the study, and suggestions for future research.

No. 12B
DECIDING ON A SUBSTANCE ABUSE SCALE

Lawrence Appleby, Ph.D., J.D., *Assistant Professor of Psychology, Department of Psychiatry, University of Illinois, 1601 West Taylor Street, Chicago, IL 60612;* Vida B. Dyson, Ph.D., Daniel J. Luchins, M.D.

SUMMARY:

Given an array of alcohol and drug measures, as well as varying amounts of information on each, a mental health administrator has the unenviable task of selecting one or more tests to use. The critical question is which criteria to use. Dr. Appleby will review basic psychometric issues of reliability and validity and apply them to the data in the principal study and related research with psychiatric patients. The presentation will focus on diagnostic accuracy, pointing out the limitations of sensitivity and specificity, especially with regard to prevalence, and accenting other clinical epidemiological indices. Findings with addictive and primary care populations also will be discussed. Additional factors for consideration include the time or point of screening, efficiency, risk of errors, use of a multiassessment battery, and current versus lifetime diagnosis. Finally, an unsettled question to be addressed is the use of self-reported versus external information in assessments.

No. 12C
PRACTICAL IMPLICATIONS FOR PUBLIC PSYCHIATRY

Daniel J. Luchins, M.D., *Associate Professor, Department of Psychiatry, University of Chicago Medical School, 5841 South Maryland Avenue, Chicago, IL 60637-2602;* Lawrence Appleby, Ph.D., J.D., Vida B. Dyson, Ph.D.

SUMMARY:

If, as the data suggest, the rate of substance abuse in public psychiatric populations is close to 75%, then why do we need screening instruments? He will focus on the need for measurement as it relates to access to treatment and some of the current barriers. First, dual diagnosis in psychiatric populations is markedly underestimated, and testing increases the probability of identification. A previous study of the effects of mandatory drug testing will be used to document the process. While screening may not detect all substance use disorders, it at least is confirmatory and enhances awareness of the problem for mental health professionals. Second, a brief, but valid and reliable, screening program can be cost-effective,

especially in heavily used emergency rooms. Third, a screening program earmarks the problem case for more careful diagnostic workup and, presumably, more appropriate treatment. Fourth, a quantifiable screening measure permits evaluation of the identification process and treatment. It affords a quick and inexpensive means for following up on our efforts, to determine whether they are effective.

REFERENCES:

1. Kofoed L: Assessment of comorbid psychiatric illness and substance disorders. *New Dir Ment Health Serv* 50:43-55, 1991.
2. Drake RE, Oshen FC, Noondsy DL, et al: Diagnosis of alcohol use disorders in schizophrenia. *Schizophrenia Bull* 18:57-67, 1990.
3. Sackett DL: A primer on the precision and accuracy of the clinical examination. JAMA 267:2638-2644, 1992.
4. Ridgely MS, Goldman HH, Willenbring M: Barriers in the care of persons with dual diagnoses: organizational and financing issues. *Schizophrenia Bull* 16:123-132, 1990.

Symposium 13 **Sunday, October 20**
3:30 p.m.-5:00 p.m.

TRAUMA AND TRAUMA RECOVERY FOR DUALLY DIAGNOSED MEN

David W. Freeman, Psy.D., *Psychologist, Community Connections, 1512 Pennsylvania Avenue, S.E., Washington, DC 20003;* Maxine Harris, Ph.D.

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this session, participants should be able to describe the impact of physical, sexual, and emotional trauma on dually diagnosed men; discuss the core issues in trauma recovery for this population; and identify the central features of a curriculum on trauma recovery for men.

OVERALL SUMMARY:

Men with severe mental illness and substance use disorder frequently have histories of exposure to recurrent, multiple, and complex trauma. Trauma experiences in childhood and adulthood, including physical abuse, sexual abuse, and community violence, have caused significant difficulties for these men. Added complications of poverty and homelessness increase the vulnerability of this population. Because this group of men has usually been excluded from trauma studies, however, the existing literature on men, male trauma, and trauma in general can make only a partial contribution to our understanding of their experience. Focus groups with dually diagnosed male trauma survivors and interviews with clinicians who provide clinical case management to this population have identified the central concerns of this population.

Dr. Harris will provide discussion for this session.

No. 13A
CORE DIMENSIONS OF TRAUMA WORK WITH MALE SURVIVORS

Roger D. Fallot, Ph.D., *Co-Director, Community Connections, 1512 Pennsylvania Avenue, S.E., Washington, DC 20003*

SUMMARY:

This presentation will offer a conceptual framework for trauma recovery in a population of urban, impoverished, dually diagnosed male trauma survivors. Derived from clinical work, focus groups, and staff discussions in an inner-city case management program, this model provides a theoretical structure for individual and group interventions in the development of trauma recovery skills.

Five developmental dimensions emerged as central in assessing the impact of trauma on male identity and on the capacity to cope with multiple problems: self-protection, self-direction, responsibility, mutuality, and self-esteem. In each of these arenas, trauma disrupts development in a way that leads to fragmented and extreme responses. Thus, male survivors may experience extremes of vulnerability and invulnerability, rigid self-control and impulsiveness, under- and overresponsibility, dependence and independence, and shame and generosity. Examples from clinical work will illustrate the relationships among trauma, psychiatric symptoms, substance use, residential instability, and these core experiences.

No. 13B
A TRAUMA RECOVERY CURRICULUM FOR DUALLY DIAGNOSED MEN

David W. Freeman, Psy.D., *Psychologist, Community Connections, 1512 Pennsylvania Avenue, S.E., Washington, DC 20003*

SUMMARY:

This curriculum on male identity, trauma, and trauma recovery is designed for dually diagnosed, urban, impoverished survivors. The core themes in the curriculum were identified by male survivors and their case management clinicians in a series of focus groups sponsored by the presenters. This curriculum is divided into three sections. The identity section addresses the cultural and personal bases of identity, problem-solving resources, and successful coping. The trauma section addresses physical, sexual, and emotional trauma in childhood and adulthood; community violence; and the interactions of trauma, mental illness, substance abuse, and homelessness. The recovery section addresses the impact of trauma along five core dimensions of development and facilitates repair and recovery along each of these five dimensions. The curriculum adopts a skills-building approach that is driven by an empowerment philosophy. Although the curriculum was designed in collaboration with dually diagnosed men in the inner city, it is applicable to other populations of male survivors.

REFERENCES:
1. McCann L, Pearlman LA: *Psychological Trauma and the Adult Survivor: Theory, Therapy, and Transformation.* Brunner/Mazel, New York, 1990.
2. Hunter M: *The Sexually Abused Male: Prevalence, Impact, and Treatment.* Lexington Books, New York, 1990.
3. Peoples KM: The trauma of incest: threats to the consolidation of the self. In Goldberg A (ed): *The Evolution of Self Psychology.* Analytic Press, Hillsdale, NJ, 1991.
4. Herman JL: *Trauma and Recovery.* Basic Books, New York, 1992.

Symposium 14 **Monday, October 21**
8:00 a.m.-9:30 a.m.

WHAT AMERICANS CAN LEARN FROM THE FRENCH SYSTEM

John A. Talbott, M.D., *Liaison, American Psychiatric Association Institute Scientific Program Committee, Professor and Chairman, Department of Psychiatry, University of Maryland School of Medicine, 645 West Redwood Street/P1G08, Baltimore, MD 21201-1542;* David L. Cutler, M.D.

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this session, participants should be able to discuss the history and current status of the French system of mental health care and to describe looming threats, "secteur" (catchment) psychiatry, funding, organizational complexity, and patient outcomes.

OVERALL SUMMARY:

This presentation will review the history and current status of, and looming threats to, the French system of mental health care; specific topics will include "secteur" (catchment) psychiatry, funding, organizational complexity, and patient outcomes.

Dr. Talbott will provide an overview and introduction to the problems of comparing mental health systems in different countries. After the individual presentations, Dr. Cutler 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. 14A
AN OVERVIEW OF THE HISTORY OF THE FRENCH SYSTEM

Simon-Daniel Kipman, M.D., *Association Francaise de Psychiatrie, 7 Rue du Montparnasse, 75006, Paris 00110, France*

SUMMARY:

Dr. Kipman will provide an overview of the history of the French system of care, including the inauguration of "secteur" psychiatry, e.g., by catchment areas, in the 1960s; the relationship of "public" and "private" services; and the role of long-term treatment in France.

No. 14B
THE COMPLEXITIES OF ORGANIZING THE FRENCH SYSTEM

Jean-Yves Cozic, M.D., *Chairman, Department of Psychiatry, Centre Hospital, University De Brest, Hospital De Bohars, Bohars 29820, France*

SUMMARY:

Dr. Cozic will review the complexities of organizing the French system of care and its various funding streams and coverage of services, such as rehabilitation, emergency services, and long-term care.

No. 14C
WHAT HAVE EXPERTS LEARNED BY STUDYING THE FRENCH SYSTEM OF CARE?

Frederic Rouillon, M.D., *Department of Psychiatry, Louis Mour Hospital, 178 Rue des Renouillers, Colombes 92701, France*

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.

Symposium 15 **Monday, October 21**
8:00 a.m.-9:30 a.m.

COMMUNITY TREATMENT OF AXIS II DISORDERS

Paul S. Links, M.D., *Professor of Psychiatry, Wellesley/St. Michael's Hospital, University of Toronto, 160 Wellesley Street East, Toronto, ONT, Canada M4Y 1J3*

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this session, participants should be able to describe the newest models of community treatment for individuals with axis II disorders.

SYMPOSIA

OVERALL SUMMARY:

Individuals with severe axis II (cluster B) disorders are frequent users of mental health services. Their contacts with traditional in- and outpatient services are often abbreviated and are generally unsuccessful. This symposium will present the newest models of community treatment for individuals with axis II disorders. These new models involve staff development and a phased approach to treatment.

No. 15A
COMMUNITY TREATMENT OF AXIS II DISORDERS: A REVIEW

Min-Lin Han, M.D., *Research Fellow, Department of Psychiatry, University of Toronto, 160 Wellesley Street East, Toronto, ONT, Canada M4Y 1J3;* Paul S. Links, M.D., Ronald J. Heslegrave, Ph.D.

SUMMARY:

Patients with severe axis II disorders are frequent users of psychiatric services and have multiple therapy contacts without apparent benefit. To determine whether assertive community treatment approaches are effective for individuals with Axis II Disorders, the presenters reviewed the English-language literature from publication of Stein and Test in 1980 to 1995. Forty relevant articles were located; few specified whether the subjects had specific personality disorders or comorbid disorders. Outcomes were reviewed with particular reference to symptom status, behavioral status (including suicidal and impulsive behaviors), social functioning, and the process of engagement. The findings suggest that assertive community treatment is a promising model for engagement and phased interventions for patients with severe personality disorders. Staff may require the acquisition of specific skills in managing axis II disorders.

No. 15B
A TEAM MODEL OF ASSERTIVE COMMUNITY TREATMENT FOR SEVERE PERSONALITY AND SUBSTANCE-RELATED DISORDERS

William R. McFarlane, M.D., *Chief of Psychiatry, Maine Medical Center, and Professor, University of Vermont Medical School, 22 Bramhall Street, Portland, ME 04102;* David Lambert, Ph.D., Charles L. Johnson, M.D.

SUMMARY:

This presentation will describe a cognitive-behavioral-psychoeducational model of assertive community treatment used for cluster B personality and substance-related disorders. It integrates motivational interviewing and dialectical behavioral therapy into a team structure, while including family and significant others in psychoeducational interventions. Treatment is phased, beginning with assertive outreach until a therapeutic relationship is established, followed by intensive efforts to establish motivation to decrease substance use, followed by social skills training and individual therapy. The goal is for patients to learn less-impulsive alternatives to extreme affective states. The presenters will describe results from a study of 30 subjects with cluster B personality disorders and substance-related disorder and a comparable cohort receiving conventional treatment. The subjects receiving the experimental treatment showed: a) a greater than 90% referral-engagement rate, b) a significant reduction in emergency and inpatient service use, and c) a 34.1% abstinence rate; 26.6% progressed to social skills training.

No. 15C
DIALECTICAL BEHAVIOR THERAPY FOR AXIS II DISORDERS

Charles R. Swenson, M.D., *Associate Professor of Clinical Psychiatry, Department of Psychiatry, Cornell Medical College, 21 Bloomingdale Road, White Plains, NY 10605-1504*

SUMMARY:

Service delivery systems have failed to develop effective, integrated treatments for patients with severe axis II disorders. Frustrated and frustrating, these patients revolve among inpatient, day treatment, residential, emergency, and standard outpatient settings. Markedly different treatment approaches are offered in the various settings, and the full range of medications is typically prescribed. The resulting systemic chaos interacts with and amplifies the emotional and interpersonal dysregulation characteristic of these patients.

Dialectical behavioral therapy is a cognitive-behavioral treatment approach for borderline personality disorder that has demonstrated effectiveness in reducing suicidal behavior, hospitalizations, therapy dropout, and anger. It has been applied in a wide range of treatment settings and recently has been used as a central organizing approach by the departments of mental health in New Hampshire, Connecticut, and Illinois and in Columbus, Ohio. One particularly valuable component is the focus on the needs of caregivers, helping them to stay within treatment guidelines and to receive ongoing support and skills. Use of dialectical behavioral therapy in integrated psychiatric systems will be discussed and illustrated, with particular emphasis on how it equips treatment personnel to remain skillful and maintain morale.

REFERENCES:
1. Links PS: Psychiatric rehabilitation model in borderline personality disorder. *Can J Psychiatry* 38:535-538, 1993.
2. Linehan M: *Cognitive-Behavioral Therapy for Borderline Personality Disorder.* Guilford Press, New York, 1993.
3. Nehls N, Diamond RJ: Developing a systems approach to caring for persons with borderline personality disorder. *Community Ment Health J* 29:161-172, 1993.
4. Stein L, Test M: Alternative to mental hospital treatment, I: conceptual model, treatment program, and clinical evaluation. *Arch Gen Psychiatry* 37:392-397, 1980.

Symposium 16 **Monday, October 21**
10:00 a.m.-11:30 a.m.

HIV PSYCHIATRY IN PRIMARY CARE SETTINGS

Glenn J. Treisman, M.D., Ph.D., *Associate Professor, Department of Psychiatry, Johns Hopkins University, 600 North Wolfe Street/Meyer 4-119, Baltimore, MD 21287-7419*

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this session, participants should be able to describe the benefits of providing psychiatric care for HIV-positive patients in a primary care setting and how the Johns Hopkins Hospital AIDS Psychiatry Service can serve, and has served, as a model.

OVERALL SUMMARY:

The AIDS Psychiatry Service at the Johns Hopkins Hospital provides psychiatric diagnostic evaluations and ongoing treatment for patients infected with HIV. The service has approximately 1,500 patient visits each year and has become a model for the provision of psychiatric care in other primary care settings. The model presumes that HIV-positive patients have a high rate of psychiatric disorders and that both medical and psychiatric compliance are improved by providing all care at one location. It provides for improved communication between various health care team members and a coherent treatment plan. This session will provide an overview of the model as implemented in a hospital-based infectious disease clinic, a community general medical clinic, a consultation/liaison service, and a nursing home. Outcome data, demonstrating the utility of the model, will also be presented.

No. 16A
AN OVERVIEW OF HIV PSYCHIATRY

Glenn J. Treisman, M.D., Ph.D., *Associate Professor, Department of Psychiatry, Johns Hopkins University, 600 North Wolfe Street/Meyer 4-119, Baltimore, MD 21287-7419*

SUMMARY:

Patients followed in the HIV clinic at Johns Hopkins Hospital have extremely high rates of psychiatric disorders. Among one group of new patients, 54% had axis I psychiatric disorders other than substance abuse, 20% were in the midst of major depressive episodes, 74% had substance use disorders, and 20% had either serious dementia or mental retardation. These data suggest that psychiatric disorders may play a role in HIV risk behaviors and the spread of infection.

Two outcome studies have shown that the treatment of patients in the clinic is successful. Of HIV-infected patients with major depression who were treated with pharmacotherapy and psychotherapy, 85% showed improvement. A three-year follow-up study showed that 127 patients treated for a mean duration of 14 months had improvement in direct correlation with compliance. Severity of illness, stage of infection, number of medical or psychiatric diagnoses, and risk factors did not predict outcome, but compliance was robustly predictive of improvement and outcome.

No. 16B
HIV PSYCHIATRY IN A HOSPITAL MEDICAL CLINIC

Constantine G. Lyketsos, M.D., *Assistant Professor, Department of Psychiatry, Johns Hopkins University, Osler 320, Baltimore, MD 21287;* Marc Fishman, M.D., Glenn J. Treisman, M.D., Ph.D.

SUMMARY:

The AIDS service of the Johns Hopkins Hospital/ University cares for more than 3,000 HIV-infected patients in the Baltimore area. Several sites are involved, including a primary care clinic in downtown Baltimore, a dedicated HIV inpatient medical unit, an HIV nursing facility, and community outreach. The AIDS Psychiatric Service was developed to provide psychiatric care in tandem with the medical care available to AIDS patients. A dedicated inpatient psychiatric unit is also in operation. Over 1,000 patients have been evaluated and treated. Current services include two-four weekly evaluations and 30-35 weekly follow-up visits. Psychiatric care is available to HIV-infected patients at all medical care sites. A multidisciplinary team includes psychiatrists, nurses, psychologists, social workers, and outreach workers. Several treatment modalities are used, including pharmacotherapy, substance abuse treatment, psychotherapy, and group therapy. The psychiatric program will be discussed, and specific data on results of the screening program and patient outcomes will be presented.

No. 16C
HIV PSYCHIATRY IN A COMMUNITY MEDICAL CLINIC

Joseph M. Schwartz, M.D., *Instructor, Department of Psychiatry, Johns Hopkins University, 2727 East Strathmore Avenue, Baltimore, MD 21287-7419*

SUMMARY:

Park West Medical Center is a community-based general medical clinic providing care for approximately 2,000 patients, of which approximately 150 are known to be HIV positive. A psychiatric consultation service was established in accordance with the model of the Johns Hopkins AIDS Psychiatry Service. Experiences establishing the service, prevalences of psychiatric disorders in this population, and some preliminary outcome data will be presented. Dr. Schwartz will also address the ease of integrating the AIDS Psychiatry Service model into an established medical practice and the response of the practice to the addition of the psychiatric consultation service.

No. 16D
HIV PSYCHIATRY IN THE INPATIENT SETTING

Marc Fishman, M.D., *Assistant Professor, Department of Psychiatry, Johns Hopkins Hospital, 600 North Wolfe Street/Meyer 4-119, Baltimore, MD 21287-7419;* Joseph M. Schwartz, M.D., Constantine G. Lyketsos, M.D., Glenn J. Treisman, M.D., Ph.D.

SUMMARY:

The Johns Hopkins AIDS Psychiatry Service provides psychiatric consultation for HIV-infected patients in: a) general psychiatric hospital wards; b) general medical, surgical, and obstetric hospital wards; and c) the specialty AIDS medical hospital ward. Additionally, the service provides psychiatric consultation in the subacute and chronic settings of the specialty AIDS intermediate-care nursing facility. Referred patients in these settings have very high rates of psychiatric morbidity. Of a series of referred acutely ill hospital patients, 33% had delirium, 28% had major depression, and 18% had mania. In the nursing facility fully half of all patients were referred to the AIDS Psychiatry Service. These referred patients had an average of three significantly impairing psychiatric symptoms each, and 60% had major psychiatric diagnoses other than dementia or delirium; 54% had dementia, and 48% had major depression. This presentation will describe the consultation experience, with emphasis on differential diagnosis and its variance with treatment setting, issues of liaison and coordination of care with other physicians, and benefits of continuity of care across treatment settings.

REFERENCES:

1. Treisman GJ, Lyketsos CG, Fishman M, et al: Psychiatric care for patients with HIV infection--the varying perspectives. *Psychosomatics* 34:432-439, 1993.
2. Treisman GJ, Fishman M, Lyketsos C: Mental health care of HIV patients. *AIDS Clin Care* 6(8):63-66, 1994.
3. Treisman G, Fishman M, Lyketsos C, et al: Evaluation and treatment of psychiatric disorders associated with HIV infection. In Price RW, Perry SW III (eds): *HIV, AIDS, and the Brain.* Raven Press, New York, 1994, pp 239-250.

Symposium 17 **Monday, October 21**
10:00 a.m.-11:30 a.m.

HOSPICE CARE FOR PATIENTS WITH END-STAGE DEMENTIA

Daniel J. Luchins, M.D., *Associate Professor, Department of Psychiatry, University of Chicago, 5841 South Maryland Avenue, Chicago, IL 60637-2602;* David A. Lindeman, Ph.D.

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this session, participants should be able to discuss the role of and need for hospice as an important service option in end-stage dementia, describe obstacles to service delivery, and identify hospice enrollment criteria that resolve these problems.

OVERALL SUMMARY:

Care of patients in the end stages of dementia is a significant clinical problem. The presenters surveyed families of dementia patients, physicians, and gerontologists regarding what kind of care they viewed as appropriate and available for end-stage dementia patients. Access to hospice care was also addressed in a national survey of hospice programs. Results from these surveys will be presented. For 80% of the hospices, the major problem in serving dementia patients was the difficulty in predicting their survival time; eligibility for the Medicare hospice benefit requires a survival time of 6 months or less. The presenters developed criteria for hospice enrollment of end-stage dementia patients. Findings from the pilot and replication studies should form the basis for empirically based standards for enrolling dementia patients in hospice, thereby increasing access to this important service.

Dr. Lindeman will be a discussant for this session.

No. 17A
ACCESS TO HOSPICE CARE FOR PATIENTS WITH END-STAGE DEMENTIA

Patricia Hanrahan, Ph.D., *Assistant Professor, Department of Psychiatry, University of Chicago, Mail Code 3077, 5841 South Maryland Avenue, Chicago, IL 60637;* Daniel J. Luchins, M.D.

SUMMARY:

Knowledge about the terminal-care preferences of patients with impaired decision-making ability is frequently unavailable; families and physicians must make surrogate judgments. The presenters surveyed more than 1,400 families of dementia patients, physicians, and gerontologists to determine what kind of care was viewed as appropriate for end-stage dementia patients. Palliative care, focusing on pain relief and symptom control, was preferred to aggressive efforts to prolong life. Only 13% of respondents knew of hospices serving dementia patients. Hospice programs across the country also were surveyed. Fewer than 1% of hospice patients had a primary diagnosis of dementia. For 80% of the hospices, the major problem in serving dementia patients was the difficulty in predicting their survival time. As a condition of enrollment, the Medicare hospice benefit requires a physician to certify that a patient is likely to die within 6 months. Because survival times are highly variable in Alzheimer's disease and related disorders, predicting survival time is difficult.

No. 17B
SURVIVAL TIME AMONG HOSPICE PATIENTS WITH END-STAGE DEMENTIA

Daniel J. Luchins, M.D., *Associate Professor, Department of Psychiatry, University of Chicago, 5841 South Maryland Avenue, Chicago, IL 60637-2602;* Patricia Hanrahan, Ph.D.

SUMMARY:

As a condition of enrollment, many hospices require that a physician have certified that the patient is likely to die within six months. This is also a requirement of Medicare reimbursement for hospice. The uncertain survival time of dementia patients thus prevents access to hospice programs. Therefore, enrollment criteria were developed on the basis of characteristics of advanced dementia and a history of medical complications. With these criteria it was possible to enroll 11 patients in a pilot hospice program over two years. The enrollment criteria proved successful in that the median survival time was five months. Preliminary findings from 56 patients in a replication study followed a similar pattern, with a median survival time of three months and an average survival time of 5.4 months. Predictors of survival time included impaired mobility (R = -0.52, $p < 0.001$), reduced interest in eating or ability to eat (R = -0.39, $p < 0.01$), and cachexia (R = -0.35, $p < 0.02$). Medicare reimbursement was also examined. The 1995 per diem rate for the Medicare hospice benefit was $104.03/day, and so for a mean survival time of 5.4 months the average cost to Medicare was $16,927 per patient. The total Medicare reimbursement for the two cohorts was approximately $1 million ($947,912) for 56 patients at the 1995 rate.

No. 17C
HOSPICE CARE FOR DEMENTIA PATIENTS IN NURSING HOMES

Kathleen Murphy, M.D., *Medical Director, Henry Ford Hospice, 6777 W. Maple Road, West Bloomfield, MI 48322;* Daniel J. Luchins, M.D., Patricia Hanrahan, Ph.D.

SUMMARY:

The fastest growing segment of the population is persons over 85, about one third of whom are likely to have dementia. Alzheimer's disease has been ranked as the fourth-leading cause of death, but relatively few hospice patients have a primary diagnosis of dementia. The presenters developed criteria for enrollment of end-stage dementia patients in hospice and conducted a longitudinal study of patients in 10 Midwestern hospices over four years; 27 patients were enrolled in home hospice, and 29 patients were enrolled in nursing home hospice.

This presentation will concern nursing home hospice and clinical aspects of managing end-stage care in an institutional setting. Survival time was a key measure and was defined as the number of days between enrollment in the hospice program and death or, if the patients was not deceased, the number of days from enrollment until the end of the study period. The mean survival time for the 29 hospice patients in institutional settings was 3.8 months, compared to an average of 7.2 months for the 27 home hospice patients (a nonsignificant difference). The average cost was well within the Medicare reimbursement limit. In addition to the Medicare hospice benefit, the hospice patients in nursing homes continued to receive Medicaid. In Illinois, Medicaid reimbursement for hospice patients was limited to 95% of the usual rate.

REFERENCES:

1. Hanrahan P, Luchins DJ: Access to hospice programs in end-stage dementia: a national survey of hospice programs. *J Am Geriatr Soc* 43:56-59, 1995.
2. Hanrahan P, Luchins DJ: Feasible criteria for enrolling end-stage dementia patients in home hospice care. *Hospice J* 10:47-53, 1995.
3. Murphy K, Luchins DJ, Hanrahan P: Survival time among end-stage dementia patients in home hospice and in institutional settings (abstract). Presented at the Annual Symposium of the International Hospice Institute, Vancouver, British Columbia, Canada, 1995.
4. Luchins DJ, Hanrahan P: What is appropriate health care for end-stage dementia? *J Am Geriatr Soc* 41:25-30, 1993.

SYMPOSIA

Symposium 18 **Monday, October 21**
10:00 a.m.-11:30 a.m.

PSYCHOLOGICAL SEQUELAE OF RAPE AND TORTURE IN THE BALKANS

Stephanie von Ammon Cavanaugh, M.D., *Professor of Psychiatry, and Chief, Psychiatric Consultation/Liaison Service, Rush Presbyterian/St. Lukes Medical Center, 1210 Spruce Street, Winnetka, IL 60093-2148*

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this session, participants should be able to: a) identify variables (i.e., demographic characteristics, premorbid factors, war experiences, social supports, and coping strategies) that result in or protect an individual from posttraumatic stress disorder (PTSD) and other psychiatric disorders, and b) describe the assessment and treatment of those having experienced the stressors of war.

OVERALL SUMMARY:

In the spring of 1994 the presenters assisted lawyers working for the United Nations Commission of Experts in gathering testimony from persons who were raped and tortured in the former Yugoslavia. The data collected from this investigation will be used by the U.N. tribunal to prosecute war criminals from the Balkan war. These trials are now beginning in the Hague.

After each witness gave legal testimony to the commission lawyer, psychiatric and medical assessments were performed and psychological and medical interventions were provided.

The individual presentations will be followed by time for questions and discussion of the issues raised.

No. 18A
PSYCHIATRIC DISORDERS RESULTING FROM RAPE AND TORTURE IN THE FORMER YUGOSLAVIA

Stephanie von Ammon Cavanaugh, M.D., *Professor of Psychiatry, and Chief, Psychiatric Consultation/Liaison Service, Rush Presbyterian/St. Lukes Medical Center, 1210 Spruce Street, Winnetka, IL 60093-2148*

SUMMARY:

Psychiatric assessment of 82 victims of rape and torture in the former Yugoslavia included collection of information on: a) demographic characteristics; b) premorbid factors (psychiatric history, physical and emotional functioning, family constellation); c) severity of the rape and torture; d) time since the rape and torture; e) resulting injury; f) observation of family members and others being injured, raped, tortured, or killed; g) loss of family members who were killed or missing; h) other stressful wartime experiences; i) present social supports; j) hope for the future; and k) present concerns (refugee/displaced status, financial worries, personal or family health, worries about the future).

A model will be presented that shows the contribution of these variables to *DSM-IV* psychiatric diagnoses (PTSD, anxiety, depression, and others); the number and severity of symptoms of PTSD, depression, and anxiety; and the *DSM-IV* Global Assessment of Functioning Scale.

The analysis of the data was funded by the John D. and Catherine T. MacArthur Foundation.

No. 18B
COPING IN RESPONSE TO RAPE, TORTURE, AND OTHER TRAUMA

Alice Geis, M.S., R.N., *Clinical Nurse Specialist, Department of Psychiatry, Rush Presbyterian/St. Lukes Hospital, 1720 West Polk Street, Chicago, IL 60612;* Stephanie von Amnon Cavanaugh, M.D.

SUMMARY:

This presentation will examine the data in the study involving the coping methods of the 82 witnesses interviewed in the former Yugoslavia. The subjects coped in ways similar to those of subjects in some other studies; valuable coping methods were proximity to loved ones and finding strength in adversity. Family and friends were cited often and were given weight as sources of strength in the face of seemingly overwhelming trauma and loss. The importance of taking action was noted by a significant number of subjects, who particularly reported benefit from giving legal testimony about the crimes committed against them. As survivors of war crimes who are able and willing to testify about their experiences, often out of a sense of altruism and despite some risk to themselves in doing so, this group may be a particularly resilient population. Quantitative and descriptive methods will be used to relate coping under severe traumatic stress to both the maintenance of mental health and the development of psychiatric disorders and symptoms.

No. 18C
RESETTLEMENT AND ADJUSTMENT OF BOSNIANS IN CHICAGO

Abigail B. Sivan, Ph.D., *Psychologist, Department of Psychiatry, Rush Presbyterian/St. Lukes Hospital, 1720 West Polk Street, Chicago, IL 60612*

SUMMARY:

Refugees from the former Yugoslavia who have resettled in the Chicago area are challenged by a number of different problems. This presentation will address the concerns and adjustment of the more than 2,000 Bosnian refugees who have come to Chicago since 1992. Data from a mental health screening of recently arrived refugees will be discussed, with emphasis on the factors that help identify refugees who have a particularly poor

prognosis for recovery from PTSD. At the same time, the data allow for the identification of protective factors for positive mental health. The availability of resources to support this community will be discussed, as will the more general issue of balancing resettlement/acculturation needs with the need to overcome trauma.

The programs described are funded by the Illinois Department of Public Health and Public Aid.

REFERENCES:

1. Davidson JRE, Foa EB (eds): *Posttraumatic Stress Disorder: DSM-IV and Beyond.* American Psychiatric Press, Washington, DC, 1992.
2. Wilson JP, Beverly R: *International Handbook of Traumatic Stress Syndromes.* Plenum Press, New York, 1993.

Symposium 19 **Monday, October 21**
10:00 a.m.-11:30 a.m.

INTERACTIVE STAFF TRAINING

Patrick W. Corrigan, Psy.D., *Director, Center for Psychiatric Rehabilitation, 7230 Arbor Drive, Tinnley Park, IL 60477*

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this session, participants should be able to describe the interactive staff training approach, identify its costs and benefits, and discuss how it might be adapted for use in the participants' own psychiatric facilities for training and development.

OVERALL SUMMARY:

Successful applications of interactive staff training, a new training approach that helps staff incorporate psychosocial treatment innovations into their rehabilitation programs on an ongoing basis will be presented. On-site collaborative training and organization development are highlights of this approach, which has been implemented in numerous Illinois Department of Mental Health and Developmental Disabilities programs with great success. Interactive staff training departs from previous training strategies in two fundamental ways: a) training is focused on the treatment *team* as a whole, and b) the goal of training is to develop *user-friendly* rehabilitation programs. Training facilitators use this approach to follow a number of distinct steps to maximize teamwork and team ownership, such that program development continues after the consulting relationship ends.

Dr. Corrigan will introduce the session by describing interactive staff training in detail and reviewing findings from the half-dozen published studies of its outcome.

No. 19A
THE IMPORTANCE OF ADDRESSING ORGANIZATIONAL DEVELOPMENT ISSUES IN TREATMENT PROGRAM DEVELOPMENT

Imat Amidjaya, Ph.D., *Singer Mental Health Center, 4402 North Main Street, Rockford, IL 61103*

SUMMARY:

Changing an existing treatment program involves making changes to the organizational system as well. Careful consideration of the organization is important for understanding the barriers to change that will inevitably arise. Resistance to change is functional; without it, treatment programs would fall apart under the slightest external pressure. By understanding and addressing the functions that resistance serves, psychiatrists will improve their ability to effect change. Mental health settings will be described from the perspective of organizational psychology, and the impact of interactive staff training on organizations will be discussed.

No. 19B
THE CONTINUOUS QUALITY IMPROVEMENT COMPONENT OF INTERACTIVE STAFF TRAINING

Marc Levinson, Ph.D., *Clyde L. Choate Mental Health and Developmental Center, 1000 North Main Street, Anna, IL 62906*

SUMMARY:

Once a new treatment program is set up and is running successfully, the next task is to ensure that the program continues after the consultants are gone. The development of continuous quality improvement teams helps to ensure that program integrity remains high and that staff are able to keep adapting the program to the other changes that inevitably arise. The continuous quality improvement team needs to accomplish four ongoing tasks: a) establishing which components of the treatment program should be systematically monitored, b) deciding on the appropriate focus of efforts, c) deciding which indicators will provide the best information for answering questions regarding continuous quality improvement, and d) making recommendations on the basis of what the continuous quality improvement indicators suggest. How to develop continuous quality improvement teams and how to ensure their effectiveness will also be discussed.

No. 19C
LEADERSHIP DEVELOPMENT USING INTERACTIVE STAFF TRAINING

Andrew Garman, Psy.D., *Research Associate, Illinois Staff Training Institute, University of Chicago, 7230 Arbor Drive, Tinley Park, IL 60477*

SUMMARY:

Dramatic and ongoing changes in the delivery of mental health services highlight the need for highly skilled leaders who can recognize organizational needs for adaptation, develop realistic plans for implementing these changes, and give staff the consistent emotional and informational support they need to keep successful programs developing. Unfortunately, few clinicians receive training in management and leadership as part of their formal graduate course work. Industrial and organizational psychology has provided a wealth of information regarding the skills and abilities related to effective leadership in a variety of settings. Recent research on leadership in rehabilitation settings suggests that a similar profile of skills is needed to successfully lead these programs. An attractive staff training approach to leadership development will be discussed.

No. 19D
USING INTERACTIVE STAFF TRAINING TO DEVELOP AN INCENTIVE THERAPY PROGRAM

Jasmeet Sekhon, Psy.D., *Elgin Mental Health Center, 750 South State Street, Elgin, IL 60123*

SUMMARY:

The level of patient involvement sets an upper limit on the effectiveness of any treatment program. Psychiatrists can increase patient involvement by making the benefits of participation more obvious and more available for patients. Token economies and other incentive therapy programs facilitate this involvement by formalizing systems of reward and patient participation. Using an interactive staff training approach, staff of the Elgin Mental Health Center and faculty of the Illinois Staff Training Institute have worked together to set up several successful incentive therapy programs. The steps involved, roadblocks encountered, and successes of this approach will be discussed.

REFERENCES:

1. Corrigan PW, Kwartini WY, Pramana W: Barriers to the implementation of behavior therapy. *Behav Mod* 16:132-134, 1992.
2. Corrigan PW, Luchins DJ, Malan RD, et al: User-friendly CQI for the mental health care team. *Med Interface* 7:89-95, 1994.
3. Corrigan PW, McCracken SG: Refocusing the training of psychiatric rehabilitation staff. *Psychiatr Serv* 46:1172-1177, 1995.
4. Corrigan PW: Use of a token economy with seriously mentally ill patients: criticisms and misconceptions. *Psychiatr Serv* 46:1258-1263, 1995.
5. Corrigan PW, McCracken SG: Psychiatric rehabilitation and staff development: educational and organizational models. *Clin Psychol Rev* 15:699-719, 1996.

Symposium 20 **Monday, October 21**
1:30 p.m.-3:00 p.m.

THE YEAR 2000: WHAT CAN WE DO TO CHANGE THE POWER OF VIOLENCE?
Joint Session with the American Association for Social Psychiatry

Leah J. Dickstein, M.D., *Professor, Department of Psychiatry and Behavioral Sciences; Associate Chair for Academic Affairs; Director, Division of Attitudinal and Behavioral Medicine; and Associate Dean for Faculty and Student Advocacy, University of Louisville School of Medicine, ACB, 550 South Jackson Street, Louisville, KY 40202*

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this session, participants should be able to: a) describe how violence affects minority youth, children, the elderly, and professionals, and b) identify strategies for addressing these problems.

OVERALL SUMMARY:

As the Decade of the Brain ends and the next century looms ahead, psychiatrists, together with colleagues in all the fields of mental health and general medicine, must focus on the increasing power of violence in our society across the life cycle, within and without the home, at work, on the streets, and in small and large communities. The presenters, all recognized national experts, will identify specific issues for the early decades of the twenty-first century.

No. 20A
THE YEAR 2000: CHANGING VIOLENCE--NONWHITE ADOLESCENTS

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

SUMMARY:

From 1946 to 1964 overall age-adjusted homicide rates were 3 per 100,000, and from 1964 to 1970 this rate doubled. The increase correlates with a similar exponential production of new firearms during this period. Similarly, from 1972 to 1985 the rate of adolescent homicide was below 4 per 100,000, but after 1985 the rate rose steadily to 11 per 100,000 in 1992. This increase correlates with a steady increase in production of 9-mm handguns in the United States, from below 100,000 per year from 1973 to 1985 to 400,000 per year by 1989. These patterns suggest that availability of lethal weapons must be reduced to change the power of violence in the year 2000.

In addition to discussing this biotechnical prevention strategy, the presenter will also discuss the need to develop different psychosocial prevention strategies for different adolescent ethnic groups, owing to the different patterns of violence within these groups. Finally, the presenter will discuss some generic psychosocial strategies for preventing violence in all ethnic groups.

No. 20B
DOMESTIC VIOLENCE: NEW TREATMENT MODELS AND CHANGE

Carole L. Warshaw, M.D., *Department of Primary Care and Internal Medicine, Cook County Hospital, 3428 North Jansen, Chicago, IL 60657-1322*

SUMMARY:

Although it has long been recognized that victimization by an intimate partner has serious psychological consequences, development of collaborative models for addressing these issues has been slow. If we truly want to play a role in preventing domestic violence, rather than just treating its consequences, we must work together to address the social and psychological conditions that create and support this kind of violence in the first place.

This presentation will address the intersection of individual and systemic barriers to intervention and prevention and will offer an expanded framework for addressing both clinical issues and social change.

No. 20C
THE POWER OF VIOLENCE FOR CHILDREN AND ADOLESCENTS

Elissa P. Benedek, M.D., *Center for Forensic Psychiatry, 3607 Chatham Way, Ann Arbor, MI 48105-2873*

SUMMARY:

National statistics, the nightly news, and individual tragedies increasingly identify the power of violence toward and by children and adolescents. This presentation will include the most important factors in parenting and schooling and the effects of community and self-esteem, as well as important biologic and genetic factors in the expression of violence involving children and adolescents.

Recommendations for change at multiple levels to decrease the destruction and destructiveness of our future generations will be offered.

No. 20D
GERIATRIC ISSUES AND VIOLENCE IN THE YEAR 2000

Gerald J. Sarwer-Foner, M.D., *Professor of Psychiatry and Behavioral Neurosciences, Wayne State University Medical School, 3220 Bloomfield Shores Drive, West Bloomfield, MI 48323*

SUMMARY:

The presenter will discuss modalities and forms of human aggression in people in the senium and how the expression of their needs for control and dominance is modified in cases of loss of physical and/or mental ability and competence. The discussion will cover the increased necessity for dependence on others and ego defenses used.

People in the senium are vulnerable to abuse, and some are victims of violence by others. The devaluation of the old and their relative helplessness makes them prey for younger persons and others of the same age.

Murder and euthanasia for a multitude of reasons will be discussed.

No. 20E
OUR INDIVIDUAL CONCERNS AND THE POWER OF VIOLENCE

Leah J. Dickstein, M.D., *Professor, Department of Psychiatry and Behavioral Sciences; Associate Chair for Academic Affairs; Director, Division of Attitudinal and Behavioral Medicine; and Associate Dean for Faculty and Student Advocacy, University of Louisville School of Medicine, ACB, 550 South Jackson Street, Louisville, KY 40202*

SUMMARY:

As professionals dealing with all forms of increasing violence in patients' lives, their care, and the broader society, we do not often reflect on our own professional and personal concerns about the power of violence and the need for change related to our own lives.

Yet professionals are victims of violence, both in our professional roles and work sites and in our personal lives. This presentation will identify areas in which professionals should become involved, both on an individual basis and with professional colleagues and institutions.

REFERENCES:

1. Dickstein LJ, Nadelson CC: *Family Violence.* American Psychiatric Press, Washington, DC, 1989.
2. Kaplan SJ (ed): *Family Violence: A Clinical and Legal Guide.* American Psychiatric Press, Washington, DC, 1996.
3. American Academy of Pediatrics Task Force on Adolescent Assault Victim Needs: Adolescent assault victim needs. *Pediatrics,* in press.
4. Lystad M (ed): *Violence in the Home: Interdisciplinary Perspectives.* Brunner/Mazel, New York, 1986.
5. Maddox GL (ed): *The Encyclopedia of Aging.* Springer, New York, 1995.
6. Faulkner LR, Grimm NR, McFarland BH, et al: Threats and assaults against psychiatrists. *Bull Am Acad Psychiatry Law* 18(1):37-46, 1990.

SYMPOSIA

Symposium 21 **Monday, October 21**
1:30 p.m.-3:00 p.m.

CHILD EMERGENCY SERVICES AND MANAGED CARE

Joanne Nicholson, Ph.D., *Assistant Professor, Department of Psychiatry, University of Massachusetts Medical School, 55 Lake Avenue North, Worcester, MA 01655*

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this session, participants should be able to apply a framework inspired by the NIMH Child and Adolescent Service System Program to the evaluation of how managed care affects decision making in mental health emergency services for children and adolescents.

OVERALL SUMMARY:

These three presentations are the latest analyses of data addressing the role of fiscal and larger system changes in decision making and service utilization in child and adolescent mental health emergencies. The transition to the management of mental health and substance abuse benefits, particularly in the public sector, occurred in Massachusetts over the past 4 years. The presentations represent an ongoing effort to apply the criteria of the NIMH Child and Adolescent Service System Program to the evaluation of private sector efforts to manage mental health benefits and reduce costs.

The presenters will provide three sets of analyses of data from child and adolescent emergency screening recidivists before and after the introduction of managed care. These analyses were conducted to address the fears of many clinicians that, in the managed care environment, clients are provided brief, "band-aid" services that do not fully address underlying problems. The assumption is made by many clinicians that utilization reviewers are reluctant to approve the services clients really need, the costlier services, without a fight or until less costly services have been tried. The common concern is that clients will have to keep coming back until their needs are adequately met.

No. 21A
RECIDIVISM IN EMERGENCY MENTAL HEALTH SERVICES PRE- AND POST-MANAGED CARE

Stephen C. Dine-Young, M.A., *Research Assistant, Department of Psychiatry, University of Massachusetts Medical School, 55 Lake Avenue North, Worcester, MA 01655;* Lorna Simon, M.A., Joanne Nicholson, Ph.D.

SUMMARY:

The focus of this presentation will be recidivism for children and adolescents in an emergency mental health service before and after the implementation of Medicaid managed mental health benefits. The rates of recidivism in these two periods will be compared, and factors that contributed to the recidivism in each period will be explored.

Decision making for children and adolescents in the Emergency Mental Health Services at the University of Massachusetts Medical Center will be examined. Recidivism reflects the service needs of children and adolescents who repeatedly experience periods of crisis in their emotional and behavioral functioning. An increase in recidivism in emergency mental health screening might indicate difficulty in identifying and obtaining adequate services.

Looking at whether there was an increase in recidivism from the pre- to post-managed care periods may help understand the changes that managed care made on decision making in a mental health service system for children and adolescents.

No. 21B
TIME BETWEEN VISITS TO AN EMERGENCY MEDICAL HEALTH SERVICE IN A MANAGED CARE CLIMATE

Lorna Simon, M.A., *Research Associate, Department of Psychiatry, University of Massachusetts Medical School, 55 Lake Avenue North, Worcester, MA 01655;* Joanne Nicholson, Ph.D., Stephen C. Dine-Young, M.A.

SUMMARY:

This presentation will examine changes in time between visits by children and adolescents to an emergency mental health screening site between one-year periods before and after the implementation of a Medicaid managed care system for mental health. Factors that led to these changes will also be discussed.

Data on all emergency mental health screening visits for the Central Massachusetts area were collected during a 2.5-year period. The first year of collection was considered the pre-managed-care period. A six-month transition period immediately followed the implementation of the managed care plan. The last year of the period, when the plan was firmly established, constituted the post-managed-care period.

Data were analyzed by using survival analysis and proportional hazards regression. Time between visits was significantly shorter in the post-managed care period. Having the medical emergency room as a referral source and having a diagnosis of disruptive behavior disorder were related to increased time between visits in the post-managed-care period, while age was related to decreased time between visits.

No. 21C
DISPOSITION PATTERNS FOR RECIDIVISTS IN AN EMERGENCY MEDICAL HEALTH SERVICE

Joanne Nicholson, Ph.D., *Assistant Professor, Department of Psychiatry, University of Massachusetts Medical School, 55 Lake Avenue North, Worcester, MA 01655;* Stephen C. Dine-Young, M.A., Lorna Simon, M.A.

SUMMARY:

The focus of this presentation will be disposition patterns for child and adolescent recidivists in emergency mental health services before and after the implementation of Medicaid managed mental health benefits in Massachusetts. While the volume of child and adolescent emergency screen episodes increased between the pre- and post-managed care periods, the percentage of dispositions to inpatient hospitalization decreased significantly.

A question that emerges is whether children's clinical needs are still being met, in spite of the decrease in dispositions to inpatient treatment. Dispositions to intermediate levels of care, i.e., community-based crisis stabilization programs, increased, but it is not clear whether these diversionary programs kept children and adolescents out of the hospital or simply delayed their ultimate inpatient admission. Simply delaying admission would conflict with the goals of serving youth in the least-restrictive environments and of cost reduction.

Clinical and insurance characteristics of recidivists falling into three groups were compared: a) those referred to increasingly restrictive settings, b) those referred to services at the same level of care, and c) those referred to settings of decreasing levels of restrictiveness.

REFERENCES:

1. John LH, Offord DR, Boyle MH, et al: Factors predicting use of mental health and social services by children 6-16 years old. *Am J Orthopsychiatry* 65:76-86, 1995.
2. Marson DC, McGovern MP, Pomp HC: Psychiatric decision making in the emergency room: a research overview. *Am J Psychiatry* 145:918-925, 1988.
3. Rabinowitz J, Slyuzberg M, Salamon I, et al: A method for understanding admission decision making in a psychiatric emergency room. *Psychiatr Serv* 46:1055-1060, 1995.
4. Hillard JR, Slomowitz M, Deddens J: Determinants of emergency psychiatric admission for adolescents and adults. *Am J Psychiatry* 145:1416-1419, 1988.
5. Gutterman EM, Markowitz JS, LoConte JS, et al: Determinants for hospitalization from an emergency mental health service. *J Am Acad Child Adolesc Psychiatry* 32:114-122, 1993.
6. Costello AJ, Dulcan MK, Kalas R: A checklist of hospitalization criteria for use with children. *Hosp Community Psychiatry* 42:823-828, 1991.

Symposium 22 **Monday, October 21**
3:30 p.m.-5:00 p.m.

COMPUTERIZED PRACTICE GUIDELINES FOR PSYCHIATRISTS

David B. Klass, M.D., *Staff Psychiatrist, Illinois Department of Mental Health, 750 South State Street, Elgin, IL 60123*

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this session, participants should be able to define professional practice guidelines, discuss where they can be used in hospital psychiatric practice, describe a database, and identify types of questions that can be asked of databases.

OVERALL SUMMARY:

Professional practice guidelines have descended upon psychiatrists and must be addressed by psychiatric care systems. As a profession we are now asked to decide for ourselves what aspects of our clinical work with patients can be made amenable to these guidelines. Second, given that we decide the domains that permit formalization, we need to create the particular structure, i.e., the guidelines. Finally, we need a means of measuring how well these guidelines are being followed by practitioners within our system.

In the Illinois Department of Mental Health and Developmental Disabilities some progress toward this goal has been made. It was decided that the use of medication should be guided by regular monitoring of blood levels, CBC, liver function, etc., and that these tests should be performed at intervals agreed on by psychiatrists. A database method requiring no additional data entry was developed for measuring how well the guidelines are being followed.

No. 22A

HOW DOES A GROUP OF PSYCHIATRISTS WITHIN A HOSPITAL SETTING RESPOND TO THE ESTABLISHMENT OF PRACTICE GUIDELINES?

David B. Klass, M.D., *Staff Psychiatrist, Illinois Department of Mental Health, 750 South State Street, Elgin IL 60123*

SUMMARY:

Since January 1995, Elgin Mental Health Center, a hospital of over 600 patients with 30 psychiatrists, has generated monthly reports detailing "lab faults." Each psychiatrist receives a list of patients who have not been monitored with the laboratory tests that are to be performed at regular intervals for patients taking lithium, valproic acid, carbamazepine, and antidepressants. The responses of the psychiatrists have evolved over the past year, as have the percentages of searches that show missing laboratory results. Some lessons are very clear. For the process to be taken seriously, the data must be absolutely accurate, clearly reflecting the presence or absence of the requisite test at the required time. Technical problems, such as arrival of results at the computer too late to be noted, must be solved to avoid angering psychiatrists, who already feel put upon by their daily work. In addition, guidelines must be flexible. Some guidelines that initially appear rational may over time prove, from the practitioners' perspective, not to necessarily be in the interest of good clinical care.

SYMPOSIA

No. 22B
THE DEMONSTRATION OF A PARADOX-BASED DATABASE FOR THE MONITORING OF PRACTICE GUIDELINES

Adam Klass, B.A., *President, Saper Development, Suite 2804, 575 West Madison, Chicago, IL 60661*

SUMMARY:

A database system within Paradox, a database manager, was built to monitor practice guidelines set by the Illinois Department of Mental Health and Developmental Disabilities. These guidelines specify the best practice for monitoring the use of antidepressants, carbamazepine, valproic acid and divalproex, and lithium. The use of each of these drugs calls for timely ordering of various blood level tests, thyroid function tests, CBCs, liver function tests, etc. The database system uses pharmacy and laboratory test data derived from the hospital system's mainframe computer to monitor how closely individual hospitals and individual doctors within this system of 20 hospitals and over 400 doctors follow their own practice guidelines. The system, a stand-alone installation running on a personal computer, is built to allow individual hospitals to easily vary some of the parameters of the guidelines. The reports produced are invaluable for satisfying accrediting agencies and managed care networks. They are also used as reminders to the doctors involved.

No. 22C
ASSESSING THE SYSTEM-WIDE IMPACT OF GUIDELINES

Daniel J. Luchins, M.D., *Associate Professor of Psychiatry, University of Chicago, 5841 South Maryland Avenue, Chicago, IL 60637-2602*

SUMMARY:

Starting in January 1996, computerized guidelines became available for all facilities operated by the Illinois Department of Mental Health and Developmental Disabilities. Before this, the system had been developed and used at a single facility and had proved useful both as a clinical tool and for medical administrators. Dr. Luchins will discuss efforts to assess the impact of this computerized system on a statewide basis.

A longitudinal analysis will be used to examine the possible impact on the quality of care provided during the period of its use. The presentation will also cover the effects of the computerized system on the role of medical directors and facility directors at each facility and how it may have influenced the perception of the quality of care as seen by the central office.

No. 22D
COMPUTERIZED PHARMACOTHERAPY QUALITY ASSURANCE

Randy D. Malan, R.Ph., *Director of Pharmacy Service, Department of Mental Health and Drug Dependence, 100 North Ninth Street, Springfield, IL 62765*

SUMMARY:

Starting in July 1987, a computerized quality assurance program was added to the electronic data processing system for pharmaceutical care in the Illinois Department of Mental Health and Developmental Disabilities. This system documents all patient-specific pharmacotherapy activity for all 21 facilities operated by the department. This system has been used to evaluate prescribing practices and, on the basis of clinical evaluation, the development of uniform practice guidelines within the department, affecting the delivery of services on approximately 3 million patient days annually. Mr. Malan will discuss the impact of the system on continuing education efforts within the department, physician prescribing habits, and clinical outcomes.

A longitudinal analysis will examine the possible impact on: a) the quality of care provided; b) the roles of medical directors, facility directors, and program directors; and c) the perception of the quality of care by the central office.

REFERENCES:

1. Green J, Wintfeld N: Report cards on cardiac surgeons: assessing New York State's approach. *N Engl J Med* 332:1229-1232, 1995.
2. Epstein A: Performance reports on quality--prototypes, problems, and prospects. *N Engl J Med* 333:57-61, 1995.
3. Corrigan PW, Luchins DJ, Malan RD, et al: User friendly continuous quality improvement for the mental health team. *Med Interface,* 1994, pp 89-95.
4. Lang JR: Drug utilization review and the new managed care pharmacist. *Med Interface,* 1993, pp 49-50.

Symposium 23 **Tuesday, October 22**
8:00 a.m.-9:30 a.m.

VIOLENCE IN THE WORKPLACE: NEW CHALLENGES

James L. Cavanaugh, Jr., M.D., *Professor of Psychiatry, Rush Medical College, 1725 West Harrison Street, Chicago, IL 60612*

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this session, participants should be able to inform mental health providers of new developments in consultation issues for the prevention of workplace violence, to identify relevant clinical and personnel issues, and to develop comprehensive intervention strategies for the prevention of violence in the workplace.

SYMPOSIA

OVERALL SUMMARY:

New directions in the evaluation and prevention of workplace violence will be reviewed. Consultation in the workplace will be explored from a multidisciplinary viewpoint, addressing issues of concern to both workers and management. The role of the mental health professional in this fast-growing area of workplace consultation will be described. New data on the incidence/prevalence of workplace consultation will be discussed, along with techniques for analyzing "new occurrences," evaluation of dysfunctional employees, and comprehensive prevention strategies. Specialized neuropsychological assessment of subtle organic brain dysfunction in certain dyscontrol syndromes will be described, and comorbidity issues in the clinical presentation of some workplace offenders will be discussed. Finally, a specific paradigm for workplace consultation will be elaborated.

No. 23A
STRUCTURED APPROACH TO WORKPLACE CONSULTATION

Joseph Kinney, M.P.A., *Executive Director, National Safe Workplace Institute, Suite 100, 2400 Crown Point Executive Drive, Charlotte, NC 28227*

SUMMARY:

Violence is a complex phenomenon and can go beyond individual employees' motives and mental health status. This presentation will be an overview of a structured approach to workplace consultation. Policies and procedures, moving from reaction to prevention of workplace violence, will be reviewed, and training of employees and employers in identification of potential problems will be described. Use of validation and documentation to ensure managers' ability to assess threats will be discussed. Informational resources for employees and managers will be disseminated.

No. 23B
DRUGS AND VIOLENCE IN THE WORKPLACE

Peter Bensinger, *President, Bensinger, DuPont, and Associates, Suite 920, 20 North Wacker Drive, Chicago, IL 60606*

SUMMARY:

Drug abuse in the workplace has been linked to violence in the workplace. This presentation will focus on the relation of the two phenomena. Models of consultation to business and industry for assessment of factors associated with workplace violence will be highlighted. Implications for strategies in the prevention of workplace violence will be discussed.

No. 23C
COMPREHENSIVE VIOLENCE PREVENTION STRATEGY

David H. Reid, M.D., *National Medical Director, United States Postal Service, 475 L'Enfant Plaza, S.W., Washington, DC 20260*

SUMMARY:

The U.S. Postal Service is one of the largest employers in the United States. Acts of violence by employees have received considerable media attention. In this presentation important clinical information gathered by the National Medical Director of the U.S. Postal Service will be described. Both internal and external strategies developed within the postal system will be discussed. Strategies to prevent workplace violence for the prehire, post-hire, and post-termination phases of employment will be highlighted.

No. 23D
NEUROPSYCHOLOGICAL ASSESSMENT OF VIOLENCE POTENTIAL

David E. Hartman, Ph.D., *Director of Neuropsychology, Isaac Ray Center, 1720 West Polk Street, Chicago, IL 60612*

SUMMARY:

Violent behavior is a complex, multidetermined phenomenon. Violence in the workplace may involve complex sociological, psychological, biological, and neurological processes. In this presentation, theoretical and practical aspects of a computerized neuropsychological testing paradigm (Human Performance Laboratory) for the assessment of mild to moderate organic brain dysfunction as related to employment fitness will be described. Applications to neuropsychological aspects of emotional dyscontrol syndromes will be noted. Additional clinical aspects of this new technology will be highlighted.

REFERENCES:

1. Kinney JA: *Violence at Work: How to Make Your Company Safer for Employees and Customers.* Prentice-Hall, 1995.
2. *Homicide in the U.S. Workplace: A Strategy for Prevention and Research.* Gordon Press, New York, 1995.
3. Gold M, Bensinger P: *Stop Drugs at Work.* Random House, New York, 1986.
4. Thomas JL: Occupational violent crime: research on an emerging issue. *J Safety Res* 23:55-62, 1992.
5. Monahan J, Steadman HJ: *Violence and Mental Disorder.* University of Chicago Press, Chicago, 1994.

WORKSHOPS

Workshop 1 **Friday, October 18**
8:00 a.m.-9:30 a.m.

INFECTIOUS DISEASES IN PSYCHIATRIC PATIENTS

William B. Lawson, M.D., Ph.D., *Chief of CMI, Department of Psychiatry, North Little Rock Veterans Affairs Medical Center, 2200 Fort Roots Drive, North Little Rock, AR 72114;* Annette S. Slater, M.D., Monica R. Shotwell, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to recognize HIV, hepatitis, and tuberculosis from known screening procedures and develop treatment strategies that take into account the cognitive impairment or high-risk behavior of psychiatric patients with infectious diseases.

SUMMARY:

Recent research has shown that psychiatric patients may be more prone to infectious diseases than the general population, because of their proximity in inpatient settings, poor judgment, and high-risk behavior. The presenters will examine three chronic infectious agents: HIV, hepatitis, and tuberculosis. All three agents can be chronic, have a long latency period, and are often underrecognized in psychiatric facilities. Moreover, close contact and high-risk behavior increase the likelihood of disease transmission. Many psychiatric patients are substance abusers, increasing the risk and complicating the treatment of these disorders. For the severely mentally ill patient, cognitive impairment impedes prevention and treatment. The presenters will discuss the difficulties in recognizing these disorders and reducing high-risk behavior and will propose effective treatment strategies.

REFERENCES:

1. Alter MJ, Margolis HS, Krawczynski K, et al: The natural history of community-acquired hepatitis C in the United States. *N Engl J Med* 327:1899-1905, 1992.
2. Kalichman SC, Kelly JA, Johnson J, et al: Factors associated with risk for HIV infection among chronically ill adults. *Am J Psychiatry* 151:221-227, 1994.

Workshop 2 **Friday, October 18**
8:00 a.m.-9:30 a.m.

DISTURBED EATING PATTERNS IN CLIENTS WITH SCHIZOPHRENIA

Thomas H. Picard, M.D., *Program Director, Hope Unit, Menninger Clinic, P.O. Box 829, Topeka, KS 66601-0829;* Pamela J. Franks, B.S.N., Tenley L. Brown, B.A., Raymond E. Padilla, A.A.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to provide assessment and education for clients and staff regarding harmful effects of disturbed eating patterns/behaviors, recognize specific signs and symptoms of disturbed eating patterns, and assess and manage eating disturbances by use of assessment skills, behavioral management, and medical interventions.

SUMMARY:

Client systems affected by chronic alterations in psychological functioning will be discussed in terms of factors that influence eating patterns/behaviors of clients with schizophrenia. Interactive discussion of eating pattern disturbances will include pica, tobacco ingestion, acuophagia, polydipsia, and disturbed eating behaviors. Biological, psychodynamic, and behavioral factors as affected by delusional systems will be analyzed and explored through interactive audience participation. The workshop will direct the audience to discuss their experiences of signs and symptoms, long-term physical/social effects, medication treatment choices, and behavioral supervision/management of eating pattern tendencies. Case studies will be used to demonstrate specific aspects of eating pattern disturbances. Two functional eating pattern assessment tools will be shared to facilitate assessment and detection of harmful eating patterns. The Client Eating Pattern Assessment Tool and the Caregiver Assessment Tool will be completed by each workshop participant for imaginary or real clients. Slides will provide information, and audience participation will be encouraged through interactive discussion and question-and-answer sessions. The presenters will include a psychiatrist, a nurse and daily living counselors.

REFERENCES:

1. Leadbetter RA, Shutty MS: Differential effects of neuroleptics and clozapine on polydipsia and intermittent hyponatremia. *J Clin Psychiatry* 55:110-113, 1994.
2. James AH, Allen-Mersh TG: Recognition and management of patients who repeatedly swallow foreign bodies. *J R Soc Med* 75:107-110, 1982.

Workshop 3 **Friday, October 18**
8:00 a.m.-9:30 a.m.

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

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

WORKSHOPS

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to differentiate various profiles of clients with mental illness and drug addiction and/or alcoholism (dual disorders), discuss disease concepts and service needs, describe a component for services for dual disorders within existing programs and with existing staff, discuss gaps in services and incompatible treatment for dual disorders, describe interventions, and use program tools and measures for screening and assessment.

SUMMARY:

The workshop will include discussions of the following topics, each including a segment for questions and answers: a) various profiles of clients with dual/multiple disorders and their program needs; b) systemic issues contrasting models of service for discrete disorders and special interventions for dual disorder clients; c) a treatment model that uses a nonconfrontational approach and engages each client at a point of readiness and motivation and includes phase-by-phase interventions from denial to recovery; d) program implementation and tools that incorporate the philosophy and methods effective with dual disorder clients, including instruments for screening, engagement, assessment, progress updates, data collection, and outcome measurement; e) staff development and supervision curriculum and in-service training; f) educational group treatment that can be used within existing programs; g) ancillary programs for family and consumer self-help and use of traditional self-help programs; h) strategies for continuity of care that involve both mental health and substance abuse services, including the Michigan example.

Participants will be encouraged to discuss implementation of treatments and programs within their clinical settings. Videotapes will demonstrate key aspects of dual disorders and treatment.

REFERENCES:

1. Sciacca K, Thompson CM: Program development and integrated treatment for dual diagnosis: mental illness, drug addiction, and alcoholism (MIDAA). *J Ment Health Admin,* in press.
2. Sciacca K, Hatfield AB: The family and the dually diagnosed patient. In Lehman AB, Dixon LB (eds): *Double Jeopardy: Chronic Mental Illness and Substance Use Disorders.* Harwood Academic Press, New York, 1995, chap 12, pp 193-209.
3. Sciacca K: An integrated treatment approach for severely mentally ill individuals with substance disorders. *New Dir Ment Health Serv* 50:69-84, 1991.

Workshop 4 - WITHDRAWN

Workshop 5 **Friday, October 18**
10:00 a.m.-11:30 a.m.

CAREERS IN COMMUNITY PSYCHIATRY

Katherine E. Watkins, M.D., *Robert Wood Johnson Clinical Scholar and Resident in Psychiatry, UCLA Neuropsychiatric Institute, 139 North Saltair Avenue, Los Angeles, CA 90049;* Daniel E. Ferber, M.D., Molly T. Finnerty, M.D., Harold I. Eist, M.D., David M. Giles, M.D., Stephen M. Goldfinger, M.D., Kenneth Minkoff, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to describe the different types of work a community psychiatrist can do and how to negotiate to get the kind of job desired.

SUMMARY:

With the breakdown of the traditional distinction between the public and private practice of psychiatry, community psychiatrists can find themselves working in a variety of settings and doing many different kinds of work. This workshop is designed for medical students, residents, and practicing psychiatrists who are considering a career in community psychiatry and wish to know more about the range of options available and how to pursue them. Featuring brief presentations by a number of individuals who practice in very different settings and with different populations, the workshop will focus on questions raised by participants. Issues such as contract negotiation, salaried versus nonsalaried models, whether to do a fellowship, and questions specific to early-career psychiatrists are just some of the topics to be addressed. In addition to these nuts-and-bolts questions, the different possible roles of a community psychiatrist (administrator, primary physician, consultant, academic) will also be explored.

REFERENCES:

1. Clark GH: Community psychiatric practice. In Dickstein L, Mogul K (eds): *Career Planning for Psychiatrists in the 1990s.* American Psychiatric Press, Washington, DC, 1995, pp 133-142.
2. Vaccaro JV, Clark GH (eds): *Practicing Psychiatry in the Community: A Manual.* American Psychiatric Press, Washington, DC, in press.

Workshop 6 **Friday, October 18**
1:30 p.m.-3:00 p.m.

USE OF NEUROPSYCHOLOGICAL TESTING IN SCHIZOPHRENIA

Daniel Yohanna, M.D., *Director, Outpatient Psychiatry, Northwestern University, 303 East Superior Street, Chicago, IL 60611;* Christopher Randolph, Ph.D., Michael McCrea, Ph.D.

WORKSHOPS

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to discuss current concepts of the neuropathophysiology of schizophrenia and identify psychological tests that can assist in differential diagnosis and treatment planning.

SUMMARY:

Schizophrenia is arguably one of the worst diseases known to medicine. The onset of the illness is typically in young adulthood, with chronic disability of varying severity across a slightly shortened life span.

This workshop will review current understanding of the neuropathophysiology and neuropsychology of schizophrenia. Schizophrenia may be best conceptualized as a neurodevelopmental disorder; a variety of empirical findings implicate specific brain regions. Neuropsychological impairment is a consistent feature of the clinical presentation of this disorder, and neuropsychological status can be important in terms of both differential diagnosis and treatment planning.

Participants will be familiarized with the standard neuropsychological tests that are useful in the assessment of patients with a possible diagnosis of schizophrenia. The nature and course of neuropsychological deficits in schizophrenia will be reviewed, with reference to the existing literature and specific case examples.

It is anticipated that participants will learn the utility of neuropsychological testing in the diagnostic workup and treatment planning for patients with schizophrenic illness. Cognitive deficits are a significant and chronic feature of this devastating disorder and play a particularly large role in determining the success of educational endeavors or vocational/skills training.

REFERENCES:

1. Randolph C, Goldberg TE, Weinberger DR: The neuropsychology of schizophrenia. In Heilman K, Valenstein E (eds): *Clinical Neuropsychology,* 3rd ed. Oxford University Press, New York, 1993.
2. Weinberger DR: Implications of normal brain development for the pathogenesis of schizophrenia. *Arch Gen Psychiatry* 44:660-669, 1987.

Workshop 7 **Friday, October 18**
3:30 p.m.-5:00 p.m.

USE OF COMPUTERS IN A COMMUNITY MENTAL HEALTH SETTING: A PRACTICAL WORKSHOP

H. Rowland Pearsall, M.D., *Associate Professor and Director of Inpatient Services, Yale University School of Medicine, P.O. Box 1842, New Haven, CT 06508-1842;* Michael J. Sernyak, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to identify potential uses of computers in a clinical setting and describe how off-the-shelf computer programs can be used to create clinically useful computer applications without additional programming.

SUMMARY:

This workshop will focus on the use of computers at the Connecticut Mental Health Center and will include examples of how computers can be used to assist in clinical work, improve staff communication, and facilitate teaching. The presentation will demonstrate how to use several commercially available computer programs to develop applications for specific purposes, such as discharge summaries, treatment plans, and patient databases. Examples of applications will be demonstrated, and the audience will have an opportunity to ask questions and to discuss their own experiences in developing practical and cost-effective uses of the computer. The workshop is intended to provide a forum for practical discussion for the slightly-to-moderately computer literate and to stimulate ideas that can be implemented by using equipment and programs that institutions likely already possess with minimal investment in new equipment or programs.

REFERENCES:

1. Modai I, Rabinowitz J: Why and how to establish a computerized system for psychiatric case records. *Hosp Community Psychiatry* 44:1091-1095, 1993.
2. Baskin D: Administrative uses for computer databases in psychiatry. *Psychiatr Ann* 24:30-32, 1994.

Workshop 8 **Saturday, October 19**
8:00 a.m.-9:30 a.m.

MULTIAXIAL TREATMENT PLANNING WITH ADDICT MOTHERS

Anne M. Seiden, M.D., *Chairperson, Department of Psychiatry, Cook County Hospital, Second Floor, 1835 West Harrison Street, Chicago, IL 60612-3701;* Deepak Kapoor, M.D., Janet Chandler, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to: a) formulate realistic treatment plans for chemically dependent women who are pregnant and/or mothers, including those with multiple and often competing problems on all five axes of *DSM-IV,* and b) orchestrate the multiple treatment modalities that are needed.

SUMMARY:

Chemically dependent women, especially as encountered in public sector settings, present a daunting and even bewildering array of clinical and practical problems. The treatment team often does not know where to start, and "dual diagnosis" is an understatement.

Multiaxial diagnosis is clarifying. The large number of potential problems can be screened for and conceptualized under all five axes. Commonly, two-ten problems per axis are found, with the largest number on axis IV.

Interdisciplinary, realistic treatment planning can address most of these problems in due time if they are meaningfully prioritized, with specification of the types and interactive seriousness of problems and thus the intensity of services required (this is the gist of the patient placement criteria of the American Society of Addiction Medicine). Addiction treatment is the cornerstone, since without success in this area it is unlikely that other goals can be achieved and maintained.

Chemical dependency almost always coexists with problems in coping skills and self-esteem. These problem areas can interfere with treatment. Linehan's treatment approach, originally developed for borderline personalities, helps the treatment team proceed systematically in addressing diffuse and multiple problems. It includes psychoeducational groups to develop social and other coping skills and individual therapy to support growth of self-esteem. Group and individual treatments must be closely integrated to work. The individual therapist empathically supports the use of new skills to solve problems but drops this agenda as needed to address risk to life or risk to remaining in treatment.

The panel members will take 20-30 minutes to present the basis of their overall treatment planning model. During the next 60-70 minutes, workshop participants will be encouraged to actively critique this model--especially its controversial aspects--and to discuss examples of multiproblem patients from their own practices that illuminate such controversies.

REFERENCES:

1. Kennedy JA: *Fundamentals of Psychiatric Treatment Planning.* American Psychiatric Press, Washington, DC, 1992.
2. *Patient Placement Criteria for the Treatment of Psychoactive Substance Use Disorders.* American Society of Addiction Medicine, Washington, DC, 1993.
3. Linehan M: *Cognitive Behavioral Treatment of the Borderline Personality.* Guilford Press, New York, 1993.
4. *Patient Records in Addiction Treatment.* Joint Commission on Accreditation of Healthcare Organizations, Oakbrook Terrace, IL, 1992.

Workshop 9 **Saturday, October 19**
8:00 a.m.-9:30 a.m.

MEDICATION IN THE FIELD: COMMUNITY OUTREACH

David C. Lindy, M.D., *Chief Psychiatrist, Visiting Nurse Service, Community Mental Health Services, Third Floor, 1250 Broadway, New York, NY 10001;* Madeleine M. O'Brien, M.D., Leila B. Laitman, M.D., Thomas A. Armistead, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to discuss issues related to the use of psychiatric medications in outreach and home-based settings.

SUMMARY:

With the shift from hospital-based to community-based psychiatric care, outreach-oriented models of treatment are increasingly of interest. These pertain to a wide variety of clinical situations, e.g., mobile crisis units, ongoing home-based treatment, consultation in the field for special populations such as the elderly or persons with AIDS, and mental health services for the homeless mentally ill. A growing literature documents the utility and cost-effectiveness of home-based psychiatric care. Psychotropic medication clearly plays a crucial role in psychiatric treatment, but there has been relatively little discussion specifically concerning the use of psychiatric medication in the field.

This workshop will explore issues related to medication in the field as distinguished from traditional practice. The Visiting Nurse Service of New York's Community Mental Health Services has ten years of experience in delivering a wide array of community-based psychiatric outreach programs. The presentations will include findings from an ongoing study of medication usage in Visiting Nurse Service programs, medication and consultation services in the field, and legal and ethical issues. Participants will be invited to form an informal work group with the goal of establishing practice guidelines for the use of psychoactive medications in the field.

REFERENCES:

1. Cohen NL: *Psychiatry Takes to the Streets: Outreach and Crisis Intervention for the Mentally Ill.* Guilford Press, New York, 1990.
2. Simpson EJ, Seager CP, Robertson JA: Home-based care and standard hospital care for patients with severe mental illness: a randomised controlled trial. *Br J Psychiatry* 162:239-243, 1993.

WORKSHOPS

Workshop 10 **Saturday, October 19**
10:00 a.m.-11:30 a.m.

ENCOUNTERS WITH EXTREMITY: PSYCHIATRIC TRAUMA STORIES

Boris M. Astrachan, M.D., *Professor and Chairman, Department of Psychiatry, University of Illinois at Chicago, 912 South Wood Street, Chicago, IL 60612;* Philip Woollcott, Jr., M.D., Stevan M. Weine, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to identify the major characteristics of encounters with persons in extremity and discuss the therapeutic implications of the narrative approach in working with such severely ill or traumatized people.

SUMMARY:

Psychiatrists and other mental health professionals who work with trauma survivors are acutely aware of the differentness of these experiences, but we struggle to find the right language as professionals to adequately describe their own experiences of it. Extremity is a humanistic literary concept that allows us to look anew at our trauma work as psychiatrists and psychotherapists and to capture its centrality and otherness in our lives. Extremity comes to us as encounters, often traumatic themselves, that are not only events for the person being described but also for the person who is observing and writing. Extremity becomes known through a narrative approach, by which the telling of and listening to stories can transform the traumas' destructive effects.

This workshop will center on the proposition that this process must also include professionals' telling of their stories. Two psychiatrists will tell stories about their encounters with extremity in their lives and in their work with different groups of survivors of trauma, including mental and medical illnesses, genocide, urban community violence, and childhood abuse and neglect. Listeners will be invited to share their stories and to enter into the narrative approach to extremity.

REFERENCES:

1. Weine S, Lamb D: Narrative construction of historical realities in testimony with Bosnian survivors of "ethnic cleansing." *Psychiatry* 58:246-260, 1995.
2. Herman JL: *Trauma and Recovery.* Basic Books, New York, 1992.

Workshop 11 **Saturday, October 19**
10:00 a.m.-11:30 a.m.

PSYCHOLOGY AND RELIGION: EASTERN AND WESTERN VIEWPOINTS

Andrea M. Cooke, M.A., *Coordinator, Mental Health Consumer Education Consortium, Tenth Floor, 160 North LaSalle Street, Chicago, IL 60601;* Arwinda Vasavada, Ph.D., The Reverend Jeffrey McClough, Maureen Kelly, M.S.W., L.C.S.W.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to describe the meaning of psychic healing from a religious point of view.

SUMMARY:

In the course of history the role of the healer has changed from the priest to the physician to the psychiatrist. The deeper understanding of the human organism and its problems extended the search for emotional health in different directions, such as religion, medicine, psychiatry, and psychology. This multisided way of looking at human problems requires a holistic approach and not only the diagnosis of a specialist. It needs the vision of one who can see and has seen through the different facets of human life. Such a person who understands problems from within could be the right person to help, even though the patient may need a specialist's, for example, a psychologist's, help. This total approach is a religious one, although it has nothing to do with rituals or ceremonies. Religion, from the Eastern viewpoint, is the need of the time to live peacefully and harmoniously in this disturbed world. Thus, religion and psychology are complementary.

From the Westem viewpoint, the relationship between Judeo-Christian expressions of religious belief and the various psychological theories and clinical practices is rooted in the tradition of pastoral care. Religion has adopted therapeutic insights for the delivery of pastoral care, and psychological interest has developed in various aspects of religious belief, such as the mobilization of expectant faith and physical healing and the diagnostic value of religious ideation.

The audience will participate by means of questions that, in turn, will initiate more discussion.

REFERENCES:

1. Jung CG: *The Portable Jung.* Campbell J, ed. Viking Penguin, New York, 1976.
2. Meissner WW: *Psychoanalysis and the Religious Experience.* Yale University Press, New Haven, CT, 1986.

WORKSHOPS

Workshop 12 **Saturday, October 19**
10:00 a.m.-11:30 a.m.

THE "FIRM MODEL" OF PATIENT CARE AND POST GRADUATE AND UNDERGRADUATE TRAINING IN PSYCHIATRY AT A VETERANS AFFAIRS MEDICAL CENTER

Frederick S. Sierles, M.D., *Department of Psychiatry and Behavioral Sciences, Finch University of Health Sciences and Chicago Medical School, and Psychiatry Service, North Chicago Veterans Affairs Medical Center, 3942 Chester Drive, Glenview, IL 60025;* Christopher G. Fichtner, M.D., David A.S. Garfield, M.D., Nutan Atre-Vaidya, M.D., Orville J. Lips, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to: a) define the firm model of patient care and medical education and distinguish it from a horizontally oriented treatment and teaching program, and b) summarize the strengths and weaknesses of this approach.

SUMMARY:

In 1993 the medicine service at the Veterans Affairs (VA) Medical Center in North Chicago embarked on a primary care program whereby each enrolled veteran is assigned to a primary care physician, typically a general internist, who is responsible for the patient's health care regardless of whether the patient requires outpatient, inpatient, nursing home, or other care. Numbers and types of patient visits, hospitalizations, and other events are recorded. Patterns of practice and utilization are analyzed in order to produce provider profiles. Primary care physicians, in turn, are assigned to one of three teams, each of which provides backup care for the patient if the patient's primary physician is unavailable. If the patient is admitted to the inpatient psychiatry service, the primary care physician follows the patient in the role of consultant to the assigned psychiatrist. Each medical resident and the psychiatric resident on a PGY-1 rotation are assigned to a primary care team. This program attracted national attention and won the 1994 federal Hammer Award for efficient, effective care.

In the spring of 1995 the psychiatry service and other mental health services at the North Chicago VA Medical Center produced a similar system in which each veteran with a major psychiatric disorder is assigned to a primary psychiatrist, who is responsible for the patient's health care regardless of whether the patient requires outpatient, inpatient, nursing home, or other care. The mental health programs are viewed within the medical center as a second tier of service, so that all psychiatry patients are first enrolled in the primary care program; this assures that each patient is linked with both a primary care physician and a psychiatrist. Continuity of care and the provider-patient relationship are core responsibilities of both programs.

Each psychiatrist is assigned to one of three multidisciplinary mental health teams (A, B, or C) that have both specialty and general practice components. Team A's specialty is geropsychiatry. Its patients are elderly and often have concurrent general medical illness, and its psychiatrists have considerable experience or special qualifications in geropsychiatry. Team B's specialty is neuropsychiatry, and its patients are primarily younger adults with severe and persistent mental illness (e.g., bipolar disorder, schizophrenia) or secondary psychiatric disorders (e.g., psychosis secondary to cerebrovascular accident or epilepsy). Team C specializes in posttraumatic stress disorder and dual diagnosis (substance abuse plus a second psychiatric disorder). Considerable numbers of team C patients have axis II disorders. Each team has the additional responsibility of performing intake examinations or briefly admitting to the inpatient service previously unassigned patients with any psychiatric diagnoses. Coincident with the maturing of the team structure and other changes in the training programs, medical student and resident ratings of their training programs improved notably.

During the first 6 months of the development of the team system, psychiatric residents were assigned to faculty on the basis of year of residency (e.g., PGY-2 residents had both inpatient and outpatient assignments) and clinician teaching skill and enthusiasm. Assignment was not linked to team membership. For example, a PGY-2 resident could be assigned to a team A inpatient service and to a team B outpatient clinic. This limited the continuity of patient care and the continuity of supervision. In January 1996 residents began being assigned primarily to attending physicians within teams. For example, a team A resident attends clinics with the same team A attending physician, who supervises the resident on the team A inpatient service. Simultaneously, a mix of inpatient and outpatient assignments that meets Residency Review Council standards for postgraduate education in psychiatry is ensured.

This patient care model resembles the "firm model" begun in the British National Health Service and, recently, at several VA medical centers (e.g., New Haven) in the United States. The North Chicago VA Medical Center is one of the first in the United States to make trainee assignments in the firm, or vertical, model.

The presentation will cover the development of these patient care and training programs and their strengths and weaknesses. It will also include recommendations for effective development and use of this model.

REFERENCES:

1. Greenfield D: Organizing psychiatric training around "firm models." *Newsletter Am Assoc Dirs Psychiatr Res Training,* Fall 1995, pp 6-7.
2. Desai PN, Sierles FS, Nasrallah HA, et al: The changing VA system: implications for academic affiliations. Presented at the 149th Annual Meeting of the American Psychiatric Association. Washington, DC, 1996, Issue Workshop 6.

WORKSHOPS

Workshop 13 **Saturday, October 19**
1:30 p.m.-3:00 p.m.

CO-OCCURRING MENTAL AND ADDICTIVE DISORDERS

1995-1996 APA/Mead Johnson Fellows Workshop

Faye M.J. Lari, M.D., *1995-1996 APA/Mead Johnson Fellow, and Resident in Psychiatry, University of Maryland, 9-D Mopec Circle, Baltimore, MD 21236;* Daniel E. Ferber, M.D., Fred C. Osher, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to discuss the prevalence of substance use disorders among persons with mental illness in various community settings, identify factors that complicate proper assessment and diagnosis, and compare and contrast various treatment models.

SUMMARY:

According to the Epidemiologic Catchment Area Study, 29% of individuals with mental illness have co-occurring drug- or alcohol-related disorders. This percentage is much higher with schizophrenia or type I bipolar disorder. Traditionally, neither the mental health system nor the substance abuse system was prepared to respond to the treatment needs of individuals with both disorders. Recently, the capacity to provide effective treatment to these individuals has grown.

This workshop will highlight techniques for identifying patients with co-occurring mental health and substance use problems. Difficulties that arise if one of the diagnoses is missed will be discussed. Problems in providing care to the dually diagnosed arise from factors involving the patient, the treatment, and the treatment system. Some of these factors will be discussed. Data from available outcome studies will be reviewed.

The presenters will share vignettes from their experiences in treating this population. After the presentations, attendees will be invited to discuss their related thoughts and experiences. This discussion will be facilitated by an expert on dual diagnosis.

REFERENCES:

1. Regier DA, Farmer ME, Rae DS, et al: Comorbidity of mental disorders with alcohol or other drug abuse: results from the Epidemiologic Catchment Area (ECA) study. *JAMA* 264:2511-2518, 1990.
2. Ries R: Clinical treatment matching models for dually diagnosed patients. *Psychiatr Clin North Am* 16:167-175, 1993.

Workshop 14 **Saturday, October 19**
1:30 p.m.-3:00 p.m.

USING CLINICAL PATHWAYS TO BRIDGE SYSTEMS

Marcia Slomowitz, M.D., *Director, Inpatient Psychiatry, and Assistant Professor of Psychiatry, Northwestern University, Room 547, 303 East Superior, Chicago, IL 60611;* Jan Bultema, M.S.N., Daniel Yohanna, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to describe the development of clinical pathways that bridge inpatient and outpatient systems and discuss the use of outcomes measures in clinical pathways.

SUMMARY:

This interactive workshop will discuss the development and implementation of clinical pathways. Pathways follow the continuity of care, beginning in the emergency service, continuing to the inpatient service, and then linking to outpatient programs. The presenters will speak of their practical experience in establishing pathways, addressing successes and pitfalls of the process. The outcomes measures incorporated within the pathways and initial data from the measures will be presented. Participants will have ample opportunity to talk with the presenters and to gather information relevant to their own service system needs.

REFERENCES:

1. Bultema JK, Mailliard L, Getzfrid MK, et al: Geriatric patients with depression--improving outcomes using a multidisciplinary clinical path model. *J Nurs Admin* 26:31-38, 1996.
2. Hofman P: Critical path method: an important tool for coordinating clinical care. *J Qual Improvement* 19:235-246, 1993.

Workshop 15 **Saturday, October 19**
1:30 p.m.-3:00 p.m.

TREATMENT PLANS: INTEGRATING THE SPIRITUAL

Barbara Sheehan, S.P., *Supervisor/Director, Urban Clinical Pastoral Education, Association of Chicago Theological Schools, 1178 East Fifty-Eighth Street, Chicago, IL 60637;* Andrea H. Schmook

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to assess spirituality, describe the dynamic elements affecting it, and identify treatment forms that integrate spirituality into the healing process.

SUMMARY:

Clinical practice and individual experience demonstrate clearly a strong imperative for integration of the spiritual into treatment plans for persons with mental illness. The focus of this workshop will be the integration of the spiritual component into the overall treatment plan or care map. Spiritual assessment and diagnostic tools will be presented, along with methods for addressing loss, belief systems, and other value systems in the healing process.

Clinical examples will demonstrate the spiritual depths encountered by those with mental illness and the raising from the depths that can be accomplished by moving through grief, using re-imaging and guided imagery, and other spiritual methods. Examples of cure and long-term healing will be incorporated in the workshop.

Spirituality is often a neglected aspect of treatment. This workshop will offer the participants some insights into the importance of the spiritual component. The participants will briefly discuss the meaning of spirituality (not religion) and will be invited to present their own clinical vignettes for discussion.

By focusing on spirituality, this workshop will be a springboard for more effective and integrated treatment of persons with mental illness.

REFERENCES:

1. Farran CJ et al: Development of a model for spiritual assessment and intervention. *J Religion Health* 28:185-194, 1989.
2. Gaiser FJ (ed): Ministry and Mental Health. *Word and World* 9:109-173, Spring 1989.

Workshop 16 **Saturday, October 19**
1:30 p.m.-3:00 p.m.

COMMUNITY TREATMENT OF RELEASED MENTALLY ILL PRISONERS

Donald H. Williams, M.D., *Professor of Psychiatry, Department of Psychiatry, Michigan State University College of Human Medicine, Room A236, East Fee Hall, East Lansing, MI 48824;* Colleen Conklin, R.N., M.S., Odeather Allen Hill, Ph.D., M.S.W., Bertram Stoffelmayr, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to identify the necessary components of a comprehensive community treatment program for released mentally ill prisoners, discuss clinical and administrative issues, and describe a pilot community correctional psychiatric treatment program and studies of treatment outcome.

SUMMARY:

The Michigan Department of Mental Health and the Michigan Department of Corrections determined that 80% of prisoners diagnosed as mentally ill are back in Michigan prisons within two years of release. The presenters are all involved with an innovative community-based treatment program for released mentally ill prisoners that is sponsored by the Detroit-Wayne County Community Mental Health Board. The program is based on an assertive community treatment model and features complete mental health and substance abuse treatment services, vocational rehabilitation services, and ongoing involvement with the state parole and probation services and state academic institutions.

The presenters will briefly describe the program and will then highlight system issues, organization and administration, design and implementation of clinical treatment programs, educational needs of staff, and evaluation of clinical outcomes.

Workshop participants will have opportunities to ask questions about the program, share concerns, or describe plans for establishing their own community-based programs for released mentally ill prisoners.

REFERENCES:

1. Becker M, Diamond R, Sainfort F: A new client-centered index for measuring quality of life in persons with severe and persistent mental illness. *Qual Life Res* 2:239-251, 1993.
2. Burns BJ, Santos AB: Assertive community treatment: an update of randomized trials. *Psychiatr Serv* 46:669-675, 1995.

Workshop 17 **Saturday, October 19**
3:30 p.m.-5:00 p.m.

LEAVING THE IVORY TOWER: FIELD-BASED YOUTH CARE

1995-1996 APA/Mead Johnson Fellows Workshop

M. LaVie Ellison, M.D., *1995-1996 APA/Mead Johnson Fellow, and Psychiatry Resident, Medical University of South Carolina, 171 Ashley Avenue, Charleston, SC 29425;* Suzanne Bender, M.D., Toi L. Blakley, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to discuss the psychiatric needs of youth, use standardized testing for culturally diverse youth, and implement multisystem therapy.

SUMMARY:

In a community treatment setting the psychiatrist must consider the patient's culture, ethnicity, and socioeconomic status in order to implement successful interventions. Assessment and treatment must be environ-

mentally sensitive. This workshop will discuss innovative strategies in the treatment and assessment of culturally diverse youth.

An accurate diagnosis is the basis of an effective treatment plan. Although standardized intelligence tests continue to be used as assessment tools for underprivileged children, there is substantial evidence that the test results may underpredict achievement in these youngsters and may therefore do more harm than good. The future of cognitive assessment for these children lies in a multidimensional approach that emphasizes remediability and instills cognitive skills.

Field-based psychiatric youth services provide innovative methods for treatment and assessment. Specifically, multisystem therapy provides ecologically sensitive, pragmatic, time-limited, individualized treatment with the goals of family preservation and parental empowerment. The therapeutic alliance is enhanced by home-based interventions that identify the strengths and weaknesses of familial interactions. This model is believed to enhance family structure, promote responsible behavior, encourage family affection, and increase family communication.

REFERENCE:

1. Santos AB, Henggeler SW, Burns BJ, et al: Research on field-based services: models for reform in the delivery of mental health care to populations with complex clinical problems. *Am J Psychiatry* 152:1111-1123, 1995.
2. Burns BJ: Mental health service use by adolescents in the 1970s and 1980s. *J Ment Health Admin* 17:87-97, 1990.

Workshop 18 **Saturday, October 19**
3:30 p.m.-5:00 p.m.

WHAT ARE THE BOUNDARIES OF SECLUSION AND RESTRAINT?

Gregory J. Van Rybroek, Ph.D., J.D., *Clinical Director, Mendota Mental Health Institute, 301 Troy Drive, Madison, WI 53704;* Kenneth I. Robbins, M.D., M.P.H.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to describe the current use of seclusion and restraint in U.S. psychiatric facilities, discuss the arguments for uniform standards for seclusion and restraint, and identify issues involving the clinical-ethical boundaries of proper implementation.

SUMMARY:

There are no nationally accepted standards for the use of seclusion and restraint, and their use varies widely. Moreover, there is very little sharing of information among facilities. Hospitals have different philosophies, different policies, and different clientele.

One example of unaddressed problem areas related to seclusion and restraint is the lack of practical definitions of what actually constitutes an emergency. Other issues include, When should clinicians decide that an emergency is over? How do we handle patients who are repeatedly aggressive? Should we simply be applying repetitive emergency measures?

Clinicians need to become proactive participants in the ongoing debate about the rationale for seclusion and restraint. Too often, clinicians are on the receiving end of civil legal actions related to controversial topics and are forced to react through an adversarial process. There is a great need to consider the boundaries of seclusion and restraint from a clinical perspective. For example, arguments can be made for application of seclusion and restraint as a planned response to repetitive aggression in support of a comprehensive treatment program.

REFERENCES:

1. Crenshaw WB, Francis PS: A national survey on seclusion and restraint in state psychiatric hospitals. *Psychiatr Serv* 46:1026-1031, 1995.
2. Robbins KI, Van Rybroek GJ: The state psychiatric hospital in a mature system. *New Dir Ment Health Serv* 66:87-100, 1995.

Workshop 19 **Saturday, October 19**
3:30 p.m.-5:00 p.m.

BRIEF, EFFECTIVE PSYCHOTHERAPIES: IMPLEMENTING NEW MODELS

Linda G. Gochfeld, M.D., *Clinical Professor of Psychiatry, Robert Wood Johnson Medical School, University of Medicine and Dentistry of New Jersey, University Behavioral HealthCare, 671 Hoes Lane, Piscataway, NJ 08855;* Honie B. Crandall, M.D., David A. Moltz, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to describe the basic principles of brief, effective psychotherapies in contrast to longer-term approaches, identify various types of brief therapy and their indications, and discuss the administrative issues in implementing these techniques.

SUMMARY:

In both community mental health and managed care, it has become important to use cost-effective, time-sensitive treatments. Some general principles distinguish these treatments from long-term models: they are action oriented, identify a clear goal and focus, emphasize the present and the future, use strengths and resources, and view the therapist as consultant and educator. Brief psy-

chodynamic therapies, interpersonal therapy, behavioral models, cognitive therapy, and Eriksonian strategic and solution-focused approaches are all useful for various patient groups.

Many administrative issues arise in reorganizing services and retraining staff to use briefer psychotherapies. A carrot-and-stick approach may be necessary, with the assignment of a flow of new intakes, while staff are given support and training in the new models. Reasons for staff resistance include the doubt that patients will be well served, philosophical differences about the essence of therapy, difficulty in functioning in more-active therapies, and simple lack of skills. Unit leaders must first be convinced. Changes in intake procedures, assessment, and treatment planning are necessary. Paperwork and other constraints must be examined.

A program to train clinicians will be described. Participants will be encouraged to share their experiences in implementing short-term treatments in their own settings.

REFERENCES:

1. Budman SH, Gurman AS: *Theory and Practice of Brief Psychotherapy.* Guilford Press, New York, 1988.
2. Barlow DH (ed): *Clinical Handbook of Psychological Disorders: A Step-by-Step Manual.* Guilford Press, New York, 1993.

Workshop 20 **Saturday, October 19**
3:30 p.m.-5:00 p.m.

GERIATRIC PSYCHIATRY IN THE COMMUNITY SETTING

Deborah A. Reed, M.D., *Assistant Professor of Clinical Psychiatry, Department of Psychiatry, Northwestern University, 400 Saddle Run, Lake Forest, IL 60045;* Robert C. Marks, M.D., Lesley M. Blake, M.D., Sandra S. Swantek, M.D., Andrea Fox, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to describe detection and management of depression and substance use problems in older adults living in the community and to outline an integrated approach involving both community resources and hospital services.

SUMMARY:

Depressive disorders are common in community-dwelling elderly people, often are undetected, and contribute to significant psychological and functional morbidity. When recognized, depressive disorders can be difficult to treat in this population for a variety of reasons. An integrated approach involving both community resources and hospital-based services will be presented. Although generally overlooked or forgotten in the practice of geriatric medicine, substance use disorders do occur and are often precipitated by social isolation and medical illness.

Careless use of analgesics and sedatives is common and can result in the appearance of depressive symptoms and disordered cognition. Methods for detection, management, and prevention of substance use disorders will be discussed. The role of the geriatric psychiatric consultant in nursing homes will also be examined. An in-home geriatric support program for integrated medical and psychiatric services will be presented. Implications for the community-based treatment of geriatric patients, who will constitute over 13% of the U.S. population by the year 2000, will be addressed.

REFERENCES:

1. Atkinson JH, Shuckit MA: Geriatric alcohol and drug misuse and abuse. *Adv Subst Abuse* 3:195-237, 1983
2. George LK, Blazer D, Hughes DC, et al: Social support and the outcome of major depression. *Br J Psychiatry* 154:478-485, 1989.

Workshop 21 **Sunday, October 20**
8:00 a.m.-9:30 a.m.

TELEPSYCHIATRY AND THE DEVELOPMENTALLY DISABLED

Robert J. Pary, M.D., *Associate Professor and Assistant Chairman, Department of Psychiatry, Southern Illinois University School of Medicine, P.O. Box 19230, Springfield, IL 62794-9230;* Earl L. Loschen, M.D., Carl J. Getto, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to identify opportunities and practical barriers in providing telepsychiatry for persons with developmental disabilities.

SUMMARY:

According to APA Task Force Report 30 (*Psychiatric Services to Adult Mentally Retarded and Developmentally Disabled Persons*), about 25% of adult and child residency training directors are interested in having presentations on the developmentally disabled at APA meetings. It is somewhat surprising that the topic of telepsychiatry for individuals with developmental disabilities has been virtually ignored since it was reported over 25 years ago. Menolascino and Osborne recognized that telemedicine technology may provide remote areas access to quality consultative services as well as a tool for training residents.

This workshop will discuss the Southern Illinois University School of Medicine's experience with telemedicine and, more specifically, telepsychiatry for the developmentally disabled. Videotapes of actual consultations will serve as stimuli for discussion of a range of topics, including financing, doing a physical examination through telemedicine, clinical barriers to telepsychiatry consultations for the developmentally disabled, and audience participants' experiences with telepsychiatry.

WORKSHOPS

REFERENCES:
1. Szymanski L, Madow L, Mallory G, et al: *Psychiatric Services to Adult Mentally Retarded and Developmentally Disabled Persons,* APA Task Force Report 30. American Psychiatric Press, Washington, DC, 1990.
2. Menolascino FG, Osborne RG: Psychiatric television consultation for the mentally retarded. *Am J Psychiatry* 127:157-162, 1970.

Workshop 22 **Sunday, October 20**
8:00 a.m.-9:30 a.m.

A RELAPSE PREVENTION PROGRAM IN A COMMUNITY MENTAL HEALTH CENTER

H. Rowland Pearsall, M.D., *Associate Professor and Director of Inpatient Services, Yale University School of Medicine, P.O. Box 1842, New Haven, CT 06508-1842;* Larry Davidson, Ph.D., Therese E. DiCosmo, M.S., Elizabeth Grottole, M.P.H.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to describe factors contributing to recurrence of psychiatric symptoms, an approach to identifying relapse signatures in readmitted patients, and possible group treatments for relapse.

SUMMARY:

Connecticut Mental Health Center is a state-funded community mental health center that provides both inpatient and outpatient services. During the past several years it has experienced a 38% increase in inpatient admissions and a decrease in the length of stay to 12-14 days. Over the same period readmissions within 90 days of discharge have increased from 17% to over 25%.

In an effort to decrease the readmission rate, a relapse-prevention program for psychiatric patients was introduced in August 1995. Key elements include: a) daily contact with outpatient clinicians, b) development of an inpatient group focused on symptoms of relapse and coping skills, c) completion of a relapse symptom checklist and discharge contract before discharge, and d) a three-month follow-up outpatient group co-led by a former patient and a member of the outpatient staff.

The presenters will discuss basic aspects of this program and will review findings from the relapse symptom checklist and their experience with the consumer/clinician-led outpatient group. Audience members will have an opportunity to discuss the benefits and difficulties of such a relapse program with a panel of clinicians, including consumer providers who have been involved in implementing the program.

REFERENCES:
1. Hogarty GE: Prevention of relapse in chronic schizophrenic patients. *J Clin Psychiatry* 54:18-23, 1993.
2. Herz MI, Mellville C: Relapse in schizophrenia. *Am J Psychiatry* 137:801-805, 1980.

Workshop 23 **Sunday, October 20**
8:00 a.m.-9:30 a.m.

PRACTICAL MANAGEMENT OF PATIENTS IN CRISIS

Todd R. Griswold, M.D., *Director, Partial Hospitalization, Department of Psychiatry, Harvard Medical School and Cambridge Hospital, 1493 Cambridge Street, Cambridge, MA 02139;* Douglas H. Hughes, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to identify and discuss the major areas of challenge and change in the management of psychiatric crisis.

SUMMARY:

Managing patients in crisis has become an area of increased clinical interest, at least partly because of the expansion of psychiatric emergency services and the changes resulting from managed care. Effective crisis treatment requires an integration of approaches: psychotherapeutic, psychopharmacologic, systems, and practical. Close attention will be given to diagnostic, medicolegal, service system, and managed care concerns.

This workshop will review these components of effective management of patients in crisis and will highlight areas of controversy and recent change. Case examples will be presented to illustrate clinical dilemmas, and workshop participants will be invited to describe how they would approach the cases. The case examples will lead to a wider discussion of approaches to crisis management. The discussion will cover hands-on restraint techniques and some of the newer drugs being used in crisis management.

REFERENCES:
1. Hughes DH: Can the clinician predict suicide? *Psychiatr Serv* 46:449-451, 1995.
2. Hughes DH: Assessment of the potential for violence. *Psychiatr Ann* 24:579-583, 1994.

Workshop 24 **Sunday, October 20**
1:30 p.m.-3:00 p.m.

COLLABORATIVE DISCHARGE PLANNING WITH CHRONIC PATIENTS

Rebecca R. Neal, M.D., *Assistant Professor, Department of Psychiatry, New Hampshire Hospital, 105 Pleasant Street, Concord, NH 03301;* Susan Spellman, M.S.N., Dorothy M. Maloney, D.Min., Jan J. Arsenault, M.S.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to identify common problems contributing to lengthy or frequent hospitalizations, list some of the guiding principles in treatment planning, and describe innovative approaches to minimizing subsequent admissions.

SUMMARY:

"Treatment resistance." "Institutionalization." "The revolving door." These terms describe phenomena that pose special challenges for mental health clinicians and severely limit the lives of our patients. Included among an array of clinical problems are lengthy and/or frequent hospital stays.

This workshop will share the efforts of a multidisciplinary group of clinicians representing staff from a state hospital inpatient unit and community clinics who collaborate regularly in the care of involuntarily committed chronically psychotic patients. The audience will be encouraged to respond to case vignettes, from which general principles will be drawn. Emphasis will be placed on skillful problem-based assessment and a working alliance among the patient, the inpatient team, and the outpatient staff as prerequisites for successful treatment planning and discharge.

REFERENCES:

1. Geller JL: Treating revolving-door patients who have "hospital-philia": compassion, coercion, and common sense. *Hosp Community Psychiatry* 44:141-146, 1993.
2. Chen A: Noncompliance in community psychiatry: a review of clinical interventions. *Hosp Community Psychiatry* 42:282-287, 1991.

Workshop 25 **Sunday, October 20**
1:30 p.m.-3:00 p.m.

OIL AND WATER, CAN THEY MIX? PUBLIC MENTAL HEALTH SERVICES AND MANAGED CARE

1995-1996 APA/Mead Johnson Fellows Workshop

Doris E. Sami, M.D., *1995-1996 APA/Mead Johnson Fellow, and Child-Adolescent Fellow, Langley Porter Psychiatric Institute, University of California at San Francisco, Box CAS-0984, 401 Parnassus Avenue, San Francisco, CA 94143;* Juanaelena Garcia, M.D., John D. McLennan, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to: a) describe potential benefits and pitfalls involved in a public system's development of its own managed mental health care versus contracting for managed care services through a private vendor, and b) identify strategies for maximizing effectiveness and patient/provider satisfaction in public managed mental health care settings.

SUMMARY:

Given increasing health care expenditures, measures are being enacted in diverse health care arenas in attempts to limit spending. In the public sector, states are in various stages of reorganizing their health care delivery services, including their provisions for mental health care.

As managed care has become significant in private sector mental health care, some states have begun a transition to a mental health care system that uses managed care principles. Accordingly, some public sector programs are contracting with private managed care vendors for mental health services, and other public programs are developing their own managed care style of mental health service delivery. Another option is integration of the two approaches--the development of one's own managed mental health program while contracting with private vendors for specific services.

The presenters have had varying levels of experience with public mental health programs experimenting with managed care options. They will report on the experiences of particular programs in making the transition to managed care principles and on patient and provider satisfaction.

REFERENCES:

1. Wells KB, Astrachan BM, Tischer GL, et al: Issues and approaches in evaluating managed mental health care. *Milbank Q* 73:57-75, 1995.
2. Mechanic D, Schlesinger M, McAlpine DD: Management of mental health and substance abuse services: state of the art and early results. *Milbank Q* 73:19-55, 1995.

Workshop 26 **Sunday, October 20**
1:30 p.m.-3:00 p.m.

DIALECTICAL BEHAVIORAL THERAPY FOR BORDERLINE PERSONALITY DISORDER: A STATE MENTAL HEALTH INITIATIVE

Ellen D. Nasper, Ph.D., *Dialectical Behavior Therapy State Project Leader, Greater Bridgeport Community Mental Health Center, 1635 Central Avenue, Bridgeport, CT 06610;* Kenneth M. Marcus, M.D., William Smalley, Ph.D., Gary Savill, Ph.D., Keith Hawkins, Psy.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to describe the following aspects of dialectical behavior therapy: basic principles of interventions for patients with borderline personality disorder, applications to community mental health populations, and interventions for nontraditional populations.

SUMMARY:

In January 1995 the Connecticut Department of Mental Health allocated funds for training in dialectical behavior therapy, a cognitive behavioral approach to treating borderline personality disorder, at sites across the state.

This workshop will review the training project and clinical interventions developed under it. Outpatient, inpatient, and community-based settings will be represented. In addition, applications of dialectical behavior therapy for hearing-impaired and lower-functioning populations will be described. Initial findings concerning project implementation will be presented, and the overall project will be reviewed. Participants will be invited to discuss applications of dialectical behavior therapy in their local systems and to consider limitations and possibilities of similar clinical intervention/training projects.

REFERENCES:

1. Linehan MM: *Cognitive-Behavioral Treatment of Borderline Personality Disorder.* Guilford Press, New York, 1993.
2. Linehan MM: *Skills Training Manual for Treating Borderline Personality Disorder.* Guilford Press, New York, 1993.

Workshop 27 **Sunday, October 20**
1:30 p.m.-3:00 p.m.

THE CHANGING FACE OF PSYCHIATRIC HOSPITALS

Randy L. Thompson, M.D., *Medical Director, Chicago-Read Mental Health Center, 4200 North Oak Park Avenue, Chicago, IL 60634;* Thomas A. Simpatico, M.D., James B. Brunner, M.D., Michael F. Caldwell, Psy.D., Kenneth I. Robbins, M.D., M.P.H., Gregory J. Van Rybroek, Ph.D., J.D., Nada L. Stotland, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to describe: a) ways to improve the continuity between hospitals and community mental health treaters, b) new approaches to treating potentially dangerous patients in a safe, therapeutic manner, c) the importance of countertransference reactions to difficult patients, and d) methods for monitoring the quality of clinical care delivered in the hospital.

SUMMARY:

Multiple forces have led to profound changes in psychiatric hospitals, and the change remains a dynamic process. These forces include: a) improved community treatment and the development of mobile treatment teams for the most treatment-refractory patients; b) economic changes, including increasing management of decreasing mental health dollars; c) increasing demands for continuity of care between inpatient and outpatient settings; d) development of creative alternatives to hospitalization; e) increasing societal violence, particularly by juveniles, and pressures to keep the most dangerous people isolated from the general population; and f) the development of a clients'-rights movement by those with mental illnesses and the legal profession. These difficult and at times contradictory forces demand thoughtful and sensitive responses from hospital clinicians and administrators, and this group of leading clinical administrators from Wisconsin and Illinois will discuss effective strategies for now and for the future.

REFERENCES:

1. Robbins KI, Van Rybroek GJ: The state psychiatric hospital in a mature system. *New Dir Ment Health Serv* 66:87-100, 1995.
2. Van Rybroek GJ, Caldwell MF, Robbins KI: Intractable inpatient aggression: new approaches to protracted emergencies. *Emerg Psychiatry* 1(2):27-30, 1995.

Workshop 28 **Sunday, October 20**
3:30 p.m.-5:00 p.m.

MENTAL ILLNESS AND MENTAL HEALTH POLICY
1995-1996 APA/Mead Johnson Fellows Workshop

Mary E. Theodore, M.D., *1995-1996 APA/Mead Johnson Fellow, and Psychiatry Resident, Payne Whitney Clinic, Cornell University, Suite 9D, 140 Charles Street, New York, NY 10014-6515*

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to describe how mental illness among politicians and their families influences their politics and mental health policies.

SUMMARY:

No one doubts that a U.S. president's politics influence the nation's mental health policies and the quality of care that is ultimately delivered to the mentally ill; yet the effects of mental illness on the president's politics have never been analyzed. The purpose of this workshop is to evaluate how a president's direct contact with mental illness in himself or close family members influenced the mental health policies of his administration.

Through a review of political and historical literature, the presenters will conduct a case-by-case analysis of every president faced with mental illness, and they will evaluate how this experience influenced the course of mental health delivery for our nation. Michael Beschloss, a renowned political historian and presidential biographer, has been invited to speak at this workshop.

REFERENCES:

1. Post JH: *When Illness Strikes the Leader.* Yale University Press, New Haven, CT, 1993.
2. Burns JM: *Leadership.* Harper and Row, New York, 1978.
3. Crispell K, Gomez C: *Hidden Illness in the White House.* Duke University Press, Durham, NC, 1988.
4. Dale PM: *Medical Biographies.* University of Oklahoma Press, Norman, OK, 1952.

WORKSHOPS

Workshop 29 **Sunday, October 20**
3:30 p.m.-5:00 p.m.

CASE MANAGEMENT IN PSYCHIATRY: AN ANALYSIS OF TASKS

Jaak Rakfeldt, Ph.D., *Associate Professor, Southern Connecticut State University, and Associate Clinical Professor, Department of Psychiatry, Yale University School of Medicine, 93 Farnham Avenue, New Haven, CT 06515;* Boris M. Astrachan, M.D., Kenneth S. Thompson, M.D., William H. Sledge, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to describe the relationship between case management and the task areas of psychiatric practice and should be able to integrate these concepts into clinical practice.

SUMMARY:

This workshop will analyze the concept of case management from the perspective of the task areas of psychiatry and will demonstrate the importance of case management in the organization of psychiatric services. Relevant literature will be reviewed, and a functional analysis of current practices will be provided. Case management is an ambiguous concept without a clear base in a professional discipline, and thus there is ongoing uncertainty about its mission, practice, and training, as well as authority and accountability issues. Case management activities in both the private and public sectors entail work in the task areas of psychiatric care: a) medical, b) rehabilitation, c) social control, d) growth and development, and e) social welfare. In all of these areas, case managers may have broad functions in boundary management and in system enhancement and development, as well as in providing clinical services. Case management has considerable potential as a means of organizing and delivering mental health services in a cost-effective manner as long as its purpose, practice, and organizational structures are consistent. Workshop participants will share their clinical experiences with case management in psychiatric practice.

REFERENCES:

1. Sledge WH, Astrachan B, Thompson K, et al: Case management in psychiatry: an analysis of tasks. *Am J Psychiatry* 152:1259-1265, 1995.
2. Astrachan B, Levinson DJ, Adler DA: The impact of national health insurance on the tasks and practice of psychiatry. *Arch Gen Psychiatry* 33:785-794, 1976.

Workshop 30 **Sunday, October 20**
3:30 p.m.-5:00 p.m.

PLANNING AND REORGANIZING STATEWIDE SERVICES

David E.K. Hunter, Ph.D., *Director of Planning, Department of Mental Health and Substance Abuse Services, c/o 525 Russell Road, Newington, CT 06111;* Roger L. Coleman, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to describe an organized approach to statewide and facility-level planning of mental health and substance abuse services; discuss integration of fiscal, clinical, and quality-improvement approaches with program planning and implementation; implement changes in program structure; establish effective lines of authority; and use indicators and data to influence clinical decisions.

SUMMARY:

Planning and reorganizing statewide public mental health and substance abuse services require well-thought-through approaches to a host of issues. Virtually every decision or recommendation is controversial. Under today's fiscal constraints, additions to one program or service result in reductions in others, and addition of one type of professional means reduction of another. It is thus necessary to apply a clearly articulated approach to service and facility planning. Leaders must scrutinize plans to determine cost-effectiveness, redesign organizations so as to delegate responsibilities and hold managers accountable, develop review mechanisms for promotion of quality, and, at the same time, include a multiplicity of constituents in the planning process.

As part of the statewide planning process, facilities in Connecticut underwent major reorganization, including closure, merger, and administrative change. At one state-operated hospital, administrative restructuring included establishment of programmatic rather than discipline-based lines of authority. This permitted implementation of an oversight process involving integrated use of indicators and data to influence clinical care. The reorganization at the facility level made it possible to influence treatment and risk management decisions when centralized analysis of quality improvement data indicated that change in treatment approaches might be needed.

This workshop will promote discussion of the numerous issues involved in statewide and facility-level reorganization aimed at promoting quality services.

REFERENCES:

1. Coleman R, Hunter D: Contemporary quality management in mental health. *Am J Med Qual* 10:120-126, 1995.
2. Elliott R: Applying quality improvement principles and techniques in public mental health systems. *Hosp Community Psychiatry* 45:439-444, 1994.

WORKSHOPS

Workshop 31 **Monday, October 21**
8:00 a.m.-9:30 a.m.

INTERNATIONAL MEDICAL GRADUATES AND THE ISSUES OF PSYCHIATRIC MANPOWER

Richard Balon, M.D., *Department of Psychiatry, Wayne State University, Suite 2000, University Square, Detroit, MI 48207;* Rodrigo A. Muñoz, M.D., Jambur V. Ananth, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to relate the role of international medical graduates to the current and future needs of psychiatric manpower in the United States.

SUMMARY:

This workshop will focus on the role of international medical graduates (IMGs) in future mental health care and issues of psychiatric manpower. Recent reports on a physician oversupply in the United States have attributed the problem to increasing numbers of IMGs. Decreased interest in psychiatry among U.S. medical school graduates and increased residency slots filled by IMGs triggered a call for downsizing in psychiatry. One suggestion includes limiting residency slots available to IMGs. However, since 1960 statistics reveal that IMGs are overrepresented among those treating seriously ill and minority patients. Demographic projections show that minorities will be the fastest-growing population in the United States, which may increase the need for IMG psychiatrists. The ongoing debate about the future of psychiatric manpower needs to take into account the role of IMGs in the treatment of severely and chronically ill and minority patients. IMGs need to be included in the calculations and projections of psychiatric manpower.

REFERENCES:

1. Cooper RA: Perspectives on the physician workforce in the year 2020. *JAMA* 274:1534-1543, 1995.
2. Balon R, Munoz RA: International medical graduates in psychiatric manpower calculations (letter). *Am J Psychiatry* 153:296, 1996.

Workshop 32 **Monday, October 21**
10:00 a.m.-11:30 a.m.

CONSUMER PROVIDERS AS A COMPLEMENT TO THE DELIVERY SYSTEM

Andrea M. Cooke, M.A., *Coordinator, Mental Health Consumer Education Consortium, 10th Floor, 160 North LaSalle Street, Chicago, IL 60601;* Larry Fricks, Garrett Smith, Linda Powell, Jo Hill

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to identify functions for consumers in mental health service delivery and describe the value of these activities.

SUMMARY:

Most mental health professionals agree that medication and office-based therapy are not enough to bring a person to recovery. Where does the rest of the help come from? A panel of consumer advocates will describe the many aids that consumers have to offer other consumers and the mental health delivery system itself. The panelists will talk about consumer services available in their respective states and the effects of these services on the service delivery systems. In Georgia, for example, consumer specialists are available in state hospitals. Some of the advantages of such programs are: a) peer companions employed to spend time with clients sometimes notice relapse earlier than do professionals, whose time with clients is limited; b) consumer organizations provide feedback to improve the service delivery system; c) consumers involved in designing their own treatment are more compliant; d) some organizations do not support the use of medication--legitimate groups prevent migration from the psychiatric system of consumers needing medication; and e) consumer groups provide outreach to those in the minority community who do not seek psychiatric help.

The audience will participate by means of questions at the end of the panel presentations.

REFERENCES:

1. Chamberlain J: *On Our Own: Patient Controlled Alternatives to the Mental Health System.* Dutton, New York, 1978.
2. Podvoll EM: *The Seduction of Madness: Revolutionary Insights into the World of Psychosis and a Compassionate Approach to Recovery at Home.* Harper-Collins, New York, 1990.

Workshop 33 **Monday, October 21**
10:00 a.m.-11:30 a.m.

VIOLENT BEHAVIOR IN PSYCHIATRIC INPATIENTS: IMPACT ON STAFF AND LEGAL CONSIDERATIONS

1995-1996 APA/Mead Johnson Fellows Workshop

Dwight D. Coleman, M.D., *1995-1996 APA/Mead Johnson Fellow, and Liaison, APA Institute Scientific Program Committee, and Resident in Psychiatry, Emory University, 3444-B North Druid Hills Road, Decatur, GA 30033;* Teresita T. Pontejos-Murphy, M.D., Albert M. Coleman, M.D., Robert T.M. Phillips, M.D., Ph.D.

WORKSHOPS

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to identify internal and external factors that contribute to violent behavior in psychiatric inpatients, describe the assessment and management of violent patients, and discuss legal limitations on the management of violent patients and incidents in psychiatric facilities.

SUMMARY:

Violent behavior by patients is an occupational hazard, especially for mental health professionals and caregivers. Management of violent patients occasionally involves conflicts between the rights of the patient and the rights of staff, and some of these issues have legal implications.

This workshop will examine violence in psychiatric inpatient settings and how these incidents affect overall staff-patient relations and staff attitudes. Legal issues that can come out of such incidents will be discussed.

The presenters will review data on violent incidents in one institution over one year. An expert discussant will discuss management of violent patients.

During the workshop the audience will have the opportunity to comment on issues raised in the presentations, contribute personal experiences or additional information, and seek the discussants' opinions on clinical or legal concems regarding patient violence in psychiatric settings.

REFERENCES:

1. Carmel H, Hunter M: Staff injuries from inpatient violence. *Hosp Community Psychiatry* 40:41-45, 1989.
2. Blomhoff S, Seim S, Frii S: Can prediction of violence among psychiatric inpatients be improved? *Hosp Community Psychiatry* 41:771-775, 1990.

Workshop 34 **Monday, October 21**
10:00 a.m.-11:30 a.m.

NOMADIC VETERANS AND THE UTILIZATION OF SERVICES

Jeffrey G. Stovall, M.D., Community Healthlink, Outpatient Department, *University of Massachusetts Medical Center, P.O. Box 229, Greendale Station, Worcester, MA 01606-0229;* Patrick L. Sanders, M.S., Lawrence Appleby, Ph.D., J.D., Prakash N. Desai, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to identify characteristics of patients who wander between Veterans Affairs medical centers and to describe the impact of their use of expensive hospital services.

SUMMARY:

High-cost utilization of medical services by specific groups of patients is a current focus of health care systems. Within the U.S. Department of Veterans Affairs (VA), there is a group of veterans who use excessive levels of services by traveling among different VA medical centers for treatment.

The presenters examined 20 of the 121 veterans who visited the four Chicago VA medical centers in a year and compared this group's patterns of service use to Chicago averages for the year. The study subjects had more admissions (3.35 versus 1.58), longer stays (15.8 days versus 14.6 days), more total hospital days for the year (84.5 versus 23.2), and fewer outpatient visits (11.95 versus 14.00) than did the average patient seen in the Chicago network. A greater proportion (95% versus 18%) of these subjects were discharged from psychiatric wards. These subjects are currently being compared with a closely matched group of psychiatric patients.

Patients who wander among different VA medical centers are significantly different from those who remain at one facility for treatment. The subjects in the presenters' study used expensive hospital services and received their care in a disjointed manner. Discussion within the workshop will focus on possible treatment and programmatic interventions for this problem.

REFERENCES:

1. Pankratz L, Jackson J: Habitually wandering patients. *N Engl J Med* 331:1752-1755, 1994.
2. Hansen TE, Elliott KD: Frequent psychiatric visitors to a Veterans Affairs medical center and emergency care unit. *Hosp Community Psychiatry* 44:372-375, 1993.

Workshop 35 **Monday, October 21**
1:30 p.m.-3:00 p.m.

HIV INFECTION IN THE SCHIZOPHRENIC PATIENT

1995-1996 APA/Mead Johnson Fellows Workshop

Molly T. Finnerty, M.D., *1995-1996 APA/Mead Johnson Fellow, and Resident, College of Physicians and Surgeons, Columbia University, Suite 68, 201 West 108th Street, New York, NY 10025;* Marianne T. Guschwan, M.D., Julie L. Leavitt, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to identify specific challenges in treating the HIV-infected schizophrenic patient and discuss the incidence of HIV infection and HIV risk behavior in specific psychiatric populations.

SUMMARY:

The reproductive health of schizophrenic patients is a largely neglected area of research despite its importance to patients and their families. In addition, recent evidence suggests that HIV infection will soon be the leading cause

of death among schizophrenic patients 40 years old and younger.

Dr. Leavitt will present a case that highlights the particular challenges of treating a young schizophrenic woman with HIV.

Dr. Guschwan will discuss the case of a mentally ill substance-abusing patient with HIV and will describe an intervention program that has been developed for an urban population of mentally ill substance-abusing patients in the Fort Washington community in New York City.

Dr. Finnerty will present preliminary data on HIV risk behavior, knowledge and use of birth control and condoms, and use of family planning services in a suburban cohort of 600 first-admission psychosis patients followed over four years.

REFERENCES:

1. Susser E, Miller M, Valencia E, et al: Injection drug use and risk of HIV transmission among homeless men with mental illness. *Am J Psychiatry* 153:794-798, 1996.
2. Carey MP, Weinhardt LS, Carey KB: Prevalence of infection with HIV among the seriously mentally ill. *Prof Psychol Res Practice* 26:262-268, 1995.

Workshop 36 **Monday, October 21**
1:30 p.m.-3:00 p.m.

ESTABLISHING RESIDENCY-SPONSORED SERVICES FOR THE HOMELESS

Donna M. Woods, M.D., *Department of Psychiatry, University of Michigan, 1700 Northbrook Drive, Ann Arbor, MI 48103;* Timothy D. Florence, M.D., Stephen M. Goldfinger, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to: a) discuss some of the complex issues involved in establishing a meaningful treatment alliance between a university-based training institution and homeless individuals with serious, chronic mental illness, and b) describe psychiatry's role in treating the disenfranchised in the age of managed care.

SUMMARY:

It is estimated that between 25% and 50% of the homeless, or 500,000 to 1,000,000 homeless individuals in the United States, have serious, chronic mental illnesses. This significant subpopulation of the mentally ill has traditionally been underserved. Current accreditation standards do not require that psychiatry residents gain exposure to this population, and few residents have an opportunity to work with the homeless.

The presenters have attempted to create an alliance between the University of Michigan and the local homeless community. These efforts have been met with many unforeseen complexities, including expectations of the shelter staff, acquisition of supervision, and the arrangement of malpractice coverage. In response to such challenges, the presenters administered a questionnaire to residency programs nationwide to determine how others have dealt with these and other related issues.

In this workshop the presenters will review their survey results. Audience participation will be promoted. It is hoped that this workshop will provide direction to residency programs in serving this population and will foster dialogue on psychiatry's role in treating the disenfranchised in the age of managed care.

REFERENCES:

1. Lamb HR, Bachrach LL, Kass FI: *Treating the Homeless Mentally Ill.* American Psychiatric Press, Washington, DC, 1992.
2. Susser E, Goldfinger SM, White A: Some clinical approaches to the homeless mentally ill. *Community Ment Health J* 26:463-480, 1990.

Workshop 37 **Monday, October 21**
1:30 p.m.-3:00 p.m.

OUTPATIENT COMMITMENT TO ASSERTIVE COMMUNITY TREATMENT TEAMS

Howard W. Telson, M.D., *Director, Outpatient Commitment in Psychiatry, Bellevue Hospital, Suite 321, 215 East Twenty-Fourth Street, New York, NY 10010-3804;* David C. Lindy, M.D., Neil Pessin, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to discuss the basic principles of outpatient commitment and assertive community treatment, describe the use of outpatient commitment and assertive community treatment in New York City, and identify ways in which these two interventions may complement and conflict with each other.

SUMMARY:

Both outpatient commitment and assertive community treatment have been used since the early 1970s to help seriously and persistently mentally ill individuals stay out of hospitals and receive necessary services in the community. It is sometimes assumed that these two interventions are based on mutually exclusive principles. However, assertive community treatment teams have historically served a significant number of individuals who have been civilly committed to their care.

This workshop will encourage discussion by exploring the variety of issues that are raised when these two modalities are combined. How can patient autonomy be respected when treatment is imposed by the state? Does

a court-ordered treatment plan limit flexibility in the clinical practice of an assertive community treatment team? Can a psychosocial rehabilitation philosophy be reconciled with a team's power to involuntarily medicate and hospitalize patients?

These questions were confronted when outpatient commitment and assertive community treatment were simultaneously introduced in New York City in July 1995. Clinical vignettes will highlight successes and problems resulting from outpatient commitment to assertive community treatment. Participants will be encouraged to share their experiences with these models of care.

REFERENCES:

1. Torrey EF, Kaplan RV: A national survey of the use of outpatient commitment. *Psychiatr Serv* 46:778-784, 1995.
2. Thompson DS, Griffith EEH, Leaf PJ: A historical review of the Madison model of community care. *Hosp Community Psychiatry* 41:625-634, 1990.

Workshop 38 **Monday, October 21**
3:30 p.m.-5:00 p.m.

CROSS-CULTURAL CURRICULA: TWO MODELS FOR TRAINING

Russell F. Lim, M.D., *Clinical Instructor, Department of Psychiatry, University of California at Los Angeles, Santa Monica West, 1525 Euclid Street, Santa Monica, CA 90404;* Jo Ellen Brainin-Rodriguez, M.D., J. Arturo Silva, M.D., Albana M. Dassori, M.D., M.P.H.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to: a) describe the components of introductory curricula for cross-cultural psychiatry, which include cultural diversity training, basic information on commonly encountered ethnic groups, and training in using the *DSM-IV* Outline for Cultural Formulation; and b) apply the cultural formulation and use it to plan treatment for patients from minority ethnic groups.

SUMMARY:

The increasing cultural diversity of the United States requires that clinicians understand cultural differences and how they affect diagnosis and treatment. In addition, the requirements of the Accreditation Council for Graduate Medical Education for residents in psychiatry now include familiarity with cultural assessment. Finally, the publication of *DSM-IV* has added new emphasis to the influence of culture on diagnosis by including an outline for cultural formulation and a glossary of culture-bound syndromes.

Two curricula, one from the University of California, San Francisco, and the other from the University of Texas Health Science Center at San Antonio, can provide trainees with a framework for assessing patients from minority ethnic groups. At the University of California, San Francisco, medical students participate in six 1-hour sessions, which include sensitivity training, use of the *DSM-IV* Outline for Cultural Formulation, and case presentations as a basis for discussions of aspects of Asian, African American, and Hispanic culture that affect diagnosis and treatment. At the University of Texas Health Science Center at San Antonio, residents attend nine 1-hour sessions that cover cultural self-awareness, traditional healing systems, interviewing techniques, and culture and *DSM-IV*. Aspects of various ethnic groups are presented in vignettes and videotapes.

The audience will participate in a cultural-awareness exercise and will be instructed in the proper use of an interpreter and a cultural consultant.

REFERENCES:

1. Budman CL, Lipson JG, Meleis AI: The cultural consultant in mental health care: the case of an Arab adolescent. *Am J Orthopsychiatry* 62:359-370, 1992.
2. Comas-Diaz L, Jacobson FM: Ethnocultural transference and countertransference in the therapeutic dyad. *Am J Orthopsychiatry* 61:392-402, 1991.
3. Lee E: Assessment and treatment of Chinese-American immigrant families. In Saba GW, Karrer BM, Hardy KV (eds): *Minorities and Family Therapy.* Haworth Press, New York, 1990, pp 99-122.
4. Lin KM, Poland RE, Nakasaki G (eds): *Psychopharmacology and Psychobiology of Ethnicity.* American Psychiatric Press, Washington, DC, 1993.
5. Lu FG, Lim RF, Mezzich JE: Issues in the assessment and diagnosis of culturally diverse individuals. In Oldham J, Riba M (eds): *American Psychiatric Press Annual Review of Psychiatry,* vol 14. American Psychiatric Press, Washington, DC, 1995, pp 477-510.
6. Pinderhughes E: *Understanding Race, Ethnicity, and Power.* Free Press, New York, 1989
7. Westermeyer JJ: Working with an interpreter. *J Nerv Ment Dis* 178:745-749, 1990.

Workshop 39 **Monday, October 21**
3:30 p.m.-5:00 p.m.

RESIDENCY TRAINING FOR THE REAL WORLD

Robert M. Factor, M.D., *Professor of Psychiatry, University of Wisconsin Medical Center, Suite B6/210, 600 Highland Avenue, Madison, WI 53792-2475;* Ann K. Morrison, M.D., C. Michelle Morgan, M.D., Michael J. Moran, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to describe the values, attitudes, and clinical and survival skills necessary for psychiatric residents who work with persons with severe and persistent mental illness and the survival skills needed for psychiatrists who work with these patients in other than model settings.

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SUMMARY:

The University of Wisconsin-Madison psychiatry residency program has successfully educated psychiatrists who work in the public sector for over 15 years. The presenters are graduates of this program and have practiced in the public sector for several years. They represent a range of community practice settings, including assertive community treatment in rural Upper Michigan, a mental health center in rural Kentucky, and academic psychiatry in Madison and Dayton.

The presenters will briefly describe the residency program's educational objectives and training methods and will present data showing the effects of such training on the careers of the graduates. They will discuss other factors that may affect residents' career choices. Finally, they will discuss the differences between training in a model program and practice elsewhere, including how they adapted to and affected the practices in their respective settings.

Early in the workshop, participants will be asked to write at least one positive and one negative element of their own training experiences and of their current practice settings. These will be used to facilitate discussion among the participants on the factors that encouraged and impeded their own practices in community psychiatry.

REFERENCES:

1. Factor RM, Stein LI, Diamond RJ: A model community psychiatry curriculum for psychiatric residents. *Community Ment Health J* 24:310-327, 1988.
2. Diamond RJ, Stein LI, Susser E: Essential and non-essential roles for psychiatrists in community mental health centers. *Hosp Community Psychiatry* 42:187-189, 1991.

Workshop 40 **Monday, October 21**
3:30 p.m.-5:00 p.m.

INTEGRATING CONSUMER PROVIDERS INTO CLINICAL SITES

Larry Davidson, Ph.D., *Assistant Professor, Department of Psychiatry, Yale University School of Medicine, 34 Park Street, New Haven, CT 06519;* David Stayner, Ph.D., Richard Weingarten, M.A.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to identify common issues encountered in integrating consumer providers into conventional clinical settings and develop strategies for addressing these issues and for redesigning models of clinical care to incorporate the values of recovery, self-help, and empowerment.

SUMMARY:

This workshop will begin by outlining the range of issues that may be encountered in efforts to integrate consumer providers into clinical settings. These issues include defining roles for consumer providers, introducing and valuing a recovery paradigm, addressing concerns about self-disclosure and boundary violations, providing supports and accommodations on the job, and weighing the pros and cons of acculturation versus co-opting in consumer providers' reactions to the existing clinical culture.

After discussion of these challenges to consumer providers and to the programs that employ them, the audience will be invited to relate their own experiences with these issues and to brainstorm potential solutions in each area. Particular emphasis will be given to the process of acculturation, providing supervision and support for consumer providers, and the implications of incorporating the consumer-oriented values of recovery, self-help, and empowerment into clinical programs, thereby revising conventional models of clinical care. Materials developed for introducing a collaborative treatment planning process will be distributed, and the audience will be invited to discuss how this process challenges conventional understanding of the clinician's role and fosters a more active, directive, and responsible role for the client.

REFERENCES:

1. Davidson L, Weingarten R, Steiner J, et al: Integrating prosumers into clinical settings. In Mowbray CT (ed): *Consumers as Providers in Psychiatric Rehabilitation: Models, Applications, and First-Person Accounts.* International Association of Psychosocial Rehabilitation Services, Columbia, MD, in press.
2. Dixon L, Krauss N, Lehman A: Consumers as service providers: the promise and challenge. *Community Ment Health J* 30:615-625, 1994.

Workshop 41 **Tuesday, October 22**
10:00 a.m.-11:30 a.m.

INPATIENT TREATMENT FOR THE DUALLY DIAGNOSED

Norman S. Miller, M.D., *Associate Professor of Psychiatry and Neurology, Department of Psychiatry, University of Illinois at Chicago, 1601 West Taylor Street, Chicago, IL 60612;* Vida B. Dyson, Ph.D., Bradley M. Pechter, M.D., Cherise Chase, R.N., M.A., Ellen B. Rayfield, RMT-BC, Constance Kusiciel, B.M., Suzanne Schmidtke, M.S.W., Phyllis Lewis Robinson, M.S.W.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants should be able to describe an integrated model for treating patients with comorbid addiction and major psychiatric

illness (dual diagnosis) and discuss development of such a program on an inpatient unit, multidisciplinary roles, and innovative group strategies.

SUMMARY:

Treatment of the dually diagnosed has become an important concern to clinicians working in the public sector. Approximately 50% to 80% of severely mentally ill individuals have been identified as suffering from comorbid addictive disorders. There are few models for effectively treating this population, and the presenters' objective was to develop a new program to address this population.

The presenters' facility is an inpatient adult research unit in an urban setting that is part of a state public sector system. They developed a dual diagnosis program based on an integrated model of treatment that emphasizes simultaneous processes of recovery for both severe mental illness and concurrent addictive illness. They strongly emphasize a multidisciplinary team approach based on the biopsychosocial model. Each discipline has a role in the recovery of the patient. A psychiatrist is the head of the team, which focuses on all aspects of patient care, i.e., detoxification, diagnosis, medication, psychosocial intervention, and aftercare planning. Psychosocial interventions in this program include psychoeducational groups, relapse prevention, music therapy, and art therapy. Experimentation and revision of the program are ongoing. Continued attention to this difficult population is indicated.

Audience participation will be encouraged through group exercises, role playing, and discussion.

REFERENCES:

1. Miller NS (ed): *Treating Coexisting Psychiatric and Addictive Disorders.* Hazelden Educational Materials, Center City, MN, 1994.
2. Minkoff K: An integrated treatment model for dual diagnosis of psychosis and addiction. *Hosp Community Psychiatry* 40:1031-1036, 1989.

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